

# Arizona

## UNIFORM APPLICATION

FY 2022/2023 Combined MHBG Application Behavioral Health  
Assessment and Plan

## SUBSTANCE ABUSE PREVENTION AND TREATMENT and COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 03/02/2022 - Expires 03/31/2025  
(generated on 11/21/2022 6.38.13 PM)

Center for Substance Abuse Prevention  
Division of State Programs

Center for Substance Abuse Treatment  
Division of State and Community Assistance

and

Center for Mental Health Services  
Division of State and Community Systems Development

## State Information

### State Information

#### Plan Year

Start Year 2022

End Year 2023

#### State SAPT DUNS Number

Number 805346798

Expiration Date

#### I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Arizona Health Care Cost Containment System (AHCCCS)

Organizational Unit

Mailing Address 801 E Jefferson MD 1900

City Phoenix

Zip Code 85034

#### II. Contact Person for the SAPT Grantee of the Block Grant

First Name Kristen

Last Name Challacombe

Agency Name Arizona Health Care Cost Containment System

Mailing Address 801 East Jefferson

City Phoenix

Zip Code 85034

Telephone 602-417-4000

Fax

Email Address kristen.challacombe@azahcccs.gov

#### State CMHS DUNS Number

Number 805346798

Expiration Date

#### I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Arizona Health Care Cost Containment System

Organizational Unit Division of Grants Administration

Mailing Address 801 East Jefferson

City Phoenix

Zip Code 85034

#### II. Contact Person for the CMHS Grantee of the Block Grant

First Name Kristen

Last Name Challacombe

Agency Name Arizona Health Care Cost Containment System (AHCCCS)

Mailing Address 801 E Jefferson MD4100

City Phoenix

Zip Code 85034

Telephone 602-417-4000

Fax

Email Address kristen.challacombe@azahcccs.gov

### III. Third Party Administrator of Mental Health Services

Do you have a third party administrator?  Yes  No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

### IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

### V. Date Submitted

Submission Date 9/1/2021 11:37:40 AM

Revision Date 7/11/2022 12:26:10 PM

### VI. Contact Person Responsible for Application Submission

First Name Michelle

Last Name Skurka

Telephone 602-364-2111

Fax

Email Address Michelle.Skurka@azahcccs.gov

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

**Footnotes:**

# State Information

## Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2022

U.S. Department of Health and Human Services  
 Substance Abuse and Mental Health Services Administrations  
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 as required by  
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 and  
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

<b>Title XIX, Part B, Subpart II of the Public Health Service Act</b>		
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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

## LIST of CERTIFICATIONS

### 1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
  - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
  - b. Collecting a certification statement similar to paragraph (a)
  - c. Inserting a clause or condition in the covered transaction with the lower tier contract

### 2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
  1. The dangers of drug abuse in the workplace;
  2. The grantee's policy of maintaining a drug-free workplace;
  3. Any available drug counseling, rehabilitation, and employee assistance programs; and
  4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  1. Abide by the terms of the statement; and
  2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
  1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

### 3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"



generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

#### **4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)**

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

#### **5. Certification Regarding Environmental Tobacco Smoke**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

### **HHS Assurances of Compliance (HHS 690)**

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: \_\_\_\_\_

Name of Chief Executive Officer (CEO) or Designee: \_\_\_\_\_

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_

Title: \_\_\_\_\_

Date Signed: \_\_\_\_\_

mm/dd/yyyy

\_\_\_\_\_ <sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

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3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
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to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

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14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

## LIST of CERTIFICATIONS

### 1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
  - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
  - b. Collecting a certification statement similar to paragraph (a)
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### 2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
  1. The dangers of drug abuse in the workplace;
  2. The grantee's policy of maintaining a drug-free workplace;
  3. Any available drug counseling, rehabilitation, and employee assistance programs; and
  4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  1. Abide by the terms of the statement; and
  2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
  1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

### 3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"



generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

#### **4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)**

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

#### **5. Certification Regarding Environmental Tobacco Smoke**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

### **HHS Assurances of Compliance (HHS 690)**

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: **Arizona**

**Kristen Challacombe**

Name of Chief Executive Officer (CEO) or Designee:

Signature of CEO or Designee<sup>1</sup>: *K. Chen Challacombe*

Title: **Deputy Director**

Date Signed: **8/24/2021**

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**



STATE OF ARIZONA  
OFFICE OF THE GOVERNOR

DOUGLAS A. DUCEY  
GOVERNOR

EXECUTIVE OFFICE

January 2, 2020

Grants Management Specialist  
Division of Grants Management  
Substance Abuse and Mental Health Services Administration  
5600 Fisher Lane  
Rockville, MD 20857

Dear Grants Management Specialist:

Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid agency that offers health care programs to serve Arizona residents. The Single State Authority (SSA) role is to provide oversight of the Substance Abuse Prevention and Treatment Block Grant (SABG) and other funding for Substance Use Disorder (SUD) treatment and intervention programs in Arizona. These funds are utilized for SUD treatment and intervention services for Medicaid and Non-Medicaid enrolled members.

Please update your records to reflect that Ms. Kristen Challacombe, the Deputy Director of Business Operations is now serving as the SSA representative. This signature authority includes the signing of any standard federal forms such as Assurances, Certification and Disclosure of Lobbying Activities.

If you have any questions, please contact Michelle Skurka, Grants Administrator, at [Michelle.Skurka@azahcccs.gov](mailto:Michelle.Skurka@azahcccs.gov) or (602) 364-2111.

Sincerely,

Douglas A. Ducey  
Governor  
State of Arizona

# State Information

## Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2022

U.S. Department of Health and Human Services  
 Substance Abuse and Mental Health Services Administrations  
 Funding Agreements  
 as required by  
 Community Mental Health Services Block Grant Program  
 as authorized by  
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
 and  
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	<a href="#">42 USC § 300x</a>
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	<a href="#">42 USC § 300x-1</a>
Section 1913	Certain Agreements	<a href="#">42 USC § 300x-2</a>
Section 1914	State Mental Health Planning Council	<a href="#">42 USC § 300x-3</a>
Section 1915	Additional Provisions	<a href="#">42 USC § 300x-4</a>
Section 1916	Restrictions on Use of Payments	<a href="#">42 USC § 300x-5</a>
Section 1917	Application for Grant	<a href="#">42 USC § 300x-6</a>
Section 1920	Early Serious Mental Illness	<a href="#">42 USC § 300x-9</a>
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	<a href="#">42 USC § 300x-51</a>
Section 1942	Requirement of Reports and Audits by States	<a href="#">42 USC § 300x-52</a>
Section 1943	Additional Requirements	<a href="#">42 USC § 300x-53</a>
Section 1946	Prohibition Regarding Receipt of Funds	<a href="#">42 USC § 300x-56</a>
Section 1947	Nondiscrimination	<a href="#">42 USC § 300x-57</a>
Section 1953	Continuation of Certain Programs	<a href="#">42 USC § 300x-63</a>
Section 1955	Services Provided by Nongovernmental Organizations	<a href="#">42 USC § 300x-65</a>



## ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.



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- b. Establishing an ongoing drug-free awareness program to inform employees about--
  1. The dangers of drug abuse in the workplace;
  2. The grantee's policy of maintaining a drug-free workplace;
  3. Any available drug counseling, rehabilitation, and employee assistance programs; and
  4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  1. Abide by the terms of the statement; and
  2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
  1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

### 3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

#### **4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)**

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

#### **5. Certification Regarding Environmental Tobacco Smoke**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

### **HHS Assurances of Compliance (HHS 690)**

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: \_\_\_\_\_

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_

Title: \_\_\_\_\_

Date Signed: \_\_\_\_\_

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

**Footnotes:**

## State Information

### Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

#### Fiscal Year 2022

U.S. Department of Health and Human Services  
 Substance Abuse and Mental Health Services Administrations  
 Funding Agreements  
 as required by  
 Community Mental Health Services Block Grant Program  
 as authorized by  
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
 and  
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

<b>Title XIX, Part B, Subpart II of the Public Health Service Act</b>		
<b>Section</b>	<b>Title</b>	<b>Chapter</b>
Section 1911	Formula Grants to States	<a href="#">42 USC § 300x</a>
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	<a href="#">42 USC § 300x-1</a>
Section 1913	Certain Agreements	<a href="#">42 USC § 300x-2</a>
Section 1914	State Mental Health Planning Council	<a href="#">42 USC § 300x-3</a>
Section 1915	Additional Provisions	<a href="#">42 USC § 300x-4</a>
Section 1916	Restrictions on Use of Payments	<a href="#">42 USC § 300x-5</a>
Section 1917	Application for Grant	<a href="#">42 USC § 300x-6</a>
<b>Title XIX, Part B, Subpart III of the Public Health Service Act</b>		
Section 1941	Opportunity for Public Comment on State Plans	<a href="#">42 USC § 300x-51</a>
Section 1942	Requirement of Reports and Audits by States	<a href="#">42 USC § 300x-52</a>
Section 1943	Additional Requirements	<a href="#">42 USC § 300x-53</a>
Section 1946	Prohibition Regarding Receipt of Funds	<a href="#">42 USC § 300x-56</a>
Section 1947	Nondiscrimination	<a href="#">42 USC § 300x-57</a>
Section 1953	Continuation of Certain Programs	<a href="#">42 USC § 300x-63</a>
Section 1955	Services Provided by Nongovernmental Organizations	<a href="#">42 USC § 300x-65</a>
Section 1956	Services for Individuals with Co-Occurring Disorders	<a href="#">42 USC § 300x-66</a>

## ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

## LIST of CERTIFICATIONS

### 1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
  - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
  - b. Collecting a certification statement similar to paragraph (a)
  - c. Inserting a clause or condition in the covered transaction with the lower tier contract

### 2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
  1. The dangers of drug abuse in the workplace;
  2. The grantee's policy of maintaining a drug-free workplace;
  3. Any available drug counseling, rehabilitation, and employee assistance programs; and
  4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  1. Abide by the terms of the statement; and
  2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
  1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

### 3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"



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The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

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1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: **Kristen Challacombe**

Signature of CEO or Designee<sup>1</sup>: *K. Chr Challacombe*

Title: **Deputy Director**

Date Signed: **8/24/2021**

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**



STATE OF ARIZONA  
OFFICE OF THE GOVERNOR

DOUGLAS A. DUCEY  
GOVERNOR

EXECUTIVE OFFICE

August 12, 2020

Grants Management Specialist  
Division of Grants Management  
Substance Abuse and Mental Health Services Administration  
5600 Fisher Lane  
Rockville, MD 20857

Dear Grants Management Specialist:

Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid agency that offers health care programs to serve Arizona residents. As the Governor of the State of Arizona, for the duration of my tenure, I delegate authority to the current Deputy Director of Business Operations, Ms. Kristen Challacombe, for all transactions require administering the Substance Abuse and Mental Health Services Administration's (SAMHSA), Mental Health Block Grant (MHBG) and Projects to Assistance in Transition to Homelessness (PATH) grant.

If you have any questions, please contact Michelle Skurka, Grants Administrator, at [Michelle.Skurka@azahcccs.gov](mailto:Michelle.Skurka@azahcccs.gov) or (602) 364-2111.

Sincerely,

A handwritten signature in cursive script that reads "Douglas A. Ducey".

Douglas A. Ducey  
Governor  
State of Arizona



**Spending Plan Proposal  
for the Implementation of the  
American Rescue Plan Act of 2021,  
Mental Health Block Grant (MHBG)**

**July 30, 2021**

**Spending Plan for Implementation of American  
Rescue Plan Act of 2021, Section 9817**

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**Spending Plan for Implementation of American  
Rescue Plan Act of 2021, Section 9817**

July 30, 2021

Dr. Miriam Delphin-Rittmon  
Assistant Secretary for Mental Health and Substance Use  
Department of Health and Human Services  
Substance Abuse Mental Health Services Administration (SAMHSA)

Dear Dr. Delphin-Rittmon:

Thank you for the opportunity to provide, for SAMHSA review, the attached narrative and spending plan proposal for implementation of Public Law 117-2, the American Rescue Plan Act of 2021 (ARPA) for the Mental Health Block Grant (MHBG), to address the effects of the COVID -19 pandemic for Arizonans with mental illness.

The Arizona Health Care Cost Containment System (AHCCCS), which serves as the Mental Health Commission for Arizona, has worked with mental health stakeholders to identify needs and gaps within the mental health and crisis services continuum and are pleased to provide these proposed strategies to actively address.

Thank you again for this opportunity to provide the attached narrative and spending plan proposal. I welcome any further questions or requests for additional information.

Sincerely,



Kristen Challacombe

Arizona Mental Health Commissioner

July 30, 2021  
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# Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817

## EXECUTIVE SUMMARY

On March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 (ARPA) (Pub.L. 117-2) into law. The Substance Abuse and Mental Health Services Administration (SAMHSA) was directed to provide additional funds to support states through the Mental Health Block Grant (MHBG) in order to address the effects of the COVID-19 pandemic for children designated with Serious Emotional Disturbance (SED), adults designated with Serious Mental Illness (SMI), and assistance for ongoing initiatives for individuals who experience a First Episode Psychosis (FEP). Key programs and projects highlighted in this ARPA MHBG proposal include:

### Children Designated with SED

1. Implementation of a statewide standardized process for early identification and referral for SED assessment;
2. Implementation of co-located models of care and strengthening of evidence-based practice delivery for justice involved youth;
3. Implementation of a Child Psychiatry Access Program (CPAP) in order to expand access to child and adolescent psychiatrists for Primary Care Providers (PCPs); and
4. Expansion of the availability of parent and family support services, Child and Family Team (CFT) coaches, and professional development opportunities to support the behavioral health workforce.

### Adults Designated with SMI

1. Expansion of technical assistance efforts and monitoring fidelity of Assertive Community Treatment (ACT), Supportive Housing, Supported Employment, and Peer Support;
2. Expansion of the availability of peer support services;
3. Expansion of the capacity of behavioral health providers to serve individuals with Intellectual and Developmental Disabilities (I-DD) through the National Association of Dually Diagnosed (NADD) accreditation and Project Extension for Community Health care Outcomes(ECHO); and
4. Implementation of a digital identification wallet.

### Crisis System

1. Implementation of an electronic crisis services locator where providers can access real-time information on available crisis beds;
2. Creation of specialized wraparound teams for crisis stabilization for children with an SED designation;
3. Development of 23 hour crisis stabilization units for children with an SED designation in regions where they are currently not available; and

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## Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817

4. Expansion of short-term behavioral health residential settings to serve children with an SED designation who present in crisis.

### First Episode Psychosis

1. Support for additional FEP positions to provide outreach and treatment services;
2. Support the training and staff time to participate in evidence-based practices;
3. Funding of supplies and outreach materials.

These proposed programs and projects will allow for increased service capacity and improved access to mental health care for individuals designated with SED or SMI to aid in the unprecedented behavioral health needs experienced due to the impact of COVID-19.

## NEEDS AND GAPS OF ARIZONA'S MENTAL HEALTH SERVICES CONTINUUM INCLUDING PREVENTION, INTERVENTION, TREATMENT, AND RECOVERY SUPPORT SERVICES

AHCCCS assesses the mental health services continuum needs and gaps through multiple means, including qualitative feedback from ongoing stakeholder engagement efforts, needs assessments, tracking of mental health service utilization trends, and assessment of quality metrics. Based on the review of these data sources, the mental health services continuum needs in Arizona include:

- 1. The need to develop standardized processes to identify, refer, and assess children for an SED designation.**

In order to adequately address the mental health needs of children in Arizona, the appropriate identification and referral mechanisms for assessment of SED must exist for child-serving systems. The systems that most commonly interface with children are the education system as well as primary care providers. Informing and providing the education system and primary care providers with a user-friendly interface for referral for SED assessment will improve early identification and initiation of service delivery for children designated as SED. This strategy will also augment the current behavioral health in schools initiative in Arizona as well as the Targeted Investments efforts to improve access to mental health care in educational and primary care settings.

In addition, Arizona will benefit from standardization of the functional impairment criteria for an SED designation as well as an assessment process. Based on a recent Statewide analysis conducted, there is variation of how functional impairment is defined and applied for SED designation.

## Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817

### 2. **The need to expand access to evidence-based mental health care for justice-involved youth with an SED designation.**

Minority youth in Arizona's juvenile justice system are disproportionately represented when compared to the general youth population. For example, in 2020, of the youth committed to the Arizona Department of Juvenile Corrections (ADJC), 15 percent were African American, 13.5 percent bi-racial, and 44.9 percent Hispanic. The most recently available Arizona census data for 2019 demonstrates that 5.2 percent of Arizona youth are African American, 2.9 percent biracial, and 31.7 percent. Addressing the mental health needs of youth in the juvenile justice system is a critical component to reducing the risk of recidivism and thus addressing these disparities.

During conversations with peer and family support providers, needs identified included:

- Parent peer support services to assist parents with navigating the behavioral health system;
- Reach-in services to assist juveniles exiting detention to facilitate and connect to services immediately upon release; and
- Increased technological infrastructure to conduct virtual services during the COVID-19 pandemic.

AHCCCS conducted a targeted needs assessment for justice-involved youth with an SED designation. Overall findings of this needs assessment, which included data gathering from key informant interviews and focus groups with youth currently in detention facilities, demonstrates the need for improved coordination of care with the outpatient mental health provider prior to release through reach-in activities and improved access to mental health care for youth on probation or parole. Additionally, based on ongoing justice system collaboration efforts and lessons learned from the AHCCCS Targeted Investments (TI) co-located behavioral health model for adults, co-location of behavioral health providers within juvenile probation and parole offices will increase access to mental health services for children with an SED designation who are involved with the juvenile justice system.

Coupled with the efforts of reach-in programs for juvenile detention and co-location with juvenile probation or parole, there is an ongoing need to increase the behavioral health system capacity to implement evidence-based treatment for justice-involved youth with an SED designation. For example, currently Arizona only has one behavioral health provider certified in Multisystemic Therapy® (MST®). Expanding the behavioral health provider system capacity to implement MST and other evidence-based treatments for justice-involved youth will be an important strategy in order to reduce the risk of recidivism and improve prosocial behaviors including school attendance and living at home.

## Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817

### **3. The need to expand the primary care workforce capacity to serve children designated with SED through access to child and adolescent psychiatrists and other mental health specialists.**

Arizona, similar to other states, has a shortage of child and adolescent psychiatrists and other licensed mental health professionals to serve children designated with SED. Although AHCCCS has made progress with expanding access to mental health care through primary care providers based on integration efforts, including the Targeted Investment Program, additional capacity is necessary to serve the increasing number of children who present with mental health needs in light of the COVID-19 pandemic. One model that has demonstrated success in other states is the Child Psychiatry Access Program (CPAP), which provides primary care providers with direct access to child and adolescent psychiatrists and other pediatric mental health specialists.

### **4. The need to expand evidence-based practices for adults designated with SMI including Assertive Community Treatment (ACT), Supportive Housing, Supported Employment, and Peer Support.**

Historically, the development and fidelity monitoring of these services focused on Maricopa County, the most populous county in Arizona. Efforts to expand this work into Northern and Southern Arizona have shown promise despite multiple challenges, including behavioral health provider shortages and the rural nature of much of these regions. Existing service providers in these regions benefit from extensive technical assistance to develop the infrastructure and provide services that meet fidelity to criteria established by SAMHSA.

In light of the additional difficulties in accessing affordable housing brought forth during the COVID-19 pandemic, there is a critical need to expand upon the supportive housing services available, while also ensuring that housing, once located, can be maintained. Housing maintenance needs include intensive supportive services focused on individuals at risk of eviction to ensure that they are not displaced from their homes. While there have been multiple programs recently established to provide monetary support to acquire and maintain housing, individuals require additional support in learning how to furnish their home, pay for groceries and utilities, and to budget, in order to make their housing stable and sustainable.

During conversations with peer and family support providers, the following needs were also identified:

- Reach-in services to individuals exiting the justice system to facilitate and connect to support services immediately upon release;
- Transitional housing and services/supports continues to be a need;

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## Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817

- Workforce development and capacity building to enhance/increase current peer support capacity, as well as to train new peer para-professionals to meet the increased demand for services;
- Intensive transitional step down programming for individuals transitioning from inpatient settings; and
- Increased technological infrastructure to conduct virtual services during the COVID-19 pandemic.

Additionally, individuals with an SMI designation, including those who experience homelessness, may not have the proper identification documents that are required for social security applications, applying for benefits, and/or are required for access to housing, social, medical and financial services. Mobile digital identity solutions through the use of digital wallet technology will assist individuals with applying for these benefits and/or services.

### **5. The need to expand and enhance service delivery for individuals with intellectual and developmental disabilities (I-DD) and designated with SMI.**

Individuals with I-DD and mental illness are at risk of delayed identification and treatment of their co-occurring mental illness, which may result in higher levels of care utilization including extended hospitalization while awaiting appropriate treatment service availability. Factors contributing to the delayed identification and treatment include a limited mental health workforce with the expertise necessary to effectively identify and implement pharmacologic and non-pharmacologic treatment. The COVID-19 pandemic exacerbated these challenges, as social distancing and change in day treatment programming to limit the spread of COVID-19 has resulted in increased community isolation for these individuals.

## NEEDS AND GAPS OF ARIZONA'S MENTAL HEALTH SERVICES RELATED TO DEVELOPING A COMPREHENSIVE CRISIS CONTINUUM

Consistent with AHCCCS efforts to identify needs and gaps within the mental health services continuum, AHCCCS also assesses the crisis services continuum needs and gaps through multiple means, including the completion of a crosswalk between Arizona's current crisis system infrastructure against SAMHSA best practice, qualitative feedback from ongoing crisis stakeholder engagement efforts, and tracking of crisis service utilization trends. Based on the review of these data sources, the crisis services continuum needs in Arizona consist of the need to further develop a comprehensive 24/7 crisis continuum for children with an SED designation and their families.

## Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817

Arizona, similar to other states, is seeing an increase in emergency department boarding for children. This trend is due to multiple factors, including the additional stressors brought upon by the COVID-19 pandemic, coupled with the lack of the availability of 23 hour crisis stabilization units, short-term residential treatment options, and intensive specialized wraparound. Children that are particularly at risk of extended emergency department boarding include children with an SED designation under the age of 12, children with co-occurring I-DD, and children with multi-system involvement. Currently, only Southern Arizona (Pima County) has a designated 23 hour crisis stabilization unit for children, which further exacerbates emergency department boarding.

The availability of the full continuum of crisis services for children designated with an SED designation is compounded by the shortage of mental health providers in the public behavioral health system. Although this issue is not new in Arizona, it has been further exacerbated by the COVID-19 pandemic as behavioral health providers report loss of workforce due to family commitments (e.g., parents staying home to support their child with at-home learning), the availability of other job opportunities, and other factors. Specific models of care that support the behavioral health workforce, including professional development opportunities, access to technology to ease workflow, and coaching are critical to maintain the public behavioral health system workforce.

Lastly, although the coverage of telehealth for behavioral health service delivery is robust in Arizona, many of the services and supports through the crisis continuum cannot be appropriately provided via telehealth modalities. For example, mobile teams and the higher levels of care such as inpatient hospital and residential must be provided in-person. Additionally, while creative hybrid telehealth and in-person models for wraparound exist, children with an SED designation and their families in crisis often benefit from in-person support. Thus, further professional development opportunities for the behavioral health workforce, including parent and family support services to provide both in-person and virtual care is essential for crisis stabilization for youth and families.

### DEVELOPMENT OF CRISIS AND OTHER NEEDED PREVENTION, INTERVENTION, TREATMENT AND RECOVERY SUPPORT SERVICES RESPONSIVE TO THE NEEDS OF ARIZONANS WITH AN SMI OR SED DESIGNATION

AHCCCS proposes to implement the following initiatives to address the needs and gaps for the mental health and crisis services continuum in Arizona:

#### Adults Designated with SMI

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## Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817

1. Expand technical assistance efforts and monitor fidelity of the evidence-based practices ACT, Supportive Housing, Supported Employment, and Peer Support for adults with an SMI designation.
  - o AHCCCS will utilize a vendor(s) to provide technical assistance using the SAMHSA best practice and related audit tools for ACT, Supportive Housing, Supported Employment, and Peer Support.
  - o AHCCCS will utilize a vendor(s) to conduct ongoing program fidelity monitoring of the implementation of ACT, Supportive Housing, Supported Employment, and Peer Support.
2. Expand the capacity of behavioral health providers to serve individuals with I-DD and designated with SMI.
  - o AHCCCS will fund technical assistance for NADD accreditation and certification costs for behavioral health providers who serve individuals with I-DD and designated with SMI.
  - o AHCCCS will implement Project ECHO for psychiatrists and psychiatric nurse practitioners with national psychopharmacological experts in the field of dual I-DD and mental illness.
3. Expand the number of peer support services available.
  - o AHCCCS will fund additional peer support positions at provider agencies.
  - o AHCCCS will fund additional peer support training and additional peer support workforce development costs.
4. Implement a Digital Identification Wallet for individuals with an SMI designation (further described in the health information technology section of this proposal).
5. Improve coordination of care for individuals transitioning between levels of care or correctional facilities.
  - o AHCCCS will fund intensive transitional step down programming for individuals transitioning from inpatient settings.
  - o AHCCCS will fund additional reach-in activities to correctional facilities.

### Children Designated with SED

1. Implement a statewide standardized process for early identification and referral for SED assessment.
  - a. AHCCCS will update policies for SED designation including the implementation of a statewide standardized definition for functional impairment.
  - b. AHCCCS will fund a standardized SED assessment model utilizing the updated AHCCCS policy.
2. Implement co-located models of care and strengthen evidence-based mental health care delivery for justice-involved youth with an SED designation.
  - a. Develop co-location models of behavioral health delivery within juvenile probation and parole offices.

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## Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817

- i. AHCCCS will partner with juvenile justice partners and behavioral health providers to strengthen reach-in activities in detention centers and referral for ongoing services once youth are released.
    - ii. AHCCCS will partner with juvenile justice partners and behavioral health providers to identify and implement co-located models of care, leveraging telehealth when indicated.
  - b. Expand mental health workforce trained to implement evidence based practice for justice-involved youth
    - i. AHCCCS will fund costs for behavioral health providers to become MST<sup>®</sup> certified.
    - ii. AHCCCS will work with juvenile justice partners to identify other evidence-based modalities and fund related technical assistance and certification costs required for implementation by behavioral health providers.
3. Implement a Child Psychiatry Access Program (CPAP) and preschool mental health consultation model in order to expand access to child mental health experts.
  - a. AHCCCS will fund a CPAP designed for Primary Care Providers (PCPs) which will include:
    - i. Telephone consultation with either a Child and Adolescent Psychiatrist or independently licensed Behavioral Health Clinician;
    - ii. Face-to-face consultation with either a Child and Adolescent Psychiatrist or independently licensed Behavioral Health Clinician when indicated;
    - iii. Resource Identification and Referral; and
    - iv. Practice-focused training and education.
  - b. Arizona will join the National Network of Child Psychiatry Access Programs (NNCPAP) to learn from other states and implement program quality improvement efforts.
  - c. Arizona will fund child care setting and preschool mental health consultation models designed to reduce risk of preschool expulsion.
4. Strengthen Child and Family Team (CFT) coaching and support.
  - a. AHCCCS will fund additional CFT coach positions to support CFTs who work with children designated with SED.
  - b. AHCCCS will fund training costs for parent and family support specialists.
  - c. AHCCCS will fund other professional development opportunities for behavioral health providers who serve children designated with SED, including professional conference costs required for maintenance of licensure, direct licensure costs, and EBP certification costs.

### Crisis System

1. Implement a Crisis Bed Registry where providers can access real-time information on available crisis beds (further described in the health information technology section of this proposal).

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## Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817

2. Creation of specialized wraparound teams for crisis stabilization for children with an SED designation. AHCCCS will fund the start-up infrastructure costs associated with the creation of specialized wraparound teams, including behavioral health provider positions, staff training and supervision costs, building improvement costs, and purchase of equipment and software.
3. Development of 23 hour crisis stabilization units for children with an SED designation in Central and Northern Arizona. AHCCCS will fund the start-up infrastructure costs associated with the creation of 23 hour crisis stabilization units, including behavioral health provider positions, staff training and supervision costs, building improvement costs, and purchase of equipment and software.
4. Expansion of short-term behavioral health residential settings to serve children with an SED designation who present in crisis. AHCCCS will fund the start-up infrastructure costs associated with the creation of new short-term behavioral health residential settings, including licensure costs, behavioral health provider positions, staff training and supervision costs, building improvement costs, and purchase of equipment and software.
5. AHCCCS will fund additional supportive and professional development opportunities for behavioral health providers who work with children designated with SED.

## COLLABORATION WITH STAKEHOLDERS TO ADDRESS MENTAL HEALTH AND CRISIS SERVICE CONTINUUM NEEDS

Throughout the ARPA MHBG project implementation, AHCCCS will leverage its formal and informal collaborative relationships with stakeholders who share a vested interest in mental health and crisis services for individuals designated with SED or SMI, including:

- The Administrative Office of the Courts
- The Arizona Department of Child Safety (DCS)
- The Arizona Department of Corrections (ADOC)
- The Arizona Department of Education (ADE)
- The Arizona Department of Emergency and Military Affairs (DEMA)
- The Arizona Department of Health Services (ADHS)
- The Arizona Department of Housing (ADOH)
- The Arizona Department of Juvenile Corrections (ADJC)
- The Arizona Department of Veterans' Services (ADVS)
- The Council of Human Service Providers
- The County Public Health Departments
- The Governor's Office of Youth, Faith, and Family (GOYFF)

Additionally, Arizona has an active Behavioral Health Planning Council (BHPC) that meets monthly. The majority (i.e., 51 percent or more) of Arizona's BHPC is composed of members and family members and



## Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817

serves to monitor, review, and evaluate the allocation and adequacy of mental health services within Arizona. Arizona will continue to utilize the expertise and membership of the BHPC throughout the life of these supplemental ARPA MHBG funds, which will include presenting data on the status of project implementation and outcome evaluation.

### TEN PERCENT SET ASIDE FOR FIRST-EPIISODE PSYCHOSIS AND FIVE PERCENT SET ASIDE FOR CRISIS SERVICES

For the ten percent set aside for first-episode psychosis (FEP), Arizona will leverage the current Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs) that are currently operating and providing First Episode Psychosis (FEP) services. Services and supports to be enhanced through these FEP providers include:

- Funding of additional FEP positions to provide outreach and treatment services
- Funding of training and staff time to participate in the following evidence-based practices to treat individuals with FEP:
  - Eye Movement Desensitization and Reprocessing (EMDR),
  - Coordinated Specialty Care (CSC), and
  - Cognitive Enhancement Therapy (CET).
- Funding of supplies and outreach materials.

For the five percent set aside for crisis services, AHCCCS has proposed the development of crisis services as outlined in this proposal.

### HEALTH INFORMATION TECHNOLOGY (IT) STANDARDS CONFORMANCE AND INFRASTRUCTURE INVESTMENTS

AHCCCS IT projects that require coordination and data sharing with the Health Information Exchange (HIE) or between organizations will follow IT standards for infrastructure or advancement and conform to all standards for confidentiality and compliance. AHCCCS will use the appropriate ANSI X12 and NCPDP electronic data standards as applicable to the type of data being exchanged including any covered transactions.

Health Current is the statewide HIE for Arizona and their technology adheres to the established national standards identified by the Office of the National Coordinator for Health Information Technology (ONC) for interoperable data exchange. This includes the 2015 Edition Common Clinical Data Set (CCDS) standards and HL7 CDA R2 Standards. The technologies to be adopted are also consistent with the 2021 Interoperability Standards Advisory (ISA) Reference Edition in support of Social Determinants of Health including standards such as SNOMED, ICD10 z codes, CPT4, HCPCs and other national accepted

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## Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817

interoperability standards. Health Current supports the state's Prescription Drug Monitoring Program (PDMP) through the use of an API directing end users to Arizona's Board of Pharmacy.

AHCCCS proposes the following health information technology infrastructure investments in order to address the needs of individuals with a SMI or SED designation:

**1. Implementation of a Crisis Bed Registry where providers can access real-time information on available crisis beds and other crisis services through Health Current.**

AHCCCS will fund Health Current, the state's HIE, to develop a real-time crisis services locator. During Phase I of implementation, the crisis services locator will include a bed registry that will enable behavioral health providers to quickly assess 23-hr stabilization and inpatient capacity at crisis facilities. Available crisis beds, including their locations, available services, and direct contact information will be included in Phase I implementation of the crisis services locator. The functionality of the crisis services locator will be expanded beyond 23-hour and inpatient bed capacity based on stakeholder feedback from Phase I implementation.

**2. Implementation of a Digital Identification Wallet for individuals with an SMI designation.**

AHCCCS will work with the Regional Behavioral Health Authorities (RBHAs) and behavioral health providers to implement a statewide solution for individuals with an SMI designation who are in need of a digital wallet/locker technology solution. AHCCCS will procure a vendor to build the digital wallet/locker program and will subsequently provide administration and management of the tool through a fee model. Members will use the data locker's electronic "wallet" or website to upload and store critical documents online. It will also enable individuals with an SMI designation to grant access to their data locker to third parties, when appropriate, to assist in eligibility or other document sharing needs, and will allow third parties to upload documents directly into the locker when necessary.

**3. Expansion of technology access to enable telehealth service delivery.**

AHCCCS will fund the technological infrastructure (e.g., smart phones, computers, internet subscription expenses) for behavioral health providers who serve individuals with an SMI or SED designation. Additionally, AHCCCS will fund the technological infrastructure necessary to enable school-based and co-located justice-based behavioral health service delivery.

**4. Evaluation of an electronic referral system for primary care providers and the education system to refer children for an SED assessment and implementation if deemed feasible.**

In Phase I, AHCCCS will consult with a vendor(s) on the feasibility of utilizing Health Current for primary care providers and the education system to send direct referrals for an SED assessment

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## Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817

via the state's HIE. If determined feasible, AHCCCS will fund the implementation of this electronic referral system in Phase II of this project.

January 14, 2022

Melissa Blackwell, MSW  
Public Health Advisor Division of State and Community Systems Development  
Center for Mental Health Services  
Substance Abuse and Mental Health Services Administration  
5600 Fishers Lane, Room 14E73B  
Rockville, MD 20857

RE: Spending Plan Proposal for the Implementation of the American Rescue Plan Act of 2021,  
Mental Health Block Grant (MHBG)

Dear Ms. Blackwell,

The Arizona Health Care Cost Containment System (AHCCCS), submitted the **Spending Plan Proposal for the Implementation of the American Rescue Plan Act of 2021, Mental Health Block Grant (MHBG)** dated July 30, 2021 to the Center for Mental Health Services (CMHS) Substance Abuse and Mental Health Services Administration (SAMHSA). AHCCCS will be removing language related to the digital locker implementation due to the correspondence we received from CMHS; this is an unallowable expense.

AHCCCS is proposing to replace the digital identification wallet to increase the workforce development activities described in the plan in addition to additional activities for individuals designated with a Serious Emotional Disturbance (SED) and/or Serious Mental Illness (SMI). AHCCCS is requesting to remove the digital identification wallet from the plan. AHCCCS previously proposed to serve individuals with an SMI designation, including those who experience homelessness, may not have the proper identification documents that are required for social security applications, applying for benefits, and/or are required for access to housing, social, medical, and financial services. Mobile digital identity solutions through the use of digital wallet technology will assist individuals with applying for these benefits and/or services. The plan was to utilize \$200,000.00 of the total amount.

AHCCCS is requesting to utilize the \$200,000.00 to increase workforce development activities outlined in the plan including two additional projects including the Continuation of Early Childhood Service Intensity Instrument (ECSII) and Youth Advisory Training.

1. **Early Childhood Service Intensity Instrument (ECSII) Training.** The American Academy of Child and Adolescent Psychiatry (AACAP) is the single agency able to provide the training and fidelity monitoring of the Early Childhood Service Intensity Instrument (ECSII), as AACAP is the sole owner of the assessment tool, training materials, and fidelity monitoring criteria.

According to AACAP, ECSII is a standardized tool used to determine the intensity of services needed for infants, toddlers, and children from ages 0-5 years. This instrument is

developmentally informed and has been created on the foundation of a System of Care approach -- embracing family-driven, youth-guided care that includes individualized strength-based and culturally sensitive service planning, supporting the use of intensive care coordination or wraparound planning teams when indicated, and providing a broad service array that includes natural supports as well as clinical services.

2. **Youth Advisory Training.** This training will (1) Promote access, equality, inclusion, and brave spaces for the celebration of diversity, through peer-based experiential learning, person-centered practices, and maximized collaboration efforts, designed to heighten knowledge, enhance skills, and foster individual life path planning, and growth; (2) Build capacity in youth and young adults (focused on ages 18-24 years old) who have a variety of disabilities, to prepare them to assume leadership roles, and provide peer-based services through peer-based training, navigation and support within Arizona, and beyond; and (3) Provide training for AHCCCS and Managed Care Organization leadership to engage young adults in meaningful leadership and engagement opportunities.

If you have additional questions, please contact Michelle Skurka at (602) 364-2111 or [Michelle.Skurka@azahcccs.gov](mailto:Michelle.Skurka@azahcccs.gov).

Sincerely,

*Michelle Skurka*

Michelle Skurka  
Grants Administrator

# State Information

## Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).

[Standard Form LLL \(click here\)](#)

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Name

Title

Organization

---

Signature:

Date:

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

**Footnotes:**

## State Information

### Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).

[Standard Form LLL \(click here\)](#)

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Name **Kristen Challacombe**

Title **Deputy Director**

Organization **AHCCCS**

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Signature:

*K. Chr Challacombe*

Date: **8/24/2021**

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**

## Planning Steps

### Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

**Footnotes:**





**SABG/MHBG Combined Application  
FY2022-23  
Planning Step 1**

**September 1, 2021**

# SABG/MHBG Combined Application FY2022-23 Planning Step 1

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## AHCCCS Overview

Arizona Health Care Cost Containment System (AHCCCS) is the single state Medicaid agency for the State of Arizona. In that capacity, it is responsible for operating the Title XIX and Title XXI programs through the State’s 1115 Research and Demonstration Waiver, which allows for the operation of a total managed care model.

AHCCCS’ mission “reaching across Arizona to provide comprehensive, quality health care to those in need” is implemented through the vision of “shaping tomorrow’s managed care...from today’s experience, quality, and innovation.” Built on a system of competition and choice, AHCCCS’ \$14 billion program operates under an integrated managed care model.

## Arizona Complete Care (ACC) Plans

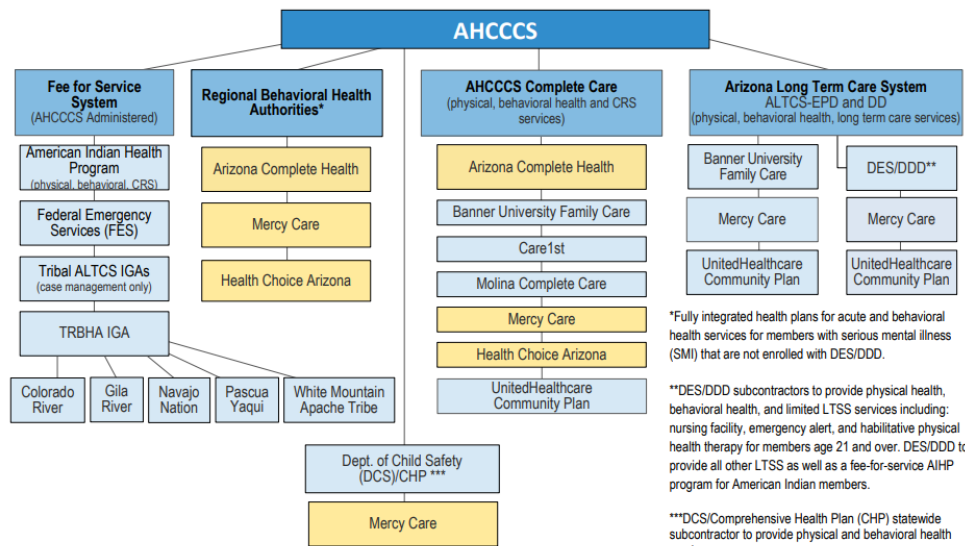
On October 1, 2018, AHCCCS took the largest step to date toward this strategic goal of fully integrated care delivery when 1.6 million members were enrolled in one of AHCCCS’ Complete Care (ACC) health plans and American Indian Health Plans (AIHP). ACC plans and AIHP provide a comprehensive network of providers to deliver all covered physical and behavioral health services to child and adult members without a Serious Mental Illness (SMI) designation. The ACC plans and AIHP also provide services for members with Children’s Rehabilitative Services (CRS) conditions. ACC plans and AIHP address the whole health needs of our state’s Medicaid population which is vitally important to improving service delivery for AHCCCS members and reducing the fragmentation that

has existed in our healthcare system. The YH19-0001 AHCCCS Complete Care Request for Proposal [ACC RFP (Request for Proposals)] awarded in March of 2018 resulted in seven awarded ACC plans across the state in three Geographic Service Areas: north, central, and south.

Through the ACC contracts, Managed Care Organizations (MCO’s) are responsible for providing physical, behavioral, and long-term care services. AHCCCS also operates the American Indian Health Program (AIHP), a fee for service program that is responsible for care for American Indian members who select AIHP. AHCCCS also has five unique intergovernmental agreements with Tribal Regional Health Authorities (TRBHAs) for the coordination of behavioral health services for American Indian members enrolled with a TRBHA.



Care Delivery System Effective July 1, 2021



\*Fully integrated health plans for acute and behavioral health services for members with serious mental illness (SMI) that are not enrolled with DES/DDD.

\*\*DES/DDD subcontractors to provide physical health, behavioral health, and limited LTSS services including: nursing facility, emergency alert, and rehabilitative physical health therapy for members age 21 and over. DES/DDD provide all other LTSS as well as a fee-for-service AIHP program for American Indian members.

\*\*\*DCS/Comprehensive Health Plan (CHP) statewide subcontractor to provide physical and behavioral health services.

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Contracted health plans coordinate and pay for physical and behavioral health care services delivered by more than 104,000 health care providers. According to the [Behavioral Health Enrolled and Served Report](#) required by Arizona Revised Statute 36-3450(D), as of June 2021, 1,814,108 members were enrolled in Medicaid Title XIX/XXI, including 269,543 (15 percent) who received behavioral health services.

### Regional Behavioral Health Authorities (RBHAs)

Three of the ACC plans are affiliated with current AHCCCS Regional Behavioral Health Authorities (RBHA) and were required to align the RBHA and ACC contracts under one organization. The following link shows the contracted ACC plans and RBHAs and the different Geographic Service Areas (GSAs) served (<https://www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSCompleteCare/>).

A RBHA is a contracted Managed Care Organization (also known as a health plan) responsible for the provision of comprehensive behavioral health services to all eligible individuals assigned by the administration and provision of comprehensive physical health services to eligible persons with a Serious Mental Illness enrolled by the Administration. The function of the RBHAs include:

- Providing integrated services for Individuals with Serious Mental Illness.
- Development and support of a regional crisis system.
- For the near term, providing behavioral health services for children that are served by the Department of Child Safety (DCS).
- Allocation of non-title XIX funding including Substance Abuse and Mental Health Services Administration (SAMHSA) grants and other sources of funding

Arizona's three Regional Behavioral Health Authorities (RBHAs) are required to maintain comprehensive networks of behavioral health providers to deliver prevention, intervention, treatment, and rehabilitation services to members enrolled in AHCCCS.

- Mercy Care – RBHA serving central Arizona, including Maricopa County
- Arizona Complete Health – RBHA serving southern Arizona, including Tucson
- Health Choice Arizona – RBHA serving northern Arizona

### Tribal Behavioral Health Authorities (TRBHAs)

A Tribal Regional Behavioral Health Authority (TRBHA) is a tribal entity that has an intergovernmental agreement with AHCCCS, the primary purpose of which is to coordinate the delivery of comprehensive behavioral health services to all eligible individuals assigned by the administration to the tribal entity. Tribal governments, through an agreement with the State, may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to American Indian members. Refer to A.R.S. §36-3401 and A.R.S. §36-3407.

- White Mountain Apache – TRBHA serving the White Mountain Apache Nation
- Gila River – TRBHA serving the Gila River Indian Community
- Pascua Yaqui – TRBHA serving the Pascua Yaqui Tribe
- Navajo Nation – TRBHA serving the Navajo Nation

The ACCs, MCOs, RBHAs, and TRBHAs are required to maintain a comprehensive network of behavioral health providers to deliver prevention, intervention, treatment, and rehabilitative services to members enrolled in the AHCCCS system. This structure allows communities to provide services in a manner appropriate to meet the unique needs of members and families residing within their local areas.

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### Single State Authority (SSA) and State Mental Health Authority (SMHA)

In addition to overseeing the managed care organizations that provide Medicaid-funded health care services, AHCCCS serves as the Single State Authority on substance use, and as the State Mental Health Authority (SMHA) responsible for the state public mental health service delivery system administration. AHCCCS is the agency responsible for mental health and substance use and provides oversight, coordination, planning, administration, regulations, and monitoring of all facets of the public behavioral health system in Arizona.

### Service Delivery System

Regardless of the type, amount, duration, scope, service delivery method, and population served, AHCCCS requires all MCOs ensure that their service delivery system:

- Coordinate and provide access to high-quality health care services informed by evidence-based practice guidelines in a cost-effective manner,
- Coordinate and provide access to high-quality health care services that are culturally and linguistically appropriate, maximize personal and family voice and choice, and incorporate a trauma-informed care approach,
- Coordinate and provide access to preventive and health promotion services, including wellness services,
- Coordinate and provide access to comprehensive care coordination and transitional care across settings; follow-up from inpatient to other settings; participation in discharge planning, and facilitating transfer from the children's system to the adult system of health care,
- Coordinate and provide access to chronic disease management support, including self-management support,
- Conduct behavioral health assessment and service planning following a Health Home model,
- Coordinate and provide access to peer and family delivered support services, based on member's needs, voice, and choice,
- Provide covered services to members in accordance with all applicable Federal and State laws, regulations, and policies,
- Coordinate and integrate clinical and non-clinical health care related needs and services across all systems,
- Implement health information technology to link services, facilitate communication among treating professionals and between the health team and individual and family caregivers, and
- Deliver services by providers that are appropriately licensed or certified, operating within their scope of practice, and registered as an AHCCCS provider.

AHCCCS further requires that at all MCOS work in partnership to meet, agree upon, and reduce to writing joint collaborative protocols with each county, district, or regional office of:

- Administrative Office of the Courts,
- Juvenile Probation and Adult Probation,
- Arizona Department of Corrections and Arizona Department for Juvenile Corrections,
- Arizona Department of Child Safety (DCS),
- Tribal Nations and Providers (Refer to this section above),
- The Veterans' Administration, and
- The county jails.

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### Continuum of Care (Adult and Child Systems)

As a leader in the public behavioral health field, Arizona's approach to managed care and service delivery is nationally recognized. AHCCCS focuses its efforts and energies toward providing leadership in activities designed to integrate and adapt the behavioral health system to meet the needs of those we serve.

AHCCCS fosters an environment of person-centered planning that includes the voice and choice of the person being served, their family, identified persons of support, advocates (as designated) and service providers, as identified. The Individual Service Planning (ISP) process is transparent, fluid and the ISP is a living and breathing document that can change as a persons' choices and treatment needs change. AHCCCS has an Adult System of Care (ASOC) that is a continuum of coordinated community and facility-based services and support for adults with, or at risk for, behavioral health challenges. The ASOC is organized into a comprehensive network to create opportunities to foster recovery and improve health outcomes by:

- Building meaningful partnerships with individuals served,
- Addressing the individuals' cultural and linguistic needs and preferences, and
- Assisting the individual in identifying and achieving personal and recovery goals.

The ASOC developed the following Nine Guiding Principles to promote recovery in the adult behavioral health system and for engaging with adults who have a serious mental illness:

#### Nine Guiding Principles:

1. **RESPECT:** Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.
2. **PERSONS IN RECOVERY CHOOSE SERVICES AND ARE INCLUDED IN PROGRAM DECISIONS AND PROGRAM DEVELOPMENT EFFORTS:** A person in recovery has choice and a voice. Their self-determination in driving services, program decisions, and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.
3. **FOCUS ON INDIVIDUAL AS A WHOLE PERSON, WHILE INCLUDING AND/OR DEVELOPING NATURAL SUPPORTS:** A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.
4. **EMPOWER INDIVIDUALS TAKING STEPS TOWARDS INDEPENDENCE AND ALLOWING RISK TAKING WITHOUT FEAR OF FAILURE:** A person in recovery finds independence through exploration, experimentation, evaluation, contemplation, and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.
5. **INTEGRATION, COLLABORATION, AND PARTICIPATION WITH THE COMMUNITY OF ONE'S CHOICE:** A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscore one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism are valued.

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6. PARTNERSHIP BETWEEN INDIVIDUALS, STAFF, AND FAMILY MEMBERS/NATURAL SUPPORTS FOR SHARED DECISION MAKING WITH A FOUNDATION OF TRUST: A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.
7. PERSONS IN RECOVERY DEFINE THEIR OWN SUCCESS: A person in recovery – by their own declaration – discovers success, in part, by quality of life outcomes, which may include an improved sense of well-being, advanced integration into the community, and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.
8. STRENGTHS-BASED, FLEXIBLE, RESPONSIVE SERVICES REFLECTIVE OF AN INDIVIDUAL'S CULTURAL PREFERENCES: A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.
9. HOPE IS THE FOUNDATION FOR THE JOURNEY TOWARDS RECOVERY: A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

In addition, AHCCCS collaborated with the child, family, and others to provide services that are tailored to meet the needs of children with serious emotional disturbances and their caregivers. The goal is to ensure that services are provided to the child and family in the most appropriate setting, in a timely manner, in accordance with the best practices and respecting the child, family, and their cultural heritage.

Arizona/AHCCCS developed **The Twelve (12) Principles** for Children's in the Behavioral Health Service Delivery System:

### Twelve (12) Guiding Principles:

1. COLLABORATION WITH THE CHILD AND FAMILY: Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.
2. FUNCTIONAL OUTCOMES: Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.
3. COLLABORATION WITH OTHERS: When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, DCS and/or DES/DDD caseworker, and the child's probation officer. The team (a)

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develops a common assessment of the child's and family's strengths and needs, (b) develops an individualized service plan, (c) monitors implementation of the plan, and (d) makes adjustments in the plan if it is not succeeding.

4. **ACCESSIBLE SERVICES:** Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.
5. **BEST PRACTICES:** Competent individuals who are adequately trained and supervised provide behavioral health services. They are delivered in accordance with guidelines adopted by ADHS that incorporate evidence-based "best practice." Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.
6. **MOST APPROPRIATE SETTING:** Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.
7. **TIMELINESS:** Children identified as needing behavioral health services are assessed and served promptly.
8. **SERVICES TAILORED TO THE CHILD AND FAMILY:** The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.
9. **STABILITY:** Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and criminal justice system. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.
10. **RESPECT FOR THE CHILD AND FAMILY'S UNIQUE CULTURAL HERITAGE:** Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.
11. **INDEPENDENCE:** Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in assessment process, and in the planning, delivery, and evaluation of



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services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.

12. CONNECTION TO NATURAL SUPPORTS: The behavioral health system identifies and appropriately utilizes natural supports available from the child and parent's own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

Overall, the Person-Centered Planning and Service Plan reflects the individual's strengths and preferences that meet the person's social, cultural, and linguistic needs and includes individualized goals and desired outcomes. Additionally, the planning process also identifies risk factors (includes risks to member rights) and puts measures in place to minimize them with individual back-up plans and other strategies as needed.

### Arizona Behavioral Health Planning Council (BHPC)

AHCCCS utilizes the Arizona Behavioral Health Planning Council to advise the state in planning and implementing a comprehensive community-based system of behavioral health and mental health Services.

### Office of Individual and Family Affairs (OIFA)

The AHCCCS Office of Individual and Family Affairs (OIFA) is staffed by individuals and family members whose lives have been touched by substance use and/or mental health disorders. As a part of the Behavioral Health Planning Council (BHPC), OIFA is in a unique position to bring more voices of the community into the oversight process. In addition to the AHCCCS OIFA, each AHCCCS health plan is contractually required to have its own OIFA. The health plan OIFAs extend the reach of the BHPC to increase prospects for more responsive and accountable substance abuse and behavioral health services.

### Division of Grants Administration (DGA)

The Division of Grants Administration (DGA) is the point of contact related to the pursuit, implementation and oversight of grants administered by the agency. DGA is inclusive of both programmatic and financial teams. Together, the teams work closely with each other to ensure the effective communication, oversight and implementation of all grants management for the agency. In 2019, AHCCCS recruited an Assistant Director to lead the unit, who reports to the Deputy Director of Business Operations within the Office of the Director. DGA staff positions include the State Opioid Treatment Authority/Opioid Treatment Network, Women's Treatment Network, National Prevention Network and National Treatment Network representatives, Grant Managers and Project/Grant Coordinators.

DGA leverages the managed care services through contracts to provide access to care for substance use disorder intervention, treatment, and recovery support services through the Substance Abuse Block Grant (SABG) funding. The SABG supports primary prevention services and treatment services for members with substance use disorders. It is used to plan, implement, and evaluate activities to prevent and treat substance use disorders. Grant funds are also used to provide early intervention services for HIV and tuberculosis disease in high-risk substance users. Arizona is not an HIV designated state, so there are not specific requirements that need to be met for SAMHSA, however prevention efforts have

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been continued to sustain the progress that has been made in reducing the rate of individuals who contract HIV.

### Substance Abuse Block Grant (SABG) Primary Prevention

To streamline prevention services, AHCCCS made the decision to administer the prevention contracts directly. This decision was effective as of July 1, 2021, and AHCCCS procured 20 local community-based coalitions through a competitive Request for Proposal (RFP) process. In addition to the administration of funding for local community-based prevention coalitions, AHCCCS has Intergovernmental Agreements (IGAs) with two of the state's TRBHAs, the Pascua Yaqui Tribe and the Gila River Indian Community, to administer SABG primary prevention funding to tribal populations within the state. AHCCCS also has a relationship with the Governor's Office of Youth, Faith, and Family (GOYFF) to provide substance abuse prevention services through Evidence Based Practices (EBPs) and community-based organizations. All SABG Primary Prevention efforts are administered utilizing the Strategic Prevention Framework (SPF) Model from the Substance Abuse and Mental Health Services Administration (SAMHSA) with these funds. AHCCCS currently utilizes a variety of providers to implement prevention services, including community-based coalitions, schools, and various state agencies. AHCCCS prevention efforts currently focus on several substances, including alcohol, tobacco, prescription drugs, and opioids. AHCCCS prevention efforts include focusing on a Risk and Protective Factor Theory, which includes reducing risk factors, and increasing protective factors, in a variety of settings. To address the unique needs of the state with these funds, AHCCCS will also address Adverse Childhood Experiences (ACEs) and trauma to ensure all high-risk individuals are receiving the appropriate types of services. AHCCCS will continue to support all prevention providers in offering services virtually, as appropriate, to ensure the health and safety of all participants. All primary prevention services will serve populations according to the Institute of Medicine (IOM) categories as follows: Universal (Indirect and Direct), Selective, and Indicated.

All primary prevention activities are quantified into the six Center for Substance Abuse Prevention (CSAP) strategies. It should be noted that AHCCCS requires the utilization of all strategies, as each strategy alone has not been proven to be effective in the reduction of substance use, misuse, and/or abuse. Some strategies to be used by AHCCCS prevention providers as part of this funding include, but are not limited to:

- Information Dissemination: This strategy provides awareness and knowledge of the nature and extent of substance use, abuse, and addiction and their effects on individuals, families, and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.
  - Tabling/booth events at health fairs, school parent nights, and local community events.
  - "Sticker Shock" campaigns, which is often a youth-driven project that seeks to inform, educate, and remind the community of the implications of selling and providing alcohol to underage youth. Prevention Education staff create a message, which is then printed onto stickers, and placed on products in liquor stores.
  - Dissemination of prevention flyers, posters, brochures, and other informational media at local grocery stores, doctor's offices, schools, etc.
  - Media campaigns aimed at increasing knowledge of local substance use and abuse trends and data, as well as focusing on risk and protective factors to reduce substance use and abuse within high-risk populations.

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- Education: This strategy involves two-way communication and is distinguished from the information dissemination strategy by the fact that interaction between the educator/ facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.
  - Parenting/Family Education curriculum, such as Strengthening Families, Guiding Good Choices, and Triple P. These programs aim to enhance parenting behaviors and skills, enhance effective child management behaviors and parent-child interactions and bonding, to teach children skills to resist peer influence, and reduce adolescent problem behaviors.
  - Curriculum that teaches youth life skills, such as LifeSkills, which are designed to prevent teenage drug and alcohol abuse, tobacco use, violence, and other risk behaviors by teaching students self-management skills, social skills, and drug awareness and resistance skills.
- Alternatives: This strategy provides for the participation of target populations in activities that exclude substance use. The assumption is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by, alcohol and drugs and would therefore minimize or obviate resort to the latter.
  - Drug-free community and/or youth events, including drug-free dances, sports tournaments, after-school youth groups/programs/clubs, etc.
  - Mentoring programs, such as Big Brothers/Big Sisters, that provide at risk youth with opportunities to connect with positive adult role models, and engage in healthy, drug-free activities.
  - Connection and engagement in cultural activities, tribal practices, and learning cultural and/or tribal ways.
- Problem Identification and Referral: This strategy aims to identify those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs to assess whether their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.
  - Programs/classes for youth who have broken school campus rules regarding alcohol, tobacco, and other drugs (ATOD), such as being in possession of ATOD or related paraphernalia. Classes aim to educate youth about the dangers of ATOD use, offer alternatives to substance use, and prevent future infractions.
  - Driving Under the Influence (DUI) education classes for first time offenders, that educate individuals around DUI, and includes steps to prevent future DUIs from occurring, harm reduction techniques, etc.
- Community-based process: This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for substance abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking. o Building and sustaining of community-based coalitions (there are currently 24 SABG funded coalitions within the state).
  - Community mobilization training and capacity building within “prevention desert” areas to build primary prevention infrastructure. o Strategic planning at state and local levels, which includes bringing together key stakeholders from the following sectors to the table to engage in effective planning:
    - Youth,

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- Parents,
- Law enforcement,
- Schools,
- Businesses,
- Media,
- Youth-serving organizations,
- Religious and fraternal organizations,
- Civic and volunteer groups,
- Health care professionals,
- State, local, and tribal agencies with expertise in substance abuse, and
- Other organizations involved in reducing substance abuse. o
- Gathering of Native Americans (GONA), a culture-based planning process where community members gather to address community-identified issues. It uses an interactive approach that empowers and supports American Indian (AI) and/or Alaskan Native (AN) tribes. The GONA approach reflects AI/AN cultural values, traditions, and spiritual practices.
- Environmental: This strategy establishes, or changes, written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. This strategy is divided into two subcategories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives.
  - The passing of local ordinances that affect the sale, manufacturing, or availability of ATODs, including alcohol tax increases, moratoriums on alcohol/marijuana advertising around schools, parks, or places where youth are present, and moratoriums on the establishment or placement of medical marijuana stores in local areas.
  - The review of current ATOD policies within schools and/or communities, including the review of policies related to prevention of ATOD use amongst youth, review of policies regarding “punishment” of youth who use or are caught, what prevention strategies are used to decrease repeat behavior, and the eventual revision of policies to be prevention focused, rather than punishment focused.

AHCCCS currently requires the use of Evidence Based Practice (EBP), Research Based Practice (RBP), or Promising Practice (PP) and allows providers to utilize Promising and Innovative Interventions at a ratio of one Evidence, Research and/or Promising Intervention to every Innovative Intervention. AHCCCS currently accepts the guidance provided by the SAMHSA document “Selecting Best-fit Programs and Practices: Guidance for Substance Misuse Prevention Practitioners” as the standard to follow when selecting programs and practices, including the best practices lists and resources. AHCCCS is aware that every community is unique and has unique needs to be addressed with prevention programming. To support innovation within communities to meet these unique needs, AHCCCS has developed parameters regarding the use of these interventions. AHCCCS utilizes the “AHCCCS Innovative Prevention Program Intervention Protocol” for all SABG Primary Prevention Activities that are not currently designated as Evidence or Research Based. The protocol, developed by AHCCCS staff, requires the prevention providers to formally submit documentation related to the intervention they are proposing to use, prior to the use of the intervention, for review and approval by AHCCCS. Upon review, AHCCCS designates an evidence-based status to the proposed intervention and provides feedback to the prevention provider regarding implementation.

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AHCCCS currently employs a variety of methods to ensure primary prevention activities are equitable and include a focus on those at greater risk for health disparities. All AHCCCS primary prevention activities follow the SPF model, which requires the infusion of “cultural competence” into each phase of the SPF model. AHCCCS prevention efforts are currently moving to a “culturally responsive” approach in lieu of “cultural competency,” but the premise of the strategies remain the same. As part of the SPF model, all AHCCCS prevention providers are required to utilize a local primary prevention needs assessment that must be completed or renewed every three years. Mandatory data to be collected within the target communities include, but are not limited to, total population level, ages, educational attainment, housing, income level, poverty level, business/economical information, race and Hispanic origin, immigrant status, and veteran status. In addition to the needs assessment, each provider is also required to utilize a prevention strategic plan that is to be updated every three years. This plan must include the provider’s plan to address equity within their target populations through cultural responsiveness, which include engaging stakeholders from various backgrounds in the planning and implementation of prevention efforts, representation on the coalition, and to identify any barriers in existence that will impede the provider’s ability to provide culturally responsive services and a plan to address said barriers, as needed.

AHCCCS is aware that every community is unique and has unique needs to be addressed with prevention programming. Current evidence-based programming can be dated, and as was reported in the 2018 AHCCCS Statewide Primary Prevention Needs Assessment, youth expressed how current programming does not speak to them, feels dated, and does not keep them engaged. This was corroborated by local substance abuse providers and stakeholders. Arizona’s populations and demographics are changing and has required the state to develop systems to enhance culturally responsive and equitable approaches to substance abuse prevention. To support innovation within communities to meet these unique needs, AHCCCS has developed parameters regarding the use of these interventions. As discussed previously, AHCCCS utilizes the “AHCCCS Innovative Prevention Program Intervention Protocol” for all SABG Primary Prevention activities that are not currently designated as evidence or research based. AHCCCS currently contracts with community based coalitions and local providers that tailor primary prevention efforts directly towards populations at high risk, with coalitions serving and focusing efforts on LGBTQ+ youth, Hispanic populations, refugee populations, border populations where health literacy and outcomes are low when compared to other areas of the state, border cities where illegal drug trade/activities are impacting youth, as well as focusing on areas of prevention deserts that historically have not had substance abuse prevention infrastructure present within the community.

AHCCCS also utilizes a “culture as prevention” framework when it comes to Arizona’s indigenous and diverse populations. Primary prevention services are currently being implemented within two of AHCCCS’ Tribal Regional Behavioral Health Authorities (TRBHAs), the Pascua Yaqui Tribe, and the Gila River Indian Community. Because the pandemic impacted Arizona’s tribal communities at a rate disproportionate to other communities, AHCCCS met with these TRBHAs to develop and research dedicated substance abuse prevention strategies to help mitigate the impact on these communities. Primary prevention interventions that included multiple outcomes in substance abuse prevention, mental health promotion, suicide prevention, and domestic violence/intimate partner violence prevention were explored to ensure that the tribal communities could select substance abuse primary prevention interventions that had a larger impact on other community needs during the pandemic. AHCCCS’ tribal partners lead the way to develop the prevention strategies that work best within their communities, focusing on cultural values, teaching of traditions, and spiritual practices.

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AHCCCS maintains a strong presence within the community to ensure all backgrounds and voices of Arizonans are represented within primary prevention program assessment, planning, implementation, and evaluation. AHCCCS has demonstrated this through various ways, including holding statewide primary prevention focus groups discussing future SABG prevention planning/efforts in July 2020, the facilitation of a statewide substance abuse prevention plan that includes data and stakeholders' feedback from over 40 local, regional, and state level prevention providers, and through regular participation and attendance at the Substance Abuse Coalition Leaders of Arizona meetings.

### Substance Abuse Block Grant (SABG) Treatment

SABG funds are used to ensure access to interventions, treatment, and long-term recovery support services for (in order of priority):

1. Pregnant women (including teenagers) who use drugs by injection,
2. Pregnant women (including teenagers) who use substances,
3. Other persons who use drugs by injection,
4. Substance using women and teenagers with dependent children and their families, including females who are attempting to regain custody of their children, and
5. All other individuals with a substance use disorder, regardless of gender or route of use, (as funding is available).

Behavioral health providers (contracted through the RBHAs and TRBHAs) must provide specialized, gender-specific treatment and recovery support services for females who are pregnant or have dependent children and their families in outpatient and residential treatment settings. Services are also provided to mothers who are attempting to regain custody of their children, and the family is treated as a unit. Providers must admit both mothers and their dependent children into treatment. The following services are provided or arranged as needed:

- Referral for primary medical care for pregnant females,
- Referral for primary pediatric care for children,
- Gender-specific substance use treatment, and
- Therapeutic interventions for dependent children.

Contractors must ensure the following issues do not pose barriers to access to obtaining substance use disorder treatment:

- Childcare
- Case management
- Transportation

The Contractors require any entity receiving amounts from the SABG for operating a program of treatment for substance use disorders to follow procedures which address how the program:

- Will, directly or through arrangements with other public or nonprofit private entities, routinely make available tuberculosis services as defined in [45 CFR 96.121] to each individual receiving treatment for such abuse,
- In the case of an individual in need of such treatment who is denied admission to the program on the basis of the lack of the capacity of the program to admit the individual, will refer the individual to another provider of tuberculosis services, and
- Will implement infection control procedures designed to prevent the transmission of tuberculosis, including the following:

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- Screening of patients,
- Identification of those individuals who are at high risk of becoming infected,
- Meeting all State reporting requirements while adhering to Federal and State confidentiality requirements, including [42 CFR part 2], and
- Will conduct case management activities to ensure that individuals receive such services.

Interim Services are required for those who meet the priority populations of pregnant women, women with dependent children, or intravenous drug users if there is a waitlist to engage in services. The purpose of interim services is to reduce the adverse health effects of substance use, promote the health of the member, and reduce the risk of transmission of disease. The minimum required interim services include:

- Education that covers prevention of and types of behaviors which increase the risk of contracting HIV, Hepatitis C, and other sexually transmitted diseases,
- Education that covers the effects of substance use on fetal development,
- Risk assessment/screening,
- Referrals for HIV, Hepatitis C, and tuberculosis screening and services, and
- Referrals for primary and prenatal medical care.

AHCCCS Contracts ensure services covered through the AHCCCS Medical Policy Manual are provided in a culturally competent manner utilizing evidence-based practices. The services are geared towards members and individuals who have a behavioral health diagnosis and identify as being a part of an identified group with norms not always addressed through traditional treatment modalities, including, but not limited to veterans, LGBTQ+, elderly, homeless, rural, and diverse populations. The Managed Care Organizations (MCOs) utilize Cultural Diversity Specialists and Community Liaisons who work with providers and communities through training, education, and technical assistance to ensure implementation and monitoring of the appropriate programs and services.

### Mental Health Block Grant (MHBG)

The MHBG is allocated to provide mental health treatment services to adults with a Serious Mental Illness (SMI) designation, children with Serious Emotional Disturbance (SED), and individuals with an Early Serious Mental Illness (ESMI) including first episode of psychosis (ESMI/FEP). The program makes funds available to Arizona to provide community mental health services. The program's objective is to support the grantees in carrying out plans for providing comprehensive community mental health services.

MHBG funds are used to provide treatment services in accordance with AHCCCS Medical Policy Manual (AMPM) 300-2B and AMPM 320-T1 and to ensure access to a comprehensive system of care, including employment, housing, case management, rehabilitation, dental, and health services as well as mental health services and supports.

Adults with a Serious Mental Illness (SMI) designation includes persons aged 18 and older who have a diagnosable behavioral, mental, or emotional condition as defined by the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM) of Mental Disorders*.

Serious Emotional Disturbance (SED) includes persons up to age 18 who have diagnosable behavioral, mental, or emotional issues (as defined by the Diagnostic and Statistical Manual of Mental Disorders

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(DSM)). Their condition results in a functional impairment that substantially interferes with, or limits, a child's role or functioning in family, school, or community activities.

First Episode Psychosis (FEP) services are supported by the 10 percent set aside for ESMI/First Episode of Psychosis (FEP) and support evidence-based programs that provide treatment and support services for those who have experienced a first episode of psychosis within the past two years. Psychosis is a brain condition that disrupts a person's thoughts and perceptions, making it difficult to differentiate between what is real and what is not. FEP Program models may include principles or core components identified by National Institute of Mental Health (NIMH) via the Recovery After an Initial Schizophrenia Episode (RAISE) initiative.

Five percent of the MHBG was set aside for crisis services to support an evidence-based crisis system. This funding is to support evidence-based crisis care programs to address the needs of individuals with an SMI designation and SED. Current projects include a pilot initiative to increase outreach and identification of under and uninsured individuals with Serious Emotional Disturbance (SED) who are experiencing crisis. This project will also support crisis providers in the provision of intensive wraparound crisis intervention services in the community to maintain children and adolescents in their homes. The goal of the program is to decrease hospitalizations and out of home placements through the provision of in-home supports to the family in both the immediate crisis resolution, and coordination of ongoing supports through outpatient providers in the community. Services may include outreach, referrals, screening/evaluation/assessment, and crisis intervention services.

AHCCCS is the designated unit of the executive branch that is responsible for administering the MHBG. AHCCCS ensures the following performance requirements are met:

- Subrecipients must submit a plan explaining how they will use MHBG funds to provide comprehensive, community mental health services to adults with serious mental illnesses and children with serious emotional disturbances,
- Subrecipients to provide annual reports on their plans,
- Subrecipients may distribute funds to local government entities and non-governmental organizations,
- Subrecipients must ensure that community mental health centers provide such services as screening, outpatient treatment, emergency mental health services, and day treatment programs,
- Subrecipients must comply with general federal requirements for managing grants. They must also cooperate in efforts by SAMHSA to monitor use of MHBG funds. For example, each year, CMHS conducts investigations (site visits) of at least ten grantees receiving MHBG funds. This is to assess how they are using the funds to benefit the population. These evaluations include careful review of the following:
  - How the grantees are tracking use of MHBG funds and their adult and child mental health programs,
  - Data and performance management systems,
  - Collaboration with consumers and the grantees' mental health planning council, and
  - Grantees receiving MHBG funds are required to form and support a state or territory mental health/behavioral health planning council.
  - Grantees receiving MHBG funds are required to form and support a state or territory mental health/behavioral health planning council.



## Planning Steps

### Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system of care.

States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

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**Footnotes:**



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**September 1, 2021**

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### Overview

The Arizona Health Care Cost Containment System (AHCCCS) utilizes several data feeds, surveys, systemic evaluations, as well as stakeholder forums to determine statewide need for services; and works in tandem with the Tribal and Regional Behavioral Health Authorities (T/RBHAs) to ensure efficient resource allocation permits system capacity to correlate with service demand. AHCCCS continues to work toward a data driven decision-making process when assessing prevention, intervention, and treatment needs for both mental health and substance use disorders. The State has received recommendations and has worked to incorporate comments suggesting improvements in reporting measures and expanding membership of the Behavioral Health Planning Council.

AHCCCS currently has active policies that allow for the assessment and monitoring of unmet needs at the contract level. Arizona Contractor Operations Manual (ACOM) Policy 415 Provider Network Development and Management Plan; Periodic Network Reporting Requirements ensure regular assessments of needs are taking place. This policy applies to AHCCCS Complete Care (ACC) and RBHA (Regional Behavioral Health Authority) Contractors. The policy states that provider networks shall be a foundation that supports an individual's needs as well as the membership in general. This policy establishes Contractor requirements for the submission of the Network Development and Management Plan and other periodic network reporting requirements. Specific items contractors are required to manage and report on include, but are not limited to, the following:

- Contractor's Workforce Development Plan
- Contractor's Value Based Purchasing/24/7 Access Points Report
- Evaluation of the prior year's Network Plan including:
  - Actions proposed in the prior year's plan,
  - Network issues over the past year that required intervention,
  - Interventions taken to resolve network issues,
  - Barriers to the interventions, and
  - Evaluation of the effectiveness of the interventions.
- Contractor's current network gaps
- Contractor's network development steps for the coming year based upon its review of the prior year's Network Plan, current identified gaps, and any other priorities identified in the current plan
- Contractor's analysis demonstrating it has the capacity and the appropriate range of services adequate for the anticipated enrollment in its assigned service area
- Description of the integrated network design by GSA for the following populations:
  - Members undergoing substance use disorder treatment:
    - Pregnant Women and/or Pregnant Women with Dependent Children,
    - Persons who use drug by Injection,
    - Adults, and
    - Children.
- General membership requiring access to the following types of substance use disorder treatment:
  - Medication Assisted Treatment,
  - Outpatient,

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- Intensive Outpatient,
- Partial Hospitalization, and
- Residential Inpatient.
- A description of subcontracts for substance abuse prevention and treatment through the Substance Abuse Block Grant (SABG) Block Grant utilizing capacity data including wait list management methods for SABG Block Grant Priority populations.

As the designated unit of the executive branch that is responsible for administering the MHBG (Mental Health Block Grant), AHCCCS ensures the following performance requirements are met:

- Subrecipients must submit a plan explaining how they will use MHBG funds to provide comprehensive, community mental health services to adults with serious mental illness (SMI) designation and children with serious emotional disturbances.
- Subrecipients to provide annual reports on their plans.
- Subrecipients may distribute funds to local government entities and non-governmental organizations.
- Subrecipients must ensure that community mental health centers provide such services as screening, outpatient treatment, emergency mental health services, and day treatment programs.
- Subrecipients must comply with general federal requirements for managing grants. They must also cooperate in efforts by SAMHSA to monitor use of MHBG funds. For example, each year, CMHS conducts investigations (site visits) of at least ten grantees receiving MHBG funds. This is to assess how they are using the funds to benefit the population. These evaluations include careful review of the following:
  - How the grantees are tracking use of MHBG funds and their adult and child mental health programs,
  - Data and performance management systems,
  - Collaboration with consumers and the grantees' mental health planning council, and
  - Grantees receiving MHBG funds are required to form and support a state or territory mental health/behavioral health planning council.
- Grantees receiving MHBG funds are required to form and support a state or territory mental health/behavioral health planning council.

The National Survey on Drug Use and Health (NSDUH), prepared by the Substance Abuse and Mental Health Services Administration (SAMHSA) provides the underlying methodology used by AHCCCS to quantify the need for substance abuse treatment in Arizona. On an annual basis, prevalence information from the NSDUH compares census data, both actual and estimated, for the State of Arizona. The results outlined treatment needs based on race/ethnicity, gender, and age group for the state, and then for each county and/or sub-state planning area.

AHCCCS policy requires that members with behavioral health needs undergo a clinical assessment, administered by a clinician through a mental health or substance use treatment program. The information gathered during this assessment process includes several identifiable factors, such as race

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and ethnicity, gender, and reasons for seeking treatment. According to [AHCCCS' Annual Report: Substance Use Treatment Programs State Fiscal Year 2019](#), between July 1, 2018, and June 30, 2019:

- 100,528 members were served with a substance use disorder,
- 15 percent were served by the northern GSA, 28 percent by the southern GSA, and 56 percent by the central GSA,
- 54.7 percent were male; 45.3 percent were female,
- 55.6 percent were white, 6.9 percent African American, 7.9 percent American Indian,
- 13.3 percent were under the age of 25; 4.1 percent were over the age of 65, and
- 19.4 percent used opiates, 18.8 percent alcohol, 19 percent marijuana, and 19.8 percent methamphetamines.

The Arizona Substance Abuse Partnership (ASAP) Epidemiology Workgroup was created in 2004 as a requirement of the Strategic Prevention Framework State Incentive Grant (SPF SIG) and continues to serve as an invaluable resource. The membership roster includes statisticians, data analysts, academics, holders of key datasets, other stakeholders from various state and federal agencies, tribal entities, private and non-profit substance abuse-related organizations, and universities. This group provides data management and analytics related to substance use and impacts within Arizona. The objective is data-driven analytics to inform decision-making to prevent, assess risks, evaluate treatments, and develop priorities. The analysis integrates, links, and associates data from multiple sources in Arizona for a comprehensive view of status and trends. AHCCCS membership and attendance at this group is necessary to ensure data reports and trends are incorporated into the planning of all substance abuse prevention, treatment, and recovery efforts. The Epidemiology Workgroup has been an integral part to AHCCCS' substance abuse prevention planning efforts, including the development and implementation of statewide needs assessments, strategic plans, and evaluation efforts.

In 2017, the ASAP launched an [interactive data dashboard](#) to provide timely data about the opioid epidemic in Arizona. The dashboard is a tool that the Arizona Department of Health Services (ADHS), Governor's Office of Youth, Faith, and Families (GOYFF), and AHCCCS use to develop interventions that will keep Arizona's communities safe. Data is displayed at multiple levels, across demographics, and over time, including tables, graphs, maps, and downloadable data files covering a variety of reporting and visualization needs.

According to a February 2021 publication from the Arizona Public Health Association, the rates of opioid and other drug related deaths have accelerated over the past year, particularly in the synthetic opioid category that includes fentanyl.

AHCCCS also relies on the results of data management and numerous qualitative surveys to determine need and direct resources accordingly. Data management on process-related performance measures occurs with contracted providers and partners reporting independent numbers no less than quarterly. The reports are then aggregated by the AHCCCS Office of Data Analytics (AODA) within the Division of Health Care Management (DHCM). Data management and analysis on impact and outcome measures occur across the partner agencies; including agencies involved in the Opioid Monitoring Initiative.

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Sending this information to AHCCCS ensures a central location for consistent packaging and reporting to SAMHSA and for public dissemination. Qualitative surveys are critical to identifying potential service gaps, as they capture the human component and the effect a lack of services can have on a community which quantitative analysis cannot adequately determine.

### Needs and Gaps of Arizona's Substance Use Disorder Primary Prevention Continuum

AHCCCS finalized a statewide substance abuse prevention needs assessment in September 2018 that highlighted areas of needs in the current statewide primary prevention system structure. The assessment generated a community prevention inventory, conducted focus groups throughout AZ, conducted key informant interviews throughout AZ, conducted an online Substance Use Prevention Workforce survey, and synthesized secondary data analysis for a multitude of data sources. In response to the completed needs assessment and following the Strategic Prevention Framework (SPF) model, AHCCCS began a Strategic Planning process utilizing an outside vendor. More than 40 stakeholders representing statewide prevention efforts were a part of the planning process, including but not limited to the following entities: local community coalitions, RBHAs, TRBHAs, Governor's Office of Youth, Faith, and Family (GOYFF), Drug Enforcement Agency (DEA), High Intensity Drug Trafficking Area (HIDTA), Arizona National Guard Counter Drug Task Force, Arizona State University (ASU), and University of Arizona (UA) were involved in the planning efforts within the development of the Strategic Plan. "Individuals, families and communities across Arizona are informed, connected, engaged, and health" was the vision developed during the planning process, the following items identified as the purpose for AHCCCS prevention services:

- Engage stakeholders to minimize duplication, ensure efficiency, and build capacity,
- Assess strengths and needs to address root problems and ensure all communities are served,
- Respect and engage different cultures and perspectives to ensure an inclusive process and equitable outcomes,
- Educate and inform stakeholders to increase understanding and buy-in, and
- Collect and monitor data on implementation and outcomes to guide continuous quality, improvement and ensure program effectiveness.

The data collected as part of the 2018 needs assessment contributed to the following 10 major findings related to substance use and mental health needs:

- An increasing number of Arizonans of all ages and in all regions are suffering from untreated mental health issues that are leading to substance use and/or misuse.
- LGBTQ+ identified individuals in all regions are experiencing significantly more risk factors for, consequences of, and issues with substance use and/or misuse as compared to non-LGBTQ+ identified individuals.
- Vaping (e-cigarettes, etc.) is increasing in Arizona for youth in middle and high schools and is significantly higher than national averages.

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- The counties that are experiencing the most severe consequences of substance use in Arizona are: (1) Gila County, (2) Navajo County, (3) Mohave County, and (4) Pima County.
- A lack of social support and/or someone to turn to/talk to is a protective factor for substance use and/or misuse to which many Arizonans do not have access.
- The normalization of marijuana and other substances may be leading to increased substance use.
- Reductions in funding and resources for schools prohibit effective prevention programs from being delivered to high needs communities.
- Recent efforts to combat the prescription drug opioid crisis in Arizona are leading to increased street drug use.
- Prevention programs that are culturally competent, engaging, and up to date are more effective and should be prioritized.
- If basic needs are not being met (e.g., shelter, food, safety, physical health, mental health, social support, etc.) then prevention programs and efforts often fail.

While this assessment was completed prior to the onset of the COVID-19 pandemic, AHCCCS has noted an increase in related substance use and mental health needs among Arizonans through both administrative and anecdotal data sources. Statewide data sources and survey implementations have been impacted and/or delayed by COVID-19 but preliminary data indicates an increased need for additional services within the state due to the pandemic.

The Arizona Department of Health Services (ADHS) recently released Opioid related death data, and 2020 numbers show that the state has seen an increase in Opioid deaths since the onset of the pandemic (confirmed through death certificate data reported to ADHS Vital Records). Figure 1 shows the increase based on current numbers:

*Figure 1. Arizona Opioid Deaths 2019 & 2020 (ADHS, 2021)*

Month	2019	2020*
January	105	142
February	81	118
March	105	159
April	103	144
May	110	181
June	89	212
July	133	224
August	128	196
September	129	136
October	128	159
November	118	165
December	130	124
<b>TOTAL Year to Date</b>	<b>1359</b>	<b>1960</b>

The counties that have seen the highest increased rates of opioid deaths per 100,000 citizens are



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Maricopa (30.59), Pima (30.25), and Yavapai (27.54). (ADHS, 2021) The age group experiencing the highest rates of opioid deaths continues to be Arizonans aged 25-34, with this age group reporting 603 deaths in 2020, and 362 deaths in 2019. (ADHS, 2021) Arizona's youth have shown an uptick in opioid-related deaths, with 14 deaths in the under 15 years age group (data suppressed in 2019 due to less than 10 occurrences), and 361 deaths in the 15-24 age groups (reported 227 deaths in 2019). (ADHS, 2021) In terms of substances involved within verified opioid overdoses, fentanyl was the outlier reported in 42.4 percent of overdoses. Oxycodone was the second highest substance reported at 15.2 percent. Heroin and benzodiazepines each reported at 10.7 percent of Arizona's overdoses. (ADHS, 2021)

The 2020 Arizona Youth Survey administered by the Arizona Criminal Justice Commission (ACJC) during the COVID-19 pandemic shows that alcohol, e-cigarettes, and marijuana use are the top three substances used by Arizona youth in grades eight through 12 for more than 30 days. When asked for the reasons for using substances, youth cited the following reasons, in order of prevalence:

1. To have fun,
2. To get high or feel good,
3. To deal with the stress from my school,
4. To deal with the stress from my parents and family, and
5. I was feeling sad or down.

It should be noted that each of these reasons for use have increased by approximately 4-5 percentage points from the previous survey administration in 2018. The reason for use with the largest increase in 2020 was "I was feeling sad or down." This preliminary data corroborates anecdotal data AHCCCS has received from stakeholders and contractors stating that Arizona's youth are experiencing increased mental health needs that lead to increased substance misuse, especially in the wake of isolation resulting from COVID-19. The closure of schools, after school activities, youth groups, sports, and faith-based activities has contributed to the feelings of isolation and the reduction of protective factors for substance abuse and mental health needs among Arizona youth. Efforts have been made statewide to continue services virtually using teleconferencing, social media, and various online platforms, yet access to reliable internet connections and the necessary technological infrastructure continue to be an issue, especially in rural and remote areas within the state.

Through a collaboration with the Arizona National Guard's Counter Drug Task Force and other stakeholders including the Governor's Office of Youth, Faith and Family (GOYFF); Arizona Department of Health Services (ADHS); local substance abuse prevention leaders; and Banner Health Poison and Drug Information Center, Arizona has begun identifying areas of "prevention deserts" within the state. These are areas of high need based on substance abuse rates, substance abuse related consequences, rate of population growth in the last 10 years, and location within the state. For example, border towns or regions considered frontier (meaning the location is sparsely populated and is geographically isolated from population centers and services) have little or no prevention services or infrastructure such as community mobilization (e.g., coalition development). Through the development of a mapping tool that includes the identification criteria listed above, Arizona has identified and prioritized the following areas

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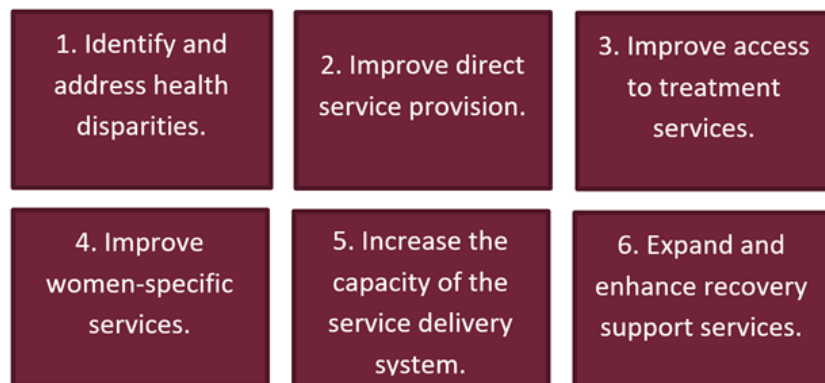
as prevention deserts that must be targeted for enhanced development and prevention service infrastructure building:

- Avondale,
- Casas Adobes,
- Gilbert,
- Goodyear,
- Queen Creek,
- San Tan Valley,
- Surprise,
- Winslow/Holbrook, and
- Yuma.

While AHCCCS has made SABG prevention services available to the entire state, it should be noted that the areas identified above did not submit a bid for prevention services during the last procurement opportunity in December 2020. Through fact-finding meetings with local stakeholders, it was discovered that while the need for services is apparent within these communities, they do not have the basic infrastructure to complete a grant application. This fact is driven by a lack of prevention champions and organizations, which are critical and necessary to lead mobilization efforts; and lack of mentoring from nearby established coalitions to build local prevention efforts, hold town hall meetings, and mobilize training for active community members. Adding these infrastructure building activities will lead to the formation of coalitions and /or community-based organizations that can lead prevention efforts in their areas.

### Needs and Gaps of Arizona’s Substance Use Disorder Service Continuum

Arizona has identified six key areas of need and gaps related to intervention, treatment, and recovery services.



#### 1. Identify and Address Known Health Disparities Related to Substance Use Disorder (SUD).

- SUD treatment and recovery needs of Arizonans have changed significantly due to the COVID-19 pandemic. There is a need to gather meaningful, reliable data on the current needs of the “new

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normal” so that the service delivery system is adaptive to changing community needs. AHCCCS seeks to identify prominent health disparities among gender, age, race/ethnicity, sexual orientation, and geography based on data, establish baseline data, and track measurable outcomes, and determine where resources are inadequate or inaccessible to meet SUD intervention, treatment, and recovery needs.

- With additional funding opportunities, more direct communication regarding the unique needs of local communities, particularly rural and remote communities, is necessary. This relationship and information are required to strategically direct critical resources to expand broad-based state and local community strategies and approaches to address SUD prevention, intervention, treatment, and recovery support services.
- Alcohol-induced deaths are more prevalent in rural and remote counties, signaling a need for additional innovations and interventions. According to 2019 data released by the Arizona Department of Health Services (ADHS), the mortality rate for alcohol-induced deaths was 17.7 per 100,000 statewide, and there are astounding discrepancies in Apache (72.4), Navajo (71.8), La Paz (58.9) and Gila (52.6) counties. Alcohol-induced deaths comprised 2.1 percent of the statewide total deaths with a disproportionate prevalence of 7.2 percent in Apache, 5.7 percent in Coconino, 4.2 percent in La Paz and 6.8 percent in Navajo counties.

### 2. Improve Direct Service Provision Among SUD Treatment Providers.

The following treatment needs and gaps emerged from results of the [2020 Independent Case Review](#) of the current service delivery continuum.

- Statewide, screening for tuberculosis was documented in only 57 percent of cases, and screening for hepatitis C, human immunodeficiency virus (HIV), and other infectious diseases was present in only 45 percent of cases.
- Utilization of natural supports in the development of individual service plans (ISPs) was significantly lower than expected. Only 14 percent of cases document the inclusion of family or other supports in treatment planning.
- AHCCCS’ Fiscal Year 2022 Strategic Plan includes the objective, “Standardize treatment planning and placement for individuals with substance use disorder.” AHCCCS has been promoting the use of the ASAM (American Society of Addiction Medicine) Continuum Tool and will be requiring its use statewide by October 2022. While a high percentage (86 percent) of SUD treatment providers use the ASAM criteria as part of the initial assessments according to 2020 ICR results, only 42 percent of cases documented the use of ASAM criteria during treatment to reassess the appropriate level of care. It is expected that ASAM criteria be used to reassess levels of care during treatment.
- In 2020, 81 percent of providers used social determinants of health (SDOH) information from the initial assessments to inform treatment decisions, yet most providers did not incorporate SDOH issues during treatment (other than transportation), even when SDOH concerns were identified in the initial assessment. AHCCCS’ Whole Person Health Initiative includes addressing the SDOH while accessing care, including SUD treatment. Health Current, the state’s designated Health Information Exchange (HIE), is implementing a [closed loop referral system](#) in partnership

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with AHCCCS and Soleri. This will streamline referrals from health services to social services, which will be new to the SUD provider community.

- Most cases (66 percent) failed to provide any documentation as to whether the client was attending self-help recovery groups. To maximize recovery efforts, it is critical that treatment providers discuss, offer, and connect individuals to self-help recovery groups as part of treatment planning and relapse prevention. There is a need to strengthen the relationships between SUD treatment providers and self-help recovery groups.
- In only 55 percent of the reviewed cases, providers documented completion of a relapse prevention plan prior to discharge. There is a clear need to improve discharge planning to include an array of recovery and relapse prevention services/supports.
- Once individuals disengaged from services, providers had difficulty re-engaging them. There is a need to increase the use of scientifically based outreach strategies and low barrier programming to engage and re-engage individuals.

### 3. Improve Access to SUD Treatment Services, Particularly for Underserved and High-risk Populations.

- There is a need to develop the use of digital therapeutics as a part of addiction treatment. Leveraging computer-based and mobile technologies improves access to evidence based medical and psychological treatments. Because most people have a mobile phone, this is an effective way to reach underserved and rural or frontier areas/communities. The Arizona Department of Health Services (ADHS) and AHCCCS jointly identified the need to expand the use of telehealth for Medication Assisted Treatment (MAT) treatment as a key recommendation within the [Arizona Opioid Action Plan](#). Arizona has made progress towards this goal by developing the use of FDA-approved medications and digital therapeutics as a part of addiction treatment that will improve the effectiveness of interventions.
- There continue to be needs related to information technology infrastructure, including the availability of broadband and cellular technology for providers, especially in rural and remote areas, and use of Global Positioning System (GPS) to expedite response times and to remotely meet with the individual in need of services. Broadband is being addressed statewide by another state agency. More information is needed to determine the equipment and network gaps provider agencies need to improve their service delivery and accessibility.
- Advance telehealth opportunities to expand services (i.e., counseling, assessment, case management, care coordination, intake, medication management, recovery coaching, peer services, etc.) for hard-to-reach locations, especially rural and remote areas. Expand technology options for callers, including the use of texting, telephone, and telehealth. Treatment providers have indicated a need for webcams, tablets, headsets, offline capabilities for Electronic Health Records, Wi-Fi connectivity improvements, satellite phones for remote areas, and mobile technology infrastructure to enable telehealth appointments during outreach efforts.
- AHCCCS is expanding harm reduction contracts and evidence-based supports to ensure comprehensive programming statewide, including remote and rural areas. [Naloxone distribution](#), education, and training have been key components of AHCCCS' harm reduction

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contracting and will remain primary areas of focus. According to a February 2021 publication from the Arizona Public Health Association, the rates of opioid and other drug related deaths have accelerated over the past year, particularly in the synthetic opioid category that includes fentanyl. In the last legislative session, the Arizona State Legislature passed legislation and Governor Ducey signed into law public policy allowing the use of fentanyl testing strips and syringe service programs (including access to and disposal of sterile syringes and injection equipment). AHCCCS will procure services for a comprehensive harm reduction contract to begin on January 1, 2022. There is a need for funding to expand contract requirements to include a statewide evidence-based harm reduction program inclusive of scientifically based outreach, education, training, naloxone distribution, fentanyl testing strips, and a syringe service program (once approved by the Centers for Disease Control (CDC) and SAMHSA).

- Based on current data related to health disparities, there is a need to continue the development and implementation of culturally appropriate approaches to substance use and alcohol use treatment for American Indian/ Alaska Native (AI/AN) in Arizona.
- People with substance use disorders are more likely than those without SUDs to have co-occurring mental disorders. They are also less likely to receive substance use treatment. When accessing services, there is a gap between the treatment and service needs of persons with co-occurring disorders and the care they receive. Using SAMHSA's [Treatment Improvement Protocol 42](#), substance use disorder treatment providers must continue to develop the evidence-based practices, skills, and expertise to screen, assess, and treat the unique needs of each individual, particularly persons with complex challenges and co-occurring disorders.

#### 4. Improve Women-specific Services.

The number of women with substance use disorder accessing services has increased by more than 10 percent since the COVID-19 pandemic. In 2018, 125,065 women diagnosed with substance use disorder were enrolled in services for nine months or more. By 2020, that number increased to 140,539. Expenditures increased from \$69.88 per woman, per month to \$99.64 per woman, per month, indicating an increase in utilization of higher cost services.

- Recent 2020 file review results indicate that only 28 percent of women statewide had access to women-specific SUD treatment services. For the same year, the Operational Review conducted by AHCCCS with all three regional behavioral health authorities resulted in identification of concerns related to gender specific treatment. Using SAMSHA's Treatment Improvement Protocol (TIP) 51, there is a need to increase the continuum of treatment and recovery options available to women (including pregnant and parenting women) that are tailored to their needs. Currently, there is little evidence of SUD treatment providers addressing healthy relationships, sexual and physical abuse, reproductive wellness, and other culturally responsive treatment services.
- The Steering Committee of Arizona's Pregnant and Postpartum Women Pilot Project (PPW-PLT) has identified several systems-level needs, such as training and screening for postpartum depression, identifying peer and family supports and providers who are trained and willing to

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work with pregnant women with substance use disorder, and integrating services among SUD treatment providers and family service agencies.

- AHCCCS' fiscal year 2022 Strategic Plan includes an objective to "reduce health disparities." AHCCCS needs to improve care for American Indian/Alaska Native (AI/AN) women. AI/AN women are more likely to have substance use disorder, have access to fewer services, and have higher utilization costs than women of other races. According to Census data, American Indians comprise 5.3 percent of the Arizona population, yet 11 percent of the Arizona women with substance use disorder are American Indians. In contrast, 82.6 percent of the Arizona population is Caucasian, and 50 percent of the Arizona women with SUD are Caucasian. In an analysis of 2018-2020 medical claims data of women with substance use disorder accessing medical services, for outpatient services, AI/AN women were below the statewide average in four of seven of the highest use categories, indicating they have access to fewer services than women of other races. Expenditures per Caucasian woman averaged \$90.73 per woman, per month in 2020, yet the cost per AI/AN woman was \$207.37 for the same year, nearly double.

### 5. Increase the Capacity of the Service-delivery System to Meet the Evolving Needs.

- AHCCCS seeks to increase network capacity for existing substance use disorder detox facilities to allow for same-day or next-day appointments, and low barrier approaches.
- AHCCCS seeks to increase network capacity for existing substance use disorder outpatient clinics in areas of greatest need. Expanding the hours of operation to evenings and weekends will enable Arizonans to see their care team on the same day. Evening and weekend availability will prevent crisis intervention and facilitate access to timely lower levels of care. Teams can respond to situations with a community-based response, providing Arizonans services where they are to address their behavioral health and treatment service needs.

### 6. Expand and Enhance a Range of Recovery Support Services.

- Arizona's epidemiological profile suggests a lack of affordable recovery housing throughout the state due to increased substance use during the COVID-19 pandemic. The demands for treatment services, recovery services/supports, and affordable housing have escalated in the past year. There is a need to create additional recovery housing options and sustain these options over time.
- According to 2020 ICR results, only 36 percent documented that peer support services were offered as part of the treatment plan. While the network of peer and family support specialists for SUD populations has increased in Arizona, those seeking these services are often unaware of how to access them, particularly in rural and remote areas of the state. Northern Arizona has been identified by the Behavioral Health Planning Council as an area in which peer and family support services are not readily accessible. Given the identified stigma challenges and the number of individuals with SUD who do not receive treatment, there is a need to increase public awareness of peer services and reduce barriers to entering and retaining in treatment services.

### Needs and Gaps of Arizona's Mental Health Services Continuum

AHCCCS assesses the mental health services continuum needs and gaps through multiple means, including qualitative feedback from ongoing stakeholder engagement efforts, needs assessments, tracking of mental health service utilization trends, and assessment of quality metrics. Based on the review of these data sources, the mental health services continuum needs in Arizona include:

#### 1. The need to develop standardized processes to identify, refer, and assess children for an SED designation.

To address the mental health needs of children in Arizona, the appropriate identification and referral mechanisms for assessment of SED must exist for child-serving systems. The systems that most commonly interface with children include the education system as well as primary care providers. Informing and providing the education system and primary care providers with a user-friendly interface for referral for SED assessment will improve early identification and initiation of service delivery for children designated as SED. This strategy will also augment the current behavioral health in schools initiative in Arizona as well as the Targeted Investments efforts to improve access to mental health care in educational and primary care settings.

In addition, Arizona will benefit from standardization of the functional impairment criteria for an SED designation as well as an assessment process. Based on a recent Statewide analysis conducted, there is variation of how functional impairment is defined and applied for SED designation.

#### 2. The need to expand access to evidence-based mental health care for justice-involved youth with an SED designation.

Minority youth in Arizona's juvenile justice system are disproportionately represented when compared to the general youth population. For example, in 2020, of the youth committed to the Arizona Department of Juvenile Corrections (ADJC), 15 percent were African American, 13.5 percent bi-racial, and 44.9 percent Hispanic. The most recently available Arizona census data for 2019 demonstrates that 5.2 percent of Arizona youth are African American, 2.9 percent biracial, and 31.7 percent. Addressing the mental health needs of youth in the juvenile justice system is a critical component to reducing the risk of recidivism and thus addressing these disparities.

During conversations with peer and family support providers, needs identified included:

- Parent peer support services to assist parents with navigating the behavioral health system,
- Reach-in services to assist juveniles exiting detention to facilitate and connect to services immediately upon release, and
- Increased technological infrastructure to conduct virtual services during the COVID-19 pandemic.

AHCCCS conducted a targeted needs assessment for justice-involved youth with an SED designation. Overall findings of this needs assessment, which included data gathering from key informant interviews

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and focus groups with youth currently in detention facilities, demonstrates the need for improved coordination of care with the outpatient mental health provider prior to release through reach-in activities and improved access to mental health care for youth on probation or parole. Additionally, based on ongoing justice system collaboration efforts and lessons learned from the AHCCCS Targeted Investments (TI) co-located behavioral health model for adults, co-location of behavioral health providers within juvenile probation and parole offices will increase access to mental health services for children with an SED designation who are involved with the juvenile justice system.

Coupled with the efforts of reach-in programs for juvenile detention and co-location with juvenile probation or parole, there is an ongoing need to increase the behavioral health system capacity to implement evidence-based treatment for justice-involved youth with an SED designation. For example, currently Arizona only has one behavioral health provider certified in Multisystemic Therapy<sup>®</sup> (MST<sup>®</sup>). Expanding the behavioral health provider system capacity to implement MST and other evidence-based treatments for justice-involved youth will be an important strategy to reduce the risk of recidivism and improve prosocial behaviors including school attendance and living at home.

### **3. The need to expand the primary care workforce capacity to serve children designated with SED through access to child and adolescent psychiatrists and other mental health specialists.**

Arizona, like other states, has a shortage of child and adolescent psychiatrists and other licensed mental health professionals to serve children designated with SED. Although AHCCCS has made progress with expanding access to mental health care through primary care providers based on integration efforts, including the Targeted Investment Program, additional capacity is necessary to serve the increasing number of children who present with mental health needs in light of the COVID-19 pandemic. One model that has demonstrated success in other states is the Child Psychiatry Access Program (CPAP), which provides primary care providers with direct access to child and adolescent psychiatrists and other pediatric mental health specialists.

### **4. The need to expand evidence-based practices for adults designated with SMI (Seriously Mental Illness) including Assertive Community Treatment (ACT), Supportive Housing, Supported Employment, and Peer Support.**

Historically, the development and fidelity monitoring of these services focused on Maricopa County, the most populous county in Arizona. Efforts to expand this work into Northern and Southern Arizona have shown promise despite multiple challenges, including behavioral health provider shortages and the rural nature of many of these regions. Existing service providers in these regions benefit from extensive technical assistance to develop the infrastructure and provide services that meet fidelity to criteria established by SAMHSA.

Considering the additional difficulties in accessing affordable housing brought forth during the COVID-19 pandemic, there is a critical need to expand upon the supportive housing services available, while also ensuring that housing, once located, can be maintained. Housing maintenance needs include intensive supportive services focused on individuals at risk of eviction to ensure that they are not displaced from



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their homes. While there have been multiple programs recently established to provide monetary support to acquire and maintain housing, individuals require additional support in learning how to furnish their home, pay for groceries and utilities, and to budget, to make their housing stable and sustainable.

During conversations with peer and family support providers, the following needs were also identified:

- Reach-in services to individuals exiting the justice system to facilitate and connect to support services immediately upon release,
- Transitional housing and services/support continues to be a need,
- Workforce development and capacity building to enhance/increase current peer support capacity, as well as to train new peer paraprofessionals to meet the increased demand for services,
- Intensive transitional step-down programming for individuals transitioning from inpatient settings, and
- Increased technological infrastructure to conduct virtual services during the COVID-19 pandemic.

Additionally, individuals with an SMI designation, including those who experience homelessness, may not have the proper identification documents that are required for social security applications, applying for benefits, and/or are required for access to housing, social, medical, and financial services. Mobile digital identity solutions using digital wallet technology will assist individuals with applying for these benefits and/or services.

### **5. The need to expand and enhance service delivery for individuals with intellectual and developmental disabilities (IDD) and an SMI designation.**

Individuals with an IDD and have an SMI designation are at risk of delayed identification and treatment of their co-occurring mental illness, which may result in higher levels of care utilization including extended hospitalization while awaiting appropriate treatment service availability. Factors contributing to the delayed identification and treatment include a limited mental health workforce with the expertise necessary to effectively identify and implement pharmacologic and non-pharmacologic treatment. The COVID-19 pandemic exacerbated these challenges, as social distancing and change in day treatment programming to limit the spread of COVID-19 has resulted in increased community isolation for these individuals.

### **Needs and Gaps of Arizona's Crisis Continuum**

Consistent with AHCCCS efforts to identify needs and gaps within the mental health services continuum, AHCCCS also assesses the crisis services continuum needs and gaps through multiple means, including the completion of a crosswalk between Arizona's current crisis system infrastructure against SAMHSA best practice, qualitative feedback from ongoing crisis stakeholder engagement efforts, and tracking of crisis service utilization trends. Based on the review of these data sources, the crisis services continuum

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needs in Arizona consist of the need to further develop a comprehensive 24/7 crisis continuum for children with an SED designation and their families.

Arizona, like other states, is seeing an increase in emergency department boarding for children. This trend is due to multiple factors, including the additional stressors brought upon by the COVID-19 pandemic, coupled with the lack of the availability of 23-hour crisis stabilization units, short-term residential treatment options, and intensive specialized wraparound. Children that are particularly at risk of extended emergency department boarding include children with an SED designation under the age of 12, children with co-occurring IDD, and children with multi-system involvement. Currently, only southern Arizona (Pima County) has a designated 23-hour crisis stabilization unit for children, which further exacerbates emergency department boarding.

The availability of the full continuum of crisis services for children designated with an SED designation is compounded by the shortage of mental health providers in the public behavioral health system. Although this issue is not new in Arizona, it has been further exacerbated by the COVID-19 pandemic as behavioral health providers report loss of workforce due to family commitments (e.g., parents staying home to support their child with at-home learning), the availability of other job opportunities, and other factors. Specific models of care that support the behavioral health workforce, including professional development opportunities, access to technology to ease workflow, and coaching are critical to maintain the public behavioral health system workforce.

Lastly, although the coverage of telehealth for behavioral health service delivery is robust in Arizona, many of the services and supports through the crisis continuum cannot be appropriately provided via telehealth modalities. For example, mobile teams and the higher levels of care such as inpatient hospital and residential must be provided in-person. Additionally, while creative hybrid telehealth and in-person models for wraparound exist, children with an SED designation and their families in crisis often benefit from in-person support. Thus, further professional development opportunities for the behavioral health workforce, including parent and family support services to provide both in-person and virtual care are essential for crisis stabilization for youth and families.

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# Planning Tables

**Table 1 Priority Areas and Annual Performance Indicators**

<b>Priority #:</b>	1
<b>Priority Area:</b>	Youth Underage Alcohol (Prevention)
<b>Priority Type:</b>	SAP
<b>Population(s):</b>	PP, Other (LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

**Goal of the priority area:**

Decrease the percentage of youth reporting past 30-day alcohol use (more than just a few sips) from the 2020 levels of 9.0% to 7.0% of those in the 8th grade, 17.6% to 15.6% of those in the 10th grade, and 27.3% to 25.3% of those in the 12th grade, as measured by the 2022 Arizona Youth Survey.

**Strategies to attain the goal:**

Provide education on available evidence based practices related to addressing underage alcohol use, and provide training on how to choose EBPs based on community need. Increase the use of Evidence Based Programs (EBP) with activities to include:

Enhancing the ability of local community coalitions to more effectively provide prevention services for alcohol including organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building and networking.

Provide alternatives for underage drinking for youth including drug free dances and parties, Youth/adult leadership/mentor activities, community drop-in centers and community service activities.

Establish or change written and unwritten community standards and codes and attitudes that factor into underage alcohol use, including promoting the establishment or review of alcohol, tobacco and drug use policies in schools, technical assistance to communities to maximize local enforcement, procedures governing availability and distribution of alcohol, tobacco, and other drug use, modifying alcohol and tobacco advertising practices, and product pricing strategies.

Provide underage alcohol use education and educational opportunities that involve two-way communication and is distinguished from the Information Dissemination by the fact that interaction between the educator/facilitator and the participants is the basis of its activities, including education to affect critical life and social skills, decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.

Provide awareness and knowledge of the nature and extent of local and state underage alcohol use, abuse and addiction and their effects on individuals, families and communities, and increase awareness of available prevention programs and services through clearinghouse/information resource center(s), resource directories, media campaigns, brochures, radio/TV public service announcements, speaking engagements, and health fairs/health promotion.

Identify those who have indulged in illegal/age-inappropriate use of alcohol in order to assess if their behavior can be reversed through education, including student assistance programs, and driving while under the influence/driving while intoxicated education programs.

**Annual Performance Indicators to measure goal success**

<b>Indicator #:</b>	1
<b>Indicator:</b>	Annual Performance Indicators to measure success on a yearly basis
<b>Baseline Measurement:</b>	The percentage of Arizona students reporting past 30 day alcohol use (more than just a few sips) from the 2020 levels of 9.0% to 7.0% of those in the 8th grade, 17.6% to 15.6% of those in the 10th grade, and 27.3% to 25.3% of those in the 12th grade, as measured by the 2022 Arizona Youth Survey.
<b>First-year target/outcome measurement:</b>	Reduce the amount of Arizona students reporting past 30 day alcohol use (more than just a few sips) from the 2020 levels of 9.0% to 8.0% of those in the 8th grade, 17.6% to 16.6% of those in the 10th grade, and 27.3% to 26.3% of those in the 12th grade, as measured by the 2022 Arizona Youth Survey.
<b>Second-year target/outcome measurement:</b>	The percentage of Arizona students reporting past 30 day alcohol use (more than just a few sips) from the 2020 levels of 9.0% to 7.0% of those in the 8th grade, 17.6% to 15.6% of

those in the 10th grade, and 27.3% to 25.3%% of those in the 12th grade, as measured by the 2022 Arizona Youth Survey.

**Data Source:**

Arizona Youth Survey (AYS)

**Description of Data:**

Data obtained from the Pre and Post Tests (Adolescent Core Measure) from the AYS

**Data issues/caveats that affect outcome measures:**

AYS is released every two years and has an impact on annual reporting.

<https://www.azcjc.gov/Programs/Statistical-Analysis-Center/Arizona-Youth-Survey>

**Priority #:**

2

**Priority Area:**

Youth Underage ATOD (Prevention)

**Priority Type:**

SAP

**Population(s):**

PP, Other (LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disabilities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

**Goal of the priority area:**

Reduce the amount of Arizona students with high risk (defined as the percentage of students who have more than a specified number of risk factors operating in their lives; 8th grade: 8 or more risk factors, 10th & 12th grades: 9 or more risk factors) from 32.0% in 2020 to 30.0%, as measured by the 2022 Arizona Youth Survey.

**Strategies to attain the goal:**

Provide education to increase awareness of available evidence based practices that address community, family, school, and peer/individual risk factors, and provide training on how to choose EBPs based on community need. Activities to include:

Enhancing the ability of local community coalitions to more effectively provide prevention services for ATOD including organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building and networking

Provide alternatives of ATOD use for youth including drug free dances and parties, Youth/adult leadership/mentor activities, community drop-in centers and community service activities.

Establish or change written and unwritten community standards and codes and attitudes that factor into ATOD use, including promoting the establishment or review of alcohol, tobacco and drug use policies in schools, technical assistance to communities to maximize local enforcement, procedures governing availability and distribution of alcohol, tobacco, and other drug use, modifying alcohol and tobacco advertising practices, and product pricing strategies.

Provide ATOD education and educational opportunities that involve two-way communication and is distinguished from information dissemination by the fact that interaction between the educator/facilitator and the participants is the basis of its activities, including education to affect critical life and social skills, decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.

Provide awareness and knowledge of the nature and extent of local and state ATOD use, abuse and addiction and their effects on individuals, families and communities, and increase awareness of available prevention programs and services through clearinghouse/information resource center(s), resource directories, media campaigns, brochures, radio/TV public service announcements, speaking engagements, and health fairs/health promotion.

Identify those who have indulged in illegal/age-inappropriate use of ATOD in order to assess if their behavior can be reversed through education, including student assistance programs, and driving while under the influence/driving while intoxicated education programs.

**Annual Performance Indicators to measure goal success**

**Indicator #:**

1

**Indicator:**

Annual Performance Indicators to measure success on a yearly basis

**Baseline Measurement:**

The percentage of Arizona students with high risk (defined as the percentage of students who have more than a specified number of risk factors operating in their lives; 8th grade: 8

or more risk factors, 10th & 12th grades: 9 or more risk factors) is 32.0%, according to the 2020 Arizona Youth Survey.

**First-year target/outcome measurement:** Reduce the amount of Arizona students with high risk (defined as the percentage of students who have more than a specified number of risk factors operating in their lives; 8th grade: 8 or more risk factors, 10th & 12th grades: 9 or more risk factors) from 32.0% in 2020 to 31.0%, as measured by the 2022 Arizona Youth Survey.

**Second-year target/outcome measurement:** Reduce the amount of Arizona students with high risk (defined as the percentage of students who have more than a specified number of risk factors operating in their lives; 8th grade: 8 or more risk factors, 10th & 12th grades: 9 or more risk factors) from 31.0% in 2020 to 30.0%, as measured by the 2022 Arizona Youth Survey.

**Data Source:**

Arizona Youth Survey (AYS)

**Description of Data:**

Data obtained from the Pre and Post Tests (Adolescent Core Measure) from the AYS.

**Data issues/caveats that affect outcome measures:**

AYS is released every two years and has an impact on annual reporting.

<https://www.azcjc.gov/Programs/Statistical-Analysis-Center/Arizona-Youth-Survey>

**Priority #:** 3

**Priority Area:** Tuberculosis

**Priority Type:** SAT

**Population(s):** TB

**Goal of the priority area:**

Increase the number of tuberculosis screenings for members entering substance abuse treatment.

**Strategies to attain the goal:**

Strategies that providers are and will continue to implement include integrating TB education, in addition to hepatitis C, HIV, and other infectious diseases into member orientations, educational material, referrals handouts for TB, hepatitis C, and HIV testing at specified locations, as well as including elements to capture TB screening documentation in contactor's audit tools.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** Annual Performance Indicators to measure success on a yearly basis

**Baseline Measurement:** FY 2020 data on the number of members receiving substance abuse treatment with documentation of TB services documented in their chart. Current baseline for SFY 2020 is 57%.

**First-year target/outcome measurement:** First-year target/outcome measurement (Progress to end of SFY 2021), 60%.

**Second-year target/outcome measurement:** Second-year target/outcome measurement (Final to end of SFY 2022), 65%.

**Data Source:**

Independent Case Review (ICR)

**Description of Data:**

A random sample of charts will be pulled and scored based on pre-determined elements that include documented evidence of screenings and referrals for TB services.

**Data issues/caveats that affect outcome measures:**

None noted.

**Priority #:** 4  
**Priority Area:** Suicide  
**Priority Type:** MHS  
**Population(s):** SMI, SED, ESMI

**Goal of the priority area:**

Reduce the Arizona Suicide Rate to 18.0% per 100,000 by the end of calendar year (CY) 2021. The rate is currently 18.7%.

**Strategies to attain the goal:**

HCCCS will continue to work collaboratively with other state agencies and stakeholders to implement suicide prevention strategies for all Arizonans, but specifically to address priority populations including: American Indians, those age 65 and older, the LGBTQI community, veterans, and teens. . Strategies will include but are not limited to community and conference presentations, social media messaging, social marketing/public awareness campaigns, youth leadership programs, gatekeeper trainings, improved data surveillance, and ongoing collaboration with stakeholders for systemic improvement.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** Annual Performance Indicators to measure success on a yearly basis  
**Baseline Measurement:** The suicide rate in Arizona for CY2020 was 18.7 per 100,000 population 1419 suicide deaths/population.  
**First-year target/outcome measurement:** First-year target/outcome measurement (Progress to end of CY 2021), 18.0 per 100,000.  
**Second-year target/outcome measurement:** Second-year target/outcome measurement (Final to end of CY 2022), 17.8 per 100,000.

**Data Source:**

The Centers for Disease Control and Prevention (CDC): <https://www.cdc.gov/nchs/pressroom/states/arizona/az.htm>

**Description of Data:**

Each Fall, the Arizona Department of Health Services, Division of Public Health and Statistics (ADHS/PHS) calculates the State's suicide rate by determining the number of death certificates of Arizona residents where "Suicide" was indicated by a medical examiner as the cause of death during the second most recent complete calendar year (i.e. CY 2021 data will be made available in Fall 2022). Aggregated across the general population, this number establishes a suicide rate per 100,000 persons.

**Data issues/caveats that affect outcome measures:**

AHCCCS and ADHS do not have a current data sharing agreement. AHCCCS suicide prevention team members have to wait for ADHS to publish their annual suicide data to understand what is happening statewide.

**Priority #:** 5  
**Priority Area:** Engaging youth with substance use disorder in treatment  
**Priority Type:** SAT  
**Population(s):** PWID, Other (Criminal/Juvenile Justice)

**Goal of the priority area:**

To increase the participation of youth with substance use disorder in appropriate intervention, treatment, and recovery services.

**Strategies to attain the goal:**

1. Pilot a pre-peer support program for youth in recovery.
2. Arizona Health Care Cost Containment System (AHCCCS) Managed Care Organizations (MCOs) lines of business will continue to collaborate and meet regularly with child/adolescent providers to share information on substance abuse screening, trends, and best practices.

- 3. Require contractors to provide and promote access to substance abuse training initiatives among child/adolescent providers including those employed through other agencies such as the OJJDP Detention Centers.
- 4. Pursue a standardized, parent-friendly, screening tool to identify substance use/abuse in the children and adolescents.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** In the last 12 months, the percentage of minors in the behavioral health system with a diagnosis of substance use disorder who received a substance use-related treatment service.

**Baseline Measurement:** SFY21 (7/1/20-6/30/21): 41.44%

**First-year target/outcome measurement:** By the end of SFY2022, at least 44% of the minors diagnosed with SUD will receive a SUD-related treatment.

**Second-year target/outcome measurement:** By the end of SFY2023, at least 47% of the minors diagnosed with SUD will receive a SUD-related treatment.

**Data Source:**

AHCCCS recipient data

**Description of Data:**

Denominator is the number of youth under the age of 18 diagnosed with any substance use disorder (need not be primary diagnosis) in the past 12 months.

**Data issues/caveats that affect outcome measures:**

**Priority #:** 6

**Priority Area:** Social determinants of health for individuals with substance use disorders

**Priority Type:** SAT

**Population(s):** PWWDC, PWID

**Goal of the priority area:**

Address the social determinants of health for individuals with substance use disorders to support stable, long term recovery.

**Strategies to attain the goal:**

1. Increase the funding invested in Oxford Houses.
2. Educate and encourage the participation of service providers in the Closed Loop Referral System.
3. Leverage supported housing opportunities provided through the Statewide Housing Administrator.
4. Alleviate barriers to accessing childcare.
5. Expand capacity for supported independent living programs.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** The number of Oxford Houses operating in the state of Arizona.

**Baseline Measurement:** For SFY2021, there were 41 houses.

**First-year target/outcome measurement:** By the end of SFY2022, there will be 44 houses.

**Second-year target/outcome measurement:** By the end of SFY2023, there will be 47 houses.

**Data Source:**

Contract deliverable to AHCCCS

**Description of Data:**



**Data issues/caveats that affect outcome measures:**

**Indicator #:** 2

**Indicator:** The number of non Title XIX childcare claims coded T1009 and/or funded alternatively through SABG.

**Baseline Measurement:** For SFY2021, there were 0 documented requests for reimbursable childcare services.

**First-year target/outcome measurement:** By the end of SFY2022, there will be 25 documented requests for reimbursable childcare services.

**Second-year target/outcome measurement:** By the end of SFY2023, there will be 100 documented requests for reimbursable childcare services.

**Data Source:**

AHCCCS claims and encounter data, and contract deliverable to AHCCCS

**Description of Data:**

Requests for reimbursable childcare services maybe documented in claims data or other contract deliverables.

**Data issues/caveats that affect outcome measures:**

**Priority #:** 7

**Priority Area:** Integration of family care and substance use treatment

**Priority Type:** SAT

**Population(s):** PWWDC

**Goal of the priority area:**

Coordinate prenatal care, postpartum care, and substance use treatment.

**Strategies to attain the goal:**

1. Leverage the PPW-PLT Learning Collaborative to identify opportunities for cross sector collaboration, education, and referrals.
2. Identify a SUD screening tool or tools for providers of prenatal and postpartum treatment services that considers gender and cultural specific needs of pregnant and postpartum women.
3. Provide gender specific substance use disorder training to provider networks of both substance use disorder treatment, prenatal care, and postpartum treatment.
4. Conduct an environmental scan of providers (including peers) trained to address perinatal and postpartum depression among women with substance use disorder and develop an online resource guide.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** In last 12 months, percent of pregnant women enrolled in a SUD treatment program who accessed outpatient primary medical care within 3 months prior to the delivery of a baby.

**Baseline Measurement:** SFY21 (7/1/20 - 6/30/21): 11.58%

**First-year target/outcome measurement:** By the end of SFY2022, 15% of the pregnant women with SUD will access outpatient care within 3 months prior to delivery.

**Second-year target/outcome measurement:** By the end of SFY2023, 25% of the pregnant women with SUD will access outpatient care within 3 months prior to delivery.

**Data Source:**

AHCCCS recipient, claims and encounter data

**Description of Data:**

Denominator is the number of pregnant women enrolled to a SUD treatment service in the last 12 months.

**Data issues/caveats that affect outcome measures:**

**Indicator #:** 2

**Indicator:** In last 12 months, percent of pregnant women admitted to SUD treatment service who accessed outpatient care within 3 months after the delivery of a baby.

**Baseline Measurement:** SFY21 (7/1/20 - 6/30/21): 92.75%

**First-year target/outcome measurement:** By the end of SFY2022, 94% of the women in SUD treatment who gave birth will receive outpatient care within 3 months following delivery.

**Second-year target/outcome measurement:** By the end of SFY2023, 95% of the women in SUD treatment who gave birth will receive outpatient care within 3 months following delivery.

**Data Source:**

AHCCCS recipient, claims and encounter data

**Description of Data:**

Denominator is the number of pregnant women admitted to a SUD treatment service who gave birth in the last 12 months.

**Data issues/caveats that affect outcome measures:**

**Priority #:** 8

**Priority Area:** Retention in SUD treatment services

**Priority Type:** SAT

**Population(s):** PWWDC, PWID

**Goal of the priority area:**

Provide support to individuals receiving community SUD treatment services early in the treatment process that is gender specific and culturally responsive to improve completion rates of treatment programs.

**Strategies to attain the goal:**

1. Require contractors to plan to document in each individual service plan the individual's natural supports.
2. Require contractors to plan to increase the use of peer support services throughout the treatment and recovery processes.
3. Require contractors to document in the individual service plan when an individual declines peer support services and the reasons for declining.
4. Revise the Independent Case Review evaluation tool to reflect changes in requirements.
5. Require contractors to provide training and support to providers on evidence-based engagement strategies by providing training.
6. Identify providers to engage in developing a range of Practice-Based Evidence engagement strategies as defined by SAMHSA to support the positive culture and traditions of local communities.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** In last 12 months, percent of individuals receiving an SUD treatment service who continue to receive a SUD service every month for at least 3 consecutive months after enrollment in a SUD treatment program.

**Baseline Measurement:** SFY21 (7/1/20 - 6/30/21): 10.38%

**First-year target/outcome measurement:** By the end of SFY2022, 12% of the individuals receiving SUD services will sustain them for at least 3 consecutive months.

**Second-year target/outcome measurement:** By the end of SFY2023, 15% of the individuals receiving SUD services will sustain them for at least 3 consecutive months.

**Data Source:**

AHCCCS recipient data

**Description of Data:**

Denominator is all (unduplicated) individuals admitted to SUD treatment in the previous 12 months receiving a SUD service the month following admission.

**Data issues/caveats that affect outcome measures:**

**Indicator #:** 2

**Indicator:** In last 12 months, percent of files including documentation of natural supports.

**Baseline Measurement:** In the FY20 ICR, 14% of the files documented the inclusion of family or other supports in treatment planning.

**First-year target/outcome measurement:** By the end of SFY2022, 18% of the files reviewed will document the inclusion of family or other supports in treatment planning.

**Second-year target/outcome measurement:** By the end of SFY2023, 20% of the files reviewed will document the inclusion of family or other supports in treatment planning.

**Data Source:**

Independent Case Review

**Description of Data:**

**Data issues/caveats that affect outcome measures:**

**Indicator #:** 3

**Indicator:** In last 12 months, percent of files including documentation that peer or family support was offered as part of the treatment plan.

**Baseline Measurement:** In the FY20 ICR, 36% of the files documented that peer support services were offered as part of the treatment plan.

**First-year target/outcome measurement:** By the end of SFY2022, 45% of the files reviewed will document that peer support services were offered as part of the treatment plan.

**Second-year target/outcome measurement:** By the end of SFY2023, 55% of the files reviewed will document that peer support services were offered as part of the treatment plan.

**Data Source:**

Independent Case Review

**Description of Data:**

**Data issues/caveats that affect outcome measures:**

**Priority #:** 9

**Priority Area:** Substance use treatment that addresses the specific needs of women

**Priority Type:** SAT

**Population(s):** PWWDC

**Goal of the priority area:**

To improve treatment engagement, retention, and outcomes for women with substance use disorder

**Strategies to attain the goal:**

1. Implement a training collaborative for service providers focused on the unique needs of women with substance use disorder.
2. Formalize processes for monitoring gender specific treatment among contractors, including the use of the annual Independent Case Review, Operational Review, and Secret Shopper program.
3. Provide ongoing training through a learning management system on gender specific treatment for women with substance use disorder.
4. Leverage the PPW-PLT Learning Collaborative to identify emerging needs and address them.
5. Leverage opportunities in new contracts to require evidence-based and practice-based gender-specific treatment.
6. Revise Measure V of the Independent Case Review to collect more specific information on gender-specific treatment.
7. Define gender-specific treatment in contract and policy.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** Percentage of clinical files for women which include evidence that gender specific treatment (GST) was offered.

**Baseline Measurement:** For SFY2021, 28% of the files reviewed documented access to GST.

**First-year target/outcome measurement:** By the end of SFY2022, 35% of the files reviewed documented access to GST.

**Second-year target/outcome measurement:** By the end of SFY2023, 40% of the files reviewed documented access to GST.

**Data Source:**

Independent Case Review

**Description of Data:**

**Data issues/caveats that affect outcome measures:**

**Priority #:** 10

**Priority Area:** Persons Who Inject Drugs

**Priority Type:** SAT

**Population(s):** PWID

**Goal of the priority area:**

Increase the engagement of persons who inject drugs in harm reduction program services.

**Strategies to attain the goal:**

Expand harm reduction services by implementing programs through the state. Monitor the self-reported number of persons who inject drugs with harm reduction service providers.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** The number of persons receiving services from the harm reduction program services annuals who report injecting drugs.

**Baseline Measurement:** This baseline will be zero as this is not currently being monitored.

**First-year target/outcome measurement:** The number of individuals utilizing harm reduction program services in Calendar Year 2022.

**Second-year target/outcome measurement:** Increase the number of individuals utilizing harm reduction program services by 2% in Calendar Year 2023.

**Data Source:**

Harm Reduction RFP provider. Deliverables SABG Numbers Served Report quarterly report.

**Description of Data:**

Harm Reduction RFP provider. Deliverables SABG Numbers Served Report quarterly report.

**Data issues/caveats that affect outcome measures:**

The Indicator measure covers calendar years because the Harm Reduction RFP programming contract is on a calendar year basis. The deliverables are quarterly based on a calendar year.

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**Footnotes:**

## Planning Tables

**Table 2 State Agency Planned Expenditures [SA]**

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023. ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG) <sup>a</sup>	I. COVID-19 Relief Funds (SABG) <sup>a</sup>	J. ARP Funds (SABG) <sup>b</sup>
1. Substance Abuse Prevention <sup>c</sup> and Treatment										
2. Pregnant Women and Women with Dependent Children <sup>c</sup>	\$7,001,554.00								\$5,281,294.00	\$2,625,583.00
3. All Other	\$58,198,814.00		\$983,946,072.00	\$31,443,639.00	\$16,213,182.00				\$23,137,877.00	\$15,782,289.00
4. Primary Prevention <sup>d</sup>										
5. Substance Abuse Primary Prevention	\$17,386,765.00								\$7,578,446.00	\$4,908,767.00
6. Mental Health Primary Prevention										
7. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
8. Tuberculosis Services	\$0.00									
9. Early Intervention Services for HIV	\$0.00									
10. State Hospital										
11. Other 24-Hour Care										
12. Ambulatory/Community Non-24 Hour Care										
13. Administration (excluding program/provider level) MHBG and SABG must be reported separately	\$4,346,691.00			\$2,105,577.00					\$1,894,611.00	\$1,227,191.00
14. Crisis Services (5 percent set-aside)										
<b>15. Total</b>	<b>\$86,933,824.00</b>	<b>\$0.00</b>	<b>\$983,946,072.00</b>	<b>\$33,549,216.00</b>	<b>\$16,213,182.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$37,892,228.00</b>	<b>\$24,543,830.00</b>

<sup>a</sup> The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

<sup>b</sup> The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

<sup>c</sup> Prevention other than primary prevention

<sup>d</sup> The 20 percent set aside funds in the SABG must be used for activities designed to prevent substance misuse.

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**Footnotes:**

8/19/2021 - Arizona plans to expend 75% (\$24,543,830) of the ARP Award (\$32,725,106) during the timeframe 7/1/21 - 6/30/23.

6/20/22- Arizona has updated Column A to reflect the June 13, 2022 NOA - and to comply with revision request dated 5/23/22

## Planning Tables

**Table 2 State Agency Planned Expenditures [MH]**

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023. Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG) <sup>a</sup>	I. COVID-19 Relief Funds (SABG)	J. ARP Funds (MHBG) <sup>b</sup>
1. Substance Abuse Prevention and Treatment										
2. Pregnant Women and Women with Dependent Children										
3. All Other										
4. Primary Prevention										
5. Substance Abuse Primary Prevention										
6. Mental Health Primary Prevention <sup>e</sup>		\$0.00					\$0.00			\$0.00
7. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG) <sup>d</sup>		\$4,052,417.00					\$2,271,157.00			\$2,942,180.00
8. Tuberculosis Services										
9. Early Intervention Services for HIV										
10. State Hospital										
11. Other 24-Hour Care		\$2,593,548.00	\$788,961,262.00		\$35,106,056.00		\$1,453,540.00			\$1,691,947.00
12. Ambulatory/Community Non-24 Hour Care		\$29,825,793.00	\$3,545,401,951.00		\$157,758,163.00		\$16,715,712.00			\$19,457,389.00
13. Administration (excluding program/provider level) <sup>f</sup> MHBG and SABG must be reported separately		\$2,026,208.00	\$0.00	\$274,275.00			\$1,135,578.00			\$1,471,090.00
14. Crisis Services (5 percent set-aside) <sup>g</sup>		\$2,026,208.00					\$1,135,578.00			\$3,859,194.00
<b>15. Total</b>	<b>\$0.00</b>	<b>\$40,524,174.00</b>	<b>\$4,334,363,213.00</b>	<b>\$274,275.00</b>	<b>\$192,864,219.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$22,711,565.00</b>	<b>\$0.00</b>	<b>\$29,421,800.00</b>

<sup>a</sup> The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

<sup>b</sup> The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states

<sup>d</sup> Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

<sup>e</sup> While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

<sup>f</sup> Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

<sup>g</sup> Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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**Footnotes:**

8/19/2021 - Arizona plans to expend 75% (\$29,421,800) of the ARP Award (\$39,229,067) during the timeframe 7/1/21 - 6/30/23 .

06/20/22 - In compliance with Revision request 5/23/22 - AHCCCS has updated the Table 2 column B. planning application to reflect the increase in FY22 award received 5/20/22. The planning base for FY23 is level funding from FY22 award.

# Planning Tables

**Table 3 SABG Persons in need/receipt of SUD treatment**

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	4,133	986
2. Women with Dependent Children	24,340	5,574
3. Individuals with a co-occurring M/SUD	69,739	24,335
4. Persons who inject drugs	502	358
5. Persons experiencing homelessness	13,237	6,892

**Please provide an explanation for any data cells for which the state does not have a data source.**

Not applicable

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**Footnotes:**



# Planning Tables

**Table 4 SABG Planned Expenditures**

Planning Period Start Date: 10/1/2021      Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award <sup>1</sup>	ARP Award <sup>2</sup>	FFY 2023 SA Block Grant Award	COVID-19 Award <sup>1</sup>	ARP Award <sup>2</sup>
1 . Substance Use Disorder Prevention and Treatment <sup>3</sup>	\$32,600,184.00	\$28,419,171.00	\$18,407,872.00	\$32,600,184.00	\$27,806,097.00	\$18,407,872.00
2 . Primary Substance Use Disorder Prevention	\$8,693,382.00	\$7,578,446.00	\$4,908,767.00	\$8,693,382.00	\$7,288,888.00	\$4,908,767.00
3 . Early Intervention Services for HIV <sup>4</sup>	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
4 . Tuberculosis Services	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
5 . Administration (SSA Level Only)	\$2,173,346.00	\$1,894,611.00	\$1,227,191.00	\$2,173,346.00	\$1,808,746.00	\$1,217,693.00
<b>6. Total</b>	<b>\$43,466,912.00</b>	<b>\$37,892,228.00</b>	<b>\$24,543,830.00</b>	<b>\$43,466,912.00</b>	<b>\$36,903,731.00</b>	<b>\$24,534,332.00</b>

<sup>1</sup>The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

<sup>2</sup>The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

### <sup>3</sup>Prevention other than Primary Prevention

<sup>4</sup>For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant (SABG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC.), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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#### **Footnotes:**

8/18/2021 - Arizona plans to expend 75% of the ARP Award during the timeframe 10/1/21 - 9/30/23 (\$32,725,106).

6/20/22 - Arizona revised Column FY2022 SA Block to reflect the increase in block grant allocation per NOA dated 6/13/22 - as requested on revision request dated 5/23/22

7/21/22 - Arizona/AHCCCS attached "Arizona JJ Proposal Package 8.18.21" for requesting to use SABG for treatment services in juvenile detention settings to the FY2022 plan, per SAMHSA's request (approved via email 7/11/22). AHCCCS is also attaching the SAMHSA approval letter "AZ's SUD Treatment Services in Juvenile Detention Plan Use of SABG Funds\_Approval\_07.10.2022 (1)" to the FY22-23 plan as requested.

August 18, 2021

Theresa Mitchell Hampton, DrPH, M.Ed.  
Public Health Advisor/State Project Officer HHS Region IX  
U.S. Department of Health and Human Services (DHHS)  
Substance Abuse and Mental Health Services Administration (SAMHSA)  
Center for Substance Abuse Treatment (CSAT)  
5600 Fishers Lane, Station 13N16–E  
Rockville, MD 20857

Dear Dr. Mitchell:

Thank you for the opportunity to pursue the use of Substance Abuse Block Grant funds for treatment services for adolescents in juvenile detention centers. Youth in juvenile justice systems often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. AHCCCS welcomes the opportunity to enhance services available to them.

As previously determined, SAMHSA's Center for Substance Abuse Treatment does not consider juvenile detention facilities meeting the description provided by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to be correctional or penal facilities; therefore, they are not subject to the restriction on expenditures as outlined in 42 U.S. Code § 300x–31 and 45 CFR §96.135(b)(2).

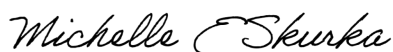
According to Arizona policy AMPM 320 T1 regarding Adolescents in Detention, the following limitations apply:

- a. Services may only be provided in juvenile detention facilities meeting the description provided by the Office of Juvenile Justice and Delinquency Prevention (OJJDP). Although TXIX services are limited for inmates of public institutions, for purposes of administering SABG, juvenile detention facilities are used only for temporary and safe custody, are not punitive, and are not correctional or penal institutions.
- b. Services shall be provided only to voluntary members, by qualified BHPs/BHTs/BHPPs, based upon assessed need for SUD services, utilizing evidence-based practices, following an individualized service plan, for a therapeutically indicated amount of duration and frequency, and with a relapse prevention plan completed prior to discharge/transfer to a community-based provider.

With policy in mind, Regional Behavioral Health Authorities were invited to submit plans for providing substance use disorder treatment to juveniles in Arizona's juvenile detention facilities with SABG funds. AHCCCS presents these plans for your review and potential approval.

Should you have any questions regarding this proposal, do not hesitate to contact Michelle Skurka at [Michelle.Skurka@azahcccs.gov](mailto:Michelle.Skurka@azahcccs.gov).

Sincerely,



Michelle Skurka  
Grants Administrator



# Arizona Juvenile Justice Proposal Substance Abuse Block Grant

August 15, 2021



# Arizona Juvenile Justice Proposal Substance Abuse Block Grant

## Table of Contents

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August 13, 2021

1



# Arizona Juvenile Justice Proposal Substance Abuse Block Grant

## State Responses

### State contact information

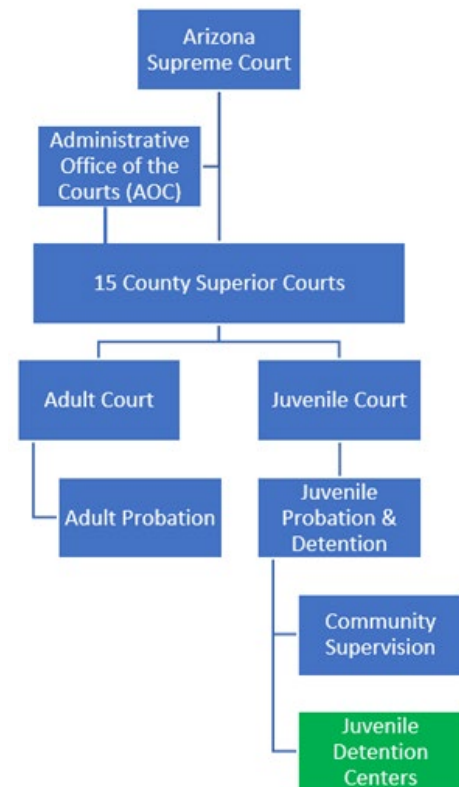
NAME	TITLE	CONTACT NUMBER	EMAIL ADDRESS
Michelle Skurka	Grants Administrator	602-364-2111	Michelle.skurka@azahcccs.gov
Mattie Lord	Grants Manager	602-417-4714	Mattie.lord@azahcccs.gov
DeAnna Granado	Grants Coordinator	602-417-4890	Deanna.granado@azahcccs.gov

### Who oversees the children?

According to the Arizona Juvenile Commission State Plan, the Administrative Office of the Courts, Juvenile Justice Services Division (AOC/JJSD) has administrative authority over all the courts in each county, and court programs, including juvenile detention centers. This means that the state contributes most of the program funding and provides administrative oversight to the detention facilities. In addition, the Arizona Supreme Court is responsible for monitoring the Juvenile Intensive Probation Supervision (JIPS) programs in all 15 Arizona counties. Arizona has 12 juvenile detention centers: two in Maricopa County and one each in nine other counties. Apache, Gila, Greenlee, Navajo, and La Paz counties have contractual agreements to use juvenile facilities in adjacent counties.

Each locally operated program is custom designed to utilize the resources and meet the special needs of the juveniles in that county. Juvenile detention centers are required to comply with statewide policies and procedures outlined in the Arizona Juvenile Detention Standards that were established in 2009. Secure juvenile facilities must implement these best practice standards to guide operational, environmental and admissions procedures. Each detention center is operated by the Juvenile Probation Department unique to that county. Facilities are staffed by Juvenile Detention Officers who work for the county probation departments. Juvenile detention personnel are mandated by the state to receive specialized training that prepares them to serve and address the special needs of youth as stated in standard I B 3 of the Arizona Juvenile Detention Standards. Periodic inspections are conducted by the AOC/JJSD to ensure compliance.

Each juvenile detention facility offers services beyond providing secure housing to detained juveniles. Services include education, healthcare, nutrition, recreation, and family visits. Many facilities also provide behavioral health services such as parenting skills classes, anger management classes, and substance abuse treatment.



## Arizona Juvenile Justice Proposal Substance Abuse Block Grant

### What is their current legal status while in detention?

The current legal status of a juvenile in detention means they have been adjudicated incorrigible or delinquent. In addition, a child can be found dually adjudicated both incorrigible and delinquent.

According to Arizona Revised Statute 8-201

"Incorrigible child" means a child who:

- (a) Is adjudicated as a child who refuses to obey the reasonable and proper orders or directions of a parent, guardian, or custodian and who is beyond the control of that person.
- (b) Is habitually truant from school as defined in section 15-803, subsection C.
- (c) Is a runaway from the child's home or parent, guardian, or custodian.
- (d) Habitually behaves in such a manner as to injure or endanger the morals or health of self or others.
- (e) Commits any act constituting an offense that can only be committed by a minor and that is not designated as a delinquent act.
- (f) Fails to obey any lawful order of a court of competent jurisdiction given in a noncriminal action.

A "delinquent juvenile" means a child who is adjudicated to have committed a delinquent act.

### What is the average length of stay or level of service provision for the juveniles?

The average length of stay for AHCCCS-enrolled youth in a detention facility during CY 2019 was 85 days for those with an Serious Emotional Disturbance (SED) diagnosis and 49 days for those without an SED diagnosis. It should also be noted that youth may have had multiple stays in a detention facility during CY 2019. Stays in the detention facility during CY 2019 could have started prior to January 1, 2019 and could have continued past December 31, 2019. In FY2019, 3,466 youth were remanded to a county detention facility. In total, the mean is less than 30 days.

#### Exhibit 1

**Average Length of Stay While in Juvenile  
Detention (in days)**

	With SED Diagnosis	Without SED Diagnosis
Statewide	85	49
Maricopa County only	86	46
Pima County only	88	54
All Other Counties	74	34

Exhibit 1 above shows that, although there is variation in length of stay based on the presence of the SED diagnosis, there is little variation by region within the two categories. For youth with a SED diagnosis, 32 percent of detention stays were for 15 days or less: for non-SED members, 40 percent of stays. For youth with a SED diagnosis, just under half (49 percent) of stays were for under 30 days: for non-SED members, 61 percent of stays. Alternatively, when looking at longer lengths of stays 21 percent youth with a SED diagnosis stayed for three months or longer and 5 percent of these members stayed 12 months or longer.

## Arizona Juvenile Justice Proposal Substance Abuse Block Grant

### State Resources for more information

<https://www.azcourts.gov/jjsd/Automation/AZYAS>

<https://ojdp.ojp.gov/>

<https://www.azcourts.gov>

<https://superiorcourt.maricopa.gov/juvenile/delinquency/>

August 13, 2021

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**SFY 2022 SABG – Juvenile Justice Plan  
Regional Behavioral Health Authority**



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Date:	June 30, 2021
Report Period:	July 1, 2021 – June 30, 2022
RBHA:	Mercy Care
Service Provider(s):	Community Bridges, Community Medical Services, Terros, Valle del Sol

## Background

SAMHSA’s Center for Substance Abuse Treatment does not consider juvenile detention facilities meeting the description provided by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to be correctional or penal facilities; therefore, they are not subject to the restriction on expenditures as outlined in 42 U.S. Code § 300x–31 and 45 CFR §96.135(b)(2).

According to [AMPM 320 T1](#) regarding Adolescents in Detention:

Most adjudicated youth from secure detention do not have community follow-up or supervision, therefore, risk factors remain unaddressed. Youth in juvenile justice systems often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services.

Contractors and TRBHAs requesting to use SABG funding shall provide AHCCCS with a comprehensive and detailed plan that includes services and activities that will be provided to adolescents in detention. AHCCCS approval is contingent on funding availability and the Contractor’s and TRBHA’s comprehensive and detailed plan. For adolescents in detention, the following limitations apply:

- Services may only be provided in juvenile detention facilities meeting the description provided by the Office of Juvenile Justice and Delinquency Prevention (OJJDP). Although TXIX services are limited for inmates of public institutions, for purposes of administering SABG, juvenile detention facilities are used only for temporary and safe custody, are not punitive, and are not correctional or penal institutions,
- Services shall be provided:
  - Only to voluntary members,
  - By qualified BHPs/BHTs/BHPPs,
  - Based upon assessed need for SUD services,
  - Utilizing EBPPs,
  - Following an individualized service plan,
  - For a therapeutically indicated amount of duration and frequency, and
  - With a relapse Prevention plan completed prior to discharge/transfer to a community-based provider.

# Opportunity

Regional Behavioral Health Authorities are invited to submit plans for providing substance use disorder treatment to juveniles in Arizona’s juvenile detention facilities with SABG funds in the state fiscal year 2022.

Complete this plan template and email it with an annual budget projection and any pertinent policies and procedures to Mattie Lord at [Mattie.Lord@azahcccs.gov](mailto:Mattie.Lord@azahcccs.gov) with a cc to [BHSInvoices@azahcccs.gov](mailto:BHSInvoices@azahcccs.gov).

Both AHCCCS and SAMHSA will need to review and approve these documents before implementation.

**Table 1 – RBHA Contact information**

Name	Title	Contact Number	Email Address
Matthew Gioia	Grants Administrator	602-329-9985	<a href="mailto:Gioiam2@mercycaresaz.org">Gioiam2@mercycaresaz.org</a>
Jeremy Reed	Special Projects Manager – SABG Treatment Lead	480-392-4815	<a href="mailto:ReedJ6@MercyCareAZ.org">ReedJ6@MercyCareAZ.org</a>
Paula Krasselt	Justice Services Administrator	480-215-8722	<a href="mailto:KrasseltP@mercycaresaz.org">KrasseltP@mercycaresaz.org</a>
David Bridge	Juvenile Justice Engagement Team (JJET) Liaison	480-651-2957	<a href="mailto:BridgeD@MercyCareAZ.org">BridgeD@MercyCareAZ.org</a>

**Table 2 – Contact Information of Provider Staff**

Name	Title	Contact Number	Email Address
Community Bridges	Eric Alfrey		<a href="mailto:EAlfrey@cbridges.com">EAlfrey@cbridges.com</a>
Community Medical Services	Tina Braham		<a href="mailto:Tina.Braham@cmshope.com">Tina.Braham@cmshope.com</a>
Terros Health	Jennifer Nye		<a href="mailto:Jennifer.Nye@terroshealth.org">Jennifer.Nye@terroshealth.org</a>
Valle del Sol	Vickey Edwards		<a href="mailto:VickeyE@valledelsol.com">VickeyE@valledelsol.com</a>

## Plan

### A. Describe the identified need in the Geographic Service Area.

#### At a minimum:

1. indicate the number of juvenile detention facilities within the GSA,
2. the level to which each facility provides substance use disorder treatment, and
3. any contracts the RBHA has with providers to serve juveniles in detention facilities.

1. According to the Detention Services Bureau, Maricopa County Juvenile Probation Department currently operates one Juvenile Detention facility. In accordance with Administrative Order 2020-063, operational changes occurred in Juvenile Detention. These changes include the shift of all new screenings to the Durango facility on April 5, 2020 and the temporary closure of the Southeastern Facility beginning May 11, 2020. The lone Juvenile Detention Facility in the central GSA is:

a. Durango Facility - 3131 W Durango St Phoenix, AZ 85009

2. Maricopa County Juvenile Probation Department’s Clinical Services Manager reports detention clinicians provide, “limited treatment work on substance abuse due to the temporary nature of the youth’s time in detention.” (Lantsman-Waugh, 2021). This tenure narrative is supported by data. Maricopa County Juvenile Probation Department’s *Data Connection – Monthly Key Indicators Report* (February FY2021) suggests the average length of stay for juveniles in these facilities was 26.2 days in FY20, while the same report suggests this figure has risen 15.4% in year-to-date FY21 (30.3 days). Preliminary discussions with Maricopa County Juvenile Probation Department have anecdotally shared an anticipated increase in detention volume and duration as the public health emergency subsides.

3. Mercy Care does not currently contract with providers to specifically serve juveniles in detention facilities. However, select providers have leveraged Mental Health Block Grant awards to sustain treatment relationships with youth in detention for individuals meeting grant eligibility. Typically, these treatment interventions would facilitate the provision of medication management or other telehealth services which were identified as treatment needs for individuals prior to entering detention settings. It may be worth noting that the Public Health Emergency has modified in-reach activities for providers with most services being delivered through a telehealth medium. Providers have also leveraged MHBG funds to conduct assessments consistent with AMPM 320-T1.

### Identify the projected number of juveniles in a detention center to be served with SABG funding.

Maricopa County Juvenile Probation Department’s Clinical Services Manager reports an absence of, “definitive data on the number/percentage of youth in detention that have a need for substance use treatment” (Lantsman-Waugh, 2021). According to Substance Abuse & Mental Health Services Administration however, 39% of juveniles entering detention settings met criteria for substance use disorders (SAMHSA, 2011). SAMHSA also suggests that after adjudication, 47% of youth put in secure placement have substance abuse disorder. When applying these figures to the youth in detention reported within Maricopa County Juvenile Probation Department’s *Data Connection – Monthly Key Indicators Report*, we can deduce anywhere between 807 (37%) and

972 (47%) youth in detention may have met criteria for substance abuse disorder in FY20. Mercy Care does not currently possess inferential data regarding the percentage of juveniles in detention who would be considered eligible for substance abuse block grant (re: AHCCCS suspended or Non-Title XIX/XXI).

**Identify at least one outcome measure or SMART goal to be impacted with the additional programming.**

Given the absence of historical data around this population leveraging Substance Abuse Block grant in detention facilities, Mercy Care would like to advance SMART Goal(s) which attempt to identify a baseline of utilization among other clinical indicators of care efficacy.

1. Establish a baseline of utilization for youth in detention leveraging Substance Abuse Block Grant for FY22. SABG Utilization of selected providers will be measured between July 1<sup>st</sup> 2021 (or the inception of the program; whichever occurs first) & June 30<sup>th</sup>, 2022 by Non-Title Enrollments and affiliated claim detail with U7 modifiers for unduplicated AHCCCS ID #'s. Affiliated utilization data measured will include:
  - a. Count of SUD DXs
  - b. Count of Procedure Codes
  - c. Count of unique utilizers per agency
  - d. Age of unique utilizers

**What level of assessment is used to identify needs for substance use disorder treatment services?**

1. Identify the screening and assessment tool(s) already used within the juvenile detention centers. (I.e., CASII, AZYAS, ASAM, etc.)
  2. Identify any supplemental assessments used by or proposed for use by the RBHA.
  3. Describe how assessment information will be shared, coordinated, and utilized to benefit the juveniles.
1. According to Maricopa County Juvenile Probation Department's Clinical Services Manager, the Arizona Youth Assessment System (AZYAS) is utilized for all adjudicated youth for the purpose of determining risk to recidivate and associated criminogenic needs to make disposition recommendations.
  2. For determining appropriate community-based levels of care and other prior authorized covered services under Substance Abuse Block Grant pre-disposition, Mercy Care would recommend that network contracted SABG providers or MCJPD-Durango Clinical Staff administer the ASAM for continuity in screening and assessment.
  3. Mercy Care is proposing to leverage current SABG providers that also have the capacity to serve the youth populations with SUD. Currently Mercy Care contracts with 4 providers that also have MAT youth/adolescent specific programming. *Terros Health, Community Bridges Inc., Valle del Sol* and *Community Medical Services* with their existing footprint in the justice arena and ability to serve youth/adolescents with OP and MAT services would be able to provide reach-in efforts for youth in detention.

If a detained youth already has an *existing* relationship with a treatment provider these reach in efforts would look like case management and release planning for the youth while in detention to ensure that there is a transition plan that meets the needs of the youth upon release.

If a youth/adolescent does not have an existing relationship these reach-in efforts would be involved in engaging the youth for treatment services and if applicable, commence while the youth is still in a detention setting. Additionally, the reach in efforts would be involved in transition planning to make sure at minimum that the youth is connected to services to meet their individual needs upon release from detention.

For youth in detention with an existing treatment relationship with a contracted provider, Information sharing agreements through Collaborative Protocols between Mercy Care and Maricopa County Juvenile Probation Department as well as a Superior Court Administrative Order support the coordination of assessment information amongst probation and treating provider. It may be worth noting, the Collaborative Protocols establish the process of sharing information but still require Releases of Information (ROI). Mercy Care is also proposing to leverage SABG COVID Supplemental awards to fund MCJPD workforce infrastructure of independently licensed Durango Clinicians &/or Behavioral Health Technicians to support with administering ASAM assessments, temporary care coordination/delivery, discharge planning with community-based treatment providers. This approach would mirror an existing partnership between Mercy Care and Maricopa County Adult Probation Drug Court Program and will dramatically enhance care continuity between treating clinicians in the detention setting and the youth’s probation team. To help promote this initiative Mercy Care would fund \$200K in salaries annually over the next two years to meet the demands and increase in staffing for additional clinicians/staffing at the Durango facility. It is worth noting, these dollars would not manifest in reimbursable claim activity through the grant and would instead be used to address infrastructure gaps and ensure care is provided irrespective of the member’s title status.

**What treatment planning is involved as part of the treatment services?**

- 1. Describe the planning process that follows the assessments, including efforts to coordinate among entities to avoid duplication and utilize all available information.**
- 2. Describe the key components of a service plan created for juveniles while in detention. If multiple plans are developed and used by different entities, explain.**
- 3. Explain how juveniles are involved in the planning process for their own treatment and recovery.**
- 4. Explain how co-occurring disorders are addressed in the planning process.**

1. According to Maricopa County Juvenile Probation Department’s Clinical Services Manager, case plans and AZYAS are done post disposition and in collaboration with the youth, family, and treatment providers (if applicable). If a youth is on probation, they will have a case plan. Pre-dispositioned youth would not have a case plan. Case plan goals are individualized and sustained if plan objectives can be fulfilled while in detention. MCJPD detention staff continue to work on affiliated case plans while the youth is in detention – however, in many

unquantifiable instances, these youth may not be eligible for SABG because they will be post-adjudicated and NOT AHCCCS suspended.

2. Key components of a service plan created for pre-dispositioned juveniles while in detention would be SMART goals that are Strengths-based and member-centric while focusing on elements intended to reduce recidivism and increase retention in treatment services. The Collaborative Protocols and Releases of Information would support the coordination and care continuity between youth, probation, and the community provider as applicable. MCJPD staff and Community-based treatment providers or navigators would be focused primarily on sustaining existing care and development of release/discharge planning initiatives based on appropriate ASAM level of care.
3. Juveniles and any identified supports of choice would be involved in their treatment planning in conjunction with probation and external treatment provider. Providers would develop plans consistent with AMPM 320-O while delivering services consistent with AMPM 320-T1, which are:
  - a. Voluntary
  - b. Offered by Qualified BHPs/BHTs/BHPPs
  - c. Based on assessed need for SUD services
  - d. Evidence-Based
  - e. Therapeutically indicated for duration and frequency
  - f. Inclusive of relapse prevention plan prior to discharge/transfer to community-based provider
4. Mercy Care’s proposed navigator providers identified above are also considered integrated clinics provider types and would assess presence, address treatment needs of youth presenting as co-occurring.

#### What level of care placement is used as a part of the treatment services?

1. How does/will the RBHA work with the juvenile detention facility to utilize the American Society of Addiction Medicine’s criteria for placing juveniles in the appropriate level of care?
2. Through Justice System Collaboration between the County and the RBHA/MCO, what levels of care are available within detention?
3. How does/will the RBHA ensure juveniles receive the appropriate level of care upon release from detention?

1. Should the youth not have an existing treatment relationship with a community-based treatment provider, SABG COVID Supplemental-Funded MCJPD Detention staff could coordinate with SABG COVID supplemental-Funded navigators responsible for:
  - a. Conducting ASAM with youth to determine appropriate level of care and
  - b. developing treatment plan and release plan to community-based providers capable of offering appropriate ASAM level of care.
2. Services delivered for youth in detention would be consistent with ASAMs outpatient level of care. According to a survey of behavioral health providers administered as part of AHCCCS’ *Arizona MHBG “Mini” Needs Assessment – Mental Health Needs of Youth Involved in the*



*Juvenile Justice System (AHCCCS, 2020)*, current services being provided in detention settings included:

- a. Care Coordination upon entry
- b. Screening while in detention
- c. Assessments while in detention
- d. Behavioral Health Services such as counseling and skill building
- e. Care Coordination prior to release.

It may be worth noting the current Public Health Emergency have impacted the degree of activity occurring within detention settings for youth.

3. Care coordination will occur throughout the detainment for youth with existing teams or treatment relationships. For youth without clinical teams, Mercy Care’s Juvenile Justice Engagement Team (JJET) may support with coordination of assessment information, grant eligibility and continuity of appropriate, community-based care with SABG COVID Supplemental-Funded Justice Navigators. Given the brief amount of time in detention for most youth, it is unlikely that treatment could be concluded and would require a definitive plan for community transition. Discharge planning should begin to occur at time of admission or shortly thereafter with youth, probation staff, guardian(s) and existing treatment providers. For youth **without** an existing treatment relationship, Detention Clinic Staff should leverage assessment information and Mercy Care Justice Liaisons to identify appropriate community-based treatment providers capable of delivering care consistent with the youth’s needs and begin planning for transfer of treatment to the community. For either scenario, the youth’s family/guardian is involved throughout the duration of treatment. This may include treatment/discharge/relapse-prevention planning, family support, counseling, or the provision of other services as needed or clinically appropriate.

To support a discharge/transfer/release Durango Clinic Staff can work with the youth, probation, guardian(s) to either:

- a. Coordinate transition from detention with any provider whom the youth has an existing treatment relationship.
- b. Coordinate with Mercy Care Justice Liaisons to identify community-based SABG providers consistent with the treatment needs identified in the assessment. Youth and their guardians will need to execute ROIs for sharing assessment or affiliated treatment documentation with external SABG providers to continue care delivery, post-release.

**Explain how the RBHA ensures contracted behavioral health providers deliver the following services:**

- **Assisting families to coordinate services with the Health Plan/RBHA while in detention.**
- **Following protocol to ensure that planning is occurring, and needs are identified prior to the youth being released from detention.**
- **Assisting juvenile probation officers in resolving any barriers or concerns with a youth receiving services.**
- **Providing guidance for justice system partners and justice involved families regarding navigation through the behavioral health system.**



Mercy Care’s Juvenile Justice Engagement Team (JJET) Liaisons are actively involved through referrals to assist families in care coordination with the health plan while in detention. JJET’s primary purpose is to resolve service barriers and other concerns for Probation, families, or other treatment stakeholders – these processes are already in place and functioning as part of the collaborative protocols. Should SABG be made available to youth in detention, demand for JJET stewardship will only increase. As a result, Mercy Care is advocating for SABG COVID Supplemental funding to expand the JJET team to include an additional FTE.

**Detail the proposed services and costs, either below or in an attachment.**

**Table 3 – Proposed Services and Costs**

Description	Cost	Units	Total
<b>Navigator Teams</b>			
<b>Community Bridges</b>	\$200,000.00	2	\$400,000.00
<b>Community Medical Services</b>	\$200,000.00	2	\$400,000.00
<b>Terros Health</b>	\$200,000.00	2	\$400,000.00
<b>Valle del Sol</b>	\$200,000.00	2	\$400,000.00
<b>Maricopa County</b>			
<b>MCJPD- Clinic Personnel</b>	\$200,000.00	2	\$400,000.00
<b>Mercy Care</b>			
<b>Mercy Care JJET FTE</b>	\$60,000.00	2	\$120,000.00
<b>Mercy Care JJET FTE - Fringe</b>	\$120,000.00	0.28	\$33,600.00
<b>Total</b>			\$2,153,600.00



Mercy References:

[https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/AZ\\_MHBG\\_NeedsAssessment2020.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/AZ_MHBG_NeedsAssessment2020.pdf)

<https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/juvenile-drug-courts-help-youth>

Maricopa County Juvenile Probation Department Data Connection Monthly Key Indicators  
February FY2021

**AzCH-CCP Juvenile Justice Plan**

DATE:	June 30, 2021
REPORT PERIOD:	July 1, 2021 – June 30, 2022
RBHA:	Arizona Complete Health-Complete Care Plan (AzCH-CCP)
SERVICE PROVIDER(S):	TBD

**Background**

SAMHSA’s Center for Substance Abuse Treatment does not consider juvenile detention facilities meeting the description provided by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to be correctional or penal facilities; therefore, they are not subject to the restriction on expenditures as outlined in 42 U.S. Code § 300x–31 and 45 CFR §96.135(b)(2).

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- b. *Services shall be provided:*
  - i. *Only to voluntary members,*
  - ii. *By qualified BHPs/BHTs/BHPPs,*
  - iii. *Based upon assessed need for SUD services, iv. Utilizing EBPPs,*

**AzCH-CCP Juvenile Justice Plan**

- iv. *Following an individualized service plan,*
- v. *For a therapeutically indicated amount of duration and frequency, and*
- vi. *With a relapse Prevention plan completed prior to discharge/transfer to a community-based provider.*

**Opportunity**

Regional Behavioral Health Authorities are invited to submit plans for providing substance use disorder treatment to juveniles in Arizona’s juvenile detention facilities with SABG funds in the state fiscal year 2022.

**Complete this plan template and email it with an annual budget projection and any pertinent policies and procedures to Mattie Lord at [Mattie.Lord@azahcccs.gov](mailto:Mattie.Lord@azahcccs.gov) with a cc to [BHSInvoices@azahcccs.gov](mailto:BHSInvoices@azahcccs.gov).**

Both AHCCCS and SAMHSA will need to review and approve these documents before implementation.

**RBHA Contact information:**

NAME	TITLE	CONTACT NUMBER	EMAIL ADDRESS
Juston Knight	Manager; Justice Systems	520-307-9501 520-809-6655	juknight@azcompletehealth.com
Tania Long-Gervais, MC	Manager; Behavioral Health and Special Programs	520-809-6625 520-310-7793	TALONG@AZCompleteHealth.com

**Contact Information of Provider Staff:**

NAME	TITLE	CONTACT NUMBER	EMAIL ADDRESS
TBD			

**Plan**

**AzCH-CCP Juvenile Justice Plan**

A. Describe the identified need in the Geographic Service Area.  
At a minimum,  
1. indicate the number of juvenile detention facilities within the GSA,  
2. the level to which each facility provides substance use disorder treatment, and  
3. any contracts the RBHA has with providers to serve juveniles in detention facilities.

1. WITHIN THE SOUTHERN GSA, THERE ARE 4 JUVENILE DETENTION CENTERS IN USE: PIMA, PINAL, SANTA CRUZ, AND YUMA

2. FACILITIES:

- a. PINAL COUNTY STAFF OFFER INDIVIDUAL THERAPY SESSIONS AS DETERMINED BY NEED, AND WEEKLY TEEN ADDICTION ANONYMOUS GROUPS (FOLLOWING THE TEEN AA 12 STEP PROGRAM).
- b. PIMA COUNTY’S CONTRACTED MEDICAL PROVIDER OFFERS INDIVIDUAL AND GROUP THERAPY (FOCUS ON TREATMENT READINESS AND STAGES OF CHANGE). SUBSTANCE ABUSE GROUPS ARE ALSO OFFERED TO YOUTH IDENTIFIED FOR SERVICES.
- c. YUMA COUNTY PROVIDES GENERAL INDIVIDUAL THERAPY ONLY. NO SPECIFIC THERAPEUTIC SERVICES FOR SUBSTANCE USE
- d. SANTA CRUZ COUNTY PROVIDES A DETENTION SCREENING INSTRUMENT CAPTURING SUBSTANCE USE (CURRENT/PAST). IF YES, THE NURSE PROVIDES AN ADDITIONAL ASSESSMENT. IF APPROPRIATE, JUVENILES ARE PROVIDED A WEEKLY INDIVIDUAL THERAPY SESSION WITH A COUNSELOR (SATURDAY). IF A HIGHER LEVEL OF THERAPEUTIC SERVICE IS REQUIRED, THE MEDICAL STAFF WILL NOTIFY PROBATION, WHO WILL COORDINATE WITH COMMUNITY PROVIDERS FOR SERVICES.

3. IN PIMA COUNTY, AZCH-CCP CURRENTLY FUNDS TWO HALF TIME OUTREACH STAFF WITH COPE AND SIN PUERTAS TO COORDINATE RE-ENTRY PLANNING AND COMMUNITY SERVICES FOR YOUTH WHO HAVE AN IDENTIFIED SUD TREATMENT NEED. THE OUTREACH SPECIALISTS ARE CURRENTLY FUNDED THROUGH SABG DOLLARS, BUT DO NOT PROVIDE CLINICAL SUD TREATMENT SERVICES FOR YOUTH IN THE DETENTION FACILITY

Identify the projected number of juveniles in a detention center to be served with SABG funding.

In Pinal County (average daily census FY2020 – 22.4):  
*For Fiscal Year 2019:*  
*Total Pinal Youth Detained: 212*  
*Total Pinal Youth on AHCCCS: 126*  
*Percentage of Pinal youth on AHCCCS: 59%*

*For Fiscal Year 2020:*  
*Total Pinal Youth Detained: 196*  
*Total Pinal Youth on AHCCCS: 129*  
*Percentage of Pinal youth on AHCCCS: 65%*

*For Fiscal Year 2021 as of 06/22/21:*  
*Total Pinal Youth Detained: 156*  
*Total Pinal Youth on AHCCCS: 82*  
*Percentage of Pinal youth on AHCCCS: 52%*

**AzCH-CCP Juvenile Justice Plan**

In Pima County, the average daily census is roughly 30, prior to COVID-19 the census was relatively stable at 40-45.

In Yuma County, the average daily census is roughly 20. The juvenile court/detention anticipate future daily average will remain constant within a range of 20-25)

In Santa Cruz County:

25 youth were detained between January 2021 and June 2021

- 20 of the 25 admitted on the Health Screening Intake Form to drug use and/or drug related offense (80%).
- Of the 25 youth checked for AHCCCS; 10 had eligibility, 8 had no eligibility, and 7 had their AHCCCS suspended.
- Between January and May there was an Average Daily Population of 3.7 youth detained

On average 60-70% of detained youth are AHCCCS eligible or enrolled. Leaving 30%-40% of the population who may be uninsured or carry private insurance (underinsured).

County Juvenile Court Centers/Services differ in the ratio of detained youth who have their TXIX coverage suspended, and therefore it is difficult to provide verifiable data.

Identify at least one outcome measure or SMART goal to be impacted with the additional programming.

TIMEFRAME	PROGRAM	ACTIVITIES	EXPECTED OUTCOMES	MEASURES OF SUCCESS
2021-2022	Youth Substance Use Programming in Detention	Outreach staff from Providers providing outreach in identified counties for Juvenile Detention, schools and community	1. Youth with substance use disorder to be engaged in substance use and behavioral health services following detention release or before law enforcement is involved. This can decrease youth in the detention system and also decrease recidivism. 2. Decrease length of stay for members who meet medical necessity for OOH placement due to SUD.	Providers will provide monthly and annual reports to AzCH-CCP, including outreach, engagement, enrollment and discharge outcomes.

**What level of assessment is used to identify needs for substance use disorder treatment services?**

1. Identify the screening and assessment tool(s) already used within the juvenile detention centers. (I.e., CASII, AZYAS, ASAM, etc.)
2. Identify any supplemental assessments used by or proposed for use by the RBHA.
3. Describe how assessment information will be shared, coordinated, and utilized to benefit the juveniles.

1. All tools approved through AHCCCS to assess SUD treatment need can be administered by contracted Behavioral or Integrated Health providers
  - a. Pinal County and Pima County staff utilize the MASYI-2 during intake (booking). All probation departments utilize the AZYAZ to help understand substance use and other factors in the juvenile's life.
  - b. Pinal County staff complete a full mental health assessment within 72 hours on each youth, which asks comprehensive questions about substance use. When identified, licensed counselors provide counseling on SUD for these youth while detained.
  - c. Pima County staff complete a health assessment upon entry to detention. Assessment collects information about substance use. The medical provider also utilizes the SASSI to assess treatment need.
  - d. Yuma County completes a health assessment within 24hrs of entry into detention. They do not currently utilize a substance abuse assessment tool consistently across the detained population.
2. In addition to the Comprehensive Intake Assessment and ASAM, the CRAFFT is utilized by providers as a substance use screening and tool. Providers also utilize the SOCRATES (The Stages of Change Readiness and Treatment Eagerness Scale) and URICA (University of Rhode Island Change Assessment) as readiness for change screening tools.
3. Assessment information can and is shared through the CFT process to support re-entry planning and ISP development with all parties involved with the treatment team. AzCH-CCP will continue to support the communication of assessment scores and healthcare services performed by the medical staff to the appropriate community provider(s).

**What treatment planning is involved as part of the treatment services?**

1. Describe the planning process that follows the assessments, including efforts to coordinate among entities to avoid duplication and utilize all available information.
2. Describe the key components of a service plan created for juveniles while in detention. If multiple plans are developed and used by different entities, explain.
3. Explain how juveniles are involved in the planning process for their own treatment and recovery.
4. Explain how co-occurring disorders are addressed in the planning process.



**AzCH-CCP Juvenile Justice Plan**

1. Assessments will be completed by the enrolled provider prior to detainment, and communicate appropriately to meet the member’s and family’s needs (as required per AMPM 1000). If a member was not enrolled in services prior to being detained, a referral can be made for services specific to SUD needs. Outreach or provider Liaison staff will then make contact with the healthcare decision maker to obtain service information and approval. Pending approval from the guardian/parent, the Outreach or provider Liaison staff will seek to make contact with the juvenile member to assess need and level of care, and assist family with enrollment into a community service agency.
2. Key components should include all appropriate parties in the juvenile’s and family’s treatment team. The necessary action items needed by the juvenile, parent/guardian/family, provider (HCC and/or BHP), probation, specialty provider (if applicable), and MCO Care Coordinator/Manager (if applicable) in order for the juvenile to be able to fluidly transition from a secure setting to the community or placement. ISP should also include contingency plan(s) if the initial plan for higher levels of care is not approved, along with a Crisis Plan (which should not include calling 911 as an initial step). ISP should be strength based and focused on transition planning, with scheduled timeframes to meet again within 10-30days post-release. Post-release CFT meetings should focus on updating the ISP to support the member and family in the community and treatment team communication (further assessments may be needed, along with referrals for specialty services).
  - a. If multiple ISP’s have been created by multiple agencies, all entities providing service are required to communicate effectively to coordinate care. All ISP’s should be integrated into one living document.
3. Juvenile members should be supported in voicing their concerns/wants/needs during CFT meetings and the CFT process. ISP’s are developed through the CFT process. CFT meetings should include as many parties as the member and guardians request, but within the detention facility guidelines.
4. If the juvenile member was enrolled with a community provider prior to being detained the provider will follow all appropriate policies/procedures per contract and AMPM 1020 to meet the needs of the member and provide support to the family/guardian. If the juvenile was not previously enrolled, the Outreach or provider Liaison staff will follow the same process to obtain the approval from the parent/guardian and initial assessment of the juvenile. For juvenile with more complex care needs/co-occurring disorders the Outreach or provider Liaison staff will work with the juvenile and family to enroll in an integrated care clinic to meet all healthcare needs, post release.

**What level of care placement is used as a part of the treatment services?**

1. How does/will the RBHA work with the juvenile detention facility to utilize the American Society of Addiction Medicine’s criteria for placing juveniles in the appropriate level of care?
2. Through Justice System Collaboration between the County and the RBHA/MCO, what levels of care are available within detention?
3. How does/will the RBHA ensure juveniles receive the appropriate level of care upon release from detention?

**AzCH-CCP Juvenile Justice Plan**

1. AzCH-CCP will work with the Juvenile Court Centers/Services/Detention Centers and contracted BH or Integrated providers to allow Outreach or provider Liaison staff to meet with the parent/guardian, discuss service options and gain permission to provide services to the detained juvenile. The providers are required to meet the American Society of Addiction Medicine’s criteria, along with Medicaid policy/procedures requirements to determine Medical Necessity and appropriate level(s) of care (to include OOH placement).
2. Individual therapy and case management are the types of service most commonly offered to juveniles in a detention setting (Pinal County offers group Teen AA classes). There may be potential to offer Medicaid funded group therapy within detention facilities, pending detention and Court leadership approval.
3. Appropriate level of care will be determined through identifying Medical Necessity, as dictated by AHCCCS policy and contract

Explain how the RBHA ensures contracted behavioral health providers deliver the following services:

- Assisting families to coordinate services with the Health Plan/RBHA while in detention.
- Following protocol to ensure that planning is occurring, and needs are identified prior to the youth being released from detention.
- **Assisting juvenile probation officers in resolving any barriers or concerns with a youth receiving services.**
- Providing guidance for justice system partners and justice involved families regarding navigation through the behavioral health system.

- AzCH-CCP currently collaborates with the Juvenile Detention Centers to obtain data sharing agreements, allowing for earlier identification of detained members. Creating opportunity to bridge notification of member justice involvement to community providers. Notification processes currently exist in Pima, Yuma, and Maricopa Counties.
- MOU’s and Collaborative Protocols have been executed with Juvenile Probation Departments establishing processes to receive and provide feedback and escalate concerns regarding service provision and level of care
- Regular meetings have been coordinated with Juvenile Probation Departments and community providers allowing a venue of communication around service provision, service need, and justice system modification, and Medicaid system updates/changes

Detail the proposed services and costs, either below or in an attachment.

**AzCH-CCP Juvenile Justice Plan**

<b>Projected Counties to Pilot Programming</b>	<b>Approximate Number of Non-19 Adolescents in Detention Annually</b>	<b>Projected Annual Spend</b>
<b>PIMA</b>	187 Members	\$315,300
<b>PINAL</b>	80 Members	\$150,730
<b>SANTA CRUZ</b>	30 Members	\$51,540
<b>YUMA</b>	126 Members	\$290,730
<b>Total</b>	<b>423 Members</b>	<b>\$808,300</b>

The above budget represents a combination of 7.5 FTE of non-billable outreach and coordination staff for the identified detention centers as well as billable Covered Services to include Treatment Services and Support Services.

Staffing costs are identified as 1FTE per 40 youth in detention. Staffing costs include personnel, ERE, travel, training, overhead and administrative costs.

Providers are required to have Policies and Procedures in place related to financial tracking. The minimum requirements of the policies is attached.

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# POLICY AND PROCEDURE

<b>DEPARTMENT:</b> Medical Management	<b>REFERENCE NUMBER:</b> AZ.MM.72
<b>EFFECTIVE DATE:</b> 05/15/2018	<b>POLICY NAME:</b> Coordinating with Government Entities and AHCCCS Contractors
<b>REVIEWED/REVISED DATE:</b> 03/10/2021	<b>RETIRED DATE:</b> N/A
<b>PRODUCT TYPE:</b> Arizona Medicaid	<b>PAGE:</b> 1

## SCOPE:

This policy applies to all directors, officers, and employees of Centene Corporation for its Arizona health plans (the “health plan”).

## PURPOSE:

To outline the requirements for the Arizona (AZ) Medicaid Plan for establishing and maintaining collaborative relationships with other government entities including other AHCCCS Contractors who are governmental entities in order to ensure that members have proper access to care, optimal quality of service and coordination of care.

## POLICY:

The AZ Medicaid Plan will coordinate services and communicate with other government entities, including other AHCCCS Contractors who are governmental entities, to ensure that members have proper access to care, optimal quality of service and coordination of care. These entities include:

- Division of Developmental Disabilities (DDD)
- Courts and Corrections
  - Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR)
  - Arizona Department of Juvenile Corrections (ADJC)
  - Administrative Offices of the Court (AOC)
- Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA)
- Arizona Department of Child Safety/Arizona Families F.I.R.S.T
- Arizona Department of Education
- Department of Economic Security/Arizona Early Intervention Program (DES/AzEIP)
- The Veteran’s Administration

## PROCEDURE:

### Coordinating with members dually enrolled with DDD

1. The AZ Medicaid plan coordinates member care with DDD by:
  - a. Inviting DDD staff to participate in the development of the behavioral health service plan and all subsequent planning meetings as representatives of the member’s clinical team
  - b. Incorporating information and recommendations in the Individual or Family Support Plan (ISP) developed by DDD staff, when appropriate.

# POLICY AND PROCEDURE

<b>DEPARTMENT:</b> Medical Management	<b>REFERENCE NUMBER:</b> AZ.MM.72
<b>EFFECTIVE DATE:</b> 05/15/2018	<b>POLICY NAME:</b> Coordinating with Government Entities and AHCCCS Contractors
<b>REVIEWED/REVISED DATE:</b> 03/10/2021	<b>RETIRED DATE:</b> N/A
<b>PRODUCT TYPE:</b> Arizona Medicaid	<b>PAGE:</b> 2

- c. Ensuring that the goals of the ISP, of a member diagnosed with developmental disabilities who is receiving psychotropic medications, includes reducing behavioral health symptoms and achieving optimal functioning, not merely the management and control of challenging behavior,
  - d. Actively participating in DDD team meetings
2. If the member is diagnosed with Pervasive Developmental Disorders and Developmental Disabilities, the AZ Medicaid Plan will share all relevant information from the initial assessment and ISP with DDD to ensure coordination of services.
3. The AZ Medicaid Plan makes available to providers policies and procedures that include information on DDD specific protocols or agreements

## Coordinating with Courts and Corrections

1. The AZ Medicaid Plan collaborates and coordinates care and ensures that behavioral health providers collaborate and coordinate care for members with behavioral health needs for members involved with:
  - a. Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR),
  - b. Arizona Department of Juvenile Corrections (ADJC)
  - c. Administrative Offices of the Court (AOC)
2. The AZ Medicaid plan collaborates with courts and or correctional agencies to coordinate member care by:
  - a. Working in collaboration with the appropriate staff involved with the member
  - b. Inviting probation or parole representatives to participate in the development of the ISP and all subsequent planning meetings for the Adult Recovery Team (ART) or Child and Family Team (CFT) with the member's approval.
  - c. Actively considering information and recommendations contained in probation or parole case plans when developing the ISP
  - d. Ensuring that the behavioral health provider evaluates and participates in transition planning prior to the release of eligible members and arranges and coordinates enrolled member care upon the member's release

## Coordinating with Department of Economic Security/Rehabilitation Services Administration

1. The AZ Medicaid plan coordinates member care with ADES/RSA by:
  - a. Working in collaboration with the vocational rehabilitation counselors or employment specialists in the development and monitoring of the member's employment goals,

## POLICY AND PROCEDURE

<b>DEPARTMENT:</b> Medical Management	<b>REFERENCE NUMBER:</b> AZ.MM.72
<b>EFFECTIVE DATE:</b> 05/15/2018	<b>POLICY NAME:</b> Coordinating with Government Entities and AHCCCS Contractors
<b>REVIEWED/REVISED DATE:</b> 03/10/2021	<b>RETIRED DATE:</b> N/A
<b>PRODUCT TYPE:</b> Arizona Medicaid	<b>PAGE:</b> 3

- b. Ensuring that all related vocational activities are documented in the comprehensive clinical record
- c. Inviting ADES/RSA staff to be involved in planning for employment programming to ensure that there is coordination and consistency with the delivery of vocational services
- d. Participating and cooperating with ADES/RSA in the development and implementation of a Regional Vocational Service Plan inclusive of ADES/RSA services available to adolescents, and
- e. Allocating space and other resources for vocational rehabilitation counselors or employment specialists working with enrolled members who have been determined to have a Serious Mental Illness (SMI)

### **Coordinating with Department of Child Safety**

1. The AZ Medicaid plan coordinates member care with DCS by:
  - a. Working in collaboration with DCS and behavioral health providers in the development and planning of the member's individual service plan.
  - b. Ensuring the member's CFT is meeting regularly to incorporate the information and recommendations of the child's family and/ or caregivers.
  - c. Collaborate with DCS to ensure children are receiving care in accordance with the AZ Vision and 12 principles.
  - d. Collaborate with DCS and Arizona Families F.I.R.S.T (AFF) to ensure timely and effective services through contracted providers.
  - e. Inviting DCS and AFF partners to collaborative meetings to ensure coordination of care.

### **Coordinating with Arizona Department of Education**

1. The AZ Medicaid plan coordinates member care with the AZDOE and schools by using AHCCCS funds to fund behavioral health supports and engagement specialists, which will be housed primarily on school premises.
2. The health plan will track referrals, engagement, and outcomes for any youth referred to these programs.
3. AzCH-CCP will ensure that behavioral health providers who provide service in the school setting identify the Place of Service (POS) 03.
4. The Health Plan coordinates with the Department of Education anytime a member is placed in an RTC/ BHIF setting (in-state and out-of-state) to ensure member's educational needs are met.

## POLICY AND PROCEDURE

<b>DEPARTMENT:</b> Medical Management	<b>REFERENCE NUMBER:</b> AZ.MM.72
<b>EFFECTIVE DATE:</b> 05/15/2018	<b>POLICY NAME:</b> Coordinating with Government Entities and AHCCCS Contractors
<b>REVIEWED/REVISED DATE:</b> 03/10/2021	<b>RETIRED DATE:</b> N/A
<b>PRODUCT TYPE:</b> Arizona Medicaid	<b>PAGE:</b> 4

5. The Health Plan works in collaboration with the Department of Education to approve all educational vouchers for school-aged members placed in BHIF settings.

### Coordinating with Arizona Department of Security/Arizona Early Intervention Program

1. AzCH-CCP shall ensure that behavioral health providers coordinate member care with AzEIP as follows:
  - a. Ensure that children birth to three years of age are referred to AzEIP in a timely manner when information obtained in the child's behavioral health assessment reflects developmental concerns, AHCCCS MEDICAL POLICY MANUAL CHAPTER 500 – CARE COORDINATION REQUIREMENTS 541 - Page 7 of 7
  - b. Ensure that children found to require behavioral health services as part of the AzEIP evaluation process receive appropriate and timely service delivery, and
  - c. Ensure that, if an AzEIP team has been formed for the child, the behavioral health provider coordinates team functions to avoid duplicative processes between systems.

**ATTACHMENTS:**

**REFERENCES:**  
[AHCCCS AMPM: Policy 541 – Care coordination with Other Government Agencies](#)

**DEFINITIONS:**

### REVISION LOG

REVISION LOG	DATE
Annual Review	05/14/2018
Annual Review	05/8/2019
Included additional governmental agencies to align with Provider Manual	06/19/2019
Added AzEIP, Removed some RBHA-DDD language, added ADE items, and updated overall language	02/25/2020
Added the Veteran's Administration and update language.	03/10/2021

## POLICY AND PROCEDURE

<b>DEPARTMENT:</b> Medical Management	<b>REFERENCE NUMBER:</b> AZ.MM.72
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<b>PRODUCT TYPE:</b> Arizona Medicaid	<b>PAGE:</b> 5

### POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.



# **SABG, MHBG, and Other Federal Grants Policies & Procedures Checklist Minimum Requirements of Provider**

*Information below is to assist the provider in the development of comprehensive Federal Grant Policies & Procedures. All the information below may not be in one policy, but may be in a different policy. It is up to the provider on how it determines policy development.*

1. Purpose – providers should reference the purpose of the grant. Use references below to identify the purpose for your agency:
  - a. Substance Abuse Block Grant (SABG) CFDA #93.959, AHCCCS Reference - this includes both references for Treatment and Prevention services:
    - i. <https://www.azahcccs.gov/Resources/Grants/SABG/>
    - ii. AHCCCS AMPM 320-T1:  
<https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320T1.pdf>
  - b. Mental Health Block Grant (MHBG) CFDA #93.958, AHCCCS Reference:
    - i. <https://www.azahcccs.gov/Resources/Grants/MHBG/>
    - ii. AHCCCS AMPM 320-T1:  
<https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320T1.pdf>
  - c. State Opioid Response (SOR) CFDA #93.788, AHCCCS Reference:
    - i. <https://www.azahcccs.gov/Resources/Grants/SOR/>
    - ii. [https://www.azahcccs.gov/AHCCCS/Downloads/StateOpioidResponse/SOR\\_PrimaryGoalAndObjectives.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/StateOpioidResponse/SOR_PrimaryGoalAndObjectives.pdf)
    - iii. [https://www.azahcccs.gov/AHCCCS/Downloads/StateOpioidResponse/SOR\\_Narrative.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/StateOpioidResponse/SOR_Narrative.pdf)
  - d. Arizona Emergency COVID-19 Project (ECOVID-19) CFDA #93.665, AHCCCS Reference:
    - i. <https://www.azahcccs.gov/Resources/Grants/COVID19/>
    - ii. [https://www.azahcccs.gov/Resources/Downloads/Grants/COVID19/COVID19\\_ProjectNarrative.pdf](https://www.azahcccs.gov/Resources/Downloads/Grants/COVID19/COVID19_ProjectNarrative.pdf)
  - e. COVID-19 Emergency Response for Suicide Prevention (COVID-19 ERSP) CFDA #93.665, AHCCCS Reference:
    - i. <https://www.azahcccs.gov/Resources/Grants/COVID19/suicideprevention.html>
    - ii. [https://www.azahcccs.gov/Resources/Downloads/Grants/COVID19/COVID19\\_PIMASuicidePrevention\\_ProjectNarrative.pdf](https://www.azahcccs.gov/Resources/Downloads/Grants/COVID19/COVID19_PIMASuicidePrevention_ProjectNarrative.pdf)

- f. State Pilot Grant Program for Treatment for Pregnant and Postpartum Women (PPW-PLT) Reference:
    - i. <https://www.azahcccs.gov/Resources/Grants/PPWPLT/>
    - ii. <https://www.azahcccs.gov/Resources/Downloads/Grants/PPWPLT/AZPPWPLTProjectNarrative.pdf>
2. Eligible Populations - refer to AMPM 320-T1 or grant allocation letter/approved budget
3. References – providers should have at a minimum the below references in their policy:
  - a. AzCH Provider Manual (all federal grants)
    - i. <https://www.azcompletehealth.com/providers/resources/provider-manual.html>
  - b. SABG/MHBG FAQs (SABG/MHBG)
    - i. <https://www.azahcccs.gov/Resources/Downloads/Grants/FrequentlyAskedQuestions.pdf>
  - c. Arizona Emergency COVID-19 FAQ's (E-COVID-19)
    - i. [https://www.azahcccs.gov/Resources/Downloads/Grants/COVID19/MemoEmergency\\_COVID\\_FAQ.pdf](https://www.azahcccs.gov/Resources/Downloads/Grants/COVID19/MemoEmergency_COVID_FAQ.pdf)
  - d. AMPM 300, Exhibit 300-2B (SABG/MHBG)
    - i. <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/Exhibit300-2B.pdf>
  - e. AHCCCS AMPM 320-T1 (all federal grants)
    - i. <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320T1.pdf>
  - f. Federal regulations for administrative requirements, cost principles, and audits (all federal grants)
    - i. <http://www.samhsa.gov/grants/grants-management/notice-award-noa/standard-terms-conditions>
  - g. Code of Federal Regulations, 2 CFR 200 (all federal grants)
    - i. <https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=3f069a6a975bc240947b32003d44e9a0&mc=true&n=pt2.1.200&r=PART&ty=HTML>
4. Prohibited Expenditures - must be included (all federal grants)
5. I-BHS number – include process for obtaining for each site that utilized SABG/MHBG funds
6. Marijuana Restrictions - refer to AMPM 320-T1 (all federal grants)

7. Monitoring and reporting of funds by priority populations (SABG) and funding category (all federal grants)
  - a. Procedures must include reporting and monitoring requirements to track encountering of each funding to source and to verify that treatment services are delivered at a level commensurate with funding
  - b. Procedures must state the provider will account for federal grants funds in a manner that permits separate reporting of SABG, MHBG, and Other federal grants
    - i. Monitoring should be by program type, i.e. SED, FEP, SMI, PPW, Prevention
  - c. Provider should have a policy on how it applies administrative or indirect cost to the grant (2 CFR 200.414)
    - i. Indirect Cost Rate (ICR) agreements are collected and reviewed as part of provider budget review
    - ii. Administrative Allocation
    - iii. De Minimis Rate (policy must state if De Minimis rate is chosen, it must be used consistently for all federal awards)

## 8. Internal Controls

- a. Providers should have policies that meet the standards and requirements for financial management systems as delineated in 45 CFR Part 75 Subpart D, including:
  - i. Ensuring financial systems and tracking allow the capacity to maintain adequate records to identify the sources of funds for federally assisted activities and the purposes for which the award is used. This includes authorizations, obligations, unobligated balances, assets, liabilities, outlays or expenditures, and any program income as applicable. The Provider tracking system must ensure the ability to compare actual expenditures with the approved budget for the award
  - ii. Provider will ensure that federal grant funds retain their award-specific identity and are not comingled with state funds or other federal funds
- b. Financial & Administrative Policies & Procedures related to:
  - i. Cash Management
  - ii. Procurement
  - iii. Resolution of Audit Findings
  - iv. Financial Reporting
  - v. Prohibited Expenditures
  - vi. Requesting of withdrawals (if applicable)
  - vii. Provider Payments (if applicable)
  - viii. Sub-recipient Monitoring (if applicable)

9. Update any references from Cenpatico Integrated Health to Arizona Complete Health-Complete Care Plan (AzCH-CCP) as applicable in policy

# Planning Tables

## Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2021      Planning Period End Date: 9/30/2023

Strategy	A IOM Target	B			B		
		SA Block Grant Award	COVID-19 Award <sup>1</sup>	ARP Award <sup>2</sup>	SA Block Grant Award	COVID-19 Award <sup>4</sup>	ARP Award <sup>5</sup>
1. Information Dissemination	Universal	\$2,119,380	\$753,446	\$540,000			
	Selected						
	Indicated	\$20,373	\$100,000	\$127,500			
	Unspecified	\$2,888	\$0	\$0			
	<b>Total</b>	<b>\$2,142,641</b>	<b>\$853,446</b>	<b>\$667,500</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
2. Education	Universal	\$1,276,764	\$700,000	\$412,500			
	Selected						
	Indicated	\$132,407	\$250,000	\$112,500			
	Unspecified	\$1,729	\$0	\$0			
	<b>Total</b>	<b>\$1,410,900</b>	<b>\$950,000</b>	<b>\$525,000</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
3. Alternatives	Universal	\$693,387	\$650,000	\$375,000			
	Selected						
	Indicated	\$36,489	\$175,000	\$75,000			
	Unspecified	\$1,729	\$0	\$0			
	<b>Total</b>	<b>\$731,605</b>	<b>\$825,000</b>	<b>\$450,000</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
4. Problem Identification and Referral	Universal	\$142,030	\$500,000	\$225,000			
	Selected						
	Indicated	\$101,703	\$100,000	\$56,250			
	Unspecified	\$627	\$0	\$0			
	<b>Total</b>	<b>\$244,360</b>	<b>\$600,000</b>	<b>\$281,250</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

5. Community-Based Processes	Universal						
	Selected						
	Indicated						
	Unspecified						
	<b>Total</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
6. Environmental	Universal	\$541,398	\$650,000	\$450,000			
	Selected						
	Indicated	\$9,713	\$100,000	\$56,250			
	Unspecified	\$403	\$0	\$0			
	<b>Total</b>	<b>\$551,514</b>	<b>\$750,000</b>	<b>\$506,250</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
7. Section 1926 Tobacco	Universal	\$12,866	\$100,000	\$56,250			
	Selected						
	Indicated	\$0	\$0	\$0			
	Unspecified	\$0	\$0	\$0			
	<b>Total</b>	<b>\$12,866</b>	<b>\$100,000</b>	<b>\$56,250</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
8. Other	Universal	\$0	\$0	\$0			
	Selected						
	Indicated	\$0	\$0	\$0			
	Unspecified	\$0	\$0	\$0			
	<b>Total</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Total Prevention Expenditures</b>		<b>\$5,093,886</b>	<b>\$4,078,446</b>	<b>\$2,486,250</b>			
<b>Total SABG Award<sup>3</sup></b>		<b>\$43,466,912</b>	<b>\$37,892,228</b>	<b>\$24,543,830</b>			
<b>Planned Primary Prevention Percentage</b>		<b>11.72 %</b>	<b>10.76 %</b>	<b>10.13 %</b>			

<sup>1</sup>The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

<sup>2</sup>The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY

2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned ARP expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

<sup>3</sup>Total SABG Award is populated from Table 4 - SABG Planned Expenditures

<sup>4</sup>The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

<sup>5</sup>The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned ARP expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

**Footnotes:**

8/19/2021 - The 20% Set Aside amount that will be expended under FFY2022 SA Block Grant Award is \$8,118,329. The amount of Table 6 Non-Direct Services/System Development (SA) to be expended is \$1,343,930. This amount added to the total at the bottom of Table 5a (\$6,774,399) equals \$8,118,329 from Table 4 - SABG Planned Expenditures and meets the 20% Set Aside requirement.

The 20% Set Aside amount that will be expended under FFY2022 COVID-19 Award is \$7,578,446. The amount of Table 6 Non-Direct Services/System Development (SA) to be expended is \$750,000. This amount added to the total at the bottom of Table 5a (\$6,828,446) equals \$7,578,446 from Table 4 - SABG Planned Expenditures and meets the 20% Set Aside requirement.

8/19/2021 - Arizona plans to expend 75% (\$4,908,766) of the ARP Award Primary Prevention Set-Aside (\$6,545,021) during the timeframe 7/1/21 - 6/30/23. The amount of Table 6 Non-Direct Services/System Development (SA) to be expended is \$450,000. This amount added to the total at the bottom of Table 5a (\$4,458,766) equals \$4,908,766 from Table 4 - SABG Planned Expenditures.

6/20/2022- Arizona is revising Table 5a to reflect the increased funding received in NOA 6/17/22

The 20% Set Aside amount that will be expended under FFY2022 SA Block Grant Award is \$8,693,382. The amount of Table 6 Non-Direct Services/System Development (SA) to be expended is \$1,439,125. This amount added to the total at the bottom of Table 5a (\$7,254,257) equals \$8,693,382 from Table 4 - SABG Planned Expenditures and meets the 20% Set Aside requirement.

# Planning Tables

**Table 5b SABG Primary Prevention Planned Expenditures by IOM Category**

Planning Period Start Date: 10/1/2021      Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	FFY 2022 COVID-19 Award <sup>1</sup>	FFY 2022 ARP Award <sup>2</sup>	FFY 2023 SA Block Grant Award	FFY 2023 COVID-19 Award <sup>3</sup>	FFY 2023 ARP Award <sup>4</sup>
Universal Direct	\$3,618,075	\$1,926,723	\$1,209,375			
Universal Indirect	\$2,392,619	\$1,926,723	\$1,209,375			
Selected						
Indicated	\$350,836	\$825,000	\$521,250			
<b>Column Total</b>	<b>\$6,361,530</b>	<b>\$4,678,446</b>	<b>\$2,940,000</b>			
<b>Total SABG Award<sup>5</sup></b>	<b>\$43,466,912</b>	<b>\$37,892,228</b>	<b>\$24,543,830</b>			
<b>Planned Primary Prevention Percentage</b>	<b>14.64 %</b>	<b>12.35 %</b>	<b>11.98 %</b>			

<sup>1</sup>The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President’s FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

<sup>2</sup>The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President’s FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned ARP expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

<sup>3</sup>The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President’s FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

<sup>4</sup>The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President’s FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned ARP expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

<sup>5</sup>Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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**Footnotes:**



# Planning Tables

**Table 5c SABG Planned Primary Prevention Targeted Priorities**

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021      Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award <sup>1</sup>	ARP Award <sup>2</sup>
<b>Targeted Substances</b>			
Alcohol	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prescription Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Cocaine	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Heroin	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Inhalants	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Methamphetamine	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Bath salts, Spice, K2)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<b>Targeted Populations</b>			
Students in College	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Military Families	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
LGBTQ	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
American Indians/Alaska Natives	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
African American	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Hispanic	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Homeless	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Asian	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Rural	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>



<sup>1</sup>The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

<sup>2</sup>The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

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**Footnotes:**

# Planning Tables

**Table 6 Non-Direct Services/System Development [SA]**

Planning Period Start Date: 10/1/2021      Planning Period End Date: 9/30/2023

Activity	FFY 2022					FFY 2023				
	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated <sup>1</sup>	D. COVID -19 <sup>2</sup>	E. ARP <sup>3</sup>	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated <sup>1</sup>	D. COVID -19 <sup>2</sup>	E. ARP <sup>3</sup>
1. Information Systems		\$242,733.00		\$75,000.00	\$37,500.00					
2. Infrastructure Support		\$189,835.00		\$250,000.00	\$112,500.00					
3. Partnerships, community outreach, and needs assessment		\$376,182.00		\$100,000.00	\$75,000.00					
4. Planning Council Activities (MHBG required, SABG optional)		\$0.00		\$0.00	\$0.00					
5. Quality Assurance and Improvement		\$190,482.00		\$25,000.00	\$15,000.00					
6. Research and Evaluation		\$144,471.00		\$100,000.00	\$75,000.00					

7. Training and Education		\$295,422.00		\$200,000.00	\$135,000.00					
<b>8. Total</b>	<b>\$0.00</b>	<b>\$1,439,125.00</b>	<b>\$0.00</b>	<b>\$750,000.00</b>	<b>\$450,000.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

<sup>1</sup>Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

<sup>2</sup>The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

<sup>3</sup>The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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**Footnotes:**

# Planning Tables

**Table 6 Non-Direct-Services/System Development [MH]**

MHBG Planning Period Start Date: 10/01/2021      MHBG Planning Period End Date: 09/30/2023

Activity	FFY 2022 Block Grant	FFY 2022 <sup>1</sup> COVID Funds	FFY 2022 <sup>2</sup> ARP Funds	FFY 2023 Block Grant	FFY 2023 <sup>1</sup> COVID Funds	FFY 2023 <sup>2</sup> ARP Funds	FFY 2023 <sup>3</sup> BSCA Funds
1. Information Systems	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
2. Infrastructure Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
3. Partnerships, community outreach, and needs assessment	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
4. Planning Council Activities (MHBG required, SABG optional)	\$5,000.00	\$0.00	\$0.00	\$5,000.00	\$0.00	\$0.00	
5. Quality Assurance and Improvement	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
6. Research and Evaluation	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
7. Training and Education	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
<b>8. Total</b>	<b>\$5,000.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$5,000.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

<sup>1</sup> The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

<sup>2</sup> The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

<sup>3</sup> The expenditure period for the Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022 - October 16, 2024**, which is different from the normal block grant expenditure period. Column K should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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**Footnotes:**

The amount on Line 4, Planning Council Activities, reflects the amount set aside for Planning Council members travel reimbursements from the MHBG Block Grant, if needed.

6/20/22 - Per Revision request 5/23/22 - AHCCCS does not have additional changes to this table. The increase in funding did not affect this table

# Environmental Factors and Plan

## 1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

### Narrative Question

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Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.<sup>22</sup> Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.<sup>23</sup> It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.<sup>24</sup>

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.<sup>25</sup> SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.<sup>26</sup> For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.<sup>27</sup>

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.<sup>28</sup>

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.<sup>29</sup> The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.<sup>30</sup> Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes<sup>31</sup> and ACOs<sup>32</sup> may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.<sup>33</sup> Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.<sup>34</sup>

One key population of concern is persons who are dually eligible for Medicare and Medicaid.<sup>35</sup> Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.<sup>36</sup> SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.<sup>37</sup> Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.<sup>38</sup> SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration. SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.<sup>39</sup> Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs. SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.<sup>40</sup>

SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.<sup>41</sup> However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

<sup>22</sup> BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:102-123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52-77

<sup>23</sup> Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <https://www.samhsa.gov/wellness-initiative>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <https://www.samhsa.gov/million-hearts-initiative>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

<sup>24</sup> Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <https://www.samhsa.gov/find-help/disorders>

<sup>25</sup> Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <https://www.cdc.gov/nchstp/socialdeterminants/index.html>

<sup>26</sup> <https://www.samhsa.gov/behavioral-health-equity/quality-practice-workforce-development>

<sup>27</sup> <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

<sup>28</sup> Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. [https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating\\_12.22.pdf](https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf); Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, <https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf>; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series ( 2006), Institute of Medicine, National Affordable Care Academy of Sciences, [http://books.nap.edu/openbook.php?record\\_id=11470&page=210](http://books.nap.edu/openbook.php?record_id=11470&page=210); State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

<sup>29</sup> Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

<sup>30</sup> Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, <https://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/home>; National Telehealth Policy Resource Center, <https://www.cchpca.org/topic/overview/>;

<sup>31</sup> Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

<sup>32</sup> New financing models, <https://www.integration.samhsa.gov/financing>

<sup>33</sup> Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>

<sup>34</sup> What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

<sup>35</sup> Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

<sup>36</sup> Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

<sup>37</sup> BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

<sup>38</sup> TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

<sup>39</sup> Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, [https://www.cibhs.org/sites/main/files/file-attachments/samhsa\\_bhwork\\_0.pdf](https://www.cibhs.org/sites/main/files/file-attachments/samhsa_bhwork_0.pdf); Creating jobs by addressing primary care workforce needs, <https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n>

<sup>40</sup> About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>;

<sup>41</sup> Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

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## Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

AHCCCS provides coverage of integrated health care services through Managed Care Organizations (MCOs). Most AHCCCS members receive all integrated health services through their chosen acute care program, one of seven AHCCCS Complete Care (ACC) plans. Services include, but are not limited to, primary health care, mental health counseling, psychiatric and psychologist services, and treatment for substance use disorders, including Opioid Use Disorder. The Regional Behavioral Health Authorities (RBHAs) continue to serve most individuals with a Serious Mental Illness designation, while continuing to provide crisis, grant-funded and state-only funded services. Additionally, the Arizona Long Term Care System (ALTCS) program provides health insurance for individuals who are age 65 or older or who have a disability. American Indians and Alaska Natives (AI/AN) enrolled in AHCCCS or CHIP (KidsCare) may choose to receive their coverage through the AHCCCS fee-for-service program (American Indian Health Program (AIHP), Tribal ALTCS, or Tribal RBHAs (TRBHAs enter into Intergovernmental Agreements with AHCCCS for behavioral health care management)) or one of the AHCCCS-contracted managed health plans. The fee-for-service program provides medically necessary services for enrolled members, including physical preventive and behavioral health care services.

AHCCCS MCOs are required to develop processes to identify Health Homes within their network and assign members with an SMI designation to a Health Home within five days of enrollment.? The Health Home is then responsible for either providing, or coordinating the provision of, all covered health services. In order to treat the whole person, the Health Home is also responsible to provide or coordinate a range of recovery-focused services to members, such as medication services, substance use disorder treatment, medical management, case management, transportation, peer and family support services, and health and wellness groups. Additionally, to support continuity of care and ensure coordination across systems, the Health Home is required to ensure follow up and continuing care post-crisis engagement.

Additionally, AHCCCS' Division of Fee for Service Management (DFSM) has been targeting improvement in care coordination within the tribal health care delivery system over the past five years. This has included, but is not limited to, the establishment of the American Indian Medical Home, investing in the Health Information Exchange to implement notifications related to admissions, discharges and transfers (ADTs), and working to coordinate with TRBHAs regarding Emergency Department (ED) and inpatient admissions for care management follow-ups.

In response to the Centers for Medicare & Medicaid Services' (CMS) Medicaid Mental Health Parity Final Rule (herein referenced as "Parity") to strengthen access to mental health and substance use disorder services for Medicaid beneficiaries, AHCCCS contracted with Mercer Government Human Services Consulting (Mercer) to provide technical assistance with assessing compliance with parity. Mercer drafted a comprehensive final report that includes the parity analysis methodology and compliance



recommendations, which can be accessed at  
[https://www.azahcccs.gov/Resources/GovernmentalOversight/Mental\\_Health\\_Parity.html](https://www.azahcccs.gov/Resources/GovernmentalOversight/Mental_Health_Parity.html)

As part of the analysis, AHCCCS and Mercer identified all the benefit packages to which parity applies. Parity applies when any portion of the benefit to enrollees is provided through an MCO. The AHCCCS service delivery system currently includes partially and fully integrated MCOs.

AHCCCS along with Mercer was responsible for conducting the analysis of all partially integrated benefit packages. Although AHCCCS has fully integrated populations within many of our MCOs, the ALTCS Elderly and Physically Disabled (EPD) MCOs are the only Plans responsible for providing fully integrated benefits for their entire population. For this reason, AHCCCS worked with Mercer to conduct the analysis for all programs and Contractors, with the exception of ALTCS EPD Contractors who were responsible for conducting their own parity analysis. Summary findings from that analysis included:

- \* A description informing the public about mental health and substance use disorder (MH/SUD) Parity protections under state and federal law.
- \* A description of the methodology used by AHCCCS to check for compliance.
- \* The standard used by AHCCCS to define MH/SUD and medical/surgical (M/S) benefits and how those terms have been defined.
- \* The standard used by AHCCCS to define MH/SUD and M/S benefits and how those terms have been defined.
- \* Identified Aggregate Lifetime and Annual Dollar Limits (AL/ADL), Financial Requirements (FRs) and Quantitative Treatment Limitations (QTLs).
- \* Identified Non-Quantitative Treatment Limitations (NQTLs); and
- \* Actions planned or taken by AHCCCS to resolve compliance concerns.

AHCCCS also requires MCOs to have member handbooks that provide members with the procedures for obtaining benefits, including any requirements for service authorizations. This information includes the criteria for medical necessity determinations for mental health or substance use disorder benefits whenever the service is subject to authorization by the MCO. AHCCCS further requires MCOs to provide the reason for any denial of reimbursement or payment for mental health and substance use disorder benefits to beneficiaries in a written notice of adverse benefit determination whenever service requests requiring authorization have been denied, reduced, or terminated.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring capability.

AHCCCS MCOs function as the single entity responsible for administrative and clinical integration of health care service delivery for members with an SMI designation, which includes coordinating Medicare and Medicaid benefits for these members who are dually eligible. Coordinating and integrating physical and behavioral health care produces improved access to primary care services, increased prevention, early identification, and intervention to reduce the incidence of serious physical illnesses, including chronic disease. Increasing and promoting the availability of integrated, holistic care for members with chronic behavioral and physical health conditions helps members to achieve better overall health and an improved quality of life.

The core principles of AHCCCS' system of care are based on the concepts of recovery, member input, family involvement, person-centered care, communication, and commitment. AHCCCS MCOs are expected to demonstrate an unwavering commitment to these principles, while demonstrating creativity and innovation in their oversight and management of an integrated service delivery system. MCOs are required to develop and promote care integration activities, such as establishing integrated settings which serve members' primary care and behavioral health needs and encouraging member utilization of these settings. MCOs are also required to consider the entirety of the member population's health needs during network development and provider contracting to ensure member access to care, care coordination, and management, and to reduce duplication of services.

AHCCCS MCOs are required to maintain and execute policies and procedures describing the implementation of comprehensive and coordinated delivery of integrated physical and behavioral health services, including administrative and clinical integration of health care service delivery. Integration strategies and activities are expected to focus on improving individual health outcomes, enhance care coordination (including care coordination for Medication Assisted Treatment (MAT)), and increase member satisfaction.

AHCCCS MCOs are also contractually required to report on performance measures that consider underlying performance, performance gaps, reliability and validity, feasibility, and alignment. These performance measures are also evaluated based on several demographics to reduce, to the extent practical, health disparities based on age, race, ethnicity, sex, primary language, and disability status. These measures are used to evaluate whether MCOs are fulfilling key contractual obligations and are an important element of the agency's approach to transparency in health services and Value Based Purchasing (VBP). MCO performance is publicly reported on the AHCCCS website (e.g., report cards and rating systems), as well as other means, such as the sharing of data with state agencies and other community organizations and stakeholders. MCO performance is compared to AHCCCS requirements, with the national NCQA Medicaid Mean (for NCQA HEDIS ® measures) and the CMS Medicaid Median (for CMS Core Set Only measures) for the associated measurement period serving as the performance target for each contractually required performance measure.

AHCCCS is pursuing long-term strategies that bend the cost curve while improving member health outcomes. The overall mission is to leverage the AHCCCS managed care model toward value-based health care systems where members' experience and population health are improved through aligned incentives with MCOs and provider partners, and a commitment to continuous quality improvement and learning. One critical tool, VBP, encompasses a variety of initiatives for payment reform, including Alternative Payment Models (APMs), Differential Adjusted Payments (DAP), Directed Payments and Targeted Investments (TI). Through VBP, AHCCCS is committing resources to leverage the state's successful managed care model to address inadequacies of the current health care delivery system, such as fragmentation and paying for volume instead of quality.

AHCCCS requires that all contracted health plans have an Office of Individual and Family Affairs (OIFA) as a counterpart to the AHCCCS OIFA. The health plan OIFAs are contractually required to collaborate and participate in various initiatives and activities with AHCCCS OIFA and with their counterparts across health plans. Each MCO OIFA represents and interacts directly with the specific populations that they serve. This ensures that the community participation and oversight is itself reflecting a fully integrated health system. This representation provides feedback to AHCCCS from the community as a way of overall system transformation.

Health plans are contractually required to have peer and family member participation on internal decision-making committees. This representation must reflect all populations served by the contractor including members with SUD.

Health plans are contractually required to maintain a network of providers including Peer-Run Organization (PRO) and Family-Run Organizations (FRO) serving all populations, including members with SUD. Health plan OIFAs take an active role by providing technical assistance to existing PROs and FROs; and by identifying new agencies wishing to be recognized by AHCCCS as PROs and FROs.

3. a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans?  Yes  No
- b) and Medicaid?  Yes  No
4. Who is responsible for monitoring access to M/SUD services provided by the QHP?  
AHCCCS
5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?  Yes  No
6. Do the M/SUD providers screen and refer for:
- a) Prevention and wellness education  Yes  No
- b) Health risks such as
- ii) heart disease  Yes  No
- iii) hypertension  Yes  No
- iv) high cholesterol  Yes  No
- v) diabetes  Yes  No
- c) Recovery supports  Yes  No
7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?  Yes  No
8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?  Yes  No
9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?  
N/A
10. Does the state have any activities related to this section that you would like to highlight?  
N/A  
Please indicate areas of technical assistance needed related to this section  
Technical assistance is not being requested at this time.

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**Footnotes:**

# Environmental Factors and Plan

## 2. Health Disparities - Requested

### Narrative Question

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In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)<sup>42</sup>, [Healthy People, 2020](#)<sup>43</sup>, [National Stakeholder Strategy for Achieving Health Equity](#)<sup>44</sup>, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)<sup>45</sup>.

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."<sup>46</sup>

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status<sup>47</sup>. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations<sup>48</sup>. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

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<sup>42</sup> [http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

<sup>43</sup> <http://www.healthypeople.gov/2020/default.aspx>

<sup>44</sup> [https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS\\_07\\_Section3.pdf](https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf)

<sup>45</sup> <http://www.ThinkCulturalHealth.hhs.gov>

**Please respond to the following items:**

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?
- a) Race  Yes  No
  - b) Ethnicity  Yes  No
  - c) Gender  Yes  No
  - d) Sexual orientation  Yes  No
  - e) Gender identity  Yes  No
  - f) Age  Yes  No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?  Yes  No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?  Yes  No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?  Yes  No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?  Yes  No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care?  Yes  No

7. Does the state have any activities related to this section that you would like to highlight?  
The AHCCCS Executive Management team prioritized reducing health disparities as part of continuous quality improvement within the AHCCCS SFY 2022 2-Page Strategic Plan. The Strategic Plan is publicly available on the AHCCCS website at <https://www.azahcccs.gov/AHCCCS/AboutUs/#CStrategicPlan>.

In July 2020 AHCCCS established the Health Equity Committee to better understand health disparities and develop strategies to ensure health equity for all AHCCCS members. The committee is responsible for overseeing and managing health equity considerations as they relate to policy, data, health plan oversight and emerging health care innovation strategies for over 2 million Arizonans.

Healthy People 2030 defines health equity as the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”

This committee is responsible for identifying health disparities among AHCCCS-eligible individuals and members by using AHCCCS utilization and quality improvement data to advance policy and/or contracting strategies to improve the health equity of AHCCCS’ populations and programs. This committee will communicate existing health equity strategies currently being implemented by the agency, identify needed improvements to existing strategies (if appropriate), develop and/or evaluate key metrics, and articulate future interventions aimed at eliminating health disparities.

**Health Equity Committee Goals:**

- + Understand health disparities within the AHCCCS members.
- + Effectuate policy changes and support the implementation of strategies for positive improvement where known disparities exist, creating opportunities for the more equitable provision of services and supports.
- + Raise the visibility of AHCCCS’ commitment to health equity and the strategies in place to ensure the equitable provision of services and supports.
- + Improve health outcomes for AHCCCS members.
- + Identify challenges and barriers that AHCCCS members have in accessing covered services.

The AHCCCS Health Equity Committee is currently evaluating available data, and determining how to enhance equity-related analyses and address any identified disparities.

Please indicate areas of technical assistance needed related to this section

Technical assistance is not being requested at this time.

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**Footnotes:**

## Environmental Factors and Plan

### 3. Innovation in Purchasing Decisions - Requested

#### Narrative Question

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While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

$$\text{Health Care Value} = \text{Quality} \div \text{Cost}, (\mathbf{V} = \mathbf{Q} \div \mathbf{C})$$

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,<sup>49</sup> The New Freedom Commission on Mental Health,<sup>50</sup> the IOM,<sup>51</sup> NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).<sup>52</sup> The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."<sup>53</sup> SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (**TIPS**)<sup>54</sup> are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (**KIT**)<sup>55</sup> was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

<sup>49</sup> United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

<sup>50</sup> The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

<sup>51</sup> Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

<sup>52</sup> National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

<sup>53</sup> <http://psychiatryonline.org/>

<sup>54</sup> <http://store.samhsa.gov>

<sup>55</sup> [https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019\\_0.pdf](https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf)

### Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?  Yes  No
  
2. Which value based purchasing strategies do you use in your state (check all that apply):
  - a)  Leadership support, including investment of human and financial resources.
  - b)  Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
  - c)  Use of financial and non-financial incentives for providers or consumers.
  - d)  Provider involvement in planning value-based purchasing.
  - e)  Use of accurate and reliable measures of quality in payment arrangements.
  - f)  Quality measures focused on consumer outcomes rather than care processes.
  - g)  Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
  - h)  The state has an evaluation plan to assess the impact of its purchasing decisions.
  
3. Does the state have any activities related to this section that you would like to highlight?

Arizona Health Care Cost Containment System (AHCCCS) has introduced multiple Differential Adjusted Fee Schedules to distinguish providers who have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. AHCCCS has published the following documents for reference:

1. AHCCCS Differential Adjusted Payment (DAP) Activity CYE 2022 Final Public Notice Originally Posted April 29, 2021.

The purpose of the notice was to provide the following Differential Adjusted Payment decisions:

For the contracting year October 1, 2021 through September 30, 2022 (CYE 2022), select AHCCCS-registered Arizona providers which meet agency established performance criteria will receive Differential Adjusted Payments (DAP).

AHCCCS is implementing these DAP rates to assure that payments are consistent with efficiency, economy, and quality of care, and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. AHCCCS requests provider and Managed Care Organization (MCO) feedback on current and future DAP initiatives each year.

2. AHCCCS Contractor Operations Manual/Chapter 300 Finance/ 306 – Alternative Payment Model Initiative – Withhold and Quality Measure Performance Incentive

The purpose of the policy applies to all Acute Care and Arizona Long Term Care System (ALTCS) /Elderly and Physically Disabled (EPD) Contractors. The purpose of the AHCCCS Alternative Payment Model (APM) Initiative – Withhold and Quality Measure Performance (QMP) Incentive is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings by aligning the incentives of the contractor and provider

through APM strategies.

3. AHCCCS Contractor Operations Manual/Chapter 300 Finance/307– Alternative Payment Model Initiative – Strategies and Performance-Based Payment Incentive

The purpose of the Alternative Payment Model (APM) Initiative - Strategies and Performance-Based Payments Incentive Policy applies to Acute Care, Arizona Long Term Care System Elderly and Physical Disability (ALTCS/EPD), Children's Rehabilitative Services (CRS), Regional Behavioral Health Authority (RBHA), ALTCS Division of Economic Security/Developmental Disabilities (DDD) Contractors and DDD Sub-contractors. The purpose of this initiative is to encourage contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the contractor and provider through APM strategies. AHCCCS requires a specified percentage of spend in Value Based Purchasing (VBP) arrangements. AHCCCS requests provider and MCO feedback on current and future VBP initiatives each year.

Please indicate areas of technical assistance needed related to this section.

Technical Assistance is not being requested at this time.

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**Footnotes:**



## Environmental Factors and Plan

### 4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

#### Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention\* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode ([RAISE](#)) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

\* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

#### Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)?  Yes  No
2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI?  Yes  No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

Evidence-based practices (EBPs) implemented in Arizona for early serious mental illness (ESMI) including first episode of psychosis include: The Coordinated Specialty Care (CSC) model, OnTrackNY, NAVIGATE, including the NAVIGATE Staying Well and Achieving Goals (SWAG), Cognitive Behavior Therapy (CBT) for psychosis, Systemic Family Therapy, Acceptance and Commitment Therapy (ACT), Internal Family Systems (IFS), Multifamily Group, Motivational Interviewing (MI), Cognitive Remediation, Personal Medicine, Certified Clinical Trauma Specialist-Individual (CCTSI), Cognitive Enhancement Therapy, mindfulness meditation, and peer support.

The MHBG funds 9 early intervention programs for ESMI and first episode psychosis (FEP). Below are descriptions of each program.

Banner Early Psychosis Intervention Center (EPICenter), located in Tucson, AZ, was developed from the CSC model and is the only 5-year program of its kind in the nation, providing evidence-based and intensive stage-specific treatment

including wrap-around services for adolescents and young adults (aged 15 to 35) in the early stages of a psychotic illness. The program offers members three core functions: (a) Early detection, (b) Acute care during and immediately following a psychiatric crisis, and (c) Recovery-focused continuing care, featuring multimodal interventions to enable young people to maintain or regain their social, academic, and career trajectory during the critical first 2-5 years following the onset of illness.

Resilient Health's FEP program, located in Phoenix, AZ, is a CSC approach that is 18 to 24 months in duration and serves ages 15 to 30. It is composed of a clinical director, three masters level counselors, and one case manager/employment specialist. The team has received formal training in the CSC model. Using a team-based, multi-element approach to treating FEP, the program focuses on early intervention services and works to prevent future symptomatic relapses. The program includes rapid service engagement to reduce duration of untreated psychosis, assertive case management, patient psychoeducation, family psychoeducation, low dose pharmacologic treatment, Cognitive Remediation, and vocational and education support. Resilient Health serves members ages 15-30 who are within the first 2 years of their first psychotic episode, and have a qualifying diagnosis.

For nearly two years, the Connections REACH program worked diligently to engage community partners and increase referrals to the program, having recently worked collaboratively with Pima County Crisis Response Center, behavioral health hospitals, emergency departments, and primary care physicians. However, these efforts did not result in successful intakes to the program and census remained low. Connections will no longer provide FEP services. Instead, there is coordination work occurring to bring a new FEP provider on board under the grant.

Valleywise Health FEP program, located in Avondale, AZ, serves ages 15 to 30 implements a CSC model with the team consisting of the following members: Team Specialist, Education and Employment Specialist, Peer Support Specialist, Recovery Coach, Program Supervisor, Program Assistant, Registrar, Psychiatrist, Nurse, and a Medical Assistant. Certain FEP team members are certified in Personal Medicine and as Clinical Trauma Specialist-Individual (CCTSI). The team implements strategies and modalities such as Shared Decision Making, Cognitive Enhancement Therapy, mindfulness meditation, integrated care, and more. The team uses the CSC to provide support to help divert the usual trajectory of a diagnosis of a primary psychotic disorder. The program focuses on educating members about their diagnosis, learning about the tools and resources available to them overcoming the derailment caused by psychosis symptoms can cause in a young person's life. Services members age 15-25 with a diagnosis of a primary psychotic disorder, diagnosed within the last 12 months, and the person or guardian is in agreement with the referral.

In the Northern region of Arizona, 5 health homes are funded to implement ESMI and FEP programming: Mohave Mental Health Center (MMHC) in Kingman, AZ, Spectrum Healthcare Group (SHG) in Cottonwood, AZ, Child and Family Support Services (CFSS) in Flagstaff, AZ, The Guidance Center (TGC) in Flagstaff, AZ, and West Yavapai Guidance Clinic (WYGC) in Prescott Valley, AZ. They implement a program called Fast Forward, using the CSC model, and also utilize curriculum directly from the NAVIGATE program. Although they are all structured similarly, each Health Home adjusts the program to meet their unique model and staffing structure. Each program consists of a Fast Forward Service Provider, a Behavioral Health Medical Professional, a nurse, a therapist, and other staff unique to each agency. They also operate under the empowerment model, meaning clients have the opportunities to set their own goals to work towards while in treatment, and have an active role in treatment plans and approaches.

Each of the five health homes' Fast Forward Service Providers are responsible for all aspects of case management, therapy, nursing, and coordinating with other health home staff. These providers ensure all services are provided based on the needs of the individual and family.

TGC utilizes a model similar to the high needs case management model. TGC also has a designated BHP and therapist to work with FEP participants. In addition, TGC has recently added a Youth in Transition Case Manager to the Fast Forward Team to help members transition from the children's system to the adult system of care and to provide sustainability to the FEP program.

SHG and WYGC operate a similar model to TGC, and have a dedicated Fast Forward Service Provider who functions as a high needs case manager while also providing skills training, vocational and educational services, and psychoeducation services. However, WYGC has also included a Peer Support as a member of their Fast Forward Team.

CFSS employs a Fast Forward Supervisor, who provides treatment services and coordinates care for FEP members. The Supervisor provides education on psychosis and appropriate interventions to staff working with members experiencing psychosis or identified as early SMI. CFSS also has a dedicated BHP who provides services to members and coordinates with the Supervisor.

Finally, the Connections REACH Program for FEP, which was located in Tucson, AZ, was based on the Coordinated Specialty Care model. This was a new program developed in the last 2 years and was operating with a Team Lead, a Family Education and Employment Support Specialist and a Psychiatrist. The Team Lead served as the primary clinician, individual, group, and family therapist, and case management provider. The Family Education and Employment Support Specialist provided vocational and educational goal setting, liaison with family and community groups, and peer support. The Psychiatrist was responsible for diagnosis, medical care needs, and medication management.

**3.** How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

AHCCCS promotes the use of EBPs for ESMI and FEP through the inclusion of requirements in policy and deliverable templates.

The AHCCCS Medical Policy Manual (AMPM) 320-T1 defines an FEP Program as “a program focused on the early identification and provision of evidence-based treatment and support services to individuals, who have experienced a first episode of psychosis (FEP) within the past two years. Evidence-based FEP programs have been shown to improve symptoms, reduce relapse, and lead to better outcomes. A commonly used evidenced based model is Coordinated Specialty Care, which is a recovery-based approach that uses shared decision making and offers case management, psychotherapy, medication management, family education and support, and supported education or employment.” Once the MHBG FEP allocations are released by AHCCCS, each contractor that receives MHBG FEP funds is required to submit budgets and program plans for the dollars. AHCCCS MHBG staff conduct both programmatic and financial reviews to ensure the budgets and plans meet the requirements set forth in the MHBG and are appropriate under ESMI/FEP. Finally, contractors are required to report back on their use of EBPs to fidelity in their quarterly and annual FEP Program Status Reports, including service utilization by members to ensure members are offered and receive the services prescribed under the CSC model. Additionally, contractors report on the use of EBPs by FEP providers and what is done to monitor fidelity to the model.

AHCCCS implements an integrated model of health care, combining coverage of medical and behavioral health under one managed care health plan. Contracted health plans coordinate and pay for physical and behavioral health care services delivered by more than 104,000 health care providers to more than two million Arizonans. Three of the seven AHCCCS Complete Care Plans are designated as Regional Behavioral Health Authorities (RBHAs) which are fully integrated health plans for acute and behavioral health services for members with serious emotional disturbance (SED) and serious mental illness (SMI) that are not enrolled with DES/DDD. The RBHAs are responsible for the coordination of care for members with behavioral health needs which includes those with ESMI and FEP. AHCCCS Complete Care encourages more coordination between providers within the same network which can reduce fragmentation and lead to better health outcomes for members.

In addition to the requirements for FEP providers to implement EBPs for FEP, the recent integration of physical, dental, and behavioral health under one plan for children in foster care, helps to ensure these children, who are at increased risk for psychosis, have access to comprehensive individualized treatment and integrated care. The earlier children in foster care, especially those who may be experiencing psychosis, receive integrated physical and behavioral health care, the better their health outcomes may be.

Further, the use of Child and Family Teams (CFT) for children and Assertive Community Treatment (ACT), and Adult Recovery Teams (ART) for adults ensure that children, youth, and young adults with psychosis receive integrated health care through the use of EBPs, not just for the treatment of early psychosis but for their other mental health needs as well as physical health.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI?  Yes  No
5. Does the state collect data specifically related to ESMI?  Yes  No
6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?  Yes  No
7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

The state's ESMI programs are various versions of the CSC model and related programs such as the Fast Forward CSC Program, the NAVIGATE, OnTrackNY, the Connections REACH CSC program, and training and consultation from the OnTrack program.

CSC is an evidence based model studied and shown effective in the Recovery After an Initial Schizophrenia Episode (RAISE) project. CSC focuses on offering psychotherapy, medication management, family education and support, case management, supported education and employment, in a recovery-oriented manner, with an emphasis on shared decision making. Each member works with the team of specialists and the family as much as is possible and appropriate to create an individualized treatment plan that works best for the individual. Each team of specialists is comprised of professionals to meet the key roles and functions, although the staffing in each program may vary based on local needs.

These CSC programs are currently implemented in Arizona under Resilient Health, Valleywise Health First Episode Center, Banner EPICenter, Mohave Mental Health Center, Spectrum Healthcare Group, Child and Family Support Services, The Guidance Center, and West Yavapai Guidance Clinic.

8. Please describe the planned activities for FFY 2022 and FFY 2023 for your state's ESMI programs including psychosis?

Each year, AHCCCS develops an allocation schedule for all funding sources, including MHBG and also the ESMI/FEP set aside. Once published, AHCCCS informs the Regional Behavioral Health Authorities (RBHAs) of their respective allocations, and requests they submit program plans and budgets for the ESMI/FEP dollars for the RBHA as well as the direct service providers as subcontractors. Once submitted, AHCCCS then reviews from both a programmatic and a fiscal lens and works with the RBHAs to make revisions until AHCCCS is able to approve the program plans and budgets. This process occurs throughout August and September with the goal to approve all program plans and budgets by September 30, 2021.

Although this process has not yet begun for FY 2022 and FY 2023, AHCCCS does not anticipate major variances from previous years, as each RBHA and provider are likely to continue current efforts and build upon the successes of previous years and to sustain and expand ESMI/FEP services. Major activities under the ESMI/FEP dollars are as follows:

Clinical, support, and administrative personnel to support the ESMI/FEP program

Outreach, education, and supplies including art/journaling supplies, social media campaigns, posters, brochures, parent guides,

recovery guides, office supplies  
Equipment such as electronic tablets  
Video education for clients, family members, and community members  
Training and consultations for Coordinated Specialty Care programs, clinical treatment modalities for psychosis, related conferences  
Early Psychosis Intervention (EPI) Project ECHO implementation  
Maintaining certifications, memberships and required software

One difference AHCCCS anticipates is the addition of a new FEP provider in the Southern region to replace Connections REACH program that was not able to successfully launch in the last two years. The RBHA that was contracted with the Connections REACH program provided ample support and technical assistance to the provider, but it was mutually agreed to discontinue the contract. A budget revision for this RBHA is already in process. As such, a new provider will come in to provide ESMI/FEP services and it is anticipated that the RBHA will have significant plans for program capacity building and start up such as training and technical assistance (TTA) for evidence-based practices to treat ESMI/FEP, best practices for serving members with ESMI/FEP, reporting and other relevant TTA.

In light of the unprecedented environment caused by the COVID-19 pandemic, the need for continued and additional services for First Episode Psychosis (FEP) is greater than ever. Utilizing additional block grant funding granted by SAMHSA, AHCCCS will be enhancing current and adding additional services through the following projects:

Support for additional FEP positions to provide outreach and treatment services;  
Support the training and staff time to participate in evidence-based practices;  
Provide FEP services to individuals impacted by the COVID-19 Pandemic;  
Provide support for additional workforce development activities to enhance current provider capacity to address the needs of this populations; and  
Funding of supplies and outreach materials.

These proposed programs and projects will allow for increased service capacity and improved access to mental health care for individuals designated with FEP to aid in the unprecedented behavioral health needs experienced due to the impact of COVID-19.

**9.** Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

RBHAs are required to submit FEP Program Status Reports to AHCCCS on a quarterly and annual basis regarding the ESMI/FEP 10% set aside. In order to complete this deliverable, the RBHAs may use the FEP providers' monthly or quarterly reports to the RBHA and other efforts to collect information directly from the FEP providers, and also compile information from the RBHA level. As a result, the following information is compiled at the clinic, RBHA, and state level:

Quarterly: enrollment, referral sources, discharge reasons, outreach efforts, service utilization, psychotropic medication prescribed and taken, implementation of EBPs to fidelity, barriers, successes, plans to address barriers and sustain/build successes, expenditures according to approved budget.

Annually: all the information requested in the quarterly report, plus member demographics (age, gender, race, ethnicity), employment or education status, living situation, engagement in physical health services/activities, referrals made to crisis, ED, inpatient, medication compliance, medication side effects, court and IEP status, at-risk member behavior, inpatient hospitalizations, substance use, engagement in meaningful activities, housing barriers, efforts to address housing barriers, successes and plans to build/sustain successes in housing, SAMHSA snapshot information, and planning items including baseline enrollment (previous fiscal year) versus current enrollment.[Text Wrapping Break][Text Wrapping Break]The clinics and RBHAs may also have additional clinical information, not requested by AHCCCS at this time. The MHBG Grant Coordinator reviews these quarterly and annual deliverables, meets with the RBHAs and works with them to identify any gaps, issues, or concerns in the data.

Throughout the report period of October 1, 2019 to September 30, 2020, a total of 368 members were reported to be enrolled in FEP programming. A few highlights of aggregate data reflecting reports from all three RBHAs include the following:

Out of 257 recorded, 92 (35.8%) reported attending school, 79 (30.74%) were employed, and 86 (33.46%) were employed through Vocational Rehabilitation, receiving employment/education supports.

Out of 297 recorded, 237 (79.80%) reported living with family or friends and 36 (12.12%) reported independent living (paying for own housing).

Out of 271 recorded, 163 were taking oral psychotropic medications with 96 (58.9%) were compliant, 20 were taking long acting psychotropic injectables with 14 (70%) compliant.

Out of the 368 enrollees, 31 were in court ordered treatment, 12 on probation, and 12 in an individualized education program, with all but 1 being in good standing with their program/plan.

Out of the 368 enrollees, 39 (10.60%) were reported as persistently acutely disabled, 726 (7.07%) were reported a danger to self, 10

(2.72%) were reported a danger to others, while only 1 (0.27%) was gravely disabled.

Out of 228 recorded, 163 (71.49%) were reported as not engaged in substance use/abuse, 33 (14.47%) were reported as being engaged with recreational use (less than once a week), 21 (9.21%) with regular use (at least once a week), and 11 (4.82%) as using/abusing substance and seeking substance abuse treatment.

**10.** Please list the diagnostic categories identified for your state's ESMI programs.

Per AHCCCS Medical Policy Manual (AMPM) 320-T1, the following are diagnoses that qualify under ESMI/FEP. These are not intended to include conditions that are attributable to the physiologic effects of an SUD, are attributable to an intellectual/developmental disorder, or are attributable to another medical condition:

- a. Delusional Disorder,
- b. Brief Psychotic Disorder,
- c. Schizophreniform Disorder,
- d. Schizophrenia,
- e. Schizoaffective Disorder,
- f. Other specified Schizophrenia Spectrum and Other Psychotic Disorder,
- g. Unspecified Schizophrenia Spectrum and Other Psychotic Disorder,
- h. Bipolar and Related Disorders, with psychotic features, and
- i. Depressive Disorders, with psychotic features.

The members served in the ESMI/FEP programs have diagnoses that fall within these diagnostic categories.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

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**Footnotes:**

# Environmental Factors and Plan

## 5. Person Centered Planning (PCP) - Required MHBG

### Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning?  Yes  No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication. AHCCCS has implemented person-centered planning for all populations that we serve. This has been a collaborative effort and partnership with the individuals we serve, family members, advocates, and community stakeholders. An essential part of person-centered planning is that the person drives the process. They are at the center of the "person-centered planning" process, and it is essential to gather their input, hear their voice and choice of treatment/services, who they want involved in their treatment planning process and ensure access to care is timely and efficient. Arizona's model is based upon the premise that people want and deserve dignity, respect, inclusion, and safety.

The person-centered planning process ensures that cultural and linguistic needs are identified and addressed. Person-centered planning includes a description of how care and services are delivered in a culturally competent, family/member centered manner and are responsive to diverse cultural and ethnic backgrounds. Linguistic needs are defined as providing services in a person's primary or preferred language, including sign language, and the provision of interpretation and translation services. Written materials are critical to obtaining services and the conversion of written materials from English into the person's preferred language while maintaining the original intent also occurs.

Examples include:

- Treatment Planning Documents
- Member Handbooks
- Provider Directories
- Consent Forms
- Appeal and Grievance Notices
- Denial and Termination Notices

Person-Centered Planning is based upon a foundation of Person-Centered Thinking (PCT), which inspires and guides respectful listening leading to actions, resulting in individuals who:

- Have positive control over the life they desire and find satisfying
- Are recognized and valued for their contributions to their journey toward recovery and to their families, people of support and their community/ies
- Are supported by a network of relationships, both natural and paid, within their community
- Are offered employment, education, vocational training, and opportunities to work/not work depending on an individual's unique needs and choices

4. Describe the person-centered planning process in your state.

Person-centered service planning supports AHCCCS Aging and Long-Term Care Services (ALTCS) members in planning and creating the life they want through services and supports to ensure all members are integrated into their communities and have full access to the benefits of community living. ALTCS case managers play a significant role in assessing needs and addressing barriers and challenges that our members face, through a person-centered approach.

The AHCCCS Person-Centered Service Plan (PCSP) is a requirement for the ALTCS population, and is a written plan developed

through an assessment of functional need that reflects the services and supports (paid and unpaid, including behavioral health) that are important for and important to the member in meeting the identified needs and preferences for the delivery of such services and supports. The PCSP also reflects the member's strengths and preferences that meet the member's social, cultural, and linguistic needs, individually identified goals and desired outcomes, and reflect risk factors (including risks to member rights) and measures in place to minimize risk, including the development of individualized back-up/ contingency plans and other strategies as needed.

The person-centered service planning process ensures a standardized method for assessing and documenting discussions with members during assessment and service planning meetings for all ALTCs members; promotes and support discussions with members around key indicators that help assess an individual's integration experience and access to rights afforded to them; and helps to document information shared during conversations with the members, which help to inform personal goal development and service planning. AHCCCS required training on person-centered service planning for all health plans during March of 2021.

Support Coordinators utilize person-centered service planning when assisting individuals who receive services within the Arizona Division of Developmental Disabilities (DDD). Person-centered service planning ensures that the voice and choice of the member is heard, leading to greater independence and input regarding the services that they will utilize. DDD Support Coordinators have been trained in person-centered service planning and use this approach to help the person achieve their goals, ensure their needs are met and live the way they choose to live.

AHCCCS fosters an environment of person-centered planning that includes the voice and choice of the person being served, their family, identified persons of support, advocates (as designated) and service providers, as identified. The planning process is transparent, fluid and is a living and breathing document that can change as a persons' choices and treatment needs change.

AHCCCS' Adult System of Care (ASOC) is a continuum of coordinated community and facility-based services and supports for adults with, or at risk for, behavioral health challenges. The ASOC is organized into a comprehensive network to create opportunities to foster recovery and improve health outcomes by:

1. Building meaningful partnerships with individuals served
2. Addressing the individuals' cultural and linguistic needs and preferences
3. Assisting the individual in identifying and achieving personal and recovery goals

The ASOC developed the following Nine Guiding Principles to promote recovery in the adult behavioral health system and for engaging with adults who have a serious mental illness:

Nine Guiding Principles:

1. RESPECT: Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.
2. PERSONS IN RECOVERY CHOOSE SERVICES AND ARE INCLUDED IN PROGRAM DECISIONS AND PROGRAM DEVELOPMENT EFFORTS: A person in recovery has choice and a voice. Their self-determination in driving services, program decisions, and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.
3. FOCUS ON INDIVIDUAL AS A WHOLE PERSON, WHILE INCLUDING AND/OR DEVELOPING NATURAL SUPPORTS: A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.
4. EMPOWER INDIVIDUALS TAKING STEPS TOWARDS INDEPENDENCE AND ALLOWING RISK TAKING WITHOUT FEAR OF FAILURE: A person in recovery finds independence through exploration, experimentation, evaluation, contemplation, and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.
5. INTEGRATION, COLLABORATION, AND PARTICIPATION WITH THE COMMUNITY OF ONE'S CHOICE: A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.
6. PARTNERSHIP BETWEEN INDIVIDUALS, STAFF, AND FAMILY MEMBERS/NATURAL SUPPORTS FOR SHARED DECISION MAKING WITH A FOUNDATION OF TRUST: A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.

7. PERSONS IN RECOVERY DEFINE THEIR OWN SUCCESS: A person in recovery – by their own declaration – discovers success, in

part, by quality of life outcomes, which may include an improved sense of well-being, advanced integration into the community, and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.

8. **STRENGTHS-BASED, FLEXIBLE, RESPONSIVE SERVICES REFLECTIVE OF AN INDIVIDUAL'S CULTURAL PREFERENCES:** A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.

9. **HOPE IS THE FOUNDATION FOR THE JOURNEY TOWARDS RECOVERY:** A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

In addition, Arizona/AHCCCS collaborated with the child, family, and others to provide services that are tailored to meet the needs of children with serious emotional disturbances and their caregivers. The goal is to ensure that services are provided to the child and family in the most appropriate setting, in a timely manner, in accordance with the best practices and respecting the child, family and their cultural heritage.

Arizona/AHCCCS developed The Twelve (12) Principles for Children's in the Behavioral Health Service Delivery System:

Twelve (12) Guiding Principles:

1. **COLLABORATION WITH THE CHILD AND FAMILY:** Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.

2. **FUNCTIONAL OUTCOMES:** Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.

3. **COLLABORATION WITH OTHERS:** When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, DCS and/or DDD caseworker, and the child's probation officer. The team (a) develops a common assessment of the child's and family's strengths and needs, (b) develops an individualized service plan, (c) monitors implementation of the plan, and (d) makes adjustments in the plan if it is not succeeding.

4. **ACCESSIBLE SERVICES:** Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.

5. **BEST PRACTICES:** Competent individuals who are adequately trained and supervised provide behavioral health services. They are delivered in accordance with guidelines adopted by ADHS that incorporate evidence-based "best practice." Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. **MOST APPROPRIATE SETTING:** Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.

7. **TIMELINESS:** Children identified as needing behavioral health services are assessed and served promptly.

8. **SERVICES TAILORED TO THE CHILD AND FAMILY:** The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.

9. **STABILITY:** Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a class member



is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and criminal justice system. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.

10. RESPECT FOR THE CHILD AND FAMILY'S UNIQUE CULTURAL HERITAGE: Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.

11. INDEPENDENCE: Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.

12. CONNECTION TO NATURAL SUPPORTS: The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

Overall, the Person-Centered Planning and Service Plan reflects the individuals' strengths and preferences that meet the persons' social, cultural, and linguistic needs and includes individualized goals and desired outcomes. Additionally, the planning process also identifies risk factors (includes risks to member rights) and puts measures in place to minimize them with individual back-up plans and other strategies as needed.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

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**Footnotes:**

# Environmental Factors and Plan

## 6. Program Integrity - Required

### Narrative Question

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SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: <http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf>. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

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### Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?  Yes  No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?  Yes  No
3. Does the state have any activities related to this section that you would like to highlight?

AHCCCS contracts with three Regional Behavioral Health Authorities (RBHAs) for the provision of SAMHSA Mental Health Block Grant (MHBG) and Substance Abuse Block Grant (SABG) services and funding. These Contracts delineate the requirements of the RBHAs, including their responsibilities for implementing and monitoring subcontractors who are the providers of direct care services and treatment. Notwithstanding any relationship(s) the RBHA may have with any subcontractor, the RBHA maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the Contract. RBHAs subcontract with providers in their Geographic Service Area (GSA) to ensure members may access services within their communities. Provider networks must meet access-to-care standards for the populations served.

AHCCCS also holds Intergovernmental Agreements (IGAs) with three Tribal Regional Behavioral Health Authorities (TRBHAs) for the provision of MHBG and SABG services and funding. The TRBHA IGAs ensures that services and treatment funded under the federal block grants meet all the legal requirements of the respective block grant. The TRBHAs are responsible for implementing and monitoring direct care services and treatment; and as funds are available, are responsible for the development, and implementation of primary substance abuse prevention services.

Contracts/IGAs are updated and amendments are executed as needed to revise and implement reporting, monitoring, evaluation,

and compliance requirements. Additionally, RBHAs are required to align their programs and activities with the following AHCCCS System Values and Guiding Principles:

Timely access to care,  
Culturally competent and linguistically appropriate care,  
Identification of the need for and the provision of comprehensive care coordination for physical and behavioral health service delivery,  
Integration of clinical and non-clinical health care related services,  
Education and guidance to providers on service integration and care coordination,  
Provision of disease/chronic care management including self-management support,  
Provision of preventive and health promotion and wellness services,  
Adherence with and continuing education and guidance to physical and behavioral health providers on the Adult Behavioral Health Service Delivery System-Nine Guiding Principles,  
Promotion of evidence-based practices through innovation,  
Expectation for continuous quality improvement,  
Improvement of health outcomes,  
Containment and/or reduction of health care costs without compromising quality,  
Engagement of member and family members at all system levels,  
Collaboration with the greater community,  
Maintains, rather than delegates, key operational functions to ensure integrated service delivery,  
Embraces system transformation, and  
Implementation of health information technology to link services and facilitate improved communication between treating professionals, and between the health team, the member, and member caregivers.

#### Monitoring

Within AHCCCS, many divisions collaborate to ensure compliance with block grant program integrity responsibilities. The Division of Health Care Management (DHCM), the Office of the Director (OOD), the Division of Community Advocacy & Intergovernmental Relations (DCAIR), and the Division of Fee for Service Management (DFSM) play an integral role in the ongoing monitoring for programmatic compliance, including promoting the proper expenditure of block grant funds, improving block grant program compliance, and demonstrating the effective use of block grant funds. RBHAs and TRBHAs are required to ensure reporting requirements and deliverables outlined in their contract/IGA are met.

#### Corporate Compliance/Fraud, Waste, and Abuse

AHCCCS has established a comprehensive Corporate Compliance Program to achieve the goals of preventing and detecting fraud, waste, and abuse of the program. The program ensures Contractor compliance with applicable laws, rules, regulations, and contract requirements. Continued collaboration efforts include regularly scheduled meetings held to share information with RBHAs and TRBHAs regarding their Corporate Compliance Program that includes all program integrity activities.

#### Operational Reviews

AHCCCS conducts annual SABG/MHBG Operational Reviews to verify Contractor performance which include review of internal monitoring of grant activities; verification of timely and accurate notifications to providers of sub-awards, funding, and audits; verification of tracking and implementation of decisions regarding provider audit findings; and appropriate tracking of grant funding.

#### Reporting Requirements

Regular deliverable submissions to AHCCCS by each RBHA and TRBHA are required and analyzed to ensure program integrity efforts are met. These include at a minimum: annual Independent Case Reviews; annual MHBG and SABG Activities and Expenditures Plans and Reports; quarterly Grievance and Appeal reporting; and annual/quarterly/monthly Financial Reporting. A brief description of each is provided below:

1. AHCCCS oversees the Independent Case Reviews (ICRs) to meet the Peer Review requirement of the block grant to ensure the quality and appropriateness of treatment services and indications of treatment outcomes. An ICR interdisciplinary team from an independent agency completes case reviews.
2. RBHAs and TRBHAs must provide information regarding MHBG and SABG activities and expenditures outlining use of funds, strategies for monitoring expenditures, and make adjustments in a timely manner to best meet the needs of the community.
3. RBHAs and TRBHAs must for all members, subcontractors, and providers administer all Grievances and Appeal System processes competently, expeditiously, and equitably. RBHAs and TRBHAs are required to report provider claim disputes, member grievances, SMI Grievances and SMI Appeals as delineated in Arizona Administrative Code Title 9, Chapter 21, Article 4.
4. RBHAs and TRBHAs are required to submit financial statements and reporting packages, which must comply with contractual requirements for management of federal block grant funds.

#### Policies and Procedures

In addition to the Contracts/IGAs, multiple policies and procedures are developed and implemented for RBHAs and TRBHAs to

ensure operational and programmatic compliance and appropriate service delivery. Two priority manuals are the AHCCCS Contractor Operations Manual (ACOM) and the AHCCCS Medical Policy Manual (AMPM). Policies within these manuals are written with input from multiple divisions at AHCCCS with revisions completed as needed due to Federal or State legislation, contractual requirements, operational changes, monitoring requirements, benefit coverage, etc. All applicable policies are incorporated by reference in the Contracts/IGAs.

Listed below are several policies important to note which relate to RBHA grant services and funding; member and provider notifications; and access to care requirements (this is not an all-inclusive list):

ACOM Policy 103, Fraud, Waste, and Abuse

ACOM Policy 323, RBHAs Title XIX/XXI Reconciliation and Non-Title XIX/XXI Profit Limit

ACOM Policy 404, Contractor Website and Member Information

ACOM Policy 406, Member Handbook and Provider Directory

ACOM Policy 416, Provider Information

ACOM Policy 436, Provider Network Requirements

ACOM Policy 444, Notice of Appeal Requirements (SMI Appeals)

ACOM Policy 446, Grievances and Investigations Concerning Persons with Serious Mental Illness

ACOM Policy 448, Housing

AMPM Policy 310-B, Title XIX/XXI Behavioral Health Services Benefit

AMPM 310-V, Prescription Medications-Pharmacy Services

AMPM 320-V, Behavioral Health Residential Facilities

AMPM Policy 320-T1, Block Grants and Discretionary Grants

AMPM Policy 580, Behavioral Health Referral and Intake Process

AMPM Policy 650, Behavioral Health Provider Requirements for Assisting Individuals with Eligibility Verification and Screening, Application for Public Health Benefits Provider Eligibility

AMPM Policy 960, Quality of Care Concerns

AMPM Policy 961, Incident, Accident, and Death Reporting

AMPM Policy 962, Reporting and Monitoring of Seclusion and Restraint

AMPM Policy 963, Peer and Recovery Support Service Provision Requirements

AMPM Policy 964, Credentialed Parent Family Support Requirements

AMPM Policy 1040, Outreach, Engagement, Re-Engagement and Closure for Behavioral Health

Contractors, providers, and members have full access to the ACOM, AMPM, and other Guides and Resources via the AHCCCS website. Policies are made available to stakeholders for a 45-day Tribal Consultation/Public Comment period and revision memos accompany each policy revision explaining the changes and notification of changes is sent via email. Additionally, AHCCCS hosts the AHCCCS Managed Care Organization (MCO) Update Meetings with contracted health plans, state agencies, and TRBHAs; these meetings are typically held every two months. AHCCCS also holds quarterly Tribal Consultation meetings to consult with tribes, Indian Health Service, tribal health programs operated under P.L. 93-638, and urban Indian health programs in Arizona on policy and programmatic changes that may significantly impact members. Individualized communication with each RBHA formally occurs in person during regular meetings with AHCCCS to review issues, concerns, and new information. If an improvement plan is established, oversight, and communication from AHCCCS occurs more frequently.

RBHAs and TRBHAs are responsible for ensuring that its subcontractors are notified when modifications are made to AHCCCS guidelines, policies, and manuals. In the event of a modification to AHCCCS Policy, guidelines, and manuals and are required to issue a notification of the change to its affected subcontractors within 30 calendar days of the published change and ensure amendment of any affected subcontracts. Additionally, RBHAs are contractually required to hold provider forums semi-annually to improve communication between the Contractor and providers and to address issues (or to provide general information, technical assistance, etc.).

As stated in Contracts and IGAs respectively, RBHAs and TRBHAs shall comply with all reporting requirements contained in Contract/IGA and Policy.

Please indicate areas of technical assistance needed related to this section

Technical assistance is not being requested at this time.

#### AHCCCS OIG Program Integrity Statement

The Office of Inspector General (OIG) is responsible for the Program Integrity for the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid program. The OIG is also responsible for handling reports of fraud, waste, and abuse of the AHCCCS program. All suspected fraud, waste, or abuse must be reported to the AHCCCS OIG. Anyone can report Arizona Medicaid fraud, waste, or abuse. There are no restrictions. To report suspected fraud by an AHCCCS medical provider, please call in Maricopa County: 602-417-4045, outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686. To report suspected fraud by an AHCCCS member, please call in Maricopa County: 602-417-4193, outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686. Additionally, provider and member fraud can be reported online at <https://www.azahcccs.gov/Fraud/ReportFraud/onlineform.aspx>. Questions can also be emailed to the AHCCCS OIG at [AHCCCSFraud@azahcccs.gov](mailto:AHCCCSFraud@azahcccs.gov).

TRBHA Block Grant Oversight

AHCCCS Division of Fee forService Management (DFMS) monitors the Tribal Regional Behavioral Health Authority (TRBHA) block grant services by conducting biennial Operational Reviews (OR). Block grant general requirements and prohibitions are outlined in the TRBHA Intergovernmental Agreements (IGA), along with associated deliverables. DFMS looks to the IGA, as well as collaborates with the Division of Grants Administration (DGA) for required standards which are incorporated into the OR Tool for review and monitoring. During the OR, records of members who received block grant services are reviewed according to the individual grant requirements. The OR also includes ensuring the funds are expended on appropriate activities such as services for the priority population and intervention and prevention services and that the services meet the legal requirements of each respective block grant. The audit ensures that block grant funds are the payor of last resort. Upon completion of the OR, work plans are created with each TRBHA to address any findings or standards which were not met. AHCCCS DFMS collaborates with DGA on reviewing and monitoring the work plan or providing technical assistance, as needed.

In addition to the OR, DFMS collaborates with DGA in providing additional TRBHA oversight through a variety of methods, including receiving and reviewing reports and deliverables, monitoring and reviewing spend through Contract Expenditure Reports (CERs), conducting site visits, providing technical assistance and training to the TRBHAs as needed, and holding routine finance meetings. DFMS monitors deliverables for timely submission and assists DGA when additional information from the deliverables is needed. DFMS and DGA hold monthly coordination meetings to discuss any issues or block grant opportunities for the TRBHA and to identify any need for technical assistance or training opportunities, in addition to responding to TRBHA requests for additional block grant funding.

Please indicate areas of technical assistance needed related to this section

Technical assistance is not being requested at this time.

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**Footnotes:**

# Environmental Factors and Plan

## 7. Tribes - Requested

### Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)<sup>56</sup> to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

<sup>56</sup> <https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf>

### Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

Between August 2019 – July 2021 there were 25 tribal consultation sessions.  
<https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html>

2. What specific concerns were raised during the consultation session(s) noted above?

There were several areas of discussion or concern covered at the consultation meetings throughout the year, including: the physical and behavioral health care coordination for tribal members; non-emergency transportation services; pharmacy benefits; State Plan Amendments, including traditional healing, dental benefits, and differential adjusted payments; 1115 waivers, including AHCCCS Works/community engagement requirement and prior quarter coverage ; housing; funding and payment details; Indian Health Services (IHS) 638 funding; Value Based Purchasing; legislative actions; best practices; and policy implications.

3. Does the state have any activities related to this section that you would like to highlight?

In addition to Tribal Consultation, AHCCCS holds quarterly meetings with the Tribal Regional Behavioral Health Authorities (TRBHAs). There were four meetings conducted in both State Fiscal Years (SFY) 2020 and 2021. Additionally, the TRBHA Intergovernmental Agreements (IGA) were set to expire June 30, 2021. During SFY 2021, AHCCCS spent six months in negotiation with the TRBHAs to draft new IGAs. In preparation for this process, AHCCCS also convened TRBHA IGA Listening Sessions. These discussions included feedback and recommendations related to the TRBHAs' scope of work and implementation of the block grants.

The Tribal Regional Behavioral Health Authorities (TRBHAs) continue to be actively involved in partnering with AHCCCS programmatic staff in regular meetings and conference calls to coordinate the efforts of substance use disorder prevention and treatment services, and to receive technical assistance related to the block grant reporting requirements. The State has identified a

process for which the TRBHAs can request additional block grant dollars, if needed. This process has been clearly communicated to them as well as posted to the AHCCCS website.

AHCCCS has also implemented its American Indian Medical Home Program for IHS/638 facilities for enhanced primary care case management and care coordination, as well as the implementation of Care Coordination Agreements between IHS/638 facilities and non-IHS/638 facilities to improve the delivery system for American Indians by increasing access to care and strengthening the continuity of care.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

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**Footnotes:**

# Environmental Factors and Plan

## 8. Primary Prevention - Required SABG

### Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

### Please respond to the following items

#### Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)?  Yes  No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)  Yes  No
  - a)  Data on consequences of substance-using behaviors
  - b)  Substance-using behaviors
  - c)  Intervening variables (including risk and protective factors)
  - d)  Other (please list)

Major substance use issues in the community :

Substances causing the most harm  
Causes of substance use  
Effectiveness of prevention efforts  
Recommendations for prevention approaches  
Gaps in prevention efforts

Community strengths that prevent substance use  
Subgroup differences  
Medical profession changes that reduce risk for prescription drug misuse  
Types of access to substances  
Types of substance use prevention efforts  
Challenges on implementation  
Training access/availability by county  
Training needs  
Efforts to evaluate impact  
Demographics/information on communities served



Evaluation methods used  
Evaluation needs  
Resource adequacy  
Addressing root causes  
Efforts to consider special populations  
Challenges

3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- Children (under age 12)
- Youth (ages 12-17)
- Young adults/college age (ages 18-26)
- Adults (ages 27-54)
- Older adults (age 55 and above)
- Cultural/ethnic minorities
- Sexual/gender minorities
- Rural communities
- Others (please list)

N/A

4. Does your state use data from the following sources in its Primary prevention needs assessment? (check all that apply)

- Archival indicators (Please list)

N/A

- National survey on Drug Use and Health (NSDUH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavioral Surveillance System (YRBS)
- Monitoring the Future
- Communities that Care
- State - developed survey instrument
- Others (please list)

5. Does your state use needs assessment data to make decisions about the allocation SABG primary prevention funds?  Yes  No

If yes, (please explain)

Arizona Health Care Cost Containment System (AHCCCS) completed a statewide needs assessment in September 2018 that informs prevention needs throughout the state. Utilizing an outside vendor, AHCCCS collected information using the following goals to inform all assessment related efforts: develop and implement the needs assessment approach and evaluation plan, generate a community prevention inventory, conduct focus groups throughout AZ, conduct key informant interviews throughout AZ, conduct an online Substance Use Prevention Workforce survey, and synthesize secondary data analysis for a multitude of data sources. The four questions the needs assessment addressed were:

1. What are the current substance use issues in AZ by region and subpopulation?
2. What substance use prevention programs are active in AZ?
3. What are the causes for using and/or abusing substances in AZ?
4. What are the recommendations for the future of substance use prevention in AZ?

Results of the needs assessment continue to inform AHCCCS planning and implementation. Findings included:

A lack of resources to address untreated mental health concerns,  
Health disparities facing the LGBTQ population,

Reductions in local funding for prevention activities, and

The unintended consequence that recent efforts to combat the prescription drug opioid crisis in AZ are leading to increased street drug use.

AHCCCS is addressing these findings by:

Including these gaps and priorities in the scope of work and request for proposals for prevention services, and evaluating proposals accordingly,

Highlighting identified target populations for providers,

Comparing identified needs to current resources available to that population and working to fill the gaps

Increasing utilization of prevention interventions with dual outcomes in both mental health and substance use,  
Providing education of those available interventions,  
Increasing collaborations statewide within other agencies or entities that can lead to more effective state funding spending,  
Meeting with agency level decision makers discuss the current substance abuse prevention system structure and  
recommendations for improvement, and  
Coordinating services across federal and state funding sources.

Since the needs assessment was published, AHCCCS instituted changes to strengthen the prevention system. AHCCCS contractually required SABG-funded primary prevention providers to develop and submit several deliverables that improve the science base of funded activities. This includes AHCCCS templates for deliverables such as logic models, needs assessments, and strategic plans, and mandates of basic prevention training, requiring evidence-based practices but also allowing the use of innovative practices with written review and approval by AHCCCS.

The Substance Use Prevention Workforce survey gave AHCCCS very insightful data regarding the issues that are currently affecting our prevention workforce. Many individuals reported not receiving prevention related training as often as they need or want. To address this, AHCCCS developed a statewide training plan in conjunction with the Pacific Southwest Prevention Technology Transfer Center (PTTC). This resource document includes online and in person training opportunities for the prevention workforce. It will also allow AHCCCS to concisely plan out an entire year of training courses, with topics such as Selecting Evidence Based Strategies, and Prevention Basics/Substance Abuse Prevention Skills Training (SAPST).

Local providers may also use the Arizona Statewide Prevention Needs Assessment, along with other sources of data, to inform their work. SABG Prevention providers are required to develop and submit to AHCCCS a prevention needs assessment at least once every three years. It must include information on existing prevention efforts in resources, gaps, risk and protective factors, and consequences related to substance use, trends, training capacity, prevalence of substance use issues, treatment resources, demographics, and sustainability. Additionally, the Arizona Youth Survey (AYS), administered by the Arizona Criminal Justice Commission once every two years to students in grades eight, 10, and 12, is widely used data source for AZ prevention providers that gives county, city/town, and even school level data that providers use to inform their program planning, implementation, and evaluation.

If no, (please explain) how SABG funds are allocated:

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

## Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce?  Yes  No

If yes, please describe

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?  Yes  No

If yes, please describe mechanism used

Arizona Health Care Cost Containment System (AHCCCS) is committed to advancing Arizona's Prevention System and has several mechanisms for learning about training and technical assistance (TTA) needs and providing TTA. AHCCCS is in the process of developing a statewide prevention training plan and resource guide for the statewide prevention workforce. AHCCCS is in regular communication with Arizona's designated Prevention Technology Transfer Center (PTTC) to inform the state of upcoming training and technical assistance opportunities, as well as discuss statewide training needs that the PTTC can help address. Technical assistance is crucial to implement prevention programs successfully, which includes evidence based programs, Culturally and Linguistically Appropriate Services (CLAS) standards training to address substance use disorder in a culturally appropriate manner. In addition, educational materials are available in the preferred language of members and include examples pertaining to members' culture. Any curricula used are culturally appropriate and responsive to members.

In 2020, AHCCCS contracted with LeCroy & Milligan Associates (LMA) to complete a Strategic Plan, and as part of the process, LMA collected updated information that was originally collected in the needs assessment, including TTA needs of the prevention field. Additionally in August 2020, AHCCCS conducted 3 substance use prevention focus groups among prevention stakeholders to inform AHCCCS in many areas, including prevention field TTA needs. Examples of questions that solicited answers to inform TTA needs include:

What Center for Substance Abuse Prevention (CSAP) strategy/strategies do you feel have the most influence on preventing substance abuse problems in your community?

What level of experience does the field have in competing for prevention funding and what types of resources would be helpful in writing a successful proposal?

What proportion of prevention professionals currently have some level of Prevention certification or credential?

Would the prevention specialist certification requirements be feasible, and helpful and/or useful for your everyday work in prevention?

What training requirements are in place in the current systems in which you work?

What current training opportunities are you finding to be most valuable and should continue to be offered?

What additional training does the field need to be successful with implementing primary prevention activities?

What formats of technical assistance and training is the best for the field?

What subcontractors or subcontractors are you currently utilizing to implement prevention services?

How are you currently evaluating your prevention programs for effectiveness?

Both of these data collection opportunities informed the direct service scope of work and request for proposals.

AHCCCS also meets with all prevention contractors once every 2 months to provide and request updates, which is a platform by which AHCCCS staff may learn about TTA needs or provide TTA. As of July 1, 2021, AHCCCS no longer administers SABG Prevention set aside funds through the RBHAs. Though the Governor's Office of Youth Faith and Family and the Tribal Regional Behavioral Health Authorities still receive SABG Prevention allocations, AHCCCS now also directly contracts with 19 prevention service providers. This new administrative structure allows AHCCCS to be in closer contact with the providers, to provide direct TTA, and to solicit information on TTA needs in real time. Each AHCCCS Prevention Grant Coordinator meets with the prevention providers monthly, and communicates via email more frequently to address TTA needs. AHCCCS continues to provide TTA to GOYFF and the TRBHAs as well, whether directly or through partners such as the PTTC, Wellington Consulting Group, or LeCroy & Milligan Associates.

Some recent and upcoming examples of TTA provision to prevention contractors include Logic Model training in September through November 2020, a Primary Prevention Contractor Kick Off Meeting on July 7, 2021, several recent TTA on required report deliverables since July 1, 2021, and upcoming Prevention Evaluation training.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?  Yes  No

If yes, please describe mechanism used

The AHCCCS funded prevention system follows the Strategic Prevention Framework (SPF) model, which includes the development and implementation of a statewide needs assessment at least every 3-5 years. The most recent Needs Assessment, finalized in September 2018, included a community readiness assessment that allowed AHCCCS to see the state's capacity to address current prevention needs on a large scale.

Additionally, until July 1, 2021, AHCCCS ensured RBHAs performed a community readiness assessment to determine workforce capacity and the level of community readiness to implement appropriate strategies. Now, the directly contracted providers are required to conduct a substance abuse prevention needs assessment at least once every 3 years. The TRBHAs who receive SABG Prevention funds are also required to conduct regular substance abuse prevention needs assessments, which would include a community readiness section. These assessments at the community level are required to identify and address those factors contributing to substance use problems. Prevention efforts are purposefully designed to meet the communities' needs and consider the community's readiness for prevention services and activities.

## Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

## Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?  Yes  No  
  
If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan  
Please see attached plan.
2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan)  Yes  No  N/A
3. Does your state's prevention strategic plan include the following components? (check all that apply):
  - a)  Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
  - b)  Timelines
  - c)  Roles and responsibilities
  - d)  Process indicators
  - e)  Outcome indicators
  - f)  Cultural competence component
  - g)  Sustainability component
  - h)  Other (please list):
  - i)  Not applicable/no prevention strategic plan
4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?  Yes  No
5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?  Yes  No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

Until recently, AHCCCS participated in the Evidence Based Practice Workgroup through the Pacific Southwest Prevention Technology Transfer Center (PTTC). As of July 2021, the PTTC informed AHCCCS that the workgroup will be transitioned instead into a network of prevention Subject Matter Experts (SMEs).

AHCCCS participates in and collaborates with other state, federal, and community entities through the Arizona Substance Abuse Partnership (ASAP), which is the single statewide council on substance abuse prevention, treatment and recovery efforts. In 2020,

ASAP had two workgroups: the Arizona Substance Abuse Epidemiology Workgroup, and the Program Inventory Workgroup. AHCCCS Prevention staff participated in the Program Inventory Workgroup as well. The group reviewed a broad range of programming and strategies in prevention, identified promising practices, and provided recommendations to ASAP.

Further, AHCCCS currently accepts guidance set forth from SAMHSA in the document "Selecting Best-fit Programs and Practices: Guidance for Substance Misuse Prevention Practitioners" as the standard to follow when selecting programs and practices, including the best practices lists and resources. Directly contracted prevention providers are required to implement comprehensive evidence-based programs, utilizing all 6 Center for Substance Abuse Prevention (CSAP) strategies, and serving each Institute of Medicine (IOM) Category per community need. Evidence-based programs or practices are interventions that fall into one or more of the following categories:

1. The intervention is included in a federal registry of evidence based interventions, or
2. The intervention produced positive effects on the primary targeted outcome, and these findings are reported in a peer reviewed journal, or
3. The intervention has documented evidence of effectiveness, based on guidelines developed by the Center for Substance Abuse Prevention and/or the state, tribe, or jurisdiction in which the intervention took place. Documented evidence should be implemented under four recommended guidelines, all of which shall be followed. These guidelines require interventions to be:
  - a. Based on a theory of change that is documented in a clear logic or conceptual mode,
  - b. Similar in content and structure to interventions that appear in federal registries of evidence-based interventions and/or peer-reviewed journals,
  - c. Supported by documentation showing it has been effectively implemented in the past, multiple times, and in a manner attentive to scientific standards of evidence. The intervention results should show a consistent pattern of credible and positive effects, and
  - d. Reviewed and deemed appropriate by a panel of informed prevention experts that includes qualified prevention researchers experienced in evaluating prevention interventions similar to those under review; local prevention professionals; and key community leaders, as appropriate (for example, law enforcement officials, educators, or elders within indigenous cultures).

AHCCCS is currently in the process of developing criteria for the Arizona Evidence-Based Workgroup. This is being achieved by utilizing an existing substance abuse prevention specific workgroup of the Arizona Substance Abuse Partnership (ASAP) for recommendations, as well as utilizing the National Prevention Network Representatives to inquire as to other state's EBP workgroup structures. AHCCCS has also located documents from a previous iteration of the AZ EBP Workgroup, and is currently updating these as appropriate for future use.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

## Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
  - a)  SSA staff directly implements primary prevention programs and strategies.
  - b)  The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
  - c)  The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
  - d)  The SSA funds regional entities that provide training and technical assistance.
  - e)  The SSA funds regional entities to provide prevention services.
  - f)  The SSA funds county, city, or tribal governments to provide prevention services.
  - g)  The SSA funds community coalitions to provide prevention services.
  - h)  The SSA funds individual programs that are not part of a larger community effort.
  - i)  The SSA directly funds other state agency prevention programs.
  - j)  Other (please describe)
  
2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
  - a) Information Dissemination:
 

This strategy provides awareness and knowledge of the nature and extent of substance use, abuse, and addiction and their effects on individuals, families, and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.

Tabling/Booth events at Health Fairs, School Parent Nights, and local community events

Dissemination of prevention flyers, posters, brochures, and other informational media at local grocery stores, doctor's offices, schools, etc.

Media campaigns aimed at increasing knowledge of local substance use and abuse trends and data, as well as focusing on risk and protective factors to reduce substance use and abuse within high-risk populations.
  - b) Education:
 

This strategy involves two-way communication and is distinguished from the information dissemination strategy by the fact that interaction between the educator/ facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.

Parenting/Family Education curriculum, such as Strengthening Families, Guiding Good Choices, and Triple P. These

programs aim to enhance parenting behaviors and skills, enhance effective child management behaviors and parent-child interactions and bonding, to teach children skills to resist peer influence, and reduce adolescent problem behaviors. Curriculum that teaches youth life skills, such as LifeSkills, which are designed to prevent teenage drug and alcohol abuse, tobacco use, violence and other risk behaviors by teaching students self-management skills, social skills, and drug awareness and resistance skills.

**c) Alternatives:**

This strategy provides for the participation of target populations in activities that exclude substance use. The assumption is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by, alcohol and drugs and would, therefore, minimize or obviate resort to the latter.

Drug-free community and/or youth events, including drug-free dances, sports tournaments, after-school youth groups/programs/clubs, etc.

Connection and engagement in cultural activities, tribal practices, and learning cultural and/or tribal ways.

**d) Problem Identification and Referral:**

This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.

Programs/classes for youth who have broken school campus rules regarding alcohol, tobacco, and other drugs (ATOD), such as being in possession of ATOD or related paraphernalia. Classes aim to educate youth about the dangers of ATOD use, offer alternatives to substance use, and prevent future infractions.

**e) Community-Based Processes:**

This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for substance abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking.

Building and sustaining of community-based coalitions (there are currently 20 SABG Prevention-funded coalitions within the state).

Strategic planning at state and local levels, which includes bringing together key stakeholders from the following sectors to the table to engage in effective planning:

Youth,

Parents,

Law enforcement,

Schools,

Businesses,

Media,

Youth-serving organizations,

Religious and fraternal organizations,

Civic and volunteer groups,

Healthcare professionals,

State, local, and tribal agencies with expertise in substance abuse, and;

Other organizations involved in reducing substance abuse.

**f) Environmental:**

This strategy establishes, or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. This strategy is divided into two subcategories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives.

The passing of local ordinances that affect the sale, manufacturing, or availability of ATODs, including alcohol tax increases, moratoriums on alcohol/marijuana advertising around schools, parks, or places where youth are present, and moratoriums on the establishment or placement of medical marijuana stores in local areas.

The review of current ATOD policies within schools and/or communities, including the review of policies related to prevention of ATOD use amongst youth, review of policies regarding "punishment" of youth who use or are caught, what prevention strategies are used to decrease repeat behavior, and the eventual revision of policies to be prevention focused, rather than punishment focused.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?  Yes  No

If yes, please describe

AHCCCS collaborates closely with several other state agencies and entities to ensure there is communication regarding which primary prevention services are being funded and implemented throughout the state. Examples include the Substance Abuse Coalition Leaders of Arizona (SACLAz), Governor's Office of Youth Faith and Family (GOYFF), National Guard Counter Drug Task Force, Arizona Substance Abuse Partnership (ASAP), AHCCCS staff overseeing other prevention initiatives.

These collaborations allow AHCCCS to ensure there is no service duplication, and for AHCCCS to gather information regarding any



gaps and additional needs in services throughout the state. AHCCCS is also aware of the location and strategies of current Drug Free Communities (DFC) coalitions throughout the state to address this as well.

Additionally, primary prevention providers submit contracted-required prevention deliverables to AHCCCS that allow AHCCCS to assess the use of SABG dollars against other funds. These deliverables include planning deliverables such as provider budgets, logic models, strategic plans, action plans, and evaluation plans as well as Contractor Expenditure Reports (CERs) showing actual expenditures under SABG prevention. AHCCCS staff reviews CERs from a programmatic and fiscal lens to ensure appropriateness and allowability under the grant.

In addition, AHCCCS' use of the Strategic Prevention Framework (SPF) model allows for comprehensive statewide assessment of prevention needs, resources, and capacity that helps AHCCCS identify gaps, duplications, and other prevention needs.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

## Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?  Yes  No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- a)  Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- b)  Includes evaluation information from sub-recipients
- c)  Includes SAMHSA National Outcome Measurement (NOMs) requirements
- d)  Establishes a process for providing timely evaluation information to stakeholders
- e)  Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- f)  Other (please list:)
- g)  Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- a)  Numbers served
- b)  Implementation fidelity
- c)  Participant satisfaction
- d)  Number of evidence based programs/practices/policies implemented
- e)  Attendance
- f)  Demographic information
- g)  Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- a)  30-day use of alcohol, tobacco, prescription drugs, etc
- b)  Heavy use
- Binge use
- Perception of harm
- c)  Disapproval of use

- d)**  Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- e)**  Other (please describe):

**Footnotes:**



# AHCCCS Statewide Substance Abuse Prevention Strategic Plan

December 2020



**LeCroy & Milligan**  
ASSOCIATES, INC.

# AHCCCS Statewide Substance Abuse Prevention Strategic Plan - December 2020

## Submitted to:

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## About LeCroy & Milligan Associates, Inc.:

Founded in 1991, LeCroy & Milligan Associates, Inc. is a consulting firm specializing in social services and education program evaluation and training that is comprehensive, research-driven and useful. Our goal is to provide effective program evaluation and training that enables stakeholders to document outcomes, provide accountability, and engage in continuous program improvement. With central offices located in Tucson, Arizona, LMA has worked at the local, state and national level with a broad spectrum of social services, criminal justice, education and behavioral health programs. LeCroy & Milligan Associates team members on this project included Darcy McNaughton, Tracey Thomas, Katie Haverly, Kerry Milligan, and Skyler LeCroy.

## Suggested Citation:

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# Acknowledgements

The Substance Abuse Block Grant (hereafter referenced as SABG) Program was authorized by US Congress to provide funds to States, Territories, and American Indian Tribes for the purpose of planning, implementing, and evaluating activities to prevent and treat substance use and/or misuse and is the largest Federal program dedicated to improving publicly funded substance use prevention and treatment systems. On July 1, 2016, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) the former designated State agency to administer the SABG Block Grant, merged with AHCCCS. This merger was passed by the legislature at the recommendation of the Governor and consolidated the administration of physical and behavioral health services under one agency. As a result, AHCCCS became the Single State Authority (SSA) in the administration for the SABG Block Grant. This report represents the first AHCCCS Statewide Substance Abuse Strategic Plan after this merging.

AHCCCS contracted with LeCroy & Milligan Associates (LMA) to facilitate a statewide substance abuse prevention strategic planning process to create a three-year plan to guide the agency's priorities and efforts. The LMA strategic planning team included Darcy McNaughton, MBA, who served as the Project Lead, with facilitation and plan development support from Tracey Thomas, DrPH, Katie Haverly, MA, Kerry Milligan, MSSW, and Skyler LeCroy. Notetaking and data analysis assistance was provided by LMA interns Minerva Garcia and Andrew DiCenso.

The strategic planning process was successfully completed with the assistance and coordination of a Statewide Substance Abuse Prevention Strategic Planning Steering Committee. AHCCCS and LMA would like to give a special thanks to Steering Committee members for their guidance and dedication throughout the planning process. A complete list of organizations represented on the Steering Committee is included in Exhibit 4.

In addition, AHCCCS and LMA would like to thank the many individuals who participated in information gathering opportunities through planning meetings and discussions. These individuals provided important input and insight into the needs of our state and the opportunities to address those needs. Individuals represented a diverse group of organizations, which are included in Appendix A.



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# Plan Overview

The Arizona Health Care Cost Containment System (AHCCCS) contracted with LeCroy & Milligan Associates (LMA) to facilitate a statewide substance abuse prevention strategic planning process to create a three-year plan to guide the agency's priorities and efforts. The planning process was guided by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework (SPF), which offers a comprehensive approach to understand and address substance use and related health problems unique to states and communities. Informed by this framework and aligned with the AHCCCS Statewide Substance Abuse Prevention Logic Model, this plan outlines strategies to tackle Arizona's most pressing substance-use related behavioral health problems.



SPF Graphic from SAMHSA, 2019

## Creating the Statewide Strategic Plan

### Step 1: Assessment

AHCCCS contracted with LMA to conduct a needs assessment and resource assessment to document substance use issues statewide and existing efforts and resources to address them.

### Step 2: Capacity Building

To build capacity and readiness to address prevention needs and develop a statewide plan, a Statewide Substance Abuse Prevention Strategic Planning Steering Committee was formed.

### Step 3: Planning

The Strategic Planning Group brought together representatives of **43** organizations across Arizona engaged in substance use prevention work to develop the plan. Planning committee members participated in four planning meetings to prioritize behavioral health problems, contributing risk and protective factors, and strategies.

### Step 4: Implementation

Implementation steps were identified to address priority behavioral health problems based on assessment data and input from the Strategic Planning Group and Steering Committee. Implementation efforts reflect the six Center for Substance Abuse Prevention (CSAP) strategies.

### Step 5: Evaluation

Preliminary evaluation activities were identified and will be further refined as strategies are further developed and realized.

### Cultural Competence & Sustainability

Throughout the five-step planning process, cultural competence and sustainability were prioritized, and there is commitment among stakeholders to continue prioritizing cultural competence and sustainability throughout the plan's implementation and evaluation.



# Strategic Plan Framework

## Priority Behavioral Health Problems

<p><b>Opioids</b></p> <p>Reduce percentage of adults, young adults (18–25), and youth (12–17) misusing opioids.</p>	<p><b>Alcohol</b></p> <p>Reduce percentage of adults, young adults (18–25), and youth (12–17) using and binge drinking alcohol.</p>	<p><b>Meth</b></p> <p>Reduce percentage of adults and young adults (18–25), using meth.</p>	<p><b>Marijuana</b></p> <p>Reduce percentage of young adults (18–25) and youth (12–17) using marijuana.</p>	<p><b>Vaping</b></p> <p>Reduce percentage of youth (12–17) using vapor products.</p>
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**Vision**

Individuals, families, and communities across Arizona are informed, connected, engaged, and healthy.

**Values**

Culturally responsive, equity focused & inclusive, collaborative, community-based, solution-focused, innovative, bold, compassionate, and transparent.

## Key Strategies

**Environmental**

Policies restricting sale/marketing of vapor products.

*Targeted risk/protective factors: Accessibility of substances, substance-use related social norms.*

**Positive Alternatives**

Culturally relevant community events & family recreational programs.

*Targeted risk/protective factors: Mental health, family & community connection, social isolation*

**Prevention Education**

Family & school programs, education on protective factors, & innovative delivery.

*Targeted risk/protective factors: Risk perception, substance-use related social norms, family dysfunction*

**Identification of Programs & Referral to Services**

Mechanism for knowing referral options & making referrals.

*Targeted risk/protective factors: Mental health, trauma*

**Information Dissemination**

Social media to reach parents & youth and campaigns on risks & telehealth options.

*Targeted risk/protective factors: Risk perception, substance-use related social norms, mental health.*

**Community-Based Processes**

Alignment of coalition work statewide, integrated approach to address root causes, & trauma-informed communities.

*Targeted risk/protective factors: Trauma, mental health*



# Introduction

According to the National Survey on Drug Use and Health, 2017, substance use is highly prevalent in Arizona. For example, data from 2017-2018 prevalence estimates by state suggest that over 3% of Arizonans over the age of 12 had engaged in illicit drug use (other than marijuana) in the past month with nearly 11% indicating marijuana use within that time period. Nearly 50% of Arizonans had alcohol use during the past month with almost half of those, 23% of the population, engaging in binge alcohol use. Over 1% had used methamphetamines in the past year while 4% indicated pain reliever misuse during that time period (SAMHSA, 2018).

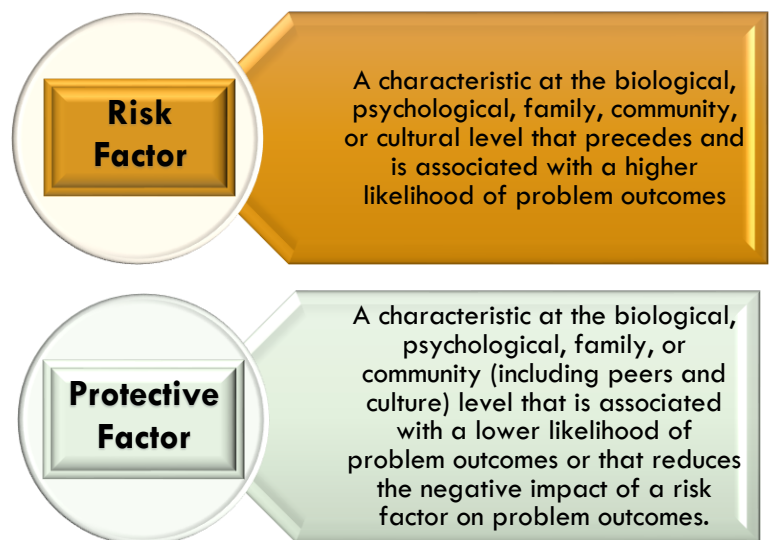
There is a great deal of data available from these and other sources that indicate the severity of the problems faced in Arizona. In order to address substance use, it is critical to think about priorities at the state and community levels, so that efforts may be aligned to have the greatest impact. This is the purpose of the SAMHSA Strategic Prevention Framework, which provides a comprehensive and consistent approach to consideration of substance misuse and related behavioral health problems (SAMHSA, 2019). Using this framework, this statewide strategic planning process and resulting document, takes a comprehensive approach to prevention, focusing on risk and protective factors that can be supported through effective programs, policies, and strategies.

There are several other key models and definitions that are utilized in the development of this plan, which are described below.

## Risk and Protective Factors

Risk and Protective factors are the core framework which informs much of prevention research and practice. Risk and protective factors are a broad framework that help explain positive program impacts, where the greater number of protective factors is an associated with better outcomes while lower numbers of risk factors being associated with reduced the chance of problem behaviors (SAMHSA, 2019).

While multiple definitions exist, the definition provided by the National Research Council and Institute of Medicine (2009) proved helpful to this planning process (shown at right).



## Socioecological Model

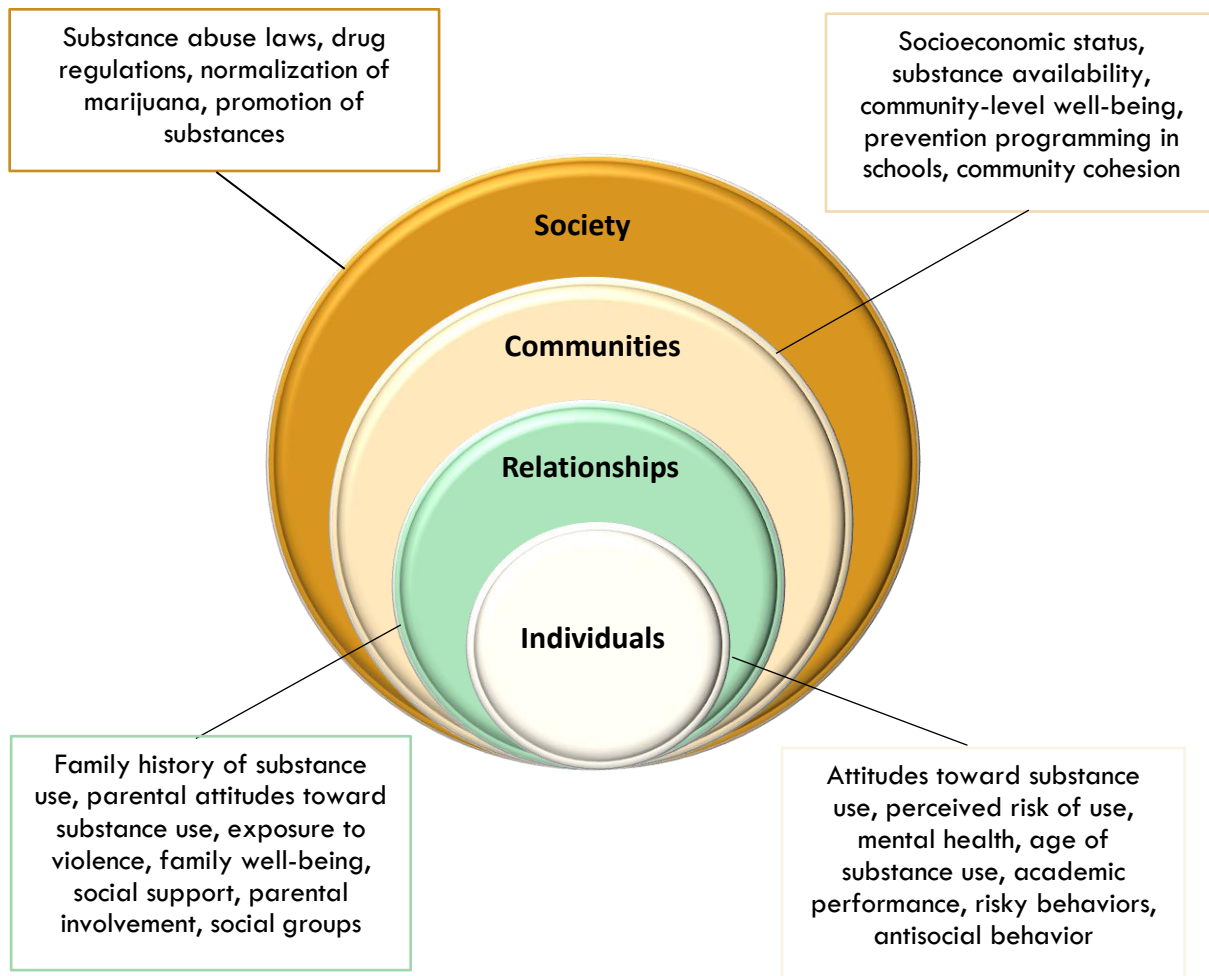
The socioecological model is a multi-level framework used to consider the context for risk and protective factors (e.g., individual, family, peer, and community levels) (SAMHSA 2019).

Important principles of this model are as follows:

- Risk and protective factors are correlated and cumulative.
- Individual factors can be associated with multiple problems.
- Risk and protective factors are influential over time.
- Levels operate within and are also influenced by the next level.

This model, and examples of some common risk and protective factors considered within each level, are shown in Exhibit 1 below.

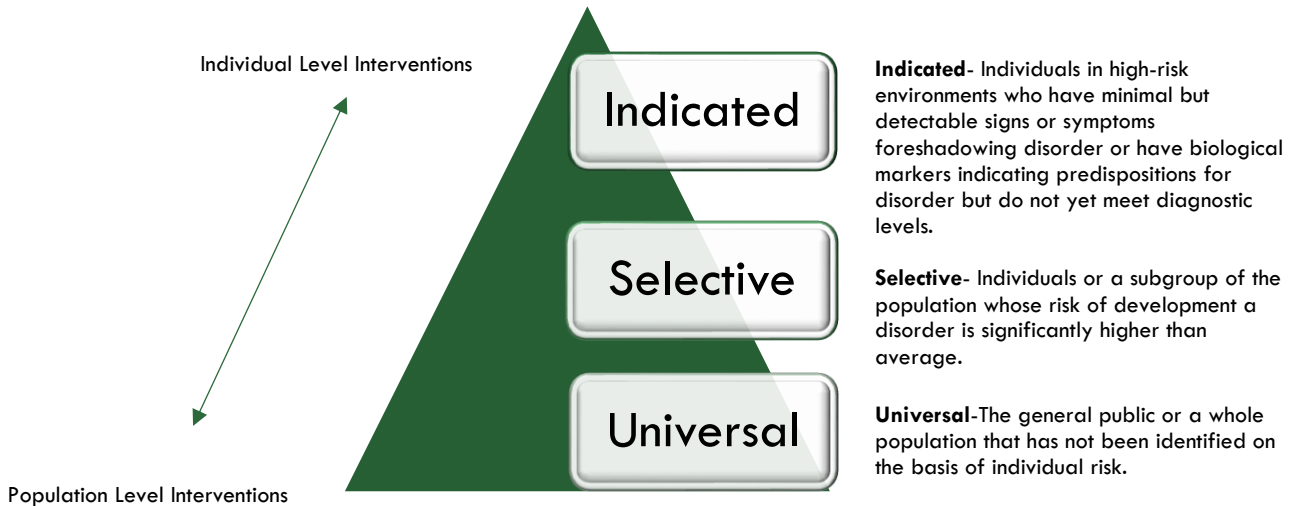
Exhibit 1. Socioecological Model with Risk and Protective Factor Examples



## Primary Prevention and Risk Level

Primary prevention includes strategies intended for individuals not identified to be in need of treatment. According to SAMHSA information available on the Substance Abuse Prevention and Treatment Block Grant (2020), it may still be helpful consider these strategies for individuals of different levels of risk as shown in Exhibit 2 below.

Exhibit 2. Primary Prevention Risk Strategy Levels



## SAMHSA Prevention Categories

SAMHSA has identified six categories of strategies, sometimes referred to as the six Center for Substance Abuse Prevention (CSAP) strategies. These are the recommended categories under which all primary prevention work may be organized.

**Community-based processes** strengthen resources such as coalitions and increase community’s ability to deliver prevention and treatment services.

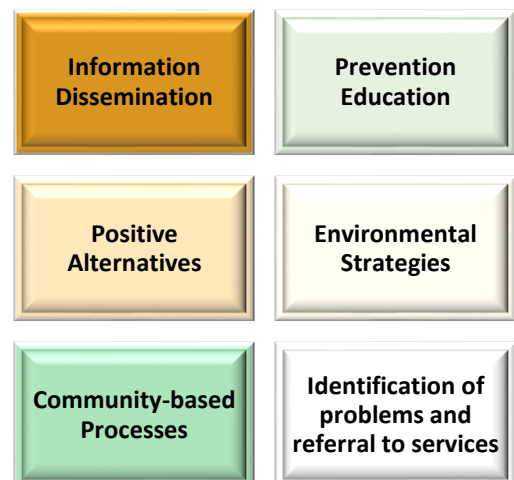
**Information dissemination** increases knowledge and changes attitudes through one-way communication.

**Environmental strategies** are aimed at the settings and conditions in which people live, work, and socialize and include policy change.

**Prevention education** is an interactive approach to teaching skills.

**Positive alternatives** provide fun, structured activities so people have constructive, healthy ways to enjoy free time and learn skills.

**Identification of problems and referral to services** include assessments and referrals for individuals who are at high risk.



# Strategic Prevention Framework Planning Process

In December 2019, the Arizona Health Care Cost Containment System (AHCCCS) contracted with LeCroy & Milligan Associates (LMA) to facilitate a statewide substance abuse prevention strategic planning process to create a three-year plan to guide the agency’s priorities and efforts. This planning process was designed to follow the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Strategic Prevention Framework (SPF) which consists of five major steps: Assessment, Capacity Building, Planning, Implementation, and Evaluation (SAMHSA, 2019). The SPF is also guided by two cross-cutting principles that should be integrated into each of the steps above and these include cultural competency and sustainability. The Strategic Prevention



Framework offers prevention planners a comprehensive approach to understanding and addressing the substance misuse and related behavioral health problems facing their states and communities to better prioritize resource distribution, improve strategy selections, and have a stronger impact on the communities served (SAMHSA, 2019).

## Assessment



According to the SPF, it is important in the assessment phase to evaluate problems and related behaviors, risk, and protective factors and then prioritize problems based on different criteria including severity and magnitude. This assessment process was initiated back in 2018, when LMA was also contracted by AHCCCS to facilitate a Statewide Substance Abuse Prevention Needs Assessment (LeCroy & Milligan Associates, 2018). This comprehensive assessment provided a detailed overview of substance abuse issues statewide and for various sub-populations, as well as an in depth look at risk and protective factors by region and subpopulation.





In addition to this effort, data was collected from prevention providers and other stakeholders via an online survey in February 2020 and again in August 2020, with the focus of the second sample being on the impact of the Coronavirus Disease of 2019 (COVID-19) on substance abuse treatment and prevention efforts statewide. Because of COVID-19, additional data collection and data were incorporated to provide a preliminary overview of the evolving impact of the pandemic on lives and services in Arizona. Also, treatment providers were interviewed to gain their input on substance abuse trends from the field. In addition, LeCroy & Milligan Associates conducted an analysis of AHCCCS service utilization data for the timeframes of January-June 2019 and January-June 2020 and reviewed data from the Crisis Counseling Assistance and Training Program (CCP), a crisis program funded through FEMA that provides free and confidential support, education, and resource connection to individuals in the state experiencing negative impacts of the COVID-19 pandemic.

Exhibit 3. Resource Assessment Participation Overview

Method	Sample 1	Sample 2
<b>Stakeholder survey</b>	<p>Conducted February 2020</p> <p><b>123</b> participants from 34 cities and representing 11 AZ counties</p> <p>21% from the North Region</p> <p>56% from the Central Region</p> <p>15% from the South region</p> <p>8% Missing Region</p> <p><u>Sector Representation*</u></p> <p>54% nonprofit</p> <p>32% government</p> <p>20% coalition.</p>	<p>Conducted August 2020</p> <p><b>83</b> participants from 26 cities and representing 9 AZ counties</p> <p>18% from the North Region</p> <p>27% from the Central Region</p> <p>53% from the South Region</p> <p>2% Missing Region</p> <p><u>Sector Representation*</u></p> <p>54% nonprofit</p> <p>18% government</p> <p>30% coalition</p>
<b>Treatment Provider Interviews</b>	Not applicable	<p>Conducted August/September 2020</p> <p>15 participants</p> <p>Collectively participants organizations' serve all 15 AZ counties (few from North Region).</p>
<b>AHCCCS Utilization Data</b>	January-June 2019 AHCCCS members with substance abuse utilization/service codes (64,161 members)**	January-June 2020 AHCCCS members with substance abuse utilization/service codes (76,475 members)**
<b>Crisis Counseling Assistance and Training Program</b>	Not applicable	Analyzed data on 540 individuals receiving services from June 22-September 30, 2020

\*Participants could indicate more than one sector, so percentage does not total to 100%. Faith-based, school and business were also represented.

\*\* Data was pulled as of August 1, 2020.



While none of these data can conclusively point to the impact of COVID-19, as other factors cannot be ruled out, it provided a snapshot of Arizona as of August 2020 and offered areas for exploration in the strategic planning process. Summary of key findings from this Resource Assessment are included in Appendix A. Findings from this report were used, along with the 2018 Needs Assessment and other secondary data, to facilitate consideration of behavioral health problems, local conditions and contributing factors, and prevention strategies during the strategic planning process.

Preparatory meetings were held with AHCCCS staff to review the assessment findings and to discuss and outline the strategic planning approach based on the findings as well as the changing prevention landscape due to COVID 19.

## Capacity Building



Graphics from SAMHSA, 2019

Capacity building relates to building local resources and readiness to address prevention needs.

A number of activities were completed to address the capacity building Step 2 of the SPF model. The first initiative was to build a Steering Committee to help guide the strategic planning process that included individuals a wide range of agencies and sectors. The agencies included State agencies, Tribal agencies, Coalitions, Universities and Regional Behavioral Health Authority agencies.

Exhibit 4. Organizations Represented on Statewide Substance Abuse Prevention Strategic Planning Steering Committee

Arizona Complete Health	Governor’s Office of Youth, Faith and Family
Arizona Health Care Cost Containment System	Mercy Maricopa
Arizona National Guard Counterdrug Task Force	Pascua Yaqui Tribe
Arizona Substance Abuse Epidemiological Work Group (Epi Work Group)	Health Choice Arizona
Arizona Substance Abuse Partnership (ASAP)	Substance Abuse Coalition Leaders in Arizona (SACLAz)
Behavioral Health Planning Council	The Inter-Tribal Council of Arizona (ITCA)
Gila River Health Care	



The first Steering Committee meeting was held on February 13, 2020. The focus of this first meeting was to share the proposed strategic planning process and timeline with the group, to discuss potential challenges and proposed solutions to the process, to discuss how to ensure diverse stakeholder representation in the planning process, and to review the needs assessment findings. Feedback received from the Steering Committee helped to inform the first meeting with the larger Strategic Planning Group. Three other Steering Committee meetings were held virtually throughout the planning period to continue to receive feedback on the planning process and approach as it moved forward.

Next was the important task of outreaching to individuals to participate in the actual planning process alongside Steering Committee members. AHCCCS reached out to a wide range of providers, advocates, coalition leaders, State agencies, Tribal agencies, Regional and Tribal Behavioral Health Authority Agencies, and Universities via several emails to encourage participation. A total of 49 organizations were ultimately represented through participation in the Strategic Planning Group. See complete list in Appendix B.

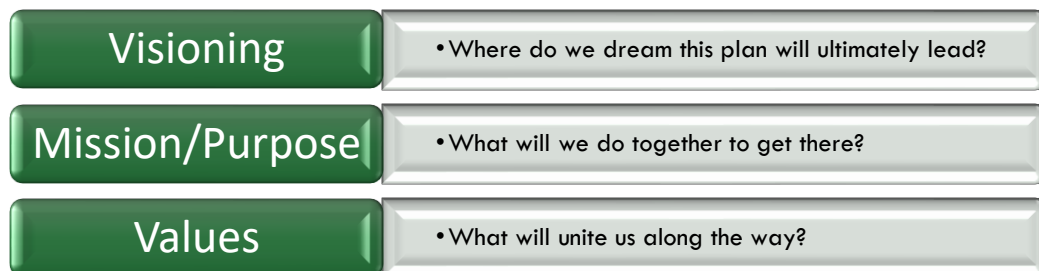
## Planning



Graphics from SAMHSA, 2019

Step 3 of the SPF model embodied a large amount of the activity that occurred as part of the strategic planning process over the sequential meetings held with the Strategic Planning Group.

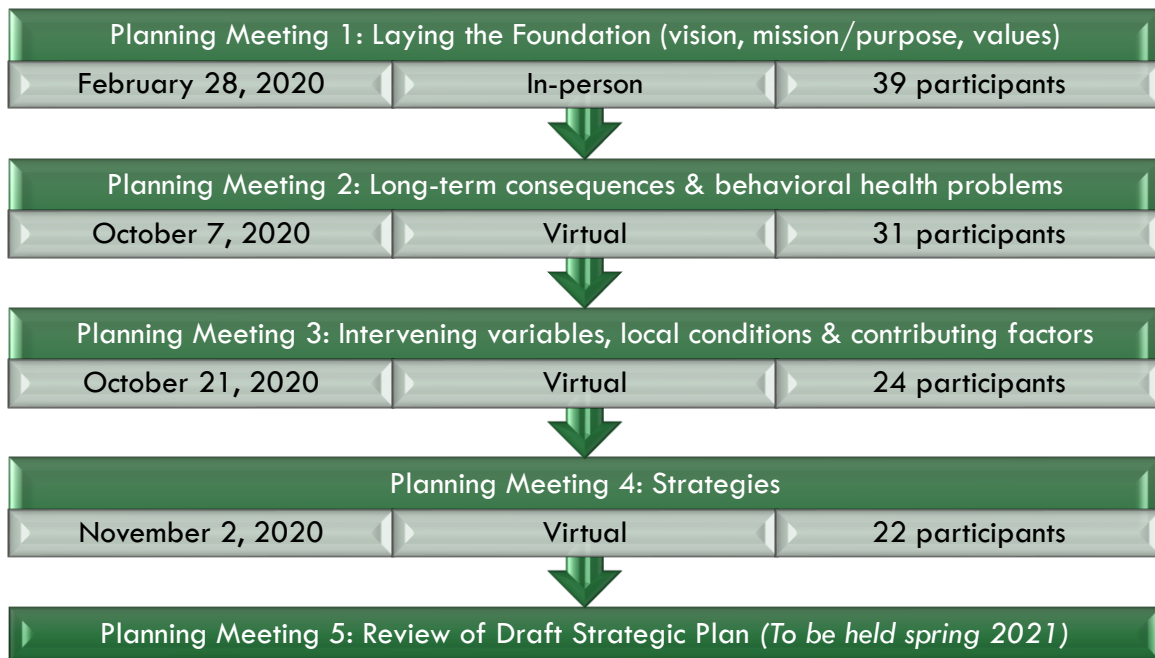
The first Strategic Planning Group meeting was held on February 28, 2020, in person before COVID 19 struck Arizona. A total of 7 Steering Committee members and 32 other Strategic Planning Group members attended the daylong session. The focus of the first meeting was to establish together the vision, mission/purpose and values that should guide the group forward in developing the strategic plan. Three questions helped to guide that process:



A number of activities were conducted with the Strategic Planning Group to help answer these questions which culminated in an overarching foundation to draw from throughout the rest of the strategic planning process. This framework is included in Exhibit 6 (page 19 of this report) as part of the strategic plan.

The second Strategic Planning Group meeting was held virtually due to COVID-19 on October 7, 2020, and 31 individuals participated. The focus of this meeting was to explore and address the long-term consequences and behavioral health problems that Arizona is currently facing regarding substance use. Data from the 2018 Arizona Statewide needs assessment, the resource assessment mentioned earlier, and AHCCCS substance use treatment utilization data were shared with the group to help provide some context for discussions that would occur in breakout sessions.

Exhibit 5. Strategic Planning Session Summary



The third Strategic Planning Group meeting was held virtually on October 21, 2020 and 24 individuals participated. The focus of this meeting was to address intervening variables (risk and protective factors) and local conditions & contributing factors to continue to develop a deeper understanding of the needs and priorities, as well as potential areas for intervention, regarding substance use prevention in Arizona. A core task of this meeting was to identify those risk and protective factors that were both of high importance and changeability.



The fourth Strategic Planning Group meeting was held virtually on November 2, 2020 and 22 individuals participated. The focus of this final meeting was the culmination of the preparatory work completed in the last three Strategic Planning Group meetings to help identify those strategies that should be targeted and prioritized in the final strategic plan and potential options for implementation.

All information and data collected from the breakout sessions for all four meetings were then utilized to help inform this strategic plan. A final session will likely be held in spring 2020 to share the plan for final consideration by stakeholders.

## Implementation



Graphics from SAMHSA, 2019

Step 4 in the SAMHSA SPF model is implementation which moves the process from planning to action. Preliminary implementation steps are included in the strategic plan, and detail some of the next steps needed to move toward specific programs and priorities. Over time, those strategies that are identified will now begin to be delivered and existing services aligned better under this agreed upon statewide framework. It will be important during this period to establish supports for implementation including leadership and administrative support, provider training and support, and implementation monitoring.



## Reporting and Evaluation



Graphics from SAMHSA, 2019

Step 5 of the SPF model is key and involves ongoing evaluation of the efforts that are being implemented as part of the Strategic Plan. Within the Strategic Plan, there are suggestions for ongoing ways to monitor and evaluate the effectiveness of the plan and the accuracy or fidelity with which it is implemented. As strategies are refined, these evaluation activities can be further specified.

In addition, AHCCCS has contracted with an external evaluator to assist with the development of the comprehensive evaluation plan for substance abuse prevention work in Arizona, that will ultimately need to align with the Strategic Plan. It is important to monitor the process/implementation of the plan in addition to the outcomes. If issues are discovered, or intended outcomes are not being realized, this ongoing evaluation allows for course corrections. In addition, it is important to be able to share the results of the evaluation with key stakeholders, providers, and communities.

## Other SPF Considerations

Two other important SPF considerations that crosscut through the five-step process include cultural competence and sustainability.

### Cultural Competence

To overcome systemic barriers that may contribute to disparities, it is important to consider cultural competence with the design of any strategic plan for substance abuse prevention. It is important that prevention programs and practices are developed and delivered in ways that ensure members of diverse cultural groups benefit from their efforts and that cultural traditions and beliefs are recognized and valued. SAMHSA identifies the following cultural competence principles for prevention planners (SAMHSA, 2019):

- Include the target population in all aspects of prevention planning.
- Use a population-based definition of community (i.e., let the community define itself).
- Stress the importance of relevant, culturally appropriate prevention approaches.
- Employ culturally competent evaluators.



- Promote cultural competence among program staff, reflecting the communities they serve.

These principles guided or were folded into the entire strategic planning process from the selection of Steering Committee and Strategic Planning Group members to the activities implemented in planning meetings. Arizona is a very diverse state with wide ranging needs across many different populations and communities, highlighting the critical importance of prioritizing the cultural competence principles as the plan is implemented and evaluated.

## Sustainability

In prevention, sustainability relates not only to the capacity of communities to maintain positive prevention programs and outcomes over time but also to lasting effective strategic planning processes as well. This can include identifying those programs and/or practices that are proven effective that should continue to be supported. The challenge identifying and then supporting these efforts is that often prevention can take time, and outcomes may not always be dramatic or easily measured. Also, prevention priorities can change, and this was seen clearly this year with COVID 19. Adaptability is part of enhancing sustainability, thus, having a well-established strategic planning process can contribute to that ability when priorities shift and change. This requires commitment from a diverse group of collaborative stakeholders and agencies to recognize and respond quickly to changes over time.



# Arizona Statewide Substance Abuse Prevention Strategic Plan

The following plan is an overarching blueprint the state may follow in order to align substance use prevention efforts across local and state levels. This plan was developed with significant data and stakeholder input, as detailed in the previous sections. For simplicity of use, not all data elements and findings are restated herein. Please reference Appendix A, along with the 2018 Needs Assessment, national secondary data sources, and the full Resource Assessment for more information about the data that led to the development of this plan. Included on the following pages are: 1) Strategic Plan Foundation (the overall vision, values, and purpose statements), 2) the completed SAMHSA Logic Model, and 3) charts of the selected strategies for each of the six SAMSHA prevention approaches.

Exhibit 6. Strategic Plan Foundation





Exhibit 7: Strategic Planning Prevention Logic Model



\*Data from the 2017–2018 NSDUH estimates unless otherwise noted. Data is rounded to the nearest percentage. \*\*Opioids includes fentanyl and misuse of prescription pain relievers.

## Overview of Logic Model

The development of the AHCCCS Statewide Substance Abuse Prevention Logic Model was informed by data collected throughout the planning process. The first step was to identify the highest priority long-term consequences of substance use in the state and the behavioral health problems that most closely lead to those outcomes. Six long-term consequences were identified as priority areas to address through statewide prevention efforts: 1) criminal involvement, 2) poor socioeconomic outcomes for individuals and families, 3) overdose fatalities; 4) child abuse and family violence, 5) poor mental health outcomes and suicide, and 6) health inequities.

The behavioral health problems that were viewed as most significantly contributing to these long-term consequences are those included in the logic model, with key substances of concern including opioids, alcohol, and methamphetamines for both adults and youth/young adults. According to 2017 and 2018 data from the National Survey on Drug Use and Health (NSDUH), 5% of adults, 3% of youth, and 7% of young adults in Arizona have misused opioids in the past year. Stakeholders viewed opioids as contributing particularly to overdose fatalities in the state, a priority long-term consequence included in the logic model.

As the most widespread substance of concern, alcohol was also identified by stakeholders as a priority substance, with 7% of adults in Arizona identified as having an alcohol use disorder (NSDUH, 2019). Further, 24% of adults in Arizona engage in binge drinking, defined as a man drinking five or more drinks or a woman drinking four or more drinks on the same occasion on at least one day in the past 30 days (NSDUH, 2019). Although NSDUH data suggests methamphetamines are used less frequently among adults and youth/young adults, as 1% of adults and 2% of young adults in Arizona used this substance, it was regarded as a priority substance due to its negative long-term health and socioeconomic consequences.

Two additional behavioral health problems, marijuana use and vaping, were identified as behaviors of concern among youth and young adults specifically. Twelve percent of youth and 32% of young adults in Arizona used marijuana in the past year (NSDUH, 2019). With the November 2020 passage of recreational marijuana in Arizona (Prop 207), stakeholders were adamant that the statewide strategic plan prioritize marijuana as a key behavioral health problem, particularly among youth. Vaping was also identified as a key behavioral health problem among youth and young adults. In 2019, 17.9% of high school students reported currently using a vapor product according to the Arizona Youth Risk Behavior Survey (YRBS). It is important to recognize the connection between marijuana use and vaping since vaping devices are used to not only consume nicotine but also marijuana products.

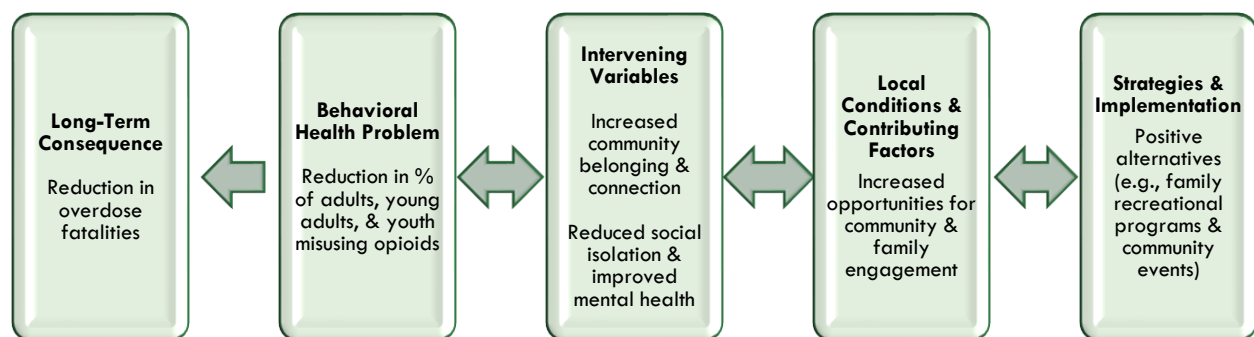
Although stakeholders often discussed behavioral health problems affecting adults and youth/young adults separately, most of the risk factors, local conditions, and contributing factors relating to these problems were the same. Namely, poor mental health, low risk



perception, and accessibility of substances were commonly identified as factors contributing to substance use in general.

Stakeholders also commonly recognized weak interpersonal ties and relationships, particularly with family, as key contributors to substance use regardless of an individual’s age. These factors were often discussed in connection to COVID-19, which seems to have expedited the deterioration of interpersonal relationships and community connectedness due to safety measures related to physical distancing. Exhibit 8 illustrates how offering positive alternatives, one of the six CSAP strategies, can impact local conditions by providing youth and adults with opportunities to engage with each other, increasing their sense of belonging to their community and connection with others, reducing social isolation, and improving mental health. This is one strategy that the state will use to reduce opioid misuse in Arizona to reduce overdose fatalities, a key long-term consequence associated with opioid use.

Exhibit 8. Logic Model Highlight on Reducing Substance Use Through Social Engagement



To reduce the statewide prevalence of priority behavioral health problems more generally, stakeholders recognized the importance of using multiple prevention strategies, many of which focus on increasing awareness of risks associated with using specific substances to influence individual behavior and eventually shift social norms. For example, stakeholders recommended using social media campaigns to increase youth’s awareness of risks associated with marijuana use that run counter to beliefs that marijuana must be “safe” since it is legal. This shift in risk perception may ultimately lead to a reduction in marijuana use among youth.

Technology is recognized as an essential tool in the implementation of various prevention strategies, as it can be used to inform, educate, and connect people. There is tremendous opportunity around telehealth, as COVID-19 has increased telehealth and other online service options available to support mental health, and it is unlikely these options will go away once the pandemic ends. Exhibit 9 illustrates how information dissemination strategies that embrace technology can improve mental health in the short term, resulting in a reduction in substance use among adults and youth that can prevent chronic mental health conditions in the long term.



Exhibit 9. Logic Model Highlight on Reducing Substance Use Through Strategies Utilizing Technology



Complementing these strategies are those focused on improving mental health by increasing protective factors such as social support and community connection through family- and community-based prevention programming. In some cases, the social benefits of a strategy are not the primary intention, as in the case with a family-based education program focused on building resiliency, but nonetheless, it is an important secondary outcome that relates to other factors associated with substance use.

While stakeholders frequently discussed the importance of addressing social factors associated with substance use, they recognized that environmental strategies, such as policies restricting the sale and marketing of certain substances, are needed to reduce the accessibility of substances. Such environmental strategies also have the potential to impact social factors, such as social norms associated with specific substance-use behaviors, and thus, they are an important strategy because they have the power to change both the social and the physical environment.

Although all six CSAP strategy areas are critical to address the behavioral health problems of interest, as the strategies are complementary in nature and enhance each other’s impact, community-based process strategies emphasize the importance of working together to address the root causes of substances use through integrated, multi-sectoral approaches. Community-based process strategies are needed to ensure that all six strategy areas are working together and in alignment to address the risk factors, local conditions, and contributing factors that drive substance in communities throughout Arizona. In the logic model, community-based processes serve as a framework for addressing all factors and conditions contributing to the behavioral health problems of interest.



# SAMHSA Framework-Based Strategies

## Community-based Process Strategies

**SAMHSA Strategy Definition:** Strengthen resources such as community coalitions to prevent substance use/misuse. Organizing, planning, and networking are included in this strategy to increase the community's ability to deliver effective prevention and treatment services (SAMHSA 2019).



### What is the strategy?

It was clear from participants throughout this planning process, that community-based work is central to effective prevention efforts in Arizona. The very premise for a statewide strategic plan, developed with a diverse body of stakeholders, is that community prevention work requires a shared and multi-faceted approach. No state or local entity alone, can fully complete the work that is required. Doing it together, with alignment of prioritized strategies, has the best likelihood of making an impact on the harmful long-term consequences of substance abuse/misuse.

“There are a lot of different groups doing lots of different pieces of prevention, but not a lot of coordination. Work [is needed] that can support the community coalition being the nexus of how prevention services get presented in a community, could activate the whole community and get them involved in the conversation.”

### The specific components to this strategy include:

- 1) Increase communication and alignment of coalition work at the state and local levels.
- 2) Share information on evidence-based practices.
- 3) Address root causes of substance use through integrated approaches with other sectors.
  - a) Encourage trauma-informed and resiliency-focused communities.
  - b) Build improved pathways to refer individuals in need of services/supports.
  - c) Collaborate with entities that support the whole person and address the social determinants of health, including in other fields such as healthcare, social services, education etc. at both the state and local levels.
- 4) Increase use of shared data for prioritization of prevention efforts and assessment of progress on shared strategies.
- 5) Increase the cultural and geographic diversity of stakeholders participating at the state level.



### **Why this strategy?**

As indicated in the AHCCCS Statewide Substance Abuse Prevention Logic Model, community-based process is the mechanism by which all sorts of local conditions may be addressed. Specifically, the collaboration and coordination between state and local organization and coalitions will help ensure strategies are strategic, effective, and targeted to local needs and populations. This framework for community-based collaborative work overlays the entirety of this plan.

### **Population or cultural considerations**

During initial planning meetings and throughout the strategic planning process, it was apparent that stakeholders saw the importance of engaging a spectrum of representatives from across Arizona. While certainly this was attempted in this process, continued work in this area may be needed to ensure that those groups and organizations participating, particularly at the state level, reflect the diverse opinions and perspectives of Native American, African American and Hispanic populations; rural and urban communities; counties statewide; and specific groups such as LGBTQ+ and other community and faith-based organizations. Specific engagement strategies may be needed to invite and involve other groups to join the conversation and collaboration work that is proposed.

### **Proposed implementation priorities**

- 1) Initiate an ongoing statewide substance abuse prevention planning group.
- 2) Identify and implement specific steps to increase the diversity and representation of this planning group. Ensure that one representative from each coalition in this state working in this area is invited and encouraged to join. This will help to ensure collaboration and integration of efforts at the state and local level.
- 3) As part of the work of the planning group, identify other entities to collaborate with to focus on supporting integrated supports for families that help address the root causes of substance abuse/misuse.
- 4) As part of this group, provide a platform/mechanism for sharing evidence-based practices, data and other communications.
- 5) Encourage this group to continue to utilize this strategic plan and ensure evaluation of the strategies are in place and executed.

### **Suggested ways to measure progress**

- ✓ Number and demographics of planning group representatives
- ✓ Number of collaborative meetings held/year; documented meeting agendas/notes
- ✓ Number and type of partnerships in place
- ✓ Documentation of information and data sharing mechanisms and types/frequency of information shared
- ✓ Annual online survey of all stakeholders in this collaborative planning group to assess the degree of integration and collaboration; document results and achievements



## Information Dissemination Strategies

### **SAMHSA Strategy Definition:**

Increase knowledge and change attitudes through communications. This method of learning is mainly one-way, such as through classroom speakers or media campaigns (SAMHSA 2019).



### **What is the strategy?**

Prevention providers in the state expressed broad support for information dissemination strategies, and many providers indicated that they are already doing this work. Because information dissemination strategies do not require face-to-face interaction, as these strategies typically use mass media, social media, and other communication channels to distribute information, their potential reach is expansive. Another key benefit of this strategy area is it offers tremendous variability, as campaigns can vary by audience (e.g., youth, parents, prescribers, specific high-risk populations), method of delivery (e.g., pamphlet, billboard, advertisement, public speaker, social media platforms), objective (e.g., behavioral change, cultural change, advocacy for policy support), and scope (e.g., schoolwide prevention campaign, community-wide, and statewide prevention campaigns). To be most effective, prevention messaging must be tailored to the target population and communication channel being used.

“Messaging to children is needed about setting goals, instilling hope, and countering fear messages aimed at adults.”

### **The specific components to this strategy include:**

- 1) Embrace social media, particularly to reach youth.
- 2) Focus on positive messaging to build resiliency and support positive behaviors or behavior change.
- 3) Design campaigns to reduce, rather than reinforce, stigma surrounding substance use.
- 4) Complement other prevention strategies with information dissemination to develop a comprehensive, coordinated prevention plan.
- 5) Pilot test messaging to ensure it is linguistically and culturally relevant to target populations.

### **Why this strategy?**

This particular strategy aligns well with interests expressed by participants throughout the planning process in shifting social norms and risk perceptions of substance use since these strategies can be implemented on a large scale – at the school, community, or state level – potentially reaching a large mass of people as well as priority populations. Information dissemination strategies occurring through online platforms are particularly positioned to reach large populations and address some, but not all, geographic challenges associated with



other prevention strategies that have traditionally occurred through face-to-face interaction. Additionally, information dissemination strategies are often used to increase awareness of substance-use related problems, which can help garner support for policies designed to address problems and influence decisions related to substance use and cessation. Thus, these strategies work well in conjunction with other prevention strategies, such as coupling an information campaign with support for an environmental strategy such as a policy change or to reinforce content delivered through prevention education. Given the potential reach of information dissemination strategies, they also tend to be cost effective.

### **Population or cultural considerations**

This strategy can be effective with diverse populations if messages are tailored to meet the language and cultural preferences of the population, a need acknowledged by participants throughout the planning process. In 2019, 27.2% of Arizonans spoke a language other than English at home (U.S. Census Bureau, 2019), highlighting the critical need for information dissemination efforts to be multilingual. Information dissemination also must reflect best practices in plain language and cultural sensitivity. Finally, it is essential that information dissemination strategies are mindful of person-first language and actively strive to de-stigmatize substance use, as mass media campaigns sometimes further stigmatize individuals, leading to fewer people seeking support or treatment.

### **Proposed implementation priorities**

- 1) Initiate a working group of the statewide substance abuse prevention planning group charged with identifying and coordinating effective prevention campaigns and other forms of information dissemination. A key first step for the group is to review previous research to identify successful examples of information dissemination strategies addressing similar populations and substance-related behaviors, attitudes, and/or perceptions.
- 2) Planning working group recommends evidence-based information dissemination strategies aligning with the priority populations and substance-related behavioral health problems. Statewide substance abuse prevention planning group identifies funding for these strategies.
- 3) Develop campaign messages based on sound research of the target group and pilot test messages during campaign development.
- 4) Design tailored, culturally relevant campaigns for target populations to raise awareness of substance-related behavioral health problems identified in the logic model, such as campaigns focusing on opioid misuse in communities, particularly among youth.
- 5) Design campaigns focusing on protective factors, such as resiliency and healthy coping, positive parent/child communication, and telehealth resources, rather than those solely focusing on the negative risks and outcomes of substance use.
- 6) Implement statewide campaign focusing on shifting norms surrounding marijuana use among youth, delivered through a coordinated state effort in schools.





- 7) Planning group seeks opportunities to collaborate with other local or statewide prevention efforts to disseminate information in a comprehensive, coordinated approach.

**Suggested ways to measure progress**

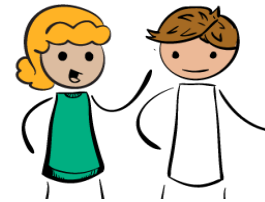
- ✓ Number and demographics of working group representatives.
- ✓ Number of working group meetings held per year.
- ✓ Number of meetings with other planning groups to identify opportunities for collaboration and coordination.
- ✓ Documentation of campaigns conducted and alignment with priority populations, risk and protective factors, and substances.
- ✓ Identify survey methods to assess the impact of key information dissemination efforts.



## Prevention Education Strategies

### **SAMHSA Strategy Definition:**

Interactive approach to teaching participants important social skills. These skills can include resisting pressure to use drugs, looking at the intent behind advertising, or developing other skills used in making healthy choices (SAMHSA 2019).



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### **What is the strategy?**

Prevention education programs are designed to reduce risk factors and increase protective factors associated with substance use behaviors and patterns in certain populations. Therefore, a key focus is how prevention education programs can strengthen protection or intervene to reduce risks, with a goal to ensure individuals engage in positive behaviors. These programs should address the substance-related behavioral health issues reflected in the local community and target modifiable risk and protective factors. Programs also must be tailored to specific populations and reflect cultural competency. Prevention providers across the state have embraced this strategy and view it as one of the key strategies to incorporate in statewide prevention efforts.

“Prevention education yields the greatest success, especially when delivered in native languages.”

### **The specific components to this strategy include:**

- 1) Increase prevention education in schools through statewide efforts to implement evidence-based curricula to reduce risk factors and bolster protective factors.
- 2) Expand reach using online strategies to provide prevention education.
- 3) Identify and deliver prevention education programs that highlight substance-specific risks and consequences of use to shift risk perception.
- 4) Ensure prevention education programs are evidence based.
- 5) Ensure prevention education programs reflect a high level of cultural competency and linguistic appropriateness.
- 6) Provide cultural competency training to individuals delivering prevention education.

### **Why this strategy?**

Prevention providers are already highly engaged in prevention education, as this was the second most reported type of prevention strategy offered among those completing the stakeholder survey, with the first being community-based process strategies. Prevention education, however, was the most frequently recommended strategy area for future funding among those completing the stakeholder survey.

Given this widespread support among prevention providers, this is an important strategy to include as part of the statewide strategic plan. This strategy also provides an opportunity to



address key risk factors associated with substance use, particularly perceptions of risk associated with certain substances, as well as key protective factors, such as healthy coping skills, emotional resiliency, and community connection. There are evidence-based and promising prevention education programs designed for families, youth, and adults that can be implemented in various settings.

### **Population or cultural considerations**

Throughout the planning process, stakeholders stressed the importance of targeting prevention education efforts to families and youth, with several stakeholders stating that a funding priority is providing prevention education programming in schools across the state. To expand the populations reached, particularly during the COVID-19 pandemic, stakeholders suggested prioritizing funding to support prevention programming through online platforms. With respect to cultural considerations, stakeholders acknowledged the importance of providing culturally competent prevention programming to meet the needs and preferences of LGBTQ+ identifying individuals. Stakeholders also stressed the importance of providing prevention programming in the target population's preferred language. Related to these cultural considerations, stakeholders suggested that individuals leading prevention education efforts participate in cultural competency training.

### **Proposed implementation priorities**

- 1) Initiate a working group of the ongoing statewide prevention education planning group charged with identifying evidence-based, promising, and culturally and linguistically appropriate programs that align with risk and protective factors noted in the logic model. Utilize tools such as the guide from SAMHSA (2018b) on identifying appropriate best practices for various prevention settings.
- 2) Build relevant systems and capacity, including funding, to provide evidence-based prevention education for grades K-12.
- 3) Identify evidence-based programs for high-risk groups (e.g., juvenile justice populations) and process/systems for reaching these groups.
- 4) Identify and include evidence-based programs focused on specific substances, as well as family education programs on building protective factors and resiliency.
- 5) Provide a platform/mechanism for sharing evidence-based prevention education programs and online trainings with prevention providers and partners.
- 6) Provide cultural competency training for prevention providers.

### **Suggested ways to measure progress**

- ✓ Number and demographics of working group representatives.
- ✓ Number of collaborative planning meetings held per year.
- ✓ Documentation of mechanisms used to share evidence-based prevention programs.
- ✓ Conduct surveys to assess knowledge gain and attitude changes based on the prevention education programming. Track program fidelity.
- ✓ Ensure use of recommended outcome measures for evidence-based programs



## Positive Alternative Strategies

### **SAMHSA Strategy Definition:**

Positive alternatives provide fun, structure activities so people have constructive, healthy ways to enjoy free time and learn skills. These alcohol- and drug-free activities help people – particularly young people – stay away from situations that encourage use of alcohol, tobacco, or illegal drugs (SAMHSA 2019).



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### **What is the strategy?**

Positive alternatives programs are primary prevention approaches designed to strengthen bonds with community members, create a rich environment for protective factors, educational opportunities, and skill building. While positive alternatives is not the most common prevention strategy for organizations, its broad applicability offers lots of opportunities. Positive alternatives are designed to strengthen protective factors and help engage individuals in healthy long-term behaviors. These programs can be highly targeted, using population specific tools and cultural competency. Additional outreach and sustainability are essential to expanding the role of positive alternative strategies.

“Older adults may be missing positive alternatives as much as young people.”

### **The specific components to this strategy include:**

- 1) Increase visibility and communication among existing state and local positive alternatives programs to reduce risk factors and strengthen protective factors.
- 2) Expand reach of existing programs using online platforms and community infrastructure.
- 3) Increase the cultural, geographic and age diversity of opportunities for community participation.
- 4) Identify specific positive alternatives that may be needed for certain populations (e.g., parents at home with youth in online school; older adults) given the challenges exacerbated by COVID-19.

### **Why this strategy?**

Positive alternatives are a key strategy that provide adults and youth opportunities for engagement which can reduce isolation and increase community cohesion/belonging. Positive alternatives are often not the focus of prevention providers already highly focused on education and treatment; therefore, this emphasizes the importance of providers sharing information and resources to highlight positive alternative opportunities that are available



more widely in communities. Community focused events and programs can be highly impactful on several risk and protective factors such as social isolation, family connection, mental health, and relationships. For youth specifically, they can also influence academic engagement, a protective factor that minimizes youth substance abuse/misuse. Positive alternatives often focus on strengthening protective factors, and some also include personal development and skill building in topics such as conflict resolution, positive self-imagery, communication, and peer pressure.

### **Population or cultural considerations**

A successful positive alternative strategy requires organizations to engage their specific communities. With the diverse population of Arizona, cultural and population specific engagement strategies show the importance of making a variety of positive alternatives available to Native American, African American, and Hispanic populations; rural and urban communities; all ages; specific groups such as LGBTQ+ and other community and faith-based organizations. Successful positive alternative strategies are most effective with community buy in; it is especially important that programming be culturally competent and delivered in the preferred languages of community members.

### **Proposed implementation priorities**

- 1) Initiate a working group of the statewide substance abuse planning group focused on best ways to promote positive alternatives that are culturally appropriate at the local level.
- 2) As part of the work of the working group, collaborate with relevant entities to support positive alternatives and initiatives that focus on well-being for families and address specific local community risk and protective factors.
- 4) Identify mechanisms for communication at the state level about existing positive alternatives.
- 5) Inventory existing positive alternative programming that is evidence-based and support promotion of these opportunities; consider innovative online alternatives for various target groups.

### **Suggested ways to measure progress**

- ✓ Number and demographics of working group representatives.
- ✓ Number of collaborative planning meetings held per year; documented meeting agendas/notes.
- ✓ Tracking of communication/messaging regarding positive alternatives.
- ✓ Complete inventory of positive alternative programming.
- ✓ Survey participants about satisfaction and perceived benefits.



## Environmental Strategies

### **SAMHSA Strategy Definition:**

Aimed at the settings and conditions in which people live, work, and socialize. These strategies call for change in policies – to reduce risk factors and increase protective factors – for example, tighter zoning restrictions on alcohol outlets or stronger enforcement to prevent underage purchases of alcohol and tobacco (SAMHSA 2019).



### **What is the strategy?**

Environmental strategies are often most effective in addressing risks and promoting protective factors across the socio-ecological model. By implementing policies and ordinances that change the environments in which people live, work, and play, these strategies can ultimately influence community norms and individual behaviors relating to substance use. Stakeholders involved in this planning process indicated that these were the least commonly used strategies by their organizations and were most difficult to garner support to implement. Although environmental strategies were recognized as being important, and critical to changing culture around substance use and addressing the social determinants of health that are often the root cause of substance use, stakeholders did not often identify an environmental strategy as warranting priority funding. The one exception that multiple stakeholders mentioned was the use of environmental strategies to reduce vaping initiation and availability among youth. Stakeholders agreed that strategies were needed at the local level through the passage of ordinances that would restrict the sale of tobacco and vaping products to individuals who are 21 years old and younger.

“Each community is at a different level of readiness. In some places environmental strategies might be laughed out of city council.”

### **The specific components to this strategy include:**

- 1) Pursue a combination of community-level and state-level environmental strategies including policy change.
- 2) Use environmental strategies in conjunction with other prevention strategies, such as developing youth coalitions to lead policy change in schools and communities or ensuring that information dissemination campaigns include a “call for action” that includes supporting environmental change strategies.
- 3) Advocate for and practice Health in All Policies (HiAP) approaches that address the social determinants of health associated with substance use as an upstream prevention strategy.
- 4) Prioritize environmental strategies to reduce the availability of substances such as age restrictions, limiting density of stores, limiting days/hours of sale, and increasing taxes to increase the unit price of legal substances.



- 5) Advocate for regulation of marijuana products given the November 2020 passage of recreational marijuana in Arizona (Prop 207).

### **Why this strategy?**

Of the six prevention strategies, environmental strategies have the most potential to lead to long-term change at the population level. Although they can be difficult to implement as they can be political in nature, they are consistently recognized as recommended prevention strategies by public health experts including the Community Preventive Services Task Force (CPSTF), which recommends multiple environmental strategies to reduce excessive drinking and tobacco use in the Guide to Community Preventive Services, a collection of evidence-based interventions (Guide to Community Preventive Services, 2020). Further, there is strong scientific evidence that environmental strategies work. The evidence is particularly well documented in tobacco research, which has demonstrated that that increasing the price of tobacco products and comprehensive smoke-free policies are effective in reducing smoking rates and shifting norms, especially when combined with communication campaigns.

Although stakeholders in this planning process viewed environmental strategies as the most difficult prevention strategy, they consistently recognized the importance of policy in restricting tobacco and vaping products. Environmental strategies may also be effective in reducing the availability of opioids, another concern among stakeholders, as the Centers for Disease Control and Prevention has identified state-initiated policies designed to curb the rate of inappropriate prescribing of opioids as a “promising” state strategy. Ultimately, there is significant opportunity related to this prevention strategy, which includes cost-effective strategies that can lead to large-scale and long-term positive change.

### **Population or cultural considerations**

It is critically important that environmental strategies, particularly policies, do not perpetuate institutional racism and systemic social and health inequities or further stigmatize certain populations, including those who use substances. Historically, misguided drug laws and disproportionate sentencing requirements have further disadvantaged communities of color. Criminalizing substance can also further stigmatize people who use substances, making it less likely that individuals using substances will seek and access treatment. The intended consequences of policies must be considered through these lenses.

### **Proposed implementation strategies**

- 1) Initiate an ongoing working group of the statewide prevention education planning group charged with exploring policy efforts aimed at behavioral health factors, including priority substances, and intervening variables identified in the state’s prevention logic model. This may include holding additional sub-group meetings during the legislative session each year to review bills that would impact priority behavioral health problems included in the logic model.



- 2) Build capacity at the local level for prevention providers to engage in environmental strategies, particularly advocacy and policymaking.
- 3) Build capacity of local coalitions to lead efforts in the passage of ordinances that increase the legal age of tobacco and vaping products to 21 years.
- 4) Working group develop a white paper summarizing evidence-based environmental strategies, including policies, that align with behavioral health factors and intervening variables included in the state's prevention logic model.
- 5) Implement environmental strategies, in combination with other prevention strategy areas, that support the use of best practices among health care providers for treating pain with opioids.

**Suggested ways to measure progress**

- ✓ Number and demographics of working group representatives.
- ✓ Number of collaborative planning meetings held per year; documented meeting agendas/notes.
- ✓ Documentation of capacity building efforts with local providers and coalitions.
- ✓ Method for collection and reporting of impact on local and state level policies.





## Identification of Problems and Referral to Services Strategies

### **SAMHSA Strategy Definition:**

Identification of problems and referral to services includes the provision of assessment and referrals when the behavior of people who are at high risk of substance abuse may require education or other intensive interventions (SAMHSA 2019). This strategy does not include any activity designed to determine if a person is in need of treatment.



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### **What is the strategy?**

Of the prevention strategies, this may be the most targeted. Bridging the gap from prevention to treatment, this set of strategies targets reaching people who are in need of greater supports in order to prevent likely future or continued use of substances. While the work of assessment and referral is often specific to the individual, establishing the mechanisms by which this can occur is the strategy of interest and was the focus of the planning meetings that discussed this topic. Participants explored, “how do we know what supports are available? How do we recommend people visit them?” Thus, the strategy needs to include development of centralized resources that support referral to services.

It was clear from planning sessions that this is also an area where the line of what is considered primary prevention, and, thus, within the scope of what can be funded by the federal SABG, is unclear. Thus, a component of the strategy is more education and conversation, led by AHCCCS, on the types of work that needs to be done in this area statewide. The remaining focus of this strategy might focus on sharing information designed to encourage individuals to reconsider substance use.

“Intersection between prevention and intervention is needed. Early intervention is the most effective way to prevent substance use disorder and needs to be funded.”

### **The specific components to this strategy include:**

- 1) Provide more information to the prevention community on best-practices in the strategy of problem identification and referral.
- 2) Identify a centralized resource that may be used by prevention providers to support referral to support services. While every local resource may not be listed, perhaps links to other local search tools or listings may be included along with statewide resource information.
- 3) Develop informational campaigns targeting youth and adults who may be at risk for substance abuse or recently engaged in first use. Engage community stakeholders from these populations in developing messaging applicable to specific communities or subpopulations.



- 4) Collaborate with other sectors (e.g., business, education, early childhood, criminal justice) to encourage the importance of adequate supports for families to minimize the likelihood of future substance misuse/abuse down the road.

### **Why this strategy?**

While often viewed as the outlier amongst the other primary prevention strategies, the inclusion of this strategy is critical to ensure that in an integrated world there are tools/supports available no matter where a person is in relation to their use of substances. This important strategy is part individual education and also can include more community-wide information dissemination strategies designed to change consideration around initial use of substances.

### **Population or cultural considerations**

Central to this strategy is an understanding that certain individuals are at increased risk of substance abuse and the resulting harmful outcomes that may occur. Individuals who have experienced more of risk factors and fewer of protective factors, those with past trauma, significant family dysfunction, poor mental health, increased access to substances, may all be at increased risk. Individuals leaving the criminal justice system were also noted as a specific population to consider in ensuring continuity of services and supports to reduce the likelihood of future use.

### **Proposed implementation priorities**

- 1) Convene a multi-sector working group of the statewide substance abuse prevention planning group to consider ways to improve this area of problem identification resources and referral in Arizona. Bring in resources from SAMHSA or other national experts, as needed, to inform best practices.
- 2) Topics of discussion this working group may need to address include mechanisms for supporting referrals at the statewide level; how to support people who are in the spectrum between prevention and treatment; multi-sector involvement in preventing future substance abuse; information campaigns needed to support at-risk populations; and harm reduction.
- 3) Develop a one-page infographic out of this working group to share with prevention providers on ways their work can support this strategy area.
- 4) Implement several statewide strategies recommended by this working group.

### **Suggested ways to measure progress**

- ✓ Number and demographics of working group participants.
- ✓ Number and type of partnerships in place.
- ✓ Number of collaborative planning meetings held per year; documented meeting agendas/notes.



- ✓ Resources produced by working group (including products and campaigns).
- ✓ Documentation of any revised processes or systems put in place to support this work statewide.



## Next Steps

Across these strategies, several overarching implementation recommendations came to light. **First, out of this initial planning effort, it is important to develop an ongoing statewide substance abuse prevention planning group, with multiple working groups addressing specific strategy areas.** Further discussion, collaboration and implementation is needed to advance strategies that are identified statewide. While time-intensive, this type of work is the best way to ensure that strategies are aligned across state and local levels, that they are meeting community needs, and that they are exhibiting a balance of evidence-based and innovative approaches needed to advance prevention in Arizona. This type of collaboration takes time, resources, and a concerted effort to engage diverse representation including geographic, demographic and sector (as applicable). Mechanisms to fund this work are needed to increase participation, enhance statewide efforts with large likelihood of impact, and reduce the siloed work of individual organizations.

**Secondly, it will be important to then develop more specific objectives and measurement plans for each SAMHSA strategy area.** As implementation evolves and specific actions are undertaken, the methods for evaluating specific objectives for each strategy should be identified. An ongoing data/evaluation working group may be needed to continue to support these efforts along with the evaluation planning that is already underway at the state level. The goal of this overarching plan is to provide framework under which state, regional and local level work may begin to align and move toward common areas of concern and common outcomes of interest. The measurement ideas listed are primarily focused on process measures, with a few outcome measures. It will be important to evaluate overall progress on the behavioral health indicators and other outcomes identified within the logic model.

COVID-19 shed light on many existing issues, and perhaps worsened others contributing to increased substance abuse. **It will be important to continue to watch the data as new information becomes available on substance use, to determine if the pandemic pushed any massive shifts that need to be addressed through prevention work.** Some are highlighted in the resource assessment, but these need to be confirmed with more data and more time for the full implications of the pandemic to be realized. Review and updates to the strategic plan may be needed if major changes are observed. Likely, changes may be made at the level of implementation/evaluation planning conducted by strategy area working groups.



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# Appendix A: Participating Organizations in Planning

## Exhibit 10. List of Participating Organizations

Organization
Apache Junction Drug Prevention Coalition
Arizona Alliance for Community Health Centers
Arizona Complete Health*
Arizona Department Juvenile Corrections
Arizona Department of Education
Arizona Department of Health Services
Arizona Department of Juvenile Corrections
Arizona Health Care Cost Containment System (AHCCCS)*
Arizona National Guard Counterdrug Task Force*
Arizona Office of the Attorney General
Arizona Prescription Drug Monitoring Project sites within the Board of Pharmacy
Arizona State Board of Pharmacy*
Arizona State University*
Arizona Trauma Informed Faith Community Network Workgroup
Arizona Youth Partnership
Be Awesome Youth Coalition
Casa Grande Alliance
Circles of Peace
Community Bridges, Inc. (CBI)
Community Partners
Division of Social Services - The Navajo Treatment Center for Children and Their Families
Drug Enforcement Administration
Governor's Office of Youth, Faith and Family*
Health Choice Arizona*
Help Enrich African American Lives (HEAAL) Coalition
Inter-Tribal Council of Arizona (ITCA)*
La Frontera Center, Inc.
La Frontera EMPACT-Suicide Prevention Center
Maricopa Community Alliance Against Substance Abuse - MCAASA
MATFORCE
Mercy Maricopa*
Navajo Nation-Division of Social Service
Nexus Coalition-Navajo County
Pascua Yaqui Tribe*
Pinal County Wellness Alliance
SCAT Prevention Program
South Mountain WORKS Coalition
Southern Arizona AIDS Foundation
Southwest Interdisciplinary Research Center at ASU



Tanner Community Development Corporation

The Substance Abuse Coalition Leaders in Arizona (SACLaz)\*

University of Arizona

Wellington Consulting Group

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\*Organizations with representation on the Statewide Substance Abuse Prevention Strategic Planning Steering Committee.



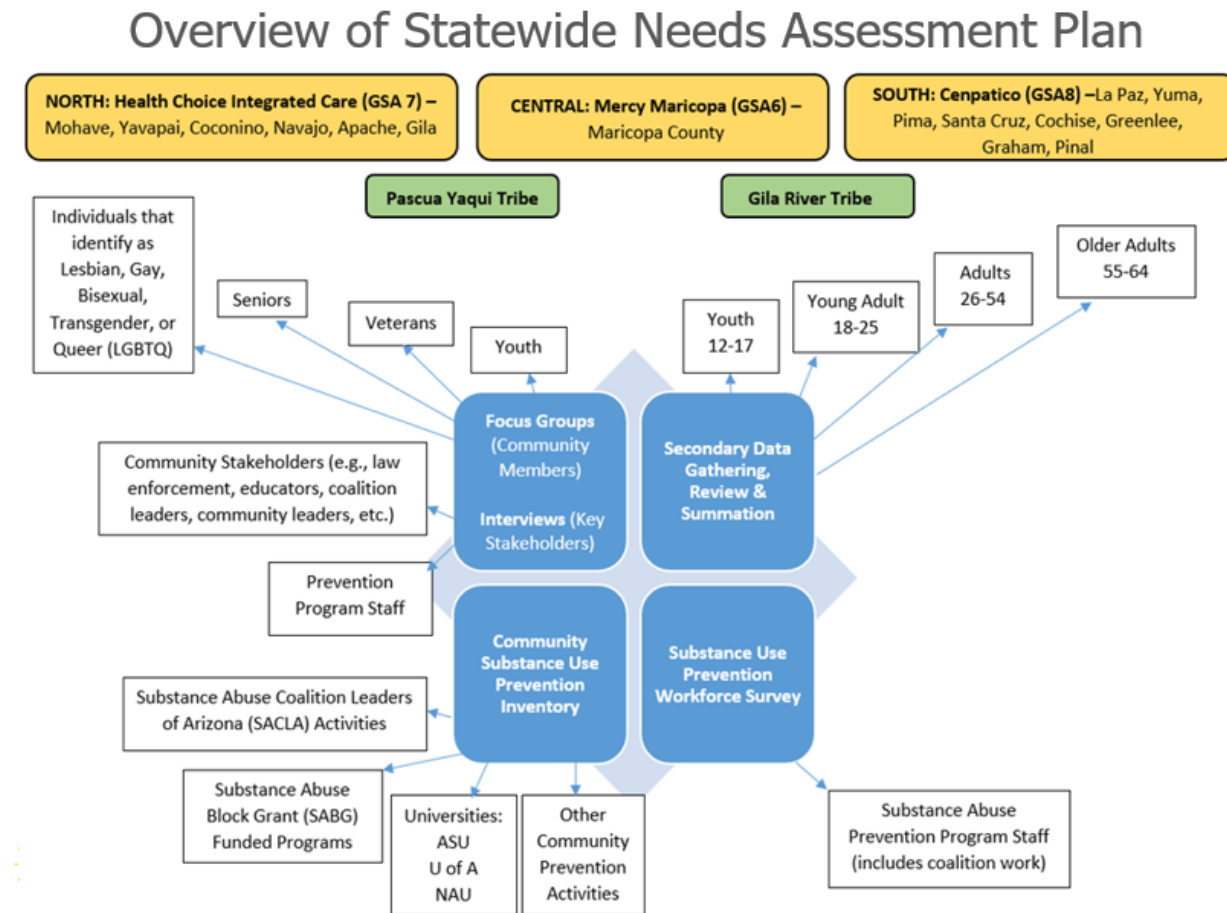
# Appendix B: Data Summaries

The following are summaries of key data sources utilized in the development of this strategic plan. Where applicable, the full sources are listed for further review.

## Statewide Prevention Needs Assessment: 2018

Excerpt from LeCroy & Milligan Associates (2018).

Exhibit 11. Needs Assessment 2018 Overview



Intended to Look at four Main Questions:

1. What are the current substance use issues in Arizona by region and subpopulation?
2. What substance use prevention programs are active in Arizona?
3. What are the causes for using and/or abusing substances in Arizona?
4. What are the recommendations for the future of substance use prevention in Arizona?





## Exhibit 12: Needs Assessment 2018 Key Findings

- 1) An increasing number of Arizonans of all ages and in all regions are suffering from untreated mental health issues that are leading to substance use and/or misuse.
- 2) LGBTQ identified individuals in all regions are experiencing significantly more risk factors for, consequences of, and issues with substance use and/or misuse as compared to non-LGBTQ identified individuals.
- 3) Vaping (e-cigarettes, etc.) is increasing in Arizona for youth in middle and high schools and is significantly higher than national averages.
- 4) The Counties that are experiencing the most severe consequences of substance use in Arizona are: (1) Gila County, (2) Navajo County, (3) Mohave County, and (4) Pima County.
- 5) A lack of social support and/or someone to turn to/talk to is a protective factor for substance use and/or misuse to which many Arizonans do not have access.
- 6) The normalization of marijuana and other substances may be leading to increased substance use.
- 7) Reductions in funding and resources for schools prohibit effective prevention programs from being delivered to high needs communities.
- 8) Recent efforts to combat the prescription drug opioid crisis in Arizona are leading to increased street drug use.
- 9) Prevention programs that are culturally competent, engaging and up to date are more effective and should be prioritized.
- 10) If basic needs are not being met (e.g., shelter, food, safety, physical health, mental health, social support) then prevention programs and efforts often fail.

Full Needs Assessment available online at:

<https://www.azahcccs.gov/Resources/Downloads/Grants/ArizonaSubstanceAbusePreventionNeedsAssessment.pdf>

## Resource Assessment: 2019-2020

LeCroy & Milligan Associates (LMA) met regularly with Arizona Health Care Cost Containment System (AHCCCS) staff in January and February 2020 to plan a resource assessment as a component of the strategic planning process. The resource assessment survey was ultimately developed with several considerations in mind:

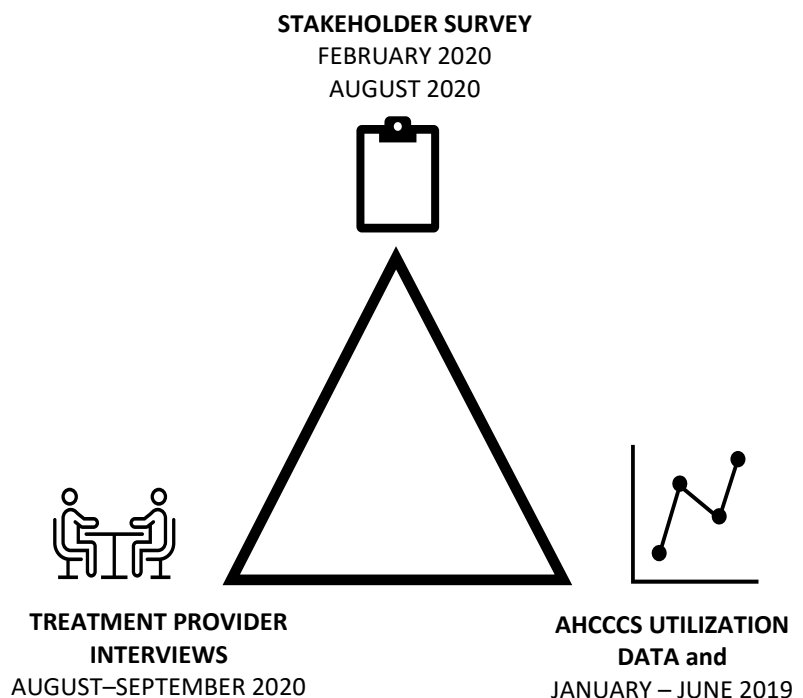
- *A Guide to SAMHSA's Strategic Prevention Framework* was reviewed as it identifies areas where data should be considered in the planning process (e.g., severity and trends of substance abuse/misuse (SAMHSA, 2019).
- The AHCCCS Logic model template (see Appendix A) was considered, and the types of data needed to develop this type of logic model statewide were identified.



- The 2018 Statewide Substance Abuse Needs Assessment was thoroughly reviewed along with the data collection tools used during this needs assessment process.<sup>1</sup> The goal was to enhance or simplify, but not duplicate, existing data.
- The discussions LMA facilitators had with the Strategic Planning Steering Committee which included some of the challenges and considerations around use of data in large group planning efforts.

In March 2020, just after the first resource assessment survey was completed, COVID-19 began to affect Arizona, ultimately impacting many aspects of life across the state. It also impacted the strategic planning process, which was delayed in the hope of continuing in-person. However, it was determined that it was best to go ahead and proceed virtually. Prior to reinitiating this process for the fall of 2020, the LMA team recommended that AHCCCS consider some additional data collection to inform the strategic planning process, given that so much had changed since the time both the Needs Assessment and the initial resource assessment were conducted. This additional effort was approved and included the following:

- Distributing to prevention providers and stakeholders a modified version of the resource assessment survey that was used in February, with additional questions also added specific to the impact of COVID-19.



- Interviews with treatment providers to inform future areas that prevention work may need to focus resources and services. Treatment providers were recommended by the Regional Behavioral Health Authorities (RBHAs) for inclusion and contacted by LMA to be asked to participate.
- A brief review of AHCCCS utilization data to look for preliminary quantitative trends in substance abuse and service provision in Arizona, again that would be informative to developing a statewide substance abuse prevention strategic plan.

<sup>1</sup> <https://www.azahcccs.gov/Resources/Downloads/Grants/ArizonaSubstanceAbusePreventionNeedsAssessment.pdf>



- AHCCCS provided data for analysis from the Crisis Counseling Assistance and Training Program (CCP), a crisis program funded through FEMA, which was also analyzed on key indicators relevant to this plan. This program provides free and confidential support, education, and resource connection to individuals in the state experiencing negative impacts of the COVID-19 pandemic.

The information below are excerpts from the full Resource Assessment report provided to AHCCCS.

## Long-term Consequences Summary

### Exhibit 13. Long-term Consequences Summary

#### Long-term Consequences of Current Substance Use Issues

**Definition:** Long-term consequences include outcomes that occur in the long run due to substance use issues (e.g., overdose deaths, substance related health problems; car accidents).

**Content Considered for this Section:** Long-term consequences of COVID-19 and current substance abuse issues.

**Data Sources Utilized:** Sample 2 (Post-COVID) Stakeholder Survey; Treatment provider interviews

#### Key Findings:

- Higher drug overdoses and drug-related death rates.
- Increased trauma and need for trauma informed care.
- Schooling/learning falling behind for many young people, especially those most at-risk.
- Increased health inequities.
- Increase in number of people struggling with mental health challenges.
- Social cost of disconnection and isolation from COVID-19.
- More people receiving care through telehealth/virtual options.
- Perhaps some increased awareness of health and its importance but also fear.
- Domestic violence and child abuse may be increasing.

**Limitations of Note:** Only minimal questions were asked in this area, due to information already available on these topics, including from the 2018 Needs Assessment. Findings were summarized and focused only on long term consequences as defined. Additional information may be added prior to reviewing this section with the Substance Abuse Strategic Planning Committee. See the Limitations section for additional limitations of all data collected in this report.

## Behavioral Health Problems Summary

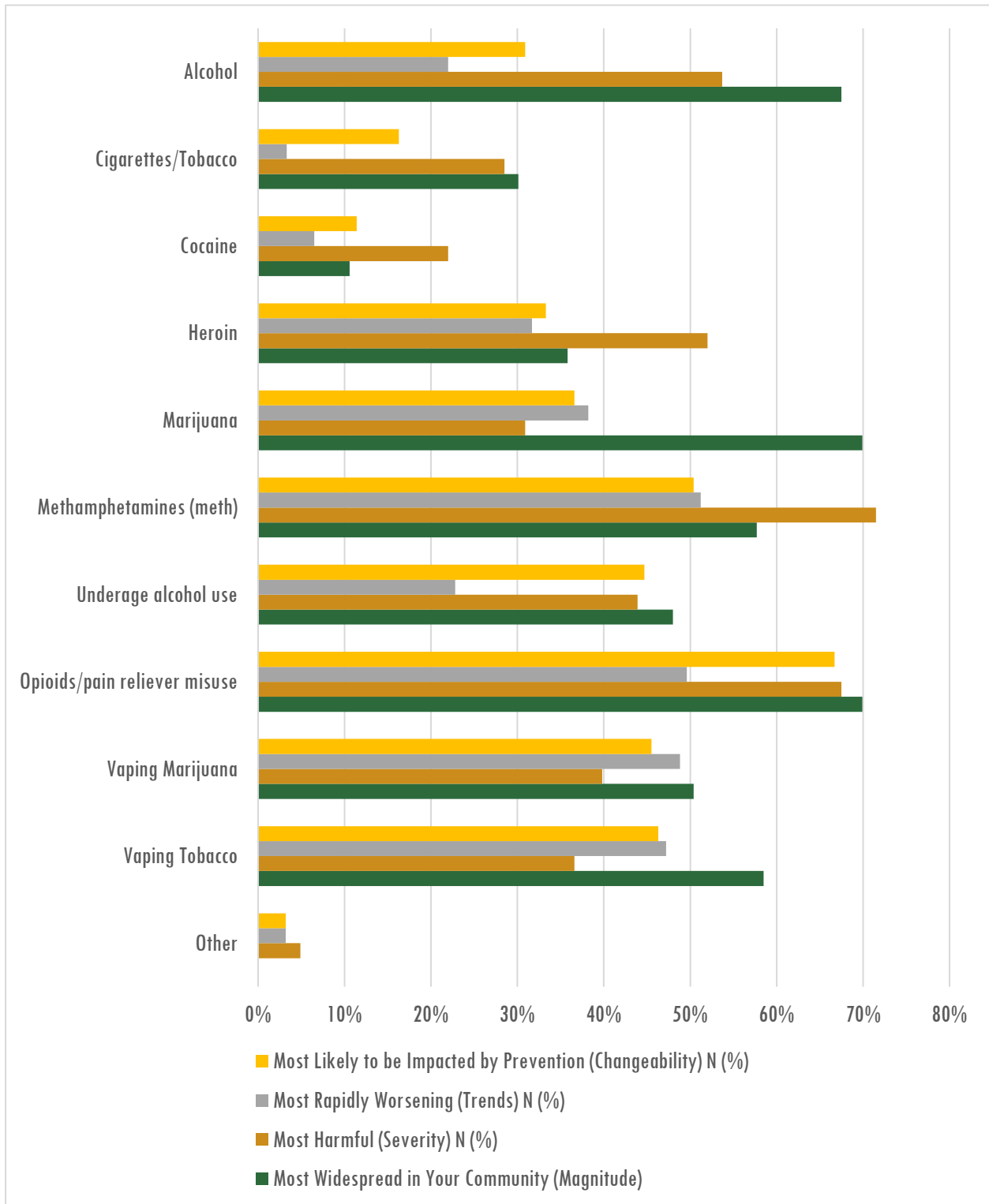
Data was collected on substance abuse from respondents to both the pre-COVID and post-COVID stakeholder surveys and in the interviews with providers. AHCCCS utilization data



also is available on this topic. Overall, findings suggest that opioids, alcohol, and methamphetamines are the substances of the greatest concern at this time and that all three can be potentially impacted with prevention efforts. Findings based on the stakeholder survey are summarized in Exhibits 14-15, which show which substances were perceived as most likely impacted by four criteria: substance abuse/misuse prevention (changeability), most rapidly worsening (trends), most harmful (severity) and most widespread (magnitude). A summary of key findings in this area are summarized in Exhibit 16.



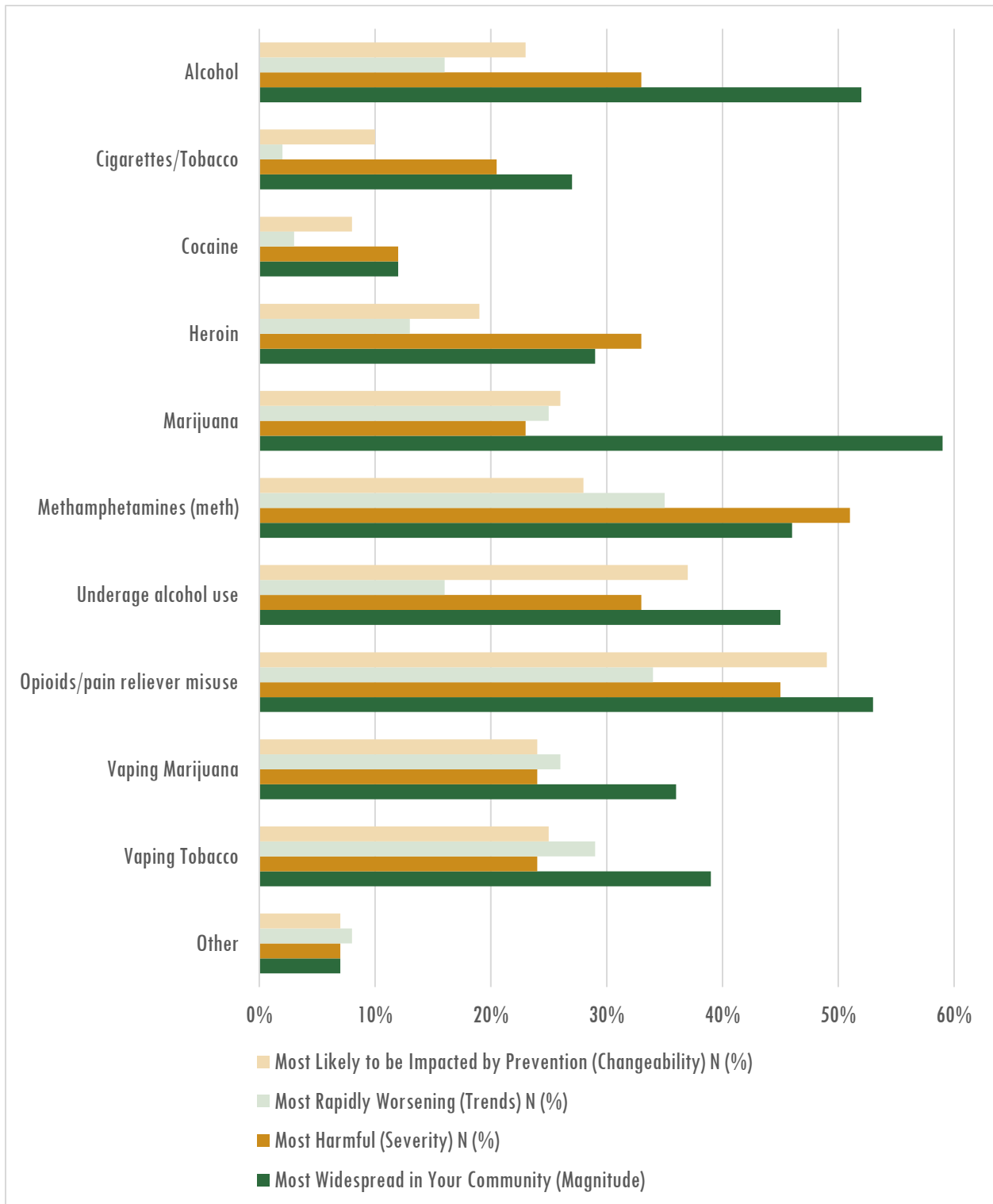
Exhibit 14. Percent of Respondents Indicating Changeability, Most Rapidly Worsening, Most Harmful, and Most Widespread—By Substance Pre-COVID Sample - FEBRUARY 2020\*



\*Respondents could indicate as many substances as applied for each of these categories, so percentages do not total to 100%. N=123



Exhibit 15. Percent of Respondents Indicating Changeability, Most Rapidly Worsening, Most Harmful, and Most Widespread—By Substance **Post-COVID** Sample - AUGUST 2020\*



\*Respondents could indicate as many substances as applied for each of these categories, so percentages do not total to 100%. N=83



## Behavioral Health Problems

**Definition:** Specific substance consumption abuse.

**Content Considered for this Section:** Specific substance abuse data.

**Data Sources Utilized:** Sample 1 (Pre-COVID) and Sample 2 (Post-COVID) Stakeholder Survey; Sample 2 (Post-COVID) Treatment provider interviews; AHCCCS utilization data

### Key Findings:

- All data sources used in this assessment point to an increase in substance use/abuse since the start of COVID-19.
- Many of the same substances continue to be the biggest issues in communities both before and after COVID-19. These include opioids, alcohol, and methamphetamines. Substance specific findings are described below, in an *approximate order of priority* based on the data provided in this resource assessment.
  - **Opioids/pain reliever misuse**—opioids were listed by participants of both survey samples as in the top two of all categories including changeability, most rapidly worsening, most harmful, and most widespread. AHCCCS utilization confirms this substance abuse type is prevalent, with over 86% of members with a substance abuse type listed having an indication of opioid abuse both in 2019 and 2020. All data points to it continuing to increase in use post COVID-19.
  - **Alcohol**—most indicators suggest alcohol use is on the rise. Some of the treatment providers interviewed suggested some were using alcohol to self-medicate during COVID-19 and over half of the post-COVID survey respondents reported observing an increase in use of alcohol. AHCCCS utilization data supports this may be increasing as well or certainly continuing to be prevalent. It was listed as one of the top four most widespread and harmful by survey participants, but not the most rapidly worsening. This supports that perhaps it has been already continuing to increase gradually over time.
  - **Methamphetamines/Stimulants** — Both samples of survey participants suggest that methamphetamines are one of the substances of greatest concern at this time. Fortunately, it was also listed as one of the top four substances in changeability, suggesting it is a good target for prevention efforts. It is one of the top four substances indicated in the categories of rapidly worsening, most harmful, and most widespread. Most of the treatment providers interviewed mentioned methamphetamines as one of the substances on the rise, both prior to COVID-19 and certainly now. Concerns were mentioned with “dirty ingredients” more frequently being mixed in making them even more lethal. As noted above, AHCCCS utilization data suggested stimulants to be potentially increasing in use as well.
  - **Marijuana/Cannabis**—Both samples of survey participants indicated that marijuana was the most widespread in their communities. It was one of the substances that showed some likelihood of changeability. While treatment providers did not call it out specifically as worsening, survey participants post-COVID indicated it as one of the top 3 most increasing substances since COVID-19. This is supported by AHCCCS utilization data which also shows it potentially increasing.
  - **Heroin**—Findings are less definitive when it comes to heroin. It is clearly indicated by survey respondents in both samples as one of the most harmful substances, but not as widespread, preventable, or worsening as many of the other substances. AHCCCS data did not provide specific information on this substance.



- **Underage Alcohol**—Findings in this area are not as definitive. This substance was indicated by survey participants in both samples as the fifth or sixth most harmful and most widespread substance. It was noted as increasing post-COVID by 34% of respondents. Interestingly, nearly 10% of respondents to the post-COVID survey also thought it might be decreasing post-COVID. Thus, the impact of the pandemic on this ongoing substance challenge is not clear. It was also listed as one of the top four substances in changeability, suggesting it is still a good target for prevention efforts. Data on underage drinking was not available from the analysis conducted of AHCCCS utilization data at this time.
- **Vaping Marijuana/Tobacco**—Data was similar for vaping of both types of substances across the two survey samples. About the same percentage of respondents identified vaping as most likely to be impacted, most rapidly worsening, and most harmful. While not in the top four in these categories, quite a few people do appear to perceive them as of concern. They do approach the top four in the category of most widespread. Survey respondents did suggest they thought vaping of both had increased post COVID-19. Vaping was not specifically mentioned by the treatment providers during the interviews and data was not available from the analysis conducted of the AHCCCS utilization data at this time.
- **Cigarettes/Tobacco**— Data does not suggest that this is one of the most critical substances to address with prevention efforts at this time.
- **Cocaine**—Data does not suggest that this is one of the most critical substances to address with prevention efforts at this time.
- Some funding priority recommendations provided in the stakeholder survey also specifically listed substances that should be of focus (though this was not asked for directly). These findings suggest that vaping, opioids, alcohol, marijuana, underage alcohol, and methamphetamines should be considered.

**Limitations of Note:** It is unclear from the data what is different between the samples and timepoints included. Trends may be attributed to the differences in who participated or other factors. Also, definitions/categories of substance were not the same for this resource assessment and AHCCCS utilization data, limiting some comparability. There is a great deal of geographic variability within these findings. The Appendices include some analyses by GSA, but given the limitations and small sample size, these regional variations are not included in this overall summary; however, they may be reviewed in the planning process. See the Limitations section for additional limitations of all data collected in this report.

## Risk/Protective Factors (Intervening Variables) Summary

Overall risk and protective factors for substance abuse are fairly well-established. A preliminary list is provided in Exhibit 1 by level of socioecological model for consideration and use during the planning process.

Survey and interview participants were asked specifically about the impact of COVID-19 on risk and protective factors for substance abuse. Across all the participants, there were fairly consistent responses when asked about the impact of COVID-19. The impact of the economic climate (e.g., unemployment, financial stress, housing), increased mental health challenges (stress, depression, anxiety) and less social and community support/engagement during isolation were primary responses. These and other factors are detailed in the table below.





## Exhibit 17. Risk/Protective Factors (Intervening Variables)

### Risk/Protective Factors

#### Definition:

**Risk Factors** are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes.

**Protective factors** are characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact. Protective factors may be viewed as positive countering events.

**Content Considered for this Section:** Impact of COVID-19 on risk and protective factors.

**Data Sources Utilized:** Sample 2 Stakeholder Survey; Treatment provider interviews

#### Key Findings:

- COVID-19 is impacting many of the areas that are considered the social determinants of health (economic stability, education, social and community context, health and health care, neighborhood, and built environment)<sup>2</sup>.
- According to participants, specific risk factors most impacted include the following:
  - Worsening mental health including more anxiety, depression, and stress during this challenging time.
  - Increased financial stresses/challenges including more unemployment and housing issues.
  - Increases in violence in the home.
  - Changes in access to substances (more accessibly around the house potentially for some people).
- According to participants, specific protective factors most impacted include the following:
  - Less social and community support during isolation (either because of quarantine and/or out of fear of spreading/catching the illness).
  - Increases in time spent with family (can be a positive or negative impact).
  - Youth without positive engagement in school and other prosocial activities.
  - Perhaps increased health awareness but also fear.
  - Changes in health care system access (can be a positive or negative impact; more virtual, but perhaps new barriers to finding care; less in-person services).

**Limitations of Note:** An existing list of risk/protective factors commonly associated with substance abuse will also be utilized during the strategic planning process and is included in Appendix G. See the Limitations section for limitations of all data collected in this report.

## Local Conditions and Contributing Factors Summary

In order to better understand the conditions across Arizona that may impact substance abuse issues, local conditions and resource availability were assessed. It is clear that COVID-19 has

<sup>2</sup> <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>



shifted resource access and availability in new ways, with some resources more accessible virtually, and some less so. But either way, the shift has been dynamic, and it appears there is still work to be done to understand what communities need to support substance abuse prevention work post-COVID. Key findings to consider in this process are included in the Exhibit below.

#### Exhibit 18. Local Conditions and Contributing Factors

### Local Conditions and Contributing Factors

**Definition:** What is specifically happening (or not happening) in communities related to these behavioral health problems and intervening variables. These should be local and short-term.

**Content Considered for this Section:** Data on resource availability, community readiness, impact on specific populations

**Data Sources Utilized:** Sample 1 (Pre-COVID) and Sample 2 (Post-COVID) Stakeholder Survey; Treatment provider interviews

#### Key Findings:

- **Resource availability**—Findings are complicated related to resource availability, likely suggesting the changing dynamics of the pandemic, the regional and local variation in the types and availability of resources, and the types of resources considered.
  - For example, some of the data suggests that there are increased resources available to support basic needs (e.g., food) and protective gear (e.g., masks) as those have been pushed out to communities during this time.
  - Looking specifically at the data from the post-COVID survey sample, community awareness and fiscal resources had the highest percent of respondents indicating they were not at all adequate or not adequate. These were the main areas identified pre-COVID as well.
  - Open-ended survey and interview responses provided some additional insight into this resource access complexity, pointing to, at a minimum a shift in the way in which many resources were available. Some were *more* available because offered online, but others, particularly if required or preferred in-person were less available. Technology also became both a door to access and a barrier for those less comfortable or able to access this method for accessing some types of services. And because of these shifts, individuals may or may not have the necessary information on how to access resources in this new and shifting environment.
  - AHCCCS utilization data points to the likely shift in substance abuse treatment resource access/availability since the start of COVID-19, with more services being offered via telehealth and at community mental health centers. Service claims appear to decrease sizably in independent clinics and FQHCs from Jan-Jun 2020 as compared to the year before. This data was through June 2020, so it is unknown whether some of these changes have shifted or righted themselves with more time for the system to adapt to the pandemic safety protocols, etc. Despite these changes, overall, there were nearly 20% more service claims from Jan-Jun 2020 than the same timeframe the year before. The top five most frequently used service treatment codes for substance abuse all



increased sizably, except for 99407—*smoking and tobacco use intensive counseling, greater than 10 minutes.*

- **Community readiness** to address substance abuse has *perhaps* decreased slightly post-COVID, but overall, most participants saw their communities as somewhere in the middle on a scale of not ready to very ready. It varies by community.
- **Substance Abuse Impact on Specific Populations**—these findings stayed fairly consistent over time.
  - Homeless individuals and young adults were indicated by both survey samples as the population most significantly impacted by substance abuse and those with the least resources available to help.
  - It appears that adults are the next most significantly impacted group, but they have more resources available than homeless and young adults. These trends held across both survey samples.
- **Populations Experiencing Substance Abuse Increase Post-COVID**
  - The population experiencing the greatest increase in substance abuse since COVID-19 according to survey and interview participants were young adults.
  - Other populations also likely seeing an increase include adults, older adults, and homeless individuals.
  - According to AHCCCS utilization data, it appears there was a greater increase in the number of distinct members with substance abuse diagnoses that identified as Black and Native American, as compared to other categories when looking at Jan-Jun 2019 and 2020 respectively. All populations showed a sizable increase in utilization in 2020, except for Hispanic, however it appears this category may be under-represented in this data as reported, so this is inconclusive about Hispanic service utilization.
  - The percent of distinct members with substance abuse diagnoses who were male increased by about 1.5% more than female when comparing Jan-Jun 2019 and Jan-Jun 2020. It is not known if this represents a significant trend.

**Limitations of Note:** Data included in this report, while pertaining to local communities across Arizona is primarily summarized by state and region. Large variations in the two survey samples pre- and post-COVID hinder the ability to make assumptions based on comparison of this data (we know geographically the samples are not similar). It will be critical in the strategic planning process to consider what areas may or may not be represented by these findings, and how that impacts state level strategic planning. See the Limitations section for additional limitations of all data collected in this report.

## Strategies and Local Implementation Summary

While this will ultimately be the work of the Strategic Planning Committee to identify at the state level, information from this resource assessment provides information on current programming including those in alignment with the SAMHSA prevention categories and the socioecological model. These key findings are included in Exhibit 19 below.



## Strategies and Local Implementation

**Definition:** Strategies and programming that fall under one of SAMHSA's primary prevention strategies.

**Content Considered for this Section:** Substance abuse provider programming; impact of COVID-19 on programming

**Data Sources Utilized:** Sample 1 (Pre-COVID) and 2 (Post-COVID) Stakeholder Survey—only participants who identified as being able to represent a provider organization or coalition were given these questions.

### Key Findings:

- **Programming—**
  - Providers reported offering on average a fairly similar numbers of evidence based, promising, and innovative practices, in the pre- and post-COVID samples, ranging from 1-2 per provider for most indicators and 2-3 per provider for EBPs.
  - A total of 25% of post-COVID survey respondents had implemented a new program and 25% also reported having stopped a program since the start of COVID.
  - Open-ended responses suggest that programming was greatly impacted by COVID-19. In-person programming came to a halt and much of it was adapted to virtual delivery. Program delivery in a virtual model proved challenging with barriers such as internet accessibility and technology.
  - School-based delivery participants felt had been the most impacted as schools have a lot to focus on with just ensuring academics and may not prioritize non-academic programming like prevention.
  - Some providers identified adapting to this new environment with increased community outreach and awareness through virtual mechanisms.
- **Provider Capacity—**providers were asked to indicate the impact COVID-19 has had on several different aspects of capacity.
  - All but one prevention provider reported that their organization is currently open with staff working in full or partial capacity, with 75% indicating the majority of staff are working virtually and 64% indicating their organization is providing virtual services and programming.
  - Fortunately, only a small percentage indicated they have had funding, staffing or other significant reductions from COVID-19. This suggests existing provider capacity.
- **SAMHSA Prevention Categories—**Prevention providers identified the three main categories of prevention programming that they offered out of the six identified by SAMHSA (community-based processes, information dissemination, environmental strategies, prevention education, positive alternatives, and identification of problems and referral to services).
  - Prevention education and community-based processes were the most frequently identified both pre- and post-COVID-19.
  - Data suggests that there was also more information dissemination post-COVID, which supports the open-ended findings that virtual mechanisms were used more to get out information in this new environment.



- **Domains Targeted**—Prevention providers were asked to indicate the top two domains they target with their prevention efforts out of society, community, relationship and individual.
  - Interestingly, there is 10-15% variation in each of these from pre to post COVID-19, which is more than on many of the indicators particularly related to programming. As always, this could have to do with the different samples, but is of note.
  - Specifically of interest, it appears that some of the individual/relationship level focus may have shifted to society/community level work. This is an area for further consideration by the Strategic Planning Committee.
- **Disparities**—Providers were asked to comment on what factors might contribute to challenges in serving all the populations in their areas or if they were only focused on specific populations.
  - Both pre- and post-COVID samples indicated that challenges with outreach and recruitment of some populations and also lack of sufficient funding to serve some populations were the main limitations as to why they did not reach all populations. Funding constraints mentioned the need for adequate staffing and long-term program funding. Challenges with collaborating with all populations were noted (e.g., barriers in working with tribes, schools hesitant to share class time or parents suggesting prevention should be done at home; lack of funds/support to do collaborative work).
  - Some organizations choose to focus on specifically serving populations such as youth/young adults, tribal communities, criminal justice involved populations, parents in dependency cases, seriously mentally ill or geographic regions.
  - Populations some noted they wanted to expand to reach more included early intervention, youth/young adults, families, populations that speak other languages, LGBTQ+ identifying individuals, low income, sex offenders, older adults/seniors and homeless).
- **Prevention Provider Demographics**—While clearly not all prevention providers in Arizona participated in the survey at pre or post COVID-19, information on who and where the prevention providers that participated are serving may point to areas for further exploration.
  - **Geographic**—the absence of prevention providers serving specifically Greenlee and La Paz should be considered and may suggest a geographic service gap. Some providers noted that COVID-19 may strain resources further in rural communities, where they are already limited.
  - **Populations Served**—Across both survey samples, over 50% of respondents indicated that children/youth, young adults and adults were priority populations for their organizations. Fewer organizations specifically focus on refugees or serving specific racial/ethnic groups, though the latter appeared higher for the post-COVID sample. Serving youth post-COVID has proved the most challenging since they have not had the ability to attend school or in-person prosocial activities.
  - **Substances Targeted**—Across both samples, marijuana, opioids and alcohol/underage alcohol were the most mentioned as being a substance of current focus for their organization/coalition. Only a few respondents indicated they target steroids, PCP or peyote and less than 10% of respondents suggested that they do not target specific substances. Fewer of the respondents in the post-COVID sample appear to target fentanyl, heroin and cocaine than in the pre-COVID sample. This may or may not be attributable to COVID-related factors. Underage alcohol was the most frequently targeted in the post-COVID sample, with nearly 60% indicating they address this substance. Respondents in the post-COVID sample did suggest in the open-ended responses that their organization had shifted to focus on different substances as the result of COVID.

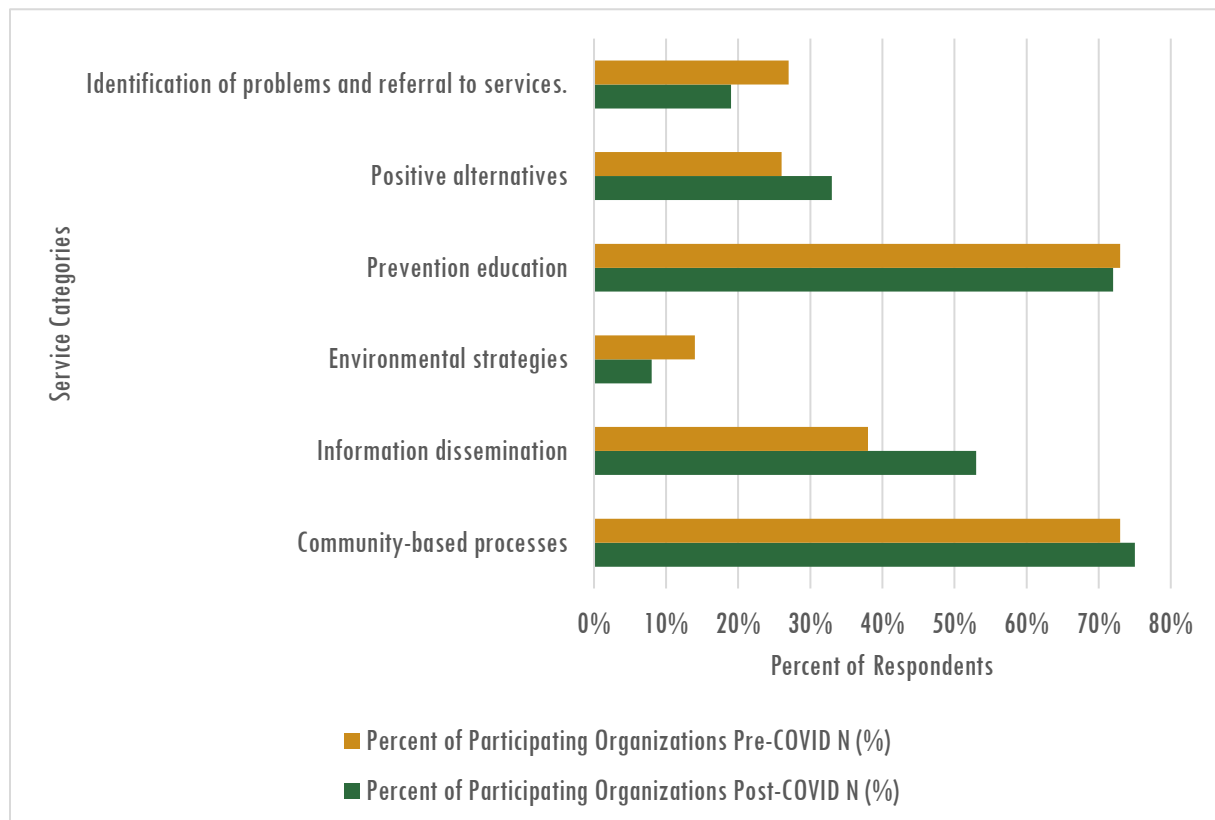


- **Funding Streams Utilized**—Providers were asked to indicate the funding streams they currently use for substance abuse/misuse programming. The primary funding sources include the Substance Abuse Block Grant (SABG) from AHCCCS and other state grants. Data from the pre-COVID sample suggest that other federal grants and private donations are also commonly utilized; however, these were less common funding sources for respondents in the post-COVID sample. Respondents did not indicate that COVID-19 had significantly impacted funding sources except for a few that experienced a decrease in private donations.

**Limitations of Note:** Data included in this report, while pertaining to local communities across Arizona is primarily summarized by state and region. It will be critical in the strategic planning process to consider what areas may or may not be represented by these findings, and how that impacts state level strategic planning. See the Limitations section for additional limitations of all data collected in this report.

Additional information on the categories of services and domains are included in Exhibits 20 and 21. Please note that the data was collected with different participants in pre- and post-COVID-19 survey timepoints and groups are likely not equivalent. Findings should be interpreted alongside other supporting data.

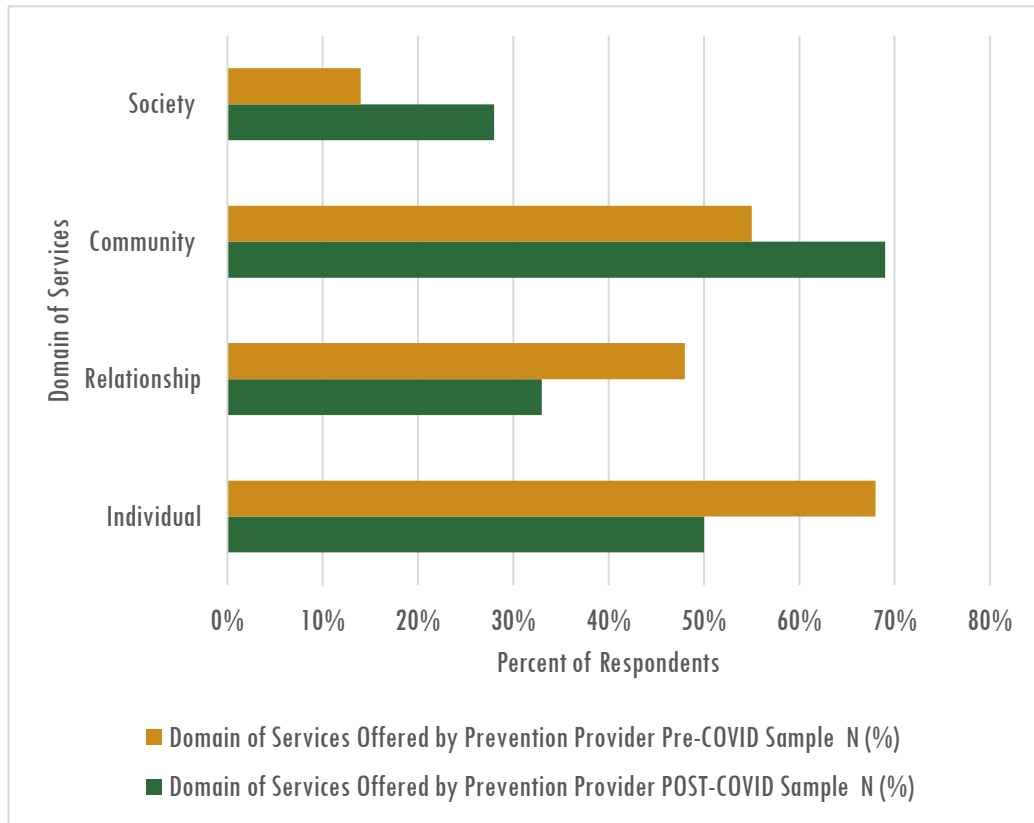
Exhibit 20. Categories of Services Offered by Participating Prevention Providers/Coalitions by Pre-COVID Sample and Post-COVID Sample \*



\*Respondents could indicate more than one category, so percentages do not total to 100%. Post-COVID Sample (Prevention Providers only): N=73; Post-COVID Sample (Prevention Providers only): N=36



Exhibit 21. Domain of Services Offered by Participating Prevention Providers/Coalitions by Sample



\*Respondents could indicate more than one category, so percentages do not total to 100%. Post-COVID Sample (Prevention Providers only): N=73; Post-COVID Sample (Prevention Providers only): N=36

### Funding Priorities Summary

Participants provided recommendations on funding priorities that the Strategic Planning Committee may want to consider. Findings are detailed in Exhibit 22 and 23. There are recommendations across all the SAMHSA prevention categories, by substance, population and overall. Children/youth/young adults were overwhelmingly the most frequently mentioned population that funding priorities should target. Prevention education strategies were the most frequently mentioned, followed by community-based processes and information dissemination. Also, while less directly applicable under SAMHSA primary prevention categories, mental health needs, suicide prevention efforts and technology and internet support were mentioned as key themes and considerations.



Exhibit 22. Funding Recommendations by SAMHSA Prevention Category (Both Pre-COVID and Post-COVID)

**SAMHSA Prevention Category and Recommendations**

**Prevention Education**

- Offer programs for families to increase connectedness, heal from trauma, etc. Also support programs and resources for parents in offering prevention to their own kids.
- Offer programs for youth (e.g., life skills and decision-making).
- Offer drug-specific programming (e.g., heroin, fentanyl, marijuana, alcohol and vaping of substances) including the specific harmfulness and effects of these substances.
- Hire staff to do more prevention work and programming in schools (consider whether should be staff internal or external to the schools themselves). Educate whole schools (e.g., like used to do with DARE).
- Educate on ways to increase protective factors. Teach healthy coping and emotional resiliency.
- Support programs for high-risk age groups and those exposed to traumatic events (including youth and juvenile justice populations).
- Provide hands-on trainings for all different stakeholder groups.
- Offer peer support programs.
- Provide culturally competent prevention programming (including specifically for LGBTQ+ identifying individuals).
- Educate from an early age about avoiding all types of addictions and targeting the reasons why youth might start using (e.g., handling stress).
- Ensure education and training are available for those *delivering* prevention services.
- Expand reach for prevention programming in online settings. \*
- K-12 prevention education in every school across the state. \*
- New and innovative outreach and education strategies due to COVID. \*

**Community Based Processes**

- Fund and support prevention coalitions.
- Increase access to community resources (including affordable housing) and mechanisms to connect people to resources.
- Build trauma-informed community.
- Build better systems and awareness of those systems within communities.
- Establish infrastructure to coordinate prevention efforts.
- Mobilize the community.
- Address root causes of substance use and use integrated approaches.





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## Information Dissemination

- Educate the community about specific drugs (e.g., marijuana, THC products, underage drinking).
- Educate about drug use and/or consequences of drug use.
- Educate on public health and risk/protective factors.
- Educate on trauma-informed care and building resiliency. \*
- Offer campaigns to reduce stigma around drug use.
- Increase awareness about what substance abuse prevention is all about.
- Use methods like statistics, storytelling and speakers at schools to reach people.
- Tailor campaigns to specific age groups, particularly highlighting resources available by age. \*
- Utilize social media to inform parents about talking with youth. \*
- Send positive messages to youth that build resilience. \*

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## Problem Identification and Referral

- Identify and help address emerging mental health issues (e.g., depression and anxiety in youth).
- Help those who have faced significant adverse childhood experiences and all forms of abuse (e.g., child abuse, domestic violence, sexual assault, drug endangerment, extreme neglect).
- Support continuity of care for those individuals coming from the criminal justice system.
- Offer harm reduction strategies to reduce death rates from substances.
- Fund early intervention as an important way to prevent substance use disorder.
- Provide intervention resources for all individuals and families at any level of involvement with drugs (e.g., use, abuse, addiction, or family member).
- Offer naloxone education.
- Provide warm lines for those contemplating resuming abuse of substances.
- Suicide prevention services—how to get help.
- Educate older adults on identifying misuse. \*
- Fund current resource mapping and development of a centralized referral list. \*

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## Positive Alternatives

- Increase programming to help reduce social isolation.
- Offer health promotion and well-being focused efforts.
- Provide youth with meaningful employment opportunities while still in high school and help with employment skills and job searches.
- Provide more afterschool programs for youth that are little to no cost.
- Fund recreational programs and facilities for youth in communities (e.g., parks, sports complexes, art studios, libraries). \*



- Partner with organizations to provide social and job events. \*
- Create online environments to provide opportunities for socialization, minimizing isolation. \*

### Environmental Strategy

- Disrupt the flow of certain drugs into the community (e.g., fentanyl).
- Consider the impacts of marijuana legalization.
- Consider social determinants/intervening variables that effect behavioral health and substance abuse issues.
- Build health-focused public policies in all sectors.
- Improve health systems.
- Change the culture around use of substances (even within the “counterculture”).
- Address vaping availability and enforcement.
- Increase funding to increase address the social determinants of health in lower income and minority communities. \*
- Funds to revitalize communities. \*

\*These recommendations were unique to the post-COVID sample.

Recommendations were also categorized according to the substances and populations that were mentioned, since many respondents volunteered their perspectives on these issues in their open-ended responses. Findings are summarized in Exhibit 23.

Exhibit 23. Funding Priority Recommendations by Substance and Population (Pre-COVID Sample and Post-COVID Sample)

### Other Recommendations

#### Drug Focus Areas

- Vaping marijuana and/or tobacco (N=18) \*
- Opioids (N=12)
- Alcohol (N=9)
- Marijuana/THC (N=11) \*
- Underage alcohol (N=6)
- Meth (N=6)
- Prescription drugs (N=4)
- Fentanyl (N=6)
- Heroin (N=3)



## Population Focus Areas

- Children/Youth/Young Adults (60) \*\*
- Families/Parents (15)
- Criminal Justice Involved (7)
- Older adults/seniors (7)
- Other vulnerable/high risk populations (e.g., homeless, rural, sex offenders, LGBTQ+, unemployed, domestic violence victims, veterans, seriously mentally ill) (13)

## Other Key Themes

- Mental health needs and services (18)
- General health/wellness efforts (11)
- Suicide prevention efforts (9)
- Support family stability (e.g., financial stability, housing, day care).
- Technology and internet support to increase access and use (3) \*\*\*

\* Responses that specifically mention vaping marijuana are included in the vaping count and not listed again under marijuana.

\*\*These are grouped together here as it was not clear from open-ended responses which ages of young people were being referenced by the use of these terms.

\*\*\*Recommendations are from the Post-COVID Sample only.

## Strategic Planning Session Summary

The following summarize key themes from discussions held during the strategic planning sessions.

### Exhibit 24. AHCCCS Strategic Planning Meeting Notes by Breakout Session Question

#### OCTOBER 7 SESSION

#### Question 1: Are there long-term consequences that are missing that you think are critically important?

##### Themes

- Criminal involvement
- Family dysfunction/family breakdown
- Suicide
- Trauma
- Unemployment

#### Question 2: What 2–4 long-term consequences do you think should drive the strategic planning process and why?

##### Themes

- Overdose fatalities
- Poor education outcomes
- Poor mental health outcomes
- Domestic violence & child abuse
- Health inequities

#### Question 3: When prioritizing substance misuse/abuse problems, which criterion or criteria do you think are most important to consider in the strategic planning process and why? (Choose 1 or 2)

##### Themes

- Changeability and severity most important (Note: this was also reflected in the poll)



**Question 4: Which substances rose to the top according to the criterion/criteria you identified as most important? Were they the same top substances?**

**Themes**

- Opioids
- Alcohol
- Heroin
- Meth
- Marijuana

**OCTOBER 21 SESSION**

**Question 1: What key risk and protective factors are associated with behavioral health problems related specifically to substance misuse/consumption?**

**Themes**

- Family recognized as both risk and protective factor, as family dysfunction may increase risk while family connection may decrease risk

**RISK**

- Accessibility of substances
- Perceived risk (particularly related to marijuana)
- Mental health & stress
- Acceptance/norms of alcohol and marijuana

**PROTECTIVE**

- Community (as protective particularly for Native Americans)

**Question 2: Reflecting upon the risk and protective factors that were discussed, which 3–5 are most important (i.e., key drivers) to consider and why?**

**Themes**

**KEY DRIVERS/KEY PROJECTIVE FACTORS**

- Family unity
- Community connections

**KEY DRIVERS/KEY RISK FACTORS**

- Isolation/lack of relationships
- Unemployment
- Access/availability of substances

**Question 3: How do current resources align with risk and protective factors (i.e., key drivers) you identified?**

**Themes**

- These are not many “themes” here, but two groups did mention family-related concerns, stating more attention is needed to be given to the family unit and parents do not have the appropriate tools to assist children, so family/parents could be an area that needs more support/resources.

**Question 4: What other conditions must be present in communities across the state in order to address key drivers, either by decreasing key risk factors or improving key protective factors?**

**Themes**

- Main theme here is collaboration.

**November 2 Session**

**Question 1: Identify which populations are the current focus of participating prevention providers and identify any populations that you believe need more attention/services.**

**Themes**

- LGBTQ
- Young adults
- Ethnic and racial minorities, specifically Native Americans, Hispanics, and African Americans.
- In one group, several comments pertained to men being a hard-to-reach group needing more intervention.



- Another group specifically discussed language barriers and fear of deportation making it more difficult to reach/serve Hispanic populations.

**Question 2: Identify substances that are the current focus of participating prevention providers and identify where more attention is needed. Discuss if there are important region-specific or county-specific considerations.**

- Themes**
- Opioids, including fentanyl, and meth were stressed across groups.
  - Alcohol and marijuana also were concerns.
  - Recognize that regional and population differences exist/matter.

**Question 3: How do we prioritize across SAMHSA strategies? Is it necessary to incorporate all SAMHSA prevention strategies, across all 6 categories, in statewide prevention efforts?**

- Themes**
- Ensure strategies align with community need and provider strengths.
  - Prevention education, environmental strategies, positive alternatives, community-based process mentioned most.
  - Should vary by population and substance.
  - Need more data to be able to know what each community needs.

**Question 4: Review recommended strategies falling under your SAMHSA prevention categories and identify gaps needed to address substance misuse/abuse. What additional strategies do you recommend?**

**Information Dissemination and Environmental Strategies**

- Trauma informed care, though not sure if this applies outside of tribal communities. Issues of generational trauma.
- Priority to get information from the community and build trauma-informed communities. Maricopa county works together on different areas, such as ACES consortium who focus on trauma care.
- Social norms campaign, redefining the normal works well with youth.
- Adding cultural competency, looking at communities and understanding their experiences. This should be recognized with disseminating information.
- Not enough focus on young adults in tribal communities as they transition.
- Messaging should have an appropriate cultural lens.
- Substance abuse and mental health strategies go hand in hand
- List of environmental strategies is comprehensive, add educating parents/guardians.
- Harm reduction elements could be added in environmental strategy, such as needle exchange programs.
- Family should be viewed as its own environment and you must be knowledgeable about all resources available that can address those areas. Helping people access power in their community, such as referring people to city council, HOA, etc.

**Prevention Education Strategies**

- Participants noted that the list was comprehensive.

**Community based process and Problem Identification or Referrals and services**

- Encouraged to use evidence-based programs and approached. The community and area being serviced should be able to weigh in on this.
- Flexibility to be creative and strategize is not always possible because there is no funding within the coalition.
- Inviting others to bring their skillset, going beyond what these resources entail. This is very important for trauma informed care as it helps identify where a person has come from and where they are going.
- Investing in a group with evidence-based approaches helps with an integrated approach.



- Making sure it is aligned with the needs of the community and knowing who you are serving, make sure it fits with their culture.
- Coalition started working with schools and working to go to the legislature.
- Levels of prevention, screening for root causes in different setting such as primary care and schools so resources can be given. Does not understand why it is not funded.
- Screening family for mental health concerns and influence on the family.
- Once people have identified what they need they tend to go for that service, making it difficult to identify and address other needs.
- No system for closing the link so one knows that a person got the services. It is hard for families to get connected to services.
- Warm lines mentioned, noted that they apply more to mental health. Possibly triggering.
- Preventions specialist would refer to hotline and services.
- Glad to see prevention moving into referral services, originally told they could not do referrals.
- Centralized referral list may be useful.
- Trust necessary and must be earned before someone discloses problems.
- Evidence based programs have not been written up with cultural backgrounds in mind.
- Using a module to see where a community is doing well.

**Question 2: Based on the list of strategies falling under each prevention category, list the top 3-5 that you recommend implementing to impact substance misuse/abuse in communities across the state.**

**Information Dissemination and Environmental Strategies**

- Enforcement of vaping in the community in terms of where and how it can be sold.
- Considering social determinants, changing culture around substance use. Consider impacts of marijuana legalization, address vaping, and allocate funds to revitalize communities.
- Agreement with social determinants and changing culture. Building health-focused public policy in all areas.
- Challenging to determine “how.”
- How can it be evaluated? Noted they gravitated towards strategies that can be effectively measured.

**Prevention Education Strategies**

- Offering programs for families for healing, trauma, drug-specific programming, education on ways to increase protective factors, educating at an early age.
- Ensuring education and training is available for those delivering prevention strategies, offering hands on training for all stakeholder groups, drug-specific programming, trauma informed care.
- Hire more prevention staff and more resources for prevention, not just in schools. Creativity is needed with COVID. Training needed for all groups involved.
- Education for parents and grandparents, increasing protective factors, support programs for high-risk age groups, culturally competent prevention programming, education for those delivering services. Possibly credentialing.
- Family connectedness and healing trauma, drug-specific programming, educating from an earlier age.



	<ul style="list-style-type: none"> <li>• Increase connectedness, increase protective factors, culturally appropriate training, drug-specific programs can be effective in some contexts. Would like action-oriented trauma responsive schools.</li> </ul>
<b>Community based process and Problem Identification or Referrals and services</b>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>
<b>Question 3: Who have been the key players with respect to each of these SAMHSA prevention strategy areas historically and what opportunities for future collaboration are there? Who is missing?</b>	
<b>Information Dissemination and Environmental Strategies</b>	<ul style="list-style-type: none"> <li>• Arizona Complete Health does a good job on prevention messaging through billboards, radio, and other PSA's. There are tribal radio stations that have prevention messaging in their native language.</li> <li>• Health departments, AHCCCS, national agencies, CDC, RBHA, and sometimes groups like MADD.</li> <li>• Many different partnerships exist. Sometimes groups can set up sports or art camps that can reach youth at their level. Partnerships with all African American politicians in the state and African American Leadership Conference.</li> <li>• Maricopa county has a recognizable brand (Be Awesome). Agencies can do well to be recognized. Bringing value with your messaging works to generate respect from the community.</li> </ul>
<b>Prevention Education Strategies and Positive Alternatives</b>	<ul style="list-style-type: none"> <li>• Business community, local government beyond departments working with special populations.</li> <li>• Key players are education and behavioral health provider. Opportunities in health care setting and focusing on reducing social isolation through collaboration, agrees that business community is valuable.</li> <li>• Older adults themselves may be missing as well as APS.</li> </ul>
<b>Community based process and Problem Identification or Referrals and services</b>	<ul style="list-style-type: none"> <li>• Religious organizations, fraternal orders, and civic organizations. Law enforcement is absent from collaborations. When they are invited, I can hear their eyes roll.</li> <li>• Some schools do not participate. Youth service organizations are needed.</li> <li>• Arizona Youth Service – access to data on youth.</li> <li>• Universities</li> <li>• Social justice systems. They can help with prevention efforts.</li> <li>• Community volunteers</li> </ul>



# Environmental Factors and Plan

## 9. Statutory Criterion for MHBG - Required for MHBG

### Narrative Question

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#### Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

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### Please respond to the following items

#### Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

AHCCCS is the agency responsible for matters related to behavioral health and substance use, and provides oversight, coordination, planning, administration, regulations, and monitoring of all facets of the public behavioral health system in Arizona. AHCCCS contracts with Regional Behavioral Health Authorities (RBHAs) and Managed Care Organizations (MCOs) to oversee the provision of comprehensive physical and behavioral health services to eligible persons with a Serious Mental Illness (SMI) designation or Serious Emotional Disturbance (SED).

AHCCCS also operates the American Indian Health Program (AIHP), a Fee-For-Service program that is responsible for care for American Indian members who select AIHP. AHCCCS has intergovernmental agreements with the Tribal Regional Health Authorities (TRBHAs) for the coordination of behavioral health services for American Indian members enrolled with the TRBHA.

There is an array of outpatient covered health services for individuals diagnosed with a SMI, SED, general mental health (GMH) disorders, substance use disorders (SUDs), and those individuals with co-occurring mental health and substance use disorders. A vast majority of the outpatient services are delivered at Integrated Health Homes/Integrated Clinics, Outpatient Treatment Clinics, Outpatient Substance Use Clinics, Medication Assisted Treatment (MAT) Clinics, and Federally Qualified Health Clinics. The goal is to serve the whole person and to provide behavioral, medical, and physical health services. Most of the facilities have primary care physicians on site to address physical health needs; this also includes pharmacy and laboratory services. If a clinic/facility site does not have integrated care or primary care services on site, it is the expectation that staff provide coordination of care between behavioral, medical, and physical health providers to ensure the needs of the whole person are addressed. This integrated system allows for reduced fragmentation and improved health outcomes for members.

AHCCCS has participated in the Targeted Investment Program which has driven the implementation of integrated care across the State of Arizona. Individuals with an SMI designation or SED are offered an array of covered health and community based services, including, but not limited to:

For adult members:

Case Management

Assertive Community Treatment (ACT) as determined by need

Supportive Level of Care as determined by need

Connective Level of Care as determined by need

Psychiatric services and assignment to a Behavioral Health Medical Provider

Evaluation and assessments

Medication/Medication Management

Nursing Services

Rehabilitation Services

Employment Services

Educational Services

Housing Services and Community Living Support

Applications, rental assistance

Primary Care Services and coordination of care between behavioral health and medical/physical providers

Substance Use services, referrals, and coordination of care

MAT as indicated

Substance Use Counseling (both individual and group as indicated) provided by Substance Use Specialists/Counselors

Coordination of crisis services as determined by need



As an example: a Crisis Mobile Team visits/Well Watch if a person is experiencing symptoms of their illness  
Crisis Mobile Team visits/Well-Watch can occur during the day, evenings, weekends and can be coordinated 24/7 to ensure a person has the supports to assist them through a challenging time.

Counseling services

Individual

Group

Non-emergent transportation and/or coordination of transportation services

Peer Support Services

Family Support Services

Assistance with applying for benefits

AHCCCS/Medicaid benefits

Social Security

Food Stamps

Public Assistance

Evidenced Based Practices (EBP) coordination of care/referrals, as indicated

Assertive Community Treatment (ACT)

Cognitive Behavioral Therapy (CBT)

Dialectical Behavior Therapy (DBT)

Applied Behavior Analysis (ABA)

Trauma Informed Care

American Association of Addiction Medicine/ASAM CONTINUUM assessment for persons with substance use challenges to determine levels of care

Motivational Interviewing

Other EBP's as indicated by assessments and treatment planning

Coordination of care and referrals to community based services and natural supports

Overall development of an Individual Services Plan (ISP) to address the unique needs of the whole person

For children/adolescents, including those with a SED, AHCCCS has implemented the Child and Family Team (CFT) practice. The CFT practice is utilized with all Medicaid eligible children, adolescents and young adults under the age of 21, who are receiving services through the children's T/RBHA system. The CASII is implemented with all children and adolescents ages six to 18 who are receiving services through the T/BRHA system.

The behavioral health services provider is responsible for facilitating a CFT practice; the CFT facilitator for a child and family with complex needs has the specialized training and skill set to perform this function. The CFT is meant to facilitate a consensus in the development of the child's/adolescents' service plan goals and interventions. The child/adolescent, their family members (biological, foster parents, other individuals of support, as determined), Department of Child Safety (DCS) case manager/s, behavioral health case manager/s, advocates can also learn to lead CFTs.

In the Arizona CFT practice model, it is the child's and family's complexity of needs that drive the development, integration, and individualization of service delivery. The level of complexity is determined individually with each child and family. One variable that is considered when determining complexity of needs for children is the involvement of other child-serving agencies, such as Juvenile Justice (Probation or Parole), Department of Economic Security/Division of Developmental Disabilities (DES/DDD), Department of Child Safety (DCS), and education (Early Intervention or Special Education). The number of system partners involved and invited to participate in CFT practice by the child and family will contribute to the level of service coordination required, as well as consideration by team members of the individual mandates for each agency involved.

A child's and family's overall health status also contributes to their complexity of needs and subsequent level of service intensity. For children with a SED and/or chronic physical condition, symptoms associated with their physical or behavioral health condition can impact their level of functioning in multiple life domains and may result in the use of medications that are monitored through a Behavioral Health Medical Practitioner (BHMP) and/or primary care physician (PCP). Thus, the intensity of service integration through CFT practice is dependent on the level of coordination necessary to support the child and family in making progress toward identified goals in their Individual Service Plan (ISP). Several stressors/risk factors are considered by the CFT when reviewing the child's and family's level of complexity, including environmental stressors such as changes in primary caregiver, inadequate social support, housing problems, mental health or substance use concerns. The team also considered out-of-home setting (group home, therapeutic foster care, etc.) and use of crisis or inpatient services.

One method for determining complexity of needs and intensity of service delivery is through the application of the CALOCUS for children ages six to 18. This instrument consists of six dimensions for assessment of service intensity: risk of harm, functional status, co-occurrence of conditions, recovery environment, resiliency, and/or response to services and involvement in services.

For individuals with co-occurring mental health and substance use disorders, outpatient providers provide MAT services, prevention, treatment, ongoing SUD counseling, coordination of care, and referrals to community based services; this also includes natural supports and resources such as Alcoholics Anonymous, Narcotics Anonymous, AI-Anon, etc.

MAT is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use

disorders. For those with an opioid disorder (OUD), medication addresses the physical challenges that one experiences when they stop taking opioids. MAT can help to re-establish normal brain function, reduce substance cravings, and prevent relapse. The longer a person engages in the treatment, the more the individual will be able to manage their dependency and move forward toward recovery.

An important piece of the MAT approach is that the medications are “assisting” other components of treatment. To increase the benefit that individuals receive from psychosocial intervention, services should be best practice. Some examples of best practice for persons who have substance use disorders include, Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Moral Reconciliation Therapy, Peer and Recovery Support Services, Twelve Step Facilitation, and Contingency Management. Arizona has 24/7 Access Point Locations providing opioid treatment services 24 hours a day, seven days a week to serve individuals seeking treatment.

MAT services are offered in various settings including Opioid Treatment Programs (OTPs) and Office-Based Opioid Treatment (OBOTs). An OTP is any treatment program certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide medication-assisted treatment for persons diagnosed with OUD. These programs are authorized to administer and distribute all forms of MAT: methadone, buprenorphine (Suboxone/Subutex) and naltrexone. Additional support services within the OTP may include case management, peer support, individual counseling, group counseling, and other types of support services.

An OBOT program allows for a qualified primary care physician (PCP) to provide opioid treatment services in their office based settings. Federal guidelines allow qualified physicians in the OBOT to prescribe medications for OUD in their office setting although it is required that the physician has the ability to connect their patients to the appropriate level of counseling and other appropriate services, as indicated by the needs of the individual and their treatment plan.

AHCCCS also supports evidence-based Permanent Supportive Housing (PSH) models, including Housing First, for serving persons experiencing homelessness, persons with behavioral health needs including mental illness or substance use disorders (SUD) and/or other hard to serve populations is premised on: 1) access to and availability of both affordable housing subsidies and capacity, and 2) individualized wrap around housing focused supportive services to support housing placement, stability and coordination with member’s other service goals and resources.

AHCCCS addresses transitions from the Arizona State Hospital, through the screening of members to be discharged to be matched with an appropriate team to address the coordination of support services such as supported employment and education and Peer Recovery Support.

AHCCCS has partnerships and an Interagency Service Agreements (ISA) with the Rehabilitation Services Administration (RSA) Vocational Rehabilitation (VR) to connect members to employment and educational support and opportunities. The VR program provides a variety of services to persons with disabilities and, with the ultimate goal to prepare for, enter into and/or retain employment. The VR program is a public program funded through a federal/State partnership and administered by the RSA, which in Arizona falls under the Arizona Department of Economic Security (DES).

Additionally and not related to the ISA, RSA/VR has assigned one of their offices to work with individuals transitioning to the community from the Arizona State Hospital and also has a VR Counselor assigned to the Human Services Campus. The VR Counselor at the Human Services Campus assists people who are experiencing homelessness and housing insecurity and wanting to re-enter the workforce. The Human Services Campus is Maricopa’s largest homeless services provider.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

- a) Physical Health  Yes  No
- b) Mental Health  Yes  No
- c) Rehabilitation services  Yes  No
- d) Employment services  Yes  No
- e) Housing services  Yes  No
- f) Educational Services  Yes  No
- g) Substance misuse prevention and SUD treatment services  Yes  No
- h) Medical and dental services  Yes  No
- i) Support services  Yes  No
- j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)  Yes  No
- k) Services for persons with co-occurring M/SUDs  Yes  No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.) AHCCCS' System of Care is a spectrum of effective community-based services and supports for individuals with, or at risk for, mental health or other challenges and their families that is organized into a coordinated network, builds meaningful partnerships with members and their families, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

Providers, MCOs and FFS Programs are required to ensure delivery of services is consistent with the following values, principles, and goals:

1. Timely access to care,
2. Culturally competent and linguistically appropriate care,
3. Identification of the need for and the provision of comprehensive care coordination for health service delivery,
4. Integration of clinical and non-clinical health care related services,
5. Education and guidance to providers on service integration and care coordination,
6. Provision of chronic disease management including self-management support,
7. Provision of preventive and health promotion and wellness services,
8. Adherence with the Adult Behavioral Health Service Delivery System-Nine Guiding Principles, and the Arizona Vision and Twelve Principles for Children Behavioral Health Service Delivery,
9. Promotion of evidence-based practices through innovation,
10. Expectation for continuous quality improvement,
11. Improvement of health outcomes,
12. Containment and/or reduction of health care costs without compromising quality,
13. Engagement of member and family members at all system levels,
14. Collaboration with the greater community,
15. Maintenance, rather than delegation of, key operational functions to ensure integrated service delivery,
16. Embrace of system transformation, and
17. Implementation of health information technology to link services and facilitate improved communication between treating.

AHCCCS has developed an Adult System of Care (ASOC) following the Nine Guiding Principles to promote a recovery focused continuum of coordinated community and facility based services and supports for adults with, or at risk for, behavioral health challenges. The ASOC is organized into a comprehensive network to create opportunities to foster recovery and improving health outcomes by:

Building meaningful partnerships with individuals served,  
Addressing the individuals' cultural and linguistic needs and preferences, and  
Assisting the individual in identifying and achieving personal and recovery goals.

Within the Children's System of Care, Arizona's Child and Family Team (CFT) practice model blends shared concepts of the 12 Arizona Principles with the 10 Principles of Wraparound: family voice and choice, team based, natural supports, collaboration, community based, culturally competent, individualized, strengths based, unconditional, and outcome based. The CFT considers involvement of the child in Juvenile Justice (Probation or Parole), Department of Economic Security/Division of Developmental Disabilities (DES/DDD), Department of Child Safety (DCS), and Education (Early Intervention or Special Education). The number of system partners involved and invited to participate in CFT practice by the child and family, contributes to the level of service coordination required, as well as consideration by team members of the individual mandates for each agency involved. Providers are required to incorporate the Arizona Model in all aspects of service delivery to children and families at all levels of need/acuity as well as children with complex needs or who are determined to have a SED.

In collaboration with the child and family and others, MCOs are required to provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services are tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child's family's cultural heritage.

AHCCCS further requires that MCOs develop, manage, and monitor provider use of Evidence Based Programs and Practices (EBPP) including, but not limited to:

1. Intake, assessment, engagement, treatment planning, service delivery, inclusion of recovery interventions, discharge planning, relapse prevention planning, harm reduction efforts, data and outcome collection, and post-discharge engagement,
2. EBPPs used by all providers for the treatment of SUD, including MAT, integrated into services as appropriate,
3. Trauma Informed Care,
4. Gender based treatment,
5. LGBTQIA+,
6. Culturally appropriate,
7. Criminal Involvement,

8. Adolescent specific, and
9. Development and use of Promising Practices, if no EBPP is available.

3. Describe your state's case management services

AHCCCS covers provider case management as a supportive service intended to improve treatment outcomes and meet individuals' Service or Treatment Plan goals. Examples of case management activities include but are not limited to:

Assistance in maintaining, monitoring, and modifying behavioral health services.

Assistance in finding necessary resources other than behavioral health services.

Coordination of care with the individual/Health Care Decision Maker (HCDM), designated representative (DR), healthcare providers, family, community resources, and other involved supports including educational, social, judicial, community, and other State agencies.

Coordination of care activities related to continuity of care between levels of care (e.g. inpatient to outpatient care) and across multiple services (e.g. personal care services, nursing services, and family counseling) and providers.

Assisting individuals in applying for Social Security benefits when using the SSI/SSDI Outreach, Access, and Recovery (SOAR) approach.

Outreach and follow-up of crisis contacts and missed appointments.

Provider case managers are responsible for monitoring the individual's current needs, services, and progress through regular and ongoing contact with the individual. The frequency and type of contact is determined during the treatment planning process, and is adjusted as needed, considering clinical need and individual preference, though generally falls within one of the following categories

1. Assertive Community Treatment (ACT) Case Management (Adult): One component of a comprehensive model of treatment based upon fidelity criteria developed by the Substance Abuse and Mental Health Services Administration. ACT case management focuses upon individuals with severe and persistent mental illness that seriously impairs their functioning in community living, in conjunction with a multidisciplinary team approach to coordinating care across multiple systems (e.g., social services, housing services, health care).

2. High Needs Case Management (Children/Adolescents): Focuses upon providing case management and other support and rehabilitation services to children with complex needs and multiple systems involvements for whom less intensive case management would likely impair their functioning. Children with high service intensity needs who require the assignment of a high needs case manager are identified as:

a.

Children 0 through five years of age with two or more of the following:

i. Other agency involvement; specifically: Arizona Early Intervention Program (AzEIP), DCS, and/or DES/DDD, and/or

ii. Out of home placement for behavioral health treatment (within past six months), and/or

iii. Psychotropic medication utilization (two or more medications), and/or

iv. Evidence of severe psycho-social stressors (e.g., family member serious illness, disability, death, job loss, eviction), and

b. Children six through 17 years of age: CALOCUS level of 4, 5, or 6.

3. Medium Level of Intensity Case Management (Adult): Focuses upon individuals for whom less intensive case management would likely impair their functioning. Supportive case management provides assistance, support, guidance and monitoring in order to achieve maximum benefit from services. Caseloads may include individuals with an SMI designation as well as individuals with a general mental health condition or substance use disorder as clinically indicated.

4. Low Level of Intensity Case Management (Adult): Focuses on individuals who have largely achieved recovery and who are maintaining their level of functioning. Case management involves careful monitoring of the individual's care and linkage to service. Caseloads may include both individuals with an SMI designation as well as individuals with a general mental health condition or substance use disorder as clinically indicated.

In addition to the levels of Case Management, as listed above, Forensic Assertive Community Treatment Teams (FACT) were also created in Maricopa County, Arizona. The FACT teams address the unique needs of people who have been diagnosed with a SMI and are justice involved and have had involvement with the criminal justice system. The goal of the FACT teams is to reduce recidivism and assist members with high needs through an array of community based services, resources and supports.

The FACT team utilizes evidence-based practices to:

Identify and engage members with complex, high needs,

Remove barriers to services and supports,

Address the whole person and provide a full range of community-based services and supports wherever and whenever they are needed, and

Reduce hospitalizations and contact with the criminal justice system, improve health outcomes, and help establish and strengthen natural community supports.

FACT team employees have experience in psychiatry, nursing, social work, rehabilitation services, substance-abuse interventions, employment support, independent-living skills, and housing. A key member of the team is a peer who has lived experience with behavioral health challenges and prior interaction with the criminal justice system. The team assists members with adhering to treatment plans, activities of daily living, employment-related services, finding and maintaining affordable housing, budgeting, obtaining benefits, and engaging in community activities through delivering services in accordance with SAMHSA evidence-based practices (EBP/s).

AHCCCS/Maricopa County also developed Medical Assertive Community Treatment Teams (MACT). MACT employees have experience in psychiatry (Behavioral Health Medical Provider), nursing, social work, rehabilitation services, substance use specialists (licensed) who provide individual and group counseling, interventions/supports, employment support, independent living skills, and

housing supports. The difference between a regular ACT team and the MACT team is that the individuals not only have an SMI designation but also have significant medical comorbid conditions. The MACT team employs a Primary Care Medical Provider and monitors closely the medical and physical condition of the member along with their behavioral health condition.

MCOs are required to submit an annual Provider Case Management Plan that addresses how the Contractor will implement and monitor provider case management standards and caseload ratios for adult and child individuals. The Provider Case Management Plan includes performance outcomes, lessons learned, and strategies targeted for improvement.

MCOs must also ensure that provider sites where provider case management services are delivered have regular and ongoing member and/or family participation in decision making, quality improvement, and enhancement of customer service.

**4.** Describe activities intended to reduce hospitalizations and hospital stays.

AHCCCS' System of Care includes a comprehensive continuum of coordinated community and facility based services and supports for adults with, or at risk for, behavioral health challenges and for children with a SED. Case managers are responsible for monitoring the individual's current needs, services, and progress through regular and ongoing contact with the individual. The frequency and type of contact is determined during the treatment planning process, and is adjusted as needed, considering clinical need, and individual preferences. The goal is to provide services in the least restrictive environment/setting and to provide outpatient services and community supports to divert crisis presentations and inpatient admissions.

Case management services, home visits (face -o-face depending on the situation and virtual due to COVID-19), appointments with the Behavioral Health Medical Provider, counseling, and other supports are available. These services are intended to address the treatment needs of a person to assist them in the community and have an impact on reduced hospitalizations and crisis situations. Regular and ongoing contact with the person, their family or other persons of support is essential to assisting them during their recovery journey.

In the event of a hospitalization, MCOs, RBHAs, and providers are required to track inpatient admissions, lengths of stay, and discharge dates. MCOs and RBHAs have care managers that track and monitor the status of individuals in hospitals/inpatient facilities to ensure coordination of care and discharge planning occurs to reintegrate back to the community. There are inpatient protocols in place for case managers/providers to have ongoing contact with the inpatient social workers and Behavioral Health Medical Providers, while the person is inpatient, to ensure coordination of care, and appropriate discharge planning occurs.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

**Criterion 2**

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	0.26%	0.07%
2.Children with SED	1.17%	0.61%

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Statewide Prevalence (B):

To calculate the Statewide Prevalence (B) of Adults with SMI, the following formula was used:

Prevalence Rate = (All new and pre-existing cases of a specific disease during a given time period) / (Total Population during the same time period) and expressed as a %.

Where the numerator (All new and pre-existing cases of a specific disease during a given time period) is equal to all individuals age 18 or older who had an SMI designation (case) during the time period of 7/1/2020 - 6/30/2021. And the denominator (Total Population during the same time period), is equal to the total state population of individuals 18 or older during the same time period.

Therefore, the Statewide Prevalence Rate (B) of Adults with SMI is equal to (The total number of individuals 18 or older identified with a new/pre-existing SMI case between 7/1/2020 - 6/30/2021) over (The total state population of individuals 18 or older during the same time period) expressed as a %.

To calculate the Statewide Prevalence (B) of Children with SED, the following formula was used:

Prevalence Rate = (All new and pre-existing cases of a specific disease during a given time period) / (Total Population during the same time period) and expressed as a %.

Where the numerator (All new and pre-existing cases of a specific disease during a given time period) is equal to all individuals age younger than 18 who had an SED diagnosis (case) during the time period of 7/1/2020 - 6/30/2021. And the denominator (Total Population during the same time period), is equal to the total state population of individuals younger than 18 during the same time period.

Therefore, the Statewide Prevalence Rate (B) of Children with SED is equal to (The total number of individuals younger than 18 identified with a new/pre-existing SED case between 7/1/2020 - 6/30/2021) over (The total state population of individuals younger than 18 during the same time period) expressed as a %.

Statewide Incidence (C):

To calculate the Statewide Incidence (C) of Adults with SMI, the following formula was used:

Incidence Rate = (Total number of new cases of specific disease during a given time period) / (Total population at risk during the same time period) and expressed as a %.

Where the numerator (Total number of new cases of a specific disease during a given time period) is equal to all individuals age 18 or older who had an SMI designation (case) during the time period of 7/1/2020 - 6/30/2021. And the denominator (Total Population at risk during the same time period), is equal to the total state population of individuals 18 or older during the same time period.

Therefore, the Statewide Incidence Rate (C) of Adults with SMI is equal to (The total number of individuals 18 or older identified with a new SMI case between 7/1/2020 - 6/30/2021) over (The total state population of individuals 18 or older at risk during the same time period) expressed as a %.

To calculate the Statewide Incidence (C) of Children with SED, the following formula was used:

Incidence Rate = (Total number of new cases of specific disease during a given time period) / (Total population at risk during the same time period) and expressed as a %.

Where the numerator (Total number of new cases of a specific disease during a given time period) is equal to all individuals age younger than 18 who had an SED diagnosis (case) during the time period of 7/1/2020 - 6/30/2021. And the denominator (Total Population at risk during the same time period), is equal to the total state population of individuals younger than 18 during the same time period.

Therefore, the Statewide Incidence Rate (C) of Children with SED is equal to (The total number of individuals younger than 18 identified with a new SED case between 7/1/2020 - 6/30/2021) over (The total state population of individuals younger than 18 at risk during the same time period) expressed as a %.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs.

**Criterion 3**

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

- a) Social Services  Yes  No
- b) Educational services, including services provided under IDE  Yes  No
- c) Juvenile justice services  Yes  No
- d) Substance misuse prevention and SUD treatment services  Yes  No
- e) Health and mental health services  Yes  No
- f) Establishes defined geographic area for the provision of services of such system  Yes  No



## Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

**Criterion 4****a.** Describe your state's targeted services to rural population.

AHCCCS contracts with Regional Behavioral Health Authorities (RBHAs) to cover over one million Arizonans throughout the state including rural and tribal areas. For the purposes of RBHA coverage, Arizona is divided into three Geographic Services Areas (GSAs) to serve the unique needs of each region of the state. While all three GSAs include rural areas, the northern and southern GSAs include most of the rural counties and regions characterized by low general population and population densities. A significant portion of Arizona's geography consists of reservation and tribal lands and similar to the RBHA structure, there are four Tribal Regional Behavioral Health Authorities (TRBHAs) that fulfill similar roles for their designated tribal groups. Each of these groups is responsible under contract with AHCCCS to establish a services network that meets the contractual requirements for all RBHAs while allowing the RBHA or TRBHA to address the specific needs of their GSA including delivery of services in a rural context. Within this service network, AHCCCS has Non-Title XIX/XXI state general funds to provide housing subsidies for persons experiencing homelessness who have a Serious Mental Illness (SMI) designation. As with other AHCCCS programs and services, these housing subsidies and supports are also allocated to each GSA and provide housing to both urban and rural populations. Homeless coordination is one way in which the RBHA/TRBHA structure meets the needs of rural communities and how collaboration and coordination with other systems have directly improved care and services for members in rural areas. AHCCCS Contractor Operations Manual Policy 448 (Housing) policies require all RBHA and TRBHA contractors and their networks of clinics, services, and housing programs to participate in the local HUD Continuum of Care (CoC) for their jurisdiction. This includes participation, when possible, in local case conferencing, homeless coordinated entry systems, care coordination, and regional homeless planning efforts. For RBHAs and TRBHAs serving rural or tribal Arizona areas, participation is in the Balance of State CoC (BoSCoC covers the 13 rural counties of Arizona outside of Maricopa County/Phoenix and Pima County/Tucson) and HMIS system. In addition to the aforementioned participation in regional planning and other coordination efforts, RBHA and their providers have established innovative partnerships to increase services to SMI and other persons with behavioral health needs in rural areas. For example, in many rural southern Arizona counties, there are no homeless service sites, shelters, or facilities to serve as HUD CoC Coordinated entry sites for purposes of connecting homeless persons, including those with mental health needs, to HUD homeless programs and housing. To address this, the southern RBHA, Arizona Complete Health (AZCH) required all of their health homes and housing providers to serve as CoC Coordinated Entry sites for persons with behavioral health needs. This includes conducting CoC required housing assessments, HMIS data entry, and enrollment on the local by name list of persons seeking CoC housing. The site can also enroll the individual, if eligible, in AHCCCS housing programs in addition to other Medicaid covered services. AHCCCS is currently working with its northern RBHA, and the BoSCoC to replicate the southern structure in its northern RBHA and network. Similarly, rural communities and counties in Arizona have had the opportunity to apply for Project for Assistance to Transition from Homelessness (PATH) grants during open procurement opportunities as administered by AHCCCS. PATH teams serving the BoSCoC also coordinate with the regional CoCs and serve as coordinated entry points to enroll members in CoC services and housing lists especially in rural areas where homeless shelters, service sites, or access points may be limited.

PATH utilizes federal and state funding dollars to contractors who serve as a point of contact for food, clothing, water, blankets, shelter, and other basic living skills individuals require to reduce homelessness for individuals with an Serious Mental Illness (SMI) designation. PATH funding is critical in creating linkages with the behavioral health crisis system, aiding enrollment into the behavioral health system, obtaining medical records, picture ID, and social security cards. PATH funding also allows for affordable housing options and conducting outreach and in-reach to adults 18 and over who are chronically homeless and have a Serious Mental Illness diagnosis.

PATH services are provided in Coconino, Mohave, and Yavapai counties through Catholic Charities; in Maricopa County through Community Bridges Inc; Cochise County through Good Neighbor Alliance; and in Pima County through La Frontera. Of those counties where services are provided, the majority of the population served is rural. The targeted services provided by PATH providers are outreach services (i.e., case management, peer support, housing services, individual living skills, etc.); Screening and diagnostic treatment (i.e. SMI determinations); Habilitation and rehabilitation; community mental health (i.e., create linkages with behavioral health system); Substance use treatment; Referrals for primary healthcare, job training, educational services, and housing services, and SOAR.

**b.** Describe your state's targeted services to the homeless population.

The Arizona Health Care Cost Containment System (AHCCCS) is awarded the Project for Assistance to Transition from Homelessness (PATH) funding from SAMHSA. Arizona finalized a competitive Request for Proposal (RFP) to PATH contractors in May 2020. These current contracts are for three initial years with two one-year options to extend, not to exceed a total contracting period of five years.

AHCCCS receives the PATH grant to provide outreach services to persons who are homeless, at risk of becoming homeless, and those with an SMI designation, including those with a co-occurring substance use disorder to six out of the fifteen counties in

Arizona; Maricopa, Pima, Cochise, Coconino, Yavapai, and Mohave. For Fiscal Year (FY) 2021 Arizona was allotted \$1,349,288 with a minimum match of \$449,763. The PATH grant provides an array of services, which include; community health screening, case management, and outreach to locations where homeless individuals commonly gather, (i.e., food banks, parks, vacant buildings, and the streets). PATH staff provides community education, field assessments and evaluations, hotel vouchers in emergent situations, assistance in meeting basic needs such as: food stamps, health care, and applying for Medicaid and/or SSI/SSDI. Additionally, PATH staff can assist individuals in obtaining behavioral health case management, medications, moving assistance, and referrals for transitional and permanent housing. Services are documented within each individual's case plan and the case plan is updated as needed, or every six months.

AHCCCS works with the aforementioned state partners, health plans and other stakeholders to provide needed services to homeless individuals. Statewide PATH teams are integrated into CoC HMIS coordination activities including coordinated entry, case conferencing, and use of By Name List to prioritize housing for most vulnerable at risk persons. On an annual basis, funded contractors, volunteers perform a point-in-time street shelter count to determine the number of individuals in Arizona, those with an SMI designation, or co-occurring illness substance disorder.

The table below is 2020 broken out by each county within Arizona.

County/Total Homeless Count/Unsheltered

Maricopa (Phoenix): 7,419/3,767

Pima (Tucson): 1,166/579

Balance State: 1,175/1,061

The PATH contractors utilize best or promising practices to target street outreach and case management to serve the most vulnerable adults who are literally or chronically homeless. Once the individual is enrolled into the PATH program, the PATH Contractor will assist with applying for mainstream services such as SSI/SSDI, housing, Temporary Assistance for Needy Families, food stamps, medical resources, etc. Services are documented within the individual's case plan and the case plan will be updated as needed or every three (3) months.

AHCCCS has recognized the importance of housing not only in solving homelessness, but as a social determinant and key factor in improving member health outcomes and reducing health care costs, especially for persons experiencing homelessness with physical or mental health issues. Through state XIX/XXI funds, AHCCCS is able to provide housing subsidies for approximately 2,800 persons each year. These housing subsidies are targeted primarily to serve homeless persons with an SMI designation, although limited subsidies are also available for homeless persons identified with General Mental Health/Substance Use Disorders. All AHCCCS housing funds are currently administered through the RBHAs for each GSA, but beginning in October of 2021, AHCCCS housing will be managed by a contracted statewide Housing Administrator to standardize processes and increase programmatic effectiveness.

AHCCCS also received limited Non-Title XIX/XXI state capital funding to allow it to acquire additional SMI homeless housing capacity. Despite these resources, current statewide housing waitlists of homeless persons with an SMI designation average between 2,800 to 3,000 persons at any given time due to need. AHCCCS endorses evidence-based permanent supportive housing (PSH) and "Housing First" approaches in its housing programs. To this end, members receiving housing subsidies to address their homelessness also receive individualized wrap-around supportive services to assist members in attaining and maintaining housing. To this end, most wrap-around supportive services are Medicaid reimbursable through AHCCCS's Managed Care Organizations (MCOs).

To evaluate the efficacy of AHCCCS housing programs, AHCCCS compared health care utilization and expenditures of members placed in its housing programs a year prior to their housing placement while homeless to their utilization and costs in the year subsequent to their housing placement. Data showed significant decreases in crisis and inpatient health and behavioral health utilization including a 31 percent reduction in emergency department visits, 44 percent reduction in inpatient admissions, and an 89 percent reduction in behavioral health residential facility admissions. Overall, members in housing showed a 45 percent reduction in total cost of care for an average cost reduction of \$5,563 per month per member across the 3,040 persons in the evaluation. In recognition of the impact of housing and housing services, housing is a major focus of AHCCCS current Whole Person Care Initiative to address social risk factors to health. As part of this initiative, AHCCCS has submitted an amendment to its 1115 Medicaid waiver renewal to CMS.

The Housing and Health Opportunities (H2O) proposal seeks to further expand Medicaid reimbursable housing supports and wrap around services to persons with an SMI designation as well as other homeless sub populations including persons with physical disabilities and physical health care conditions, young adults, and others with frequent inpatient or crisis utilization. Key waiver amendment service enhancement proposals include allowing for additional homeless transitional settings to expedite persons moving out of homelessness and into permanent housing, one-time housing supports including rent deposits, move-in assistance and eviction prevention services, increase of eligible populations for wrap around housing supports and increased outreach capacity to expand coverage. AHCCCS anticipates CMS response to its amendment in the current waiver renewal process. AHCCCS is also working closely with the local Continuum of Care in Arizona, its sister state agencies, and other key stakeholders to expand homeless services and housing options.

AHCCCS is also involved in a number of data sharing efforts to increase coordination with the homeless system. In June, AHCCCS began a HMIS/AHCCCS data share to better serve homeless persons with potential COVID-19 infections. Names and locations of individuals screened and identified with COVID-19 in HMIS experiencing homelessness, including those with an SMI determination, were provided to their MCOs and providers for follow up. This resulted in significant care coordination improvement and follow up including clinical re-engagement, housing placement, and outreach. Based on this and other homeless collaborations and data sharing efforts, AHCCCS is part of a collaborative effort funded by charitable sources to integrate data from all three Arizona CoC HMIS systems, AHCCCS and the Arizona Department of Economic Security (DES). The goal of this sharing is to further understand Arizona's homeless population and needs and to improve coordination between the homeless provider system, AHCCCS/Medicaid resources and mainstream homeless programs. The goal of the grant funding and pilot is to have a functional data sharing infrastructure and system in place by the end of 2022.

AHCCCS' MHBG efforts work in tandem with PATH efforts to ensure PATH enrollees receive the entire continuum of services they may need for recovery. PATH subrecipients are required to have Memorandums of Understanding (MOUs) with local RBHAs and TRBHAs to ensure information sharing, and referral resources as needed between the PATH subrecipients and other administrators of Arizona's behavioral health systems. MHBG subrecipients are held to contractual and policy language regarding the outreach of homeless populations to ensure services are being provided to Arizona's most vulnerable populations. AHCCCS monitors the adherence and compliance to these parameters through various reporting mechanisms, including annual Operational Reviews (ORs). If subrecipients do not meet the requirements through the OR process, AHCCCS develops a Corrective Action plan for the subrecipients and offers technical assistance as needed to the subrecipients.

c. Describe your state's targeted services to the older adult population.

AHCCCS' Arizona Long Term Care System (ALTCS) program has three health plan Contractors that manage care for members who are Elderly and/or have a Physical Disability (EPD). The health plans provide services to AHCCCS members who are elderly (65 and over), blind, or disabled and at risk of institutionalization. ALTCS-EPD members receive all their medical care under the long term care program, including doctor's office visits, hospitalizations, prescriptions, lab work, long term services and supports, and behavioral health services. The ALTCS-EPD program is recognized as a national model for its success in supporting a high percentage of individuals who receive services in their own home or in the community rather than in institutional settings. In an effort to ensure that members have the opportunity to receive services in their own home, the ALTCS health plans, consistent with other health plans, are required to have a Housing Administrator to identify homeless members and/or members with affordable housing needs and leverage community partnerships or other resources to meet those needs.

MHBG subrecipients are held to contractual and policy language regarding the outreach of older adult populations to ensure services are being provided to Arizona's most vulnerable populations. AHCCCS monitors the adherence and compliance to these parameters through various reporting mechanisms, including annual Operational Reviews (ORs). The OR includes the submission of all documentation from the subrecipient to show the progress made, as well as any administration policies, to outreach and engage this population. If subrecipients do not meet the requirements through the OR process, AHCCCS develops a Corrective Action plan for the subrecipients and offers technical assistance as needed to the subrecipients.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

**Criterion 5**

Describe your state's management systems.

AHCCCS leverages several financial resources and funding streams to provide a well-supported network of behavioral health providers to deliver covered services under the various contracted health plans. Although the Division of Grants Administration oversees the administration of grants and other Non-Title XIX/XXI funding, staff work collaboratively across divisions to leverage county, state, and federal dollars (Title XIX/XXI and Non-Title XIX/XXI) effectively and appropriately for services included in the state plan. Title XIX/XXI funds provide care for members' physical and behavioral health care needs, including behavioral health prevention/promotion, treatment, recovery, and other support services under a single one managed care or fee-for-service health plan. Non-Title XIX/XXI funds provide coverage for additional mental health services not covered by Title XIX/XXI, and for certain members who are not eligible for Title XIX/XXI but who meet other eligibility criteria. These other funding sources may include: the Children's Behavioral Health Fund for children's services including SED, the Mental Health Block Grant for SED, SMI, and ESMI/FEP, Maricopa County, Pima and Coconino County funds for certain children's or SMI services and/or Court Ordered Evaluation/Pre-Petition Screening, SMI General Fund, SMI Housing General Fund, Supported Housing General Fund, SMI Housing Trust Fund, Emergency COVID-19 grant for members with co-occurring illness, COVID-19 Emergency Response for Suicide Prevention, and state crisis service dollars.

Each funding source may have its own staffing or training requirements. Larger system training requirements are described below.

In accordance with ACOM Policy 407, AHCCCS requires that Contractors establish and maintain a Workforce Development Operation (WFDO) and employ a Workforce Development Administrator. The WFDO works together with the MCO's Network and Quality Management functions to ensure the provider network has sufficient workforce capacity, and is staffed by a workforce that is interpersonally, clinically, culturally, and technically competent in the skills needed to provide services. The WFDO is the organizational structure MCOs utilize to monitor and assess current workforce capacity and capability, forecast and plan future workforce capacities and capabilities, and, when indicated, deliver technical assistance to provider organizations to strengthen their Workforce Development (WFD) programs. AHCCCS further requires all MCOs to participate in a Single Learning Management System (LMS), and to collaborate with all other AHCCCS MCOs to use the LMS to administer the delivery, documentation, tracking and reporting of all required education and training programs.

AHCCCS requires that Contractors provide, at a minimum, annual training/s to support and develop law enforcement agencies' understanding of behavioral health emergencies and crises. Contractors are also contractually required to have regular and ongoing training for providers to assist members with how to access both Medicaid compensable services as well as Non-Medicaid funded services.

AHCCCS is committed to workforce development and support of the medical residency and dental student training programs in the State of Arizona and expects MCOs to support these efforts. AHCCCS also requires that MCOs attempt to contract with graduating residents and providers that are opening new practices in, or relocating to, Arizona, especially in rural or underserved areas. AHCCCS encourages MCOs to contract with or otherwise support the many Graduate Medical Education (GME) Residency Training Programs currently operating in the State and to investigate opportunities for resident participation in medical management and other committee activities.

In 2018, AHCCCS required all seven new ACC health plans and the three RBHAs to jointly fund a contract between the AZ Association of Health Plans (AzAHP) and an LM provider who would be responsible for operating a single, statewide LMS for physical and behavioral health workforce training. RELIAS was the selected LMS provider and remains under contract to provide LMS support to the MCOs, RBHAs and providers whose workforces use the system to deliver physical and behavioral health services training.

AHCCCS requires the use of an LMS in order to accomplish three goals:

To disseminate computer assisted policy and best practice education and training content to provider organizations across Arizona,

To collect and store training program transcripts and skill competency evaluations for provider staff and to ensure the transcripts and evaluations are available to staff and their employers upon request, and

To report training or competency requirements compliance for all AHCCCS policies or mandated practices requiring specific staff training or competency demonstrations.

The RELIAS LMS automatically collects and stores individual staff training and evaluation records. In addition, the LMS has the capability of supporting traditional in-person training and evaluation events and generating required compliance reporting. Included in the Relias LMS platform are training opportunities for the staff employed at the MCOs, RBHAs and providers to learn about the Mental Health Block Grant and services for members with SED, SMI, and/or ESMI/FEP.

AHCCCS divisions are sensitive and responsive to staffing and training needs for mental health services providers. For example, the AHCCCS Division for Fee for Service Management (DFSM) employs staff responsible for provider trainings, inclusive of behavioral health trainings. Some behavioral health trainings are posted online for ease of access for providers. If a provider has questions regarding billing and coding, they are then routed to the AHCCCS coding team. Additionally, the AHCCCS Division of Community Advocacy and Intergovernmental Relations (DCAIR) conducts educational sessions for individuals in the system, Regional Behavioral Health Authorities (RBHA) staff/provider staff and other stakeholders on various topics. AHCCCS DCAIR and the Office of Individual and Family Affairs (OIFA), have also established training requirements and credentialing standards for Peer and Recovery Support Service (PRSS) providing Peer Support within the AHCCCS programs, including qualifications, supervision, continuing education, and training. These are a few examples of additional mechanisms by which AHCCCS may ensure training for mental health providers.

Additional training is available at the health plan level through their Workforce Development Administrators, and other staff or departments. Some Contractors utilize Project ECHO for optimizing performance and spreading new medical knowledge throughout the provider network in a manner allowing community providers to learn from specialists, from each other, and for specialists to learn from community providers as well. One known example of this is the Early Psychosis Intervention (EPI) Project ECHO in the Northern region of Arizona, where project staff are responsible for providing training and education to community and system partners about the first episode of psychosis, facilitating monthly EPI ECHO sessions around cases and brief lectures. In the Southern region, contractors and providers have used Project ECHO to provide workshops on working with Black, Indigenous, and People of Color (BIPOC) persons and providing trauma-informed and culturally competent care.

#### CALOCUS/LOCUS/ECSII

AHCCCS is currently in the process of implementing the Child and Adolescent Level of Care Utilization System (CALOCUS) as the standardized mechanism for determining the level of intensity in case management supports necessary for children age 6-18. Service intensity assessment and planning is a critical independent element of overall person and family-centered service planning and is a collaborative process between the person or family served and their service providers. Cultural considerations and social determinants of health impact all these dimensions, and the CALOCUS systematically matches individuals and families' dimensional ratings to specific defined levels of case management support to ensure that their needs are met.

The CALOCUS is considered best practice for assessment of service intensity across multiple dimensions, as follows:

1. Risk of Harm
2. Functional Status
3. Medical, Addictive and Psychiatric Co-Morbidity as well as Developmental Disabilities
4. Recovery Environment:
  - O A-Stressors
  - O B-Supports
5. Treatment and Recovery History
6. Engagement and Recovery Status

#### ASAM

AHCCCS is in the process of implementing the ASAM CONTINUUM® assessment tool across the state of Arizona to improve treatment outcomes with greater assessment fidelity and proper level of care placement. This assessment tool provides the entire treatment team with a computerized clinical standard decision support system for assessing members with substance use disorders and co-occurring conditions. This is an evidenced based practice (EBP) established by the American Society of Addiction Medicine (ASAM) to assist clinicians in determining levels of care for persons who have substance use disorders.

AHCCCS has collaborated with the with the Managed Care Organizations (MCO) Workforce Development Administrators, ASAM, FEI Systems and the Arizona Association of Health Plans (AzAHP) to have the ASAM CONTINUUM® assessment training videos hosted on the Relias Learning Management System (LMS) platform. This will assist with "ease of access/use" for clinicians and providers and allow for standardized training reports.

#### Mental Health First Aid

AHCCCS has also implemented Mental Health First Aid Training in Arizona. Statistics show that approximately one (1) million people suffer a heart attack every year and teaching Cardiopulmonary Resuscitation (CPR) has become an important public health education initiative. Meanwhile, one (1) in four (4) Americans experience depression, anxiety and other mental health illnesses and

challenges. Mental Health First Aid may not be a bandage although it is an appropriate and critical part of training and education.

Mental Health First Aid is an eight (8) hour training that is available to anyone age 16 and older interested in learning about mental health. Each session can accommodate 25-33 participants. Participants learn a valuable five (5) step process to assess a situation, select and implement appropriate interventions and help a person experiencing a crisis or who may be exhibiting the signs and symptoms of mental illness.

AHCCCS is offering the training for employees at AHCCCS and there are also several trainings available in the community.

**Footnotes:**



SERVICES <sup>1</sup>		GENERAL FUNDS <sup>2</sup>	MENTAL HEALTH BLOCK GRANT (MHBG) FUNDS		SUBSTANCE ABUSE BLOCK GRANT (SABG) FUNDS	SABG OR MHBG FUNDS FOR TITLE XIX/XXI MEMBERS
			SMI	SED		
Behavioral Health Counseling and Therapy	Individual	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
	Group and Family	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
Screening, Assessment, and Evaluation Services	Screening, Evaluation, Assessment, and Testing	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>





SERVICES		GENERAL FUNDS	MENTAL HEALTH BLOCK GRANT (MHBG) FUNDS		SUBSTANCE ABUSE BLOCK GRANT (SABG) FUNDS	SABG OR MHBG FUNDS FOR TITLE XIX/XXI MEMBERS
		SMI		SED	SUD	SMI, SED, OR SUD
Other Professional	Alcohol and/or drug services: Intensive Outpatient (Treatment Program that operates at least nine hours per week over a minimum of three days and is based on an individualized treatment plan) including assessment, counseling, crisis intervention and activity therapies or education	Not Covered <sup>4</sup>	Not Covered <sup>4</sup>	Not Covered <sup>4</sup>	Covered	N/A <sup>see endnote 3</sup>



SERVICES		GENERAL FUNDS	MENTAL HEALTH BLOCK GRANT (MHBG) FUNDS		SUBSTANCE ABUSE BLOCK GRANT (SABG) FUNDS	SABG OR MHBG FUNDS FOR TITLE XIX/XXI MEMBERS
		SMI		SED	SUD	SMI, SED, OR SUD
Other Professional	Multisystemic Therapy for Juveniles	N/A	N/A	Covered	Covered <sup>5</sup>	N/A <sup>see endnote 3</sup>
	Mental Health Services (Traditional Healing Services) <sup>6</sup>	Covered	Covered	Covered	Covered	Covered
	Auricular Acupuncture <sup>6</sup>	Covered	Covered	Covered	Covered	Covered
Skills, Training and Development, and Psychosocial Rehabilitation Living Skills Training		Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
Cognitive Rehabilitation		Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>

**Exhibit 300-2B - Page 3 of 8**

Effective Dates: 06/13/17, 10/01/19

Approval Dates: 01/01/01, 10/01/01, 06/01/07, 07/01/16, 01/19/17, 03/30/17, 05/02/19



SERVICES	GENERAL FUNDS	MENTAL HEALTH BLOCK GRANT (MHBG) FUNDS		SUBSTANCE ABUSE BLOCK GRANT (SABG) FUNDS	SABG OR MHBG FUNDS FOR TITLE XIX/XXI MEMBERS
		SMI	SED	SUD	SMI, SED, OR SUD
Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion)	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
Psycho Educational Services and Ongoing Support to Maintain Employment	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
Medical Services <sup>7</sup>	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
Laboratory, Radiology, and Medical Imaging	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
Medical Management	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
Electro-Convulsive Therapy (Outpatient)	Covered	Covered	N/A	Not Covered	N/A <sup>see endnote 3</sup>

**Exhibit 300-2B - Page 4 of 8**

Effective Dates: 06/13/17, 10/01/19

Approval Dates: 01/01/01, 10/01/01, 06/01/07, 07/01/16, 01/19/17, 03/30/17, 05/02/19



AHCCCS MEDICAL POLICY MANUAL

EXHIBIT 300-2B, AHCCCS COVERED NON-TITLE XIX/XXI BEHAVIORAL HEALTH SERVICES

SERVICES	GENERAL FUNDS	MENTAL HEALTH BLOCK GRANT (MHBG) FUNDS		SUBSTANCE ABUSE BLOCK GRANT (SABG) FUNDS	SABG OR MHBG FUNDS FOR TITLE XIX/XXI MEMBERS
		SMI	SED	SUD	SMI, SED, OR SUD
Transcranial Magnetic Stimulation (Outpatient)	Covered	Covered	N/A	Not Covered	N/A <sup>see endnote 3</sup>
Case Management	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
Personal Care Services	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
Home Care Training Family (Family Support)	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
Self-Help/Peer Services	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
Therapeutic Foster Care	Not Covered	Not Covered	Covered	Not Covered	N/A <sup>see endnote 3</sup>
Unskilled Respite Care <sup>8</sup>	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
Supported Housing Services <sup>9</sup> (wraparound services)	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>

Exhibit 300-2B - Page 5 of 8

Effective Dates: 06/13/17, 10/01/19

Approval Dates: 01/01/01, 10/01/01, 06/01/07, 07/01/16, 01/19/17, 03/30/17, 05/02/19



SERVICES		GENERAL FUNDS	MENTAL HEALTH BLOCK GRANT (MHBG) FUNDS		SUBSTANCE ABUSE BLOCK GRANT (SABG) FUNDS	SABG OR MHBG FUNDS FOR TITLE XIX/XXI MEMBERS
		SMI		SED	SUD	SMI, SED, OR SUD
Transportation	Emergency	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
	Non-Emergency <sup>10</sup>	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
Child Care <sup>5,11</sup>		Not Covered	Not Covered	Not Covered	Covered	Covered
Crisis Intervention Services	(Mobile Community Based)	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
	(Stabilization, Facility Based)	Covered <sup>11</sup>	Covered <sup>11</sup>	Covered <sup>11</sup>	Covered <sup>11</sup>	N/A <sup>see endnote 3</sup>
	(Telephone)	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
Hospital		Not Covered <sup>12</sup>	Not Covered <sup>12</sup>	Not Covered <sup>12</sup>	Not Covered <sup>12</sup>	N/A <sup>see endnote 3</sup>
Subacute Facility		Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>



**AHCCCS MEDICAL POLICY MANUAL**

**EXHIBIT 300-2B, AHCCCS COVERED NON-TITLE XIX/XXI BEHAVIORAL HEALTH SERVICES**

Residential Treatment Center	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
SERVICES	GENERAL FUNDS	MENTAL HEALTH BLOCK GRANT (MHBG) FUNDS		SUBSTANCE ABUSE BLOCK GRANT (SABG) FUNDS	SABG OR MHBG FUNDS FOR TITLE XIX/XXI MEMBERS
		SMI	SED	SUD	SMI, SED, OR SUD
Behavioral Health Residential Facility (Without Room and Board)	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
Mental Health Services NOS (Room and Board) <sup>6, 13</sup>	Covered	Covered	Covered	Covered	Covered
Supervised Behavioral Health Treatment and Day Programs	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
Therapeutic Behavioral Health Services and Day Programs	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>
Community Psychiatric Supportive Treatment and Medical Day Programs	Covered	Covered	Covered	Covered	N/A <sup>see endnote 3</sup>

**Exhibit 300-2B - Page 7 of 8**

Effective Dates: 06/13/17, 10/01/19

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<sup>1</sup> Provided based upon available funding, these services are not entitlements.

<sup>2</sup> SMI General Fund appropriation can be used for Non-Title XIX/XXI covered services as shown in the Table for Non-Title XIX/XXI funded members who are designated SMI. These funds can also be used for Title XIX/XXI members who are designated SMI who need services that are only available through Non-Title XIX/XXI funding.

<sup>3</sup> Title XIX/XXI Covered Benefit

<sup>4</sup> Non-Title XIX funded members determined to have an SMI or SED who are in need of Substance Use Disorder (SUD) services could be eligible for this SUD service under SABG.

<sup>5</sup> This service is only available for adolescents up until the age of 18 who have an identified Substance Use Disorder.

<sup>6</sup> These services are only available through Non-Title XIX/XXI funding.

<sup>7</sup> See the AHCCCS Behavioral Health Drug List for further information on covered medication. Per AMPM Policy 320-T, medications covered through the SABG are limited to those identified as Medication Assisted Treatment (MAT) medications for opioid or alcohol use disorders and are limited to services treating SUD diagnoses or approved services to treat medical diagnoses related to SUD.

<sup>8</sup> No more than 600 hours of respite care per contract year (October 1 through September 30) per individual.

<sup>9</sup> Limited to comprehensive wraparound services addressing needed support to treat behavioral health symptoms impacting a member's stability in housing, which cannot otherwise be billed under other services. This does not pertain to funding for housing expenses including rental subsidies, move-in kits, assistance with deposits, utility payments, eviction prevention efforts, and property improvements.

<sup>10</sup> Transportation Services for Non-Title XIX/XXI funded members are to be provided in compliance with the requirements in AMPM Policy 310-BB in addition to AMPM Policy 320-T requirements regarding access to care.

<sup>11</sup> Limited to 72 hours

<sup>12</sup> See coverage under Crisis Stabilization facility based

<sup>13</sup> Refer to AMPM Policy 320-T for coverage limitations.

**320-T1 –BLOCK GRANTS AND DISCRETIONARY GRANTS**

EFFECTIVE DATES: 07/01/20 as specified in Section F, MENTAL HEALTH BLOCK GRANT,  
10/01/20

APPROVAL DATES: 05/04/21 Retroactive Approval for 07/01/20 changes, 07/02/20

**I. PURPOSE**

This Policy applies to ACC, DCS/CMDP (CMDP), DES/DDD (DDD), ALTCS E/PD, RBHA Contractors, and other entities who have a direct Non-Title XIX/XXI funded contractual relationship with AHCCCS (collectively ‘Contractors’; and Fee-For-Service (FFS) Programs including: American Indian Health Program (AIHP); TRBHAs; and all FFS populations. This excludes Federal Emergency Services (FES). (For FES, refer to AMPM Chapter 1100). This Policy specifies Non-Title XIX/XXI behavioral health services funded by Block Grants and Discretionary Grants available for members and Care Coordination requirements of all involved entities to ensure each member’s continuity of care.

**II. DEFINITIONS**

**ALLOCATION LETTER** Communication provided by AHCCCS to identify funding not otherwise included in the "Original" Allocation Schedule and specific terms and conditions for receipt of Non-Title XIX/XXI funding.

**ALLOCATION SCHEDULE** The schedule prepared by AHCCCS that specifies the Non-Title XIX/XXI non-capitated funding sources by program including MHBG and SABG Federal Block Grant funds, discretionary grant funds, and other funds, which are used for services not covered by Title XIX/XXI funding and for populations not otherwise covered by Title XIX/XXI funding.

**DISCRETIONARY GRANT** A competitive or non-competitive grant (or cooperative agreement) for which the federal awarding agency generally may select the recipient from among all eligible recipients, may decide to make or not make an award based on the programmatic, technical, or scientific content of an application, and can decide the amount of funding to be awarded.

**EARLY SERIOUS MENTAL ILLNESS (ESMI)** A first onset of serious mental illness which can include a first episode of psychosis and may manifest as symptoms that include problems in perception (such as seeing, hearing, smelling, tasting or feeling something that is not real), thinking (such as believing in something that is not real even when presented with facts), mood, and social functioning.



**ELIGIBLE  
POPULATIONS**

Populations that within a specific grant or funding requirements are identified as the only allowable population on which those specific funds may be expended. Eligible populations are identified using demographic information. Different grants or funding sources may have varying priority populations.

**EVIDENCE  
BASED PRACTICES AND  
PROGRAMS  
(EBPPS)**

An intervention that is recognized as effective in treating a specific health-related condition based on scientific research; the skill and judgment of health care professionals; and the unique needs, concerns and preferences of the individual receiving services.

**FIRST  
EPISODE  
PSYCHOSIS (FEP)  
PROGRAM**

A program focused on the early identification and provision of evidence-based treatment and support services to individuals, who have experienced a first episode of psychosis (FEP) within the past two years. Evidence-based FEP programs have been shown to improve symptoms, reduce relapse, and lead to better outcomes. A commonly used evidenced based model is Coordinated Specialty Care, which is a recovery-based approach that uses shared decision making and offers case management, psychotherapy, medication management, family education and support, and supported education or employment.

**FORMULA GRANT**

Allocations of federal funding to states, territories, or local units of government determined by distribution formulas in the authorizing legislation and regulations. To receive a formula grant, the entity shall meet all the eligibility criteria for the program, which are pre-determined and not open to discretionary funding decisions.

**GENERAL MENTAL  
HEALTH  
(GMH)**

Behavioral health services provided to adult members age 18 and older who have not been determined to have a Serious Mental Illness and have a behavioral health diagnosis other than substance use disorder.

**HIV EARLY  
INTERVENTION  
SERVICES**

HIV Early Intervention Services includes: appropriate pretest counseling, testing for HIV, including tests to confirm the presence of HIV, to diagnose the extent of the deficiency in the immune system, and to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system, and for preventing and treating conditions arising from the disease. Appropriate post-test counseling and Therapeutic measures will also be provided (42 USC § 300x-24(b)(7)).

**HUMAN  
IMMUNODEFICIENCY  
VIRUS  
(HIV)**

Human immunodeficiency virus (HIV) is a Sexually Transmitted Infection (STI) that damages white blood cells that are very important in helping the body fight infection and disease. HIV is also commonly transmitted through direct contact with certain bodily fluids (e.g. sharing syringes for intravenous substance use) such as blood, semen, rectal fluids and vaginal fluids, and breast milk.

**INTERAGENCY SERVICE  
AGREEMENT  
(ISA)**

A contract between state government agencies whereby one agency provides reimbursement for services performed by another agency to carry out the objectives of the funding source. Refer to A.R.S. § 35-148.

**INTERGOVERNMENTAL  
AGREEMENT  
(IGA)**

When authorized by legislative or other governing bodies, two or more public agencies or public procurement units by direct Contract or agreement may contract for services or jointly exercise any powers common to the contracting parties and may enter into agreements with one another for joint or cooperative action or may form a separate legal entity, including a nonprofit corporation to Contract for or perform some or all of the services specified in the Contract or agreement or exercise those powers jointly held by the contracting parties. A.R.S. Title 11, Chapter 7, Article 3 (§ 11-952.A).

**MEMBER**

For purposes of this Policy, an eligible individual who is enrolled in AHCCCS, as defined in A.R.S. § 36-2931, § 36-2901, and A.R.S. § 36-2981, referred to as Title XIX/XXI Member or Medicaid Member. Also, an eligible individual who needs or may be at risk of needing covered health-related services but does not meet Federal and State requirements for Title XIX or Title XXI eligibility, referred to as Non-Title XIX/XXI Member.

**NON-TITLE  
XIX/XXI FUNDING**

For purposes of this Policy, fixed, non-capitated funds, from Block Grants and Discretionary Grants which are used to fund services to Non-Title XIX/XXI members and for medically necessary services not covered by Title XIX or Title XXI programs.

**PRIMARY PREVENTION**

Delivered prior to the onset of a condition, these services or interventions are intended to prevent or reduce the risk of developing a behavioral health or substance use problem.

**PRIMARY PREVENTION  
EVIDENCE BASED  
PRACTICES  
(SUBSTANCE ABUSE  
ONLY)**

Interventions that fall into one or more of three categories:

1. The intervention is included in a federal registry of evidence-based interventions, or
2. The intervention produced positive effects on the primary targeted outcome, and these findings are reported in a peer-reviewed journal, or
3. The intervention has documented evidence of effectiveness, based on guidelines developed by the Center for Substance Abuse Prevention and/or the state, tribe, or jurisdiction in which the intervention took place. Documented evidence should be implemented under four recommended guidelines, all of which shall be followed. These guidelines require interventions to be:
  - a. Based on a theory of change that is documented in a clear logic or conceptual mode,
  - b. Similar in content and structure to interventions that appear in federal registries of evidence-based interventions and/or peer-reviewed journals,
  - c. Supported by documentation showing it has been effectively implemented in the past, multiple times, and in a manner attentive to scientific standards of evidence. The intervention results should show a consistent pattern of credible and positive effects, and
  - d. Reviewed and deemed appropriate by a panel of informed prevention experts that includes qualified prevention researchers experienced in evaluating prevention interventions similar to those under review; local prevention professionals; and key community leaders, as appropriate (for example, law enforcement officials, educators, or elders within indigenous cultures).

**PRIOR PERIOD  
COVERAGE  
(PPC)**

For Title XIX members, the period of time prior to the member's enrollment with a Contractor, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility to the day a member is enrolled with a Contractor. Refer to A.A.C. R9-22-1. If a member made eligible via the Hospital Presumptive Eligibility (HPE) program is subsequently determined eligible for AHCCCS via the full application process, prior period coverage for the member will be covered by AHCCCS Fee for Service and the member will be enrolled with the Contractor only on a prospective basis.

**SECONDARY  
PREVENTION**

Aims to reduce the impact of a behavioral health or substance use disorder that has already occurred. This is done by detecting and treating a behavioral health or substance use disorder as soon as possible to halt or slow its progress, encouraging personal strategies to prevent recurrence, and implementing programs to return people to their original health and function to prevent long-term problems.

**SERIOUS EMOTIONAL  
DISTURBANCE (SED)**

For the purposes of this Policy, a designation for persons from birth until the age of 18 who currently meet or at any time during the past year have met criteria for a mental, emotional, or behavioral disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g. most recent editions of the Diagnostic and Statistical Manual of Mental Disorders [DSM], the International Statistical Classification of Diseases and Related Health Problems [ICD])The disorder shall result in functional impairment, as determined by a standardized measure, which impedes progress towards recovery and substantially interferes with or limits the individual’s role or functioning in family, school, employment, relationships, or community activities. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance, substance use disorder, are attributable to an intellectual developmental disorder, autism spectrum disorder, or are attributable to another medical condition, unless they co-occur with another diagnosable serious emotional disturbance. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

**SERIOUS  
MENTAL ILLNESS  
(SMI)**

A designation as defined in A.R.S. § 36-550 and determined in an individual 18 years of age or older.

**SUBSTANCE USE  
DISORDER (SUD)**

A range of conditions that vary in severity over time, from problematic, short-term use/abuse of substances to severe and chronic disorders requiring long-term and sustained treatment and recovery management.

**TERTIARY PREVENTION** Aims to soften the impact of an ongoing a behavioral health or substance use disorder that has lasting effects. This is done by helping people manage long-term, often-complex health problems and injuries (e.g. chronic diseases, permanent impairments) in order to improve as much as possible their ability to function, their quality of life, and their life expectancy.

### **III. POLICY**

ACC CMDP, DDD, E/PD Contractors, AIHP, and FFS Providers do not receive or administer Non-TXIX/XXI funds. Per the Non-Title XIX/XXI Contracts/IGAs, the RBHAs and TRBHAs are responsible for administering Non-Title XIX/XXI funds. The RBHAs, TRBHAs, and other entities that have a direct Non-Title XIX/XXI funded contractual relationship with AHCCCS shall manage available Non-Title XIX/XXI funds in a manner consistent with the Non-Title XIX/XXI's identified Eligible Populations.

Contractors, TRBHAs, Tribal ALTCS, and Fee-For-Service providers shall assist Members in accessing services utilizing these funding sources and shall coordinate care for Members as appropriate.

#### **A. GENERAL REQUIREMENTS FOR CODING/BILLING**

All applicable Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) for Non-Title XIX/XXI Services are listed in the AHCCCS Behavioral Health Services Matrix (previously referred to as the B2 Matrix) found on the AHCCCS website. Providers are required to utilize national coding standards including the use of applicable modifier(s), as applicable. Refer to the AHCCCS Medical Coding Resources webpage and the AHCCCS Behavioral Health Services Matrix.

For outpatient behavioral health services, services are considered medically necessary regardless of a Member's diagnosis, so long as there are documented behaviors and/or symptoms that will benefit from behavioral health services and a valid ICD-10-CM diagnostic code is utilized.

#### **B. NON-TITLE XIX/XXI BEHAVIORAL HEALTH SERVICES**

AHCCCS covers Non-Title XIX/XXI behavioral health services (mental health and/or substance use) within certain limits for Title XIX/XXI and Non-Title XIX/XXI Members when medically necessary. Behavioral health services covered under the Block and Discretionary Grants are specified below. Refer to AMPM Policy 320-T2 for services covered under Non-Title XIX/XXI Funding (excluding Federal Grant Funds).

For information and requirements regarding Title XIX/XXI Behavioral Health Services, refer to AMPM Policy 310-B.

All services provided shall have proper documentation maintained in the Member's medical records.

For billing limitations, refer to the AHCCCS FFS Provider Manual and AHCCCS Medical Coding Resources webpage.

1. Auricular Acupuncture Services

Auricular Acupuncture services is the application of auricular acupuncture needles to the pinna, lobe, or auditory meatus to treat alcoholism, substance use or chemical dependency by a certified acupuncturist practitioner pursuant to A.R.S. § 32-3922.

2. Childcare Services (also referred to as child sitting services)

Childcare supportive services are covered when providing medically necessary Medicated Assisted Treatment or outpatient (non-residential) treatment or other supportive services for SUD to Members with dependent children, when the family is being treated as a whole. The following limitations apply:

- a. The amount of childcare services and duration shall not exceed the duration of (MAT) or Outpatient (non-residential) treatment or support services for SUD being provided to the Member whose child(ren) is present with the Member at the time of receiving services,
- b. Childcare services shall ensure the safety and well-being of the child while the Member is receiving services that prevent the child(ren) from being under the direct care or supervision of Member,
- c. The child is not an enrolled Member receiving billable services from the provider, and
- d. Other means of support for childcare for the children are not readily available or appropriate.

3. Mental Health Services (Traditional Healing Services)

Treatment services for mental health or substance use problems provided by qualified traditional healers. These services include the use of routine or advanced techniques aimed to relieve the emotional distress evident by disruption of the individual's functional ability.

4. Supported Housing

Supported housing services are provided by behavioral health professionals, behavioral health technicians, or behavioral health paraprofessionals, to assist individuals or families to obtain and maintain housing in an independent community setting including the individual's own home or apartments and homes owned or leased by a provider.

5. Mental Health Services, Room and Board

The provision of lodging and meals to an individual residing in a residential facility or supported independent living setting which may include but is not limited to:

- a. Housing costs,
- b. Services such as food and food preparation,
- c. Personal laundry, and
- d. Housekeeping.

This service may also be used to report bed hold/home pass days in Behavioral Health Residential facilities.

For room and board services, the following billing limitations apply:

- a. All other fund sources (e.g. Arizona Department of Child Safety (DCS) funds for foster care children, SSI) shall be exhausted prior to billing this service, and
- b. For Substance Abuse Block Grant (SABG) funding only, Room and Board services may be available for a Member’s dependent child(ren) as a support service for the Member when they are receiving medically necessary residential treatment services for a SUD. The Room and Board would apply to a Member with dependent children when the child(ren) reside with the Member at the Behavioral Health Residential Facility. The use of this service is limited to:
  - i. Members receiving residential services for SUD treatment where the family is being treated as a whole, but the child is not an enrolled Member receiving billable services from the provider.

#### 6. Other Non-Title XIX/XXI Behavioral Health Services

For Non-Title XIX/XXI eligible populations, most behavioral health services that are covered through Title XIX/XXI funding are also covered through Non-Title XIX/XXI funding including but not limited to: services provided in a residential setting, counseling, case management, and supportive services, but Non-Title XIX/XXI funded services may be restricted to certain Members as described in this Policy and as specified in AMPM Exhibit 300-2B and are not an entitlement. Services provided through Non-Title XIX/XXI funding are limited by the availability of funds.

### C. NON-TITLE XIX/XXI ELIGIBLE POPULATIONS

Non-Title XIX/XXI eligible Members are enrolled with a RBHA or TRBHA and other entities who have a direct Non-Title XIX/XXI funded contractual relationship with AHCCCS, enrollment is based on the zip code or tribal community in which the Member resides. When encounters are submitted for “unidentified” individuals (such as in crisis situations when an individual’s eligibility or enrollment status is unknown), Contractors shall require their providers to use the applicable pseudo-ID numbers that are assigned to each RBHA. For assistance, contact the DHCM/Operations, Encounters Unit. Pseudo-ID numbers are not assigned to TRBHAs. Encounters are not submitted for Prevention services.

Crisis Services for Title XIX/XXI Members: refer to AMPM Policy 310-B for a more detailed description of Crisis Intervention Services and responsibilities.

For Non-Title XIX/XXI eligible Members: RBHAs and TRBHAs are responsible for Crisis Intervention services for Non-Title XIX/XXI eligible Members (up to 72 hours).

### D. SUBSTANCE ABUSE BLOCK GRANT

#### 1. Purpose and Goals

The SABG is a Formula Grant, which supports treatment services for Title XIX/XXI and Non-Title XIX/XXI Members with SUDs and primary substance use and misuse Prevention efforts. The SABG is used to plan, implement, and evaluate activities to prevent and treat SUDs. Grant funds are also used to provide Early Intervention

Services for HIV and tuberculosis disease in high-risk individuals who use substances.

The SABG is specifically allocated to provide services that are not otherwise covered by Title-XIX/XXI funding.

Refer to AMPM Exhibit 300-2B for additional information on SABG covered services.

Goals of the SABG include, but are not limited to the following:

- a. To ensure access to a comprehensive system of care, including employment, housing services, case management, rehabilitation, dental services, and health services, as well as SUD services and supports,
- b. To promote and increase access to evidence-based practices for treatment to effectively provide information and alternatives to youth and other at-risk populations to prevent the onset of substance use or misuse,
- c. To ensure specialized, gender-specific, treatment as specified by AHCCCS and recovery support services for females who are pregnant or have dependent children and their families in outpatient/residential treatment settings,
- d. To ensure access for underserved populations, including youth, residents of rural areas, veterans, Pregnant Women, Women with Dependent Children, People Who Inject Drugs (PWID) and older adults,
- e. To promote recovery and reduce risks of communicable diseases, and
- f. To increase accountability through uniform reporting on access, quality, and outcomes of services.

## 2. Eligible Populations

All Members receiving SABG-funded services are required to have a Title XIX/XXI eligibility screening and application completed and documented in the medical record at the time of intake and annually thereafter.

- a. Members shall indicate active substance use within the previous 12-months to be eligible for SABG treatment services. This includes individuals who were incarcerated and reported using while incarcerated. The 12-month standard may be waived for individuals:
  - i. On medically necessary methadone maintenance upon assessment for continued necessity, and/or
  - ii. Incarcerated for longer than 12 months that indicate substance use in the 12 months prior to incarceration.

## 3. Priority Populations

SABG funds are used to ensure access to treatment and long-term supportive services for the following populations (in order of priority):

- a. Pregnant women/teenagers who use drugs by injection,
- b. Pregnant women/teenagers with a SUD,
- c. Other persons who use drugs by injection,
- d. Women and teenagers with a SUD, with dependent children and their families, including women who are attempting to regain custody of their children, and



- e. All other individuals with a SUD, regardless of gender or route of use, (as funding is available).
4. Grant funding is the payor of last resort for Title XIX/XXI behavioral health covered services which have been exhausted (e.g. respite), Non-Title XIX/XXI covered services, and for Non-Title XIX/XXI eligible Members for any services. Grant funding shall not be used to supplant other funding sources, if funds from the Indian Health Services and/or Tribal owned/or operated facilities are available, the IHS/638 funds shall be treated as the payor of last resort.
  5. Adolescents in Detention - Most adjudicated youth from secure detention do not have community follow-up or supervision, therefore, risk factors remain unaddressed. Youth in juvenile justice systems often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Contractors and TRBHAs requesting to use SABG funding shall provide AHCCCS with a comprehensive and detailed plan that includes services and activities that will be provided to adolescents in detention. AHCCCS approval is contingent on funding availability and the Contractor's and TRBHA's comprehensive and detailed plan. For adolescents in detention the following limitations apply:
    - a. Services may only be provided in juvenile detention facilities meeting the description provided by the Office of Juvenile Justice and Delinquency Prevention (OJJDP). Although TXIX services are limited for inmates of public institutions, for purposes of administering SABG, juvenile detention facilities are used only for temporary and safe custody, are not punitive, and are not correctional or penal institutions,
    - b. Services shall be provided:
      - i. Only to voluntary members,
      - ii. By qualified BHPs/BHTs/BHPPs,
      - iii. Based upon assessed need for SUD services,
      - iv. Utilizing EBPPs,
      - v. Following an individualized service plan,
      - vi. For a therapeutically indicated amount of duration and frequency, and
      - vii. With a relapse Prevention plan completed prior to discharge/transfer to a community based provider.
  6. Charitable Choice of SABG Providers - Members receiving SUD treatment services under the SABG have the right to receive services from a provider to whose religious character they do not object. Behavioral health providers providing SUD treatment services under the SABG shall notify Members at the time of intake of this right utilizing Attachment A. Providers shall document that the Member has received notice in the Member's medical record.

If a Member objects to the religious character of a behavioral health provider, the provider shall refer the Member to an alternate provider within seven days, or earlier when clinically indicated, after the date of the objection. Upon making such a referral, providers shall notify the RBHAs or TRBHAs, of the referral and ensure that the Member makes contact with the alternative provider. RBHAs and TRBHAs shall develop and make available policies and procedures that indicate

who the providers should contact and how they should notify the RBHAs or TRBHA of these referrals. RBHAs and TRBHAs' providers shall maintain a list of all referrals to alternate providers regarding charitable choice requirements to be provided to AHCCCS upon request [42 CFR Part 54 and 54a].

7. Ensure that providers promptly submit information for Priority Population Members (i.e. Pregnant Women, Women with Dependent Children, and PWID) who are waiting for placement in a Behavioral Health Residential Facility (BHRF), to the AHCCCS SABG Priority Population Waitlist, or in a different format upon written approval from AHCCCS as specified in Contract. Title XIX/XXI Members may not be added to the AHCCCS SABG Priority Population Waitlist.

Priority Population Members who are not pregnant, parenting women, or PWID shall be added to the AHCCCS SABG Priority Population Waitlist if the RBHAs, TRBHAs, or their providers are not able to place the Member in a BHRF within the Response Timeframes for Designated Behavioral Health Services as outlined in Contract.

For women who are pregnant, the requirement is within 48 hours, for women with dependent children the requirement is within five calendar days, and for all PWID the requirement is within 14 calendar days.

8. HIV Early Intervention Services - Because individuals with SUDs are considered at high risk for contracting HIV-related illness, the SABG requires HIV intervention services in order to reduce the risk of transmission of this disease. With respect to individuals undergoing treatment for substance use, the RBHAs/TRBHAs shall make available to the individual HIV early intervention services pursuant to 45 CFR 96.121 at the sites in which the individuals are undergoing such treatment.

RBHAs and TRBHAs receiving SABG funding, shall develop and make available to providers policies and procedures that describe where and how to access HIV Early Intervention Services, noting that services are provided exclusively to populations with SUDs. RBHAs and TRBHAs offering intervention services shall:

- a. Provide early intervention services for HIV in geographic areas of the state that have the greatest need and rural areas,
- b. Require programs to establish linkages with a comprehensive community resource network of related health and social services organizations to ensure a wide-based knowledge of the availability of these services,
- c. Ensure behavioral health providers provide specialized, evidence-based treatment and recovery support services for all SABG populations,
- d. Administer a minimum of one test per \$600 in SABG HIV early intervention services,
- e. Conduct site visits to HIV early intervention services providers where the Contractor's HIV Coordinator, subcontracted provider staff, and supervisors are present. Each site visit shall include the attendance at one education class, and
- f. Collect SABG HIV Activity Reports from providers, training materials provided to HIV Coordinators and HIV Early Intervention Services Providers, and other Ad hoc reports related to HIV Prevention Issues.

9. Considerations for providers when delivering services to SABG populations:
  - a. SABG treatment services shall be designed to support the long-term treatment and substance-free recovery needs of eligible Members,
  - b. Providers of treatment services that include clinical care to those with a SUD shall also be designed to have the capacity and staff expertise to utilize FDA-approved medications for the treatment of SUD/ODU and/or have collaborative relationships with other providers for service provision,
  - c. Specific requirements apply regarding preferential access to services and the timeliness of responding to a Member's identified needs, and
  - d. Providers shall submit specific data elements and record limited clinical information. Refer to the AHCCCS DUGless Portal Guide for requirements.
  
10. Restrictions - Members shall not be charged a copayment for SUD treatment or supportive services funded by the SABG. Sliding scale fees established regarding room and board do not constitute a copayment.

#### **E. SUBSTANCE ABUSE BLOCK GRANT PRIMARY PREVENTION**

The purpose of the SABG Primary Prevention funds is to implement strategies that are directed at individuals not identified to be in need of substance abuse treatment.

1. Eligible Populations  
Populations at risk for developing substance abuse disorders and related behavioral health consequences.
  
2. Primary prevention funding shall be used on interventions that prevent the use of substances, or the onset of substance use disorders.
  
3. A comprehensive prevention program employs a variety of strategies to prevent and reduce substance use. SAMHSA developed and approved the following strategies for primary prevention, referred to as CSAP strategies. Services shall be tailored to individual community or program needs and shall follow the six Center for Substance Abuse Prevention (CSAP) strategies.
  - a. Information Dissemination: Provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, misuse, and addiction, as well as their effects on individuals, families, and communities,
  - b. Education - Builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress problem solving, interpersonal communication, and systematic and judgmental capabilities,
  - c. Alternatives - Provides opportunities for target populations to participate in activities that exclude alcohol and other drugs,
  - d. Problem Identification and Referral - Aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco or alcohol, and individuals who have indulged in the first use of illicit drugs, and seeks to refer those individuals out to the appropriate services as needed,
  - e. Community-based Process - Provides ongoing networking activities and technical assistance to community groups or agencies, and

- f. Environmental - Establishes or changes written and unwritten community standards, codes, and attitudes.
4. Risk and Protective Factors  
Prevention services should be tailored to address the specific risk and protective factors that are present in the community. Risk factors are defined as characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes. Risk and protective factors and an individual's character interact through six life or activity domains. Within each domain are characteristics and conditions that can function as risk or protective factors, thus each of these domains presents opportunities for prevention. The six domains are as follows: Individual, Family, Peer, School, Community, and Environment/Society.

Protective factors are defined as characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact. Protective factors may be seen as positive countering events. Risk and protective factors and an individual's character interact through six life or activity domains. Within each domain are characteristics and conditions that can function as risk or protective factors, thus each of these domains presents opportunities for prevention. The six domains are as follows: Individual, Family, Peer, School, Community, and Environment/Society.

5. Evidence Based, Promising, and Innovative Practices/Interventions  
Services should be implemented utilizing evidenced based practices (EBPs) as much as possible, with promising and innovative practices used only in the event there is not an appropriate EBP available to meet the substance abuse prevention needs within the target population.

Evidence Based Practices/Interventions for primary prevention services are defined as interventions that fall into one or more of three categories:

- a. The intervention is included in a federal registry of evidence-based interventions, or
- b. The intervention produced positive effects on the primary targeted outcome, and these findings are reported in a peer-reviewed journal, or
- c. The intervention has documented evidence of effectiveness, based on guidelines developed by the Center for Substance Abuse Prevention and/or the state, tribe, or jurisdiction in which the intervention took place. Documented evidence should be implemented under four recommended guidelines, all of which shall be followed. These guidelines require interventions to be:
  - i. Based on a theory of change that is documented in a clear logic or conceptual mode,
  - ii. Similar in content and structure to interventions that appear in federal registries of evidence-based interventions and/or peer-reviewed journals,
  - iii. Supported by documentation showing it has been effectively implemented in the past, multiple times, and in a manner attentive to scientific standards of evidence. The intervention results should show a consistent pattern of credible and positive effects, and
  - iv. Reviewed and deemed appropriate by a panel of informed prevention experts that includes qualified prevention researchers experienced in evaluating

prevention interventions similar to those under review, local prevention professionals, and key community leaders, as appropriate (for example, law enforcement officials, educators, or elders within indigenous cultures).

6. Promising Practices/Interventions for primary prevention services are defined as interventions based on statistical analyses or a well-established theory of change, shows potential for meeting the “evidence-based” or “research based” criteria, and could include the use of a program that is evidence-based for outcomes other than the alternative use.
7. Innovative Practices/Interventions for primary prevention services are defined as interventions that serve a target population and have a promising approach but need further refinement to become ready for rigorous evaluation.
8. Restrictions - Funds cannot be used to provide treatment services, general mental health services, secondary or tertiary prevention, or suicide prevention. All funded interventions shall have a substance use/abuse outcome.

#### **F. MENTAL HEALTH BLOCK GRANT**

The MHBG is a Formula Grant, which supports treatment services for Title XIX/XXI and Non-Title XIX/XXI Members with SMI, SED, or FEP. The MHBG provides services that are not otherwise covered by Title-XIX/XXI funding. This includes mental health treatment and supportive services for Members who do not qualify for Title XIX/XXI eligibility. MHBG funds are only to be used for allowable services identified in AMPM Exhibit 300-2B.

1. The MHBG is allocated by SAMHSA for:
  - a. Providing community mental health services for adults with a serious mental illness and children with a serious emotional disturbance,
  - b. Carrying out the plan submitted under section 300x-1(a) of U.S.C 42 by the State for the fiscal year involved,
  - c. Evaluating programs and services carried out under the plan, and
  - d. Planning, administration, and educational activities related to providing services under the plan.
2. Goals of the MHBG include, but are not limited to the following:
  - a. Ensuring access to a comprehensive system of care, including employment, housing services, case management, rehabilitation, dental services, and health services, as well as mental health services and supports,
  - b. Promoting participation by consumer/survivors and their families in planning and implementing services and programs, as well as in evaluating State mental health systems,
  - c. Ensuring access for underserved populations, including people who are homeless, residents of rural areas, and older adults,
  - d. Promoting recovery and community integration for adults with SMI and children with SED, and
  - e. Increasing accountability through uniform reporting on access, quality, and outcomes of services.

### 3. Eligible Populations

All Members receiving MHBG-funded services are required to have a Title XIX/XXI eligibility screening and application completed and documented in the medical record at the time of intake and annually thereafter.

To be eligible for services under MHBG, Members shall be determined to have an SMI, an SED, or ESMI/FEP.

Screenings/assessments may be covered for Non-Title XIX/XXI eligible Members when they are conducted to determine SMI or SED eligibility, for block grant funding regardless of the assessment's determination. Other funding sources, such as the State General Fund appropriations for SMI shall be utilized before block grant funding to ensure block grants are the payor of last resort. Refer to AMPM Policy 320-O for additional information on behavioral health assessments and treatment/service planning.

For information regarding SMI Eligibility Determination, refer to AMPM Policy 320- P.

For more information regarding qualifying diagnoses, refer to the AHCCCS Behavioral Health Diagnosis List

<https://www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/index.html>

Excluded conditions, as noted in the 58 Federal Register 29422 (May 20, 1993), are substance use disorders, developmental disorders, such as autism, and disorders described by Z codes (V codes under ICD-9), unless the condition is co-occurring with a diagnosable serious emotional disturbance.

For the purposes of this Policy, the following are diagnoses that qualify under ESMI/FEP. These are not intended to include conditions that are attributable to the physiologic effects of an SUD, are attributable to an intellectual/developmental disorder, or are attributable to another medical condition:

- a. Delusional Disorder,
- b. Brief Psychotic Disorder,
- c. Schizophreniform Disorder,
- d. Schizophrenia,
- e. Schizoaffective Disorder,
- f. Other specified Schizophrenia Spectrum and Other Psychotic Disorder,
- g. Unspecified Schizophrenia Spectrum and Other Psychotic Disorder,
- h. Bipolar and Related Disorders, with psychotic features, and
- i. Depressive Disorders, with psychotic features.

Members do not have to be or designated as SMI or SED to be eligible for FEP services.

Individuals who are accessing FEP MHBG services can be GMH at the beginning, or throughout their FEP episode of care.

4. MHBG funding is the payor of last resort for Title XIX/XXI behavioral health covered services which have been exhausted (e.g. respite), Non-Title XIX/XXI covered services, and for Non-Title XIX/XXI eligible Members for any services. Grant funding shall not be used to supplant other funding sources except that, if funds from the Indian Health Services (IHS) and/or Tribal owned/or operated facilities are available, the IHS/638 funds shall be treated as the payor of last resort.
  
5. **Effective 7/1/20**, MHBG Funds for Payment of Behavioral Health Drugs for Individuals Designated with an SMI (Both Title XIX/XXI and Non-Title XIX/XXI):
  - a. The TRBHAs and RBHA Contractors shall utilize available MHBG Funds to cover applicable Medicare Part D copayments and cost sharing amounts, including payments for the Medicare Part D coverage gap, for medications to treat behavioral health diagnoses for Title XIX/XXI and Non-Title XIX/XXI individuals determined to have an SMI, subject to the following:
    - i. Coverage of cost sharing is to be used only for federal and state reimbursable medications used to treat an SMI behavioral health diagnoses,
    - ii. Medicare copayments and cost sharing are covered for medications to treat an SMI behavioral health diagnoses when dispensed by an AHCCCS-registered provider,
    - iii. The payment of Medicare Part D copayments and cost sharing amounts for medications to treat an SMI behavioral health diagnoses for individuals determined to have an SMI, shall be provided regardless of whether or not the provider is in the Contractor's provider network or whether or not prior authorization has been obtained,
    - iv. The TRBHAs and RBHA Contractors shall not apply pharmacy benefit utilization management edits when coordinating reimbursement for Medicare Cost Sharing for medications to treat a SMI behavioral health diagnoses for individuals determined to have an SMI,
    - v. When a request for a medication to treat an SMI behavioral health diagnoses has been denied by the Medicare Part D plan and the denial has been upheld through the appeals process, the Contractor shall evaluate the request and may elect to utilize MHBG Funds, if applicable, to cover the cost of the non-covered Medicare Part D medication to treat a SMI behavioral health diagnosis, and,
  - b. The Contractor does not have the responsibility to make Medicare Part D copayments and cost sharing payments to pharmacy providers that are not AHCCCS registered.
  
6. Services - The MHBG covers community mental health treatment and support services for eligible populations within certain limits for Title XIX/XXI and Non-Title XIX/XXI Members when medically necessary. Refer to AMPM Exhibit 300-2B for additional information on MHBG covered services.

Adolescents in Detention - Most adjudicated youth from secure detention do not have community follow-up or supervision, therefore, risk factors remain unaddressed. Youth in juvenile justice systems often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Contractors and TRBHAs not already providing these services for the SED population in detention facilities requesting to

use MHBG funding shall provide AHCCCS with a comprehensive and detailed plan that includes services and activities that will be provided. AHCCCS approval is contingent on funding availability and contractor's and TRBHA's comprehensive and detailed plan.

Adolescents in Detention Coverage Limitations:

- a. Services may only be provided in juvenile detention facilities meeting the description provided by the OJJDP. Juvenile detention facilities are used only for temporary and safe custody, are not punitive, and are not correctional or penal institutions,
  - b. Services shall be provided:
    - i. Only to voluntary members,
    - ii. By qualified BHPs/BHTs/BHPPs,
    - iii. Based upon assessed need for SED services,
    - iv. Utilizing EBPPs,
    - v. Following an individualized service plan,
    - vi. For a therapeutically indicated amount of duration and frequency, and
    - vii. With a transition plan completed prior to transfer to a community based provider, and
7. Non-Encounterable MHBG Activities or Positions - MHBG SED services for outreach activities or positions that are non-encounterable can be an allowable expense, but they shall be tracked, activities monitored, and outcomes collected on how the outreach is getting access to care for those Members with SED. Furthermore, the use of MHBG SED funds in schools is allowable as long as the following requirements are met:
- a. Funded positions or interventions cannot be used to fulfill the requirement for the same populations as the funds for Behavioral Health Services for School-Aged Children listed in the Title XIX/XXI Contract,
  - b. Funded positions cannot bill for services provided,
  - c. Funded positions or interventions need to focus on identifying those with SED and getting those who do not qualify for Title XIX/XXI engaged in services through the MHBG, and
  - d. This funding shall be utilized for intervention, not Prevention, meaning that Members who are displaying behaviors that could be signs of SED can be assisted, but MHBG funding shall not be used for general Prevention efforts to children who are not showing any risks of having SED.

Restrictions Members shall not be charged a copayment for mental health treatment or supportive services funded by the MHBG. Sliding scale fees established regarding room and board do not constitute a copayment.

#### **G. PROJECT FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS**

Project for Assistance in Transition from Homelessness (PATH) is designed to be an outcome driven grant program to support service delivery to individuals with a Serious Mental Illness (SMI), co-occurring SMI and substance use disorders, persons experiencing homelessness or at imminent risk of homelessness via street outreach and to engage individuals not currently connected to mainstream mental health services, primary



health care and substance use service systems. PATH is a formula-based grant program where funds are used to provide a menu of allowable services, including street outreach, case management, and services not supported by mainstream mental health programs.

1. Eligible Populations

- a. Adults (persons 18 years of age or older) who request or consent to a SMI Eligibility Determination, and
- b. Adults suffering from SMI and/or have co-occurring substance use disorder, or
- c. Adults and families with children who are homeless, or at imminent risk of homelessness.

**H. EMERGENCY GRANTS TO ADDRESS MENTAL AND SUBSTANCE USE DISORDERS DURING COVID-19 (EMERGENCY COVID-19)**

The purpose of this program is to provide crisis intervention services, mental and substance use disorder treatment, and other related recovery supports for children and adults impacted by the COVID-19 pandemic. Funding will be provided for states, territories, and tribes to develop comprehensive systems to address these needs. The purpose of this program is specifically to address the needs of individuals with Serious Mental Illness. Additionally, the program will also focus on meeting the needs of individuals with mental disorders that are less severe than serious mental illness, including those in the healthcare profession.

1. Eligible Populations

- a. Individuals diagnosed with an SMI,
- b. Individuals diagnosed with SUD,
- c. Individuals with a co-occurring (SMI/SUD), and
- d. Individuals with mental disorders that are less severe than SMI.

2. Contractors shall use grant funds primarily to provide direct services. Direct service provision shall be implemented as follows:

- a. 70 percent of direct service funding shall be used to provide direct services to one of the following: those with serious mental illness, those with SUDs, or those with co-occurring SMI and SUDs,
- b. Ten percent of direct service funding shall be used for healthcare practitioners with mental disorders (less severe than SMI) requiring mental health care as a result of COVID-19, and
- c. Twenty percent of direct service funding shall be used for all other individuals with mental disorders less severe than SMI. Contractor(s) shall clearly specify which population(s) will be served.

3. Contractors shall utilize third party reimbursements and other revenue realized from the provision of services to the extent possible and use SAMHSA grant funds only for services to individuals who are not covered by public or commercial health insurance programs, individuals for whom coverage has been formally determined to be unaffordable, or for services that are not sufficiently covered by an individual's health insurance plan.

4. Contractors shall facilitate the health insurance application and enrollment process for eligible uninsured clients.
5. Contractors shall also consider other systems from which a potential member may be eligible for services (e.g. the Veterans Health Administration or senior services), if appropriate for, and desired by, that individual to meet his/her needs.
6. Contractors shall implement policies and procedures that ensure other sources of funding are utilized before Emergency COVID-19 Grants funds are used when other funding sources are available for that individual.
7. Services - Contractor(s) shall provide the following services as stated in their contract with AHCCCS and approved budget:
  - a. Develop and implement a comprehensive plan of evidence-based mental and/or substance use disorder treatment services for individuals impacted by the COVID-19 pandemic. Ensure that service provision may occur in a telehealth context including the use of telephone,
  - b. Screen and assess clients for the presence of mental and substance use disorders and/or co-occurring disorders, and use the information obtained from the screening and assessment to develop appropriate treatment approaches,
  - c. Provide evidence-based and population appropriate treatment services,
    - i. Provide recovery support services (e.g. linkages to nutrition/food services, individual support services, childcare, vocational, educational, linkages to housing services, and transportation services) which will improve access to, and retention in services. Contractors shall ensure the ability to provide these services virtually where needed, and
    - ii. Develop and implement Crisis mental health services.
8. Restrictions Emergency COVID-19 Grants funds shall not be used to:
  - a. Directly or indirectly, purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. Refer to 45 CFR 75.300(a) (requiring HHS to “ensure that Federal funding is expended in full accordance with U.S. statutory requirements.”), 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law,
  - b. Pay for promotional items including, but not limited to, clothing and commemorative items such as pens, mugs/cups, folders/folios, lanyards, and conference bags,
  - c. Pay for the purchase or construction of any building or structure to house any part of the program,
  - d. Provide residential or outpatient treatment services when the facility has not yet been acquired, sited, approved, and met all requirements for human habitation and services provision,

- e. Provide inpatient treatment or hospital-based detoxification services. Residential services are not considered to be inpatient or hospital-based services,
- f. Make direct payments to individuals to enter treatment or continue to participate in prevention or treatment services,
- g. Provide meals unless they are an integral part of a conference grant or specifically stated as an allowable expense. Grant funds may be used for light snacks, not to exceed \$3.00 per individual per day,
- h. Purchase sterile needles or syringes for the hypodermic injection of any illegal drug. Provided, That such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with state and local law.
- i. Purchase of personal protective equipment (PPE) except for use by staff charged to the grant. Purchase of PPE for other employees or clients is not an allowable use of these funds, or
- j. Purchase equipment or supplies (e.g. pre-paid minutes, cell phones, hot spots, iPad, tablets) for clients.

## **I. STATE OPIOID RESPONSE GRANT**

The SOR program aims to address the opioid crisis by increasing access to medication-assisted treatment using the three FDA-approved medications including: methadone, buprenorphine products, including single-entity buprenorphine products, buprenorphine/naloxone tablets, films, buccal preparations, long-acting injectable buprenorphine products, buprenorphine implants, and injectable extended-release naltrexone for the treatment of Opioid Use Disorder (OUD). As well as reducing unmet treatment need and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for OUD (including illicit use of prescription opioids, heroin, and fentanyl and fentanyl analogs). This program also supports evidence-based prevention, treatment, and recovery support services to address stimulant misuse and use disorders, including for cocaine and methamphetamine.

1. Eligible Populations  
Individuals with OUD, stimulant use disorder, and populations at risk for developing either and related behavioral health consequences.
2. Contractors shall implement evidence-based treatments, practices, and interventions for OUD and make available FDA-approved MAT to those diagnosed with OUD.
3. Contractors shall implement FDA-approved MAT for OUD.

Medical withdrawal (detoxification) is not the standard of care for OUD, is associated with a very high relapse rate, and significantly increases an individual's risk for opioid overdose and death if opioid use is resumed. Therefore, medical withdrawal (detoxification) when done in isolation is not an evidence-based practice for OUD. If medical withdrawal (detoxification) is performed, it shall be accompanied by

injectable extended-release naltrexone to protect such individuals from opioid overdose in relapse and improve treatment outcomes.

Contractors shall employ effective prevention and recovery support services to ensure that individuals are receiving a comprehensive array of services across the spectrum of prevention, treatment, and recovery.

Contractors shall implement evidence-based prevention, treatment, and recovery support services to address stimulant misuse and use disorders.

4. Services - The Contractor shall offer a comprehensive array of services across the spectrum of prevention, treatment, and recovery for opioid use disorder and stimulant use disorder that should be tailored to individual community or program needs.

#### **J. NON-TITLE XIX/XXI FUNDED CARE COORDINATION REQUIREMENTS**

Providers shall make it a priority to work with the RBHA and/or TRBHA to enroll the individual in Non-Title XIX/XXI funded services immediately, while continuing to assist the individual with the processes to determine Title XIX/XXI eligibility. If the individual is deemed eligible for Title XIX/XXI funding, the Member can choose a Contractor and American Indian Members may choose either a Contractor, or AIHP, or a TRBHA if one is available in their area and receive covered services through that Contractor or AIHP or a TRBHA. The provider shall work with the Care Coordination teams of all involved Contractors or payers to ensure each Member's continuity of care. Members designated as SMI are enrolled with a RBHA. American Indian Members designated as SMI have the choice to enroll with a TRBHA for their behavioral health assignment if one is available in their area.

If a Title XIX/XXI Member loses Title XIX/XXI eligibility while receiving behavioral health services, the provider shall attempt to prevent an interruption in services. The provider shall work with the care coordinators of the Contractor or RBHA in the GSA where the Member is receiving services, or Contractor enrolled or AIHP enrolled Members, or the assigned TRBHA, to determine whether the Member is eligible to continue services through available Non-Title XIX/XXI funding. If the provider does not receive Non-Title XIX/XXI funding, the provider and Member shall work, together to determine where the Member can receive services from a provider that does receive Non-Title XIX/XXI funding. The provider shall then facilitate a transfer of the Member to the identified provider and work with the Care Coordination teams of all involved Contractors or payors. Contract language and measures stipulate that providers will be paid for treating Members while payment details between entities are determined. If a Title XIX/XXI Member, whether Contractor or AIHP enrolled, requires Non-Title XIX/XXI services, the provider shall work with the RBHA in the GSA where the Member is receiving services, or the assigned TRBHA, to coordinate the Non-Title XIX/XXI services.

Behavioral health providers are required to assist individuals with applying for Arizona Public Programs (Title XIX/XXI, Medicare Savings Programs, Nutrition Assistance, and Cash Assistance), and Medicare Prescription Drug Program (Medicare Part D), including the Medicare Part D "Extra Help with Medicare Prescription Drug Plan Costs" low

income subsidy program prior to receiving Non-Title XIX/XXI covered behavioral health services, at the time of intake for behavioral health services.

An individual who is found not eligible for Title XIX/XXI covered services may still be eligible for Non-Title XIX/XXI services. An individual may also be covered under another health insurance plan, including Medicare.

Individuals who refuse to participate in the AHCCCS screening/application process are ineligible for state funded behavioral health services. Refer to A.R.S. §36-3408 and AMPM Policy 650. The following conditions do not constitute an individual's refusal to participate:

1. An individual's inability to obtain documentation required for the eligibility determination, and/or
2. An individual is incapable of participating as a result of their mental illness and does not have a legal guardian.

Pursuant to the U.S. Attorney General's Order No. 2049-96 (61 Federal Register 45985, August 30, 1996), individuals presenting for and receiving crisis, mental health or SUD treatment services are not required to verify U.S. citizenship/lawful presence prior to or in order to receive crisis services.

Members can be served through Non-Title XIX funding while awaiting a determination of Title XIX/XXI eligibility. However, upon Title XIX eligibility determination the covered services billed to Non-Title XIX, that are Title XIX covered, shall be reversed by the Contractor and charged to Title XIX funding for the retro covered dates of Title XIX eligibility. This does not apply to Title XXI Members, as there is no PPC for these Members.

The RBHAs, TRBHAs, and other entities who have a direct Non-Title XIX/XXI funded contractual relationship with AHCCCS are responsible for managing and prioritizing Non-Title XIX/XXI funds to ensure, within the limitation of available funding, that services are available for all individuals, prioritizing those with the highest level of need and Eligible Members.

RBHAs, TRBHAs, and other entities who have a direct contractual relationship with AHCCCS are responsible for managing Non-TXIX/XXI funding to ensure that funding is available for the fiscal period and if all Non-Title XIX/XXI funding is expended, RBHAs, TRBHAs, and other entities who have a direct Non-Title XIX/XXI funded contractual relationship with AHCCCS shall provide coordination services to address the needs through other community-based options and shall maintain a database of Members referred for services that are unable to receive the service due to funding depletion and shall maintain a database of Members referred for services that are unable to receive the service due to funding. Members pending services due to funding depletion shall receive follow up to provide alternative services as possible and available until the referred service can be provided.

In addition, Contractors are responsible for ensuring a comprehensive system of care for Non-Title XIX/XXI eligible Members, and Members shifting in and out of Title XIX/XXI eligibility. Refer to policy AMPM Policy 100 for information on the Nine Guiding Principles for the Adult System of Care, and on the Twelve Guiding Principles for the Children’s System of Care. System development efforts, programs, service provision, and stakeholder collaboration shall be guided by the principles therein.

If there are any barriers to care, the provider shall work with the Care Coordination teams of all involved health plans or payers. If the provider is unable to resolve the issues in a timely manner to ensure the health and safety of the Member, the provider shall contact AHCCCS/DHCM, Clinical Resolutions Unit (CRU). If the provider believes that there are systemic problems, rather than an isolated concern, the provider shall notify AHCCCS/DHCM, CRU of the potential barrier. AHCCCS will conduct research and work with the Contractors and responsible entities to address or remove the potential barriers.

#### **K. NON-TITLE XIX/XXI FUNDING SOURCES**

All Non-Title XIX/XXI funding shall be used for medically necessary behavioral health services only.

RBHAs, TRBHAs, and other entities who have a direct Non-Title XIX/XXI funded contractual relationship shall report each Non-Title XIX/XXI funding source and services separately and provide information related to Non-Title XIX/XXI expenditures to AHCCCS upon request and/or in accordance with AHCCCS Contract/ISA/IGA or as specified in the Allocation Schedule and/or Allocation Letter.

Services provided under Non-Title XIX/XXI funds are to be encounterable. Outreach activities or positions that are non-encounterable can be allowable expenses, but they shall be pre-approved by AHCCCS, tracked, activities monitored, and outcomes collected on how the activities or funded positions are facilitating access to care for Non-Title XIX/XXI eligible populations, as specified in the Non-TXIX/XXI Contract.

Additionally, positions funded exclusively through the Non-Title XIX/XXI funding shall not bill for services to receive additional funding from any fund source. Positions partially funded through the Non-Title XIX/XXI funding may only bill for services during periods when they are not being paid with Non-Title XIX/XXI funds.

Discretionary Grants - This funding can be used for purposes set forth in the various Federal grant requirements and as defined in the terms and conditions of the Allocation Schedules or AHCCCS Contract/IGA/ISA and/or Allocation Letters. An example of a discretionary grant includes, but is not limited to, the State Opioid Response (SOR) grant.

#### **L. SABG AND MHBG REPORTING REQUIREMENTS**

Deliverable requirements regarding material changes to Contractor’s Non-Title XIX/XXI provider network are identified in Non-Title XIX/XXI Contracts. For Templates and requirements regarding the submission of a notification indicating material change to provider network, refer to ACOM Policy 439.

**1. Deliverable Templates**

For reporting requirements related to SABG and MHBG, RBHAs shall utilize the following templates for the corresponding deliverable submissions identified in each applicable Contract or IGA/ISA. Applicable deliverables shall be submitted as specified in Contract or IGA/ISA.

- a. Attachment A – Charitable Choice – Anti-Discrimination Notice to Individuals Receiving Substance Use Services,
- b. Attachment B – SED Program Status Report – MHBG SED Grant (for MHBG),
- c. Attachment C – First Episode Psychosis Program Status Report (Annually) (for MHBG),
- d. Attachment C-1 – First Episode Psychosis Program Status Report (Quarterly) (for MHBG),
- e. Attachment D – ICR Peer Review Data Pull,
- f. Attachment E – SABG HIV Activity Report,
- g. Attachment F – SABG HIV Site Visit Report,
- h. Attachment F-1 – Oxford House Financial Report,
- i. Attachment G – SABG Agreements Report,
- j. Attachment H – Oxford House Model Report,
- k. Attachment I – SABG Priority Population Waitlist Report,
- l. Attachment J – SABG Capacity Management Report, and
- m. Attachment K – SABG/Prevention/MHBG Plan (for MHBG and SABG).

**2. Block Grant Report and Plan**

Reporting timeframes for the Block Grant Report and Block Grant Plan are identified in each applicable Contract or ISA/IGA. Templates and other reporting requirements for these deliverables are mandated by SAMHSA and are subject to change. As such, templates for the Block Grant Report and Block Grant Plan will be provided by prior to due dates.

# Environmental Factors and Plan

## 10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

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### Criterion 1

#### Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

- i) Screening  Yes  No
- ii) Education  Yes  No
- iii) Brief Intervention  Yes  No
- iv) Assessment  Yes  No
- v) Detox (inpatient/social)  Yes  No
- vi) Outpatient  Yes  No
- vii) Intensive Outpatient  Yes  No
- viii) Inpatient/Residential  Yes  No
- ix) Aftercare; Recovery support  Yes  No

b) Services for special populations:

- Targeted services for veterans?  Yes  No
- Adolescents?  Yes  No
- Other Adults?  Yes  No
- Medication-Assisted Treatment (MAT)?  Yes  No



## **Criterion 2**

**Criterion 3**

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?  Yes  No
2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?  Yes  No
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?  Yes  No
4. Does your state have an arrangement for ensuring the provision of required supportive services?  Yes  No
5. Has your state identified a need for any of the following:
  - a) Open assessment and intake scheduling  Yes  No
  - b) Establishment of an electronic system to identify available treatment slots  Yes  No
  - c) Expanded community network for supportive services and healthcare  Yes  No
  - d) Inclusion of recovery support services  Yes  No
  - e) Health navigators to assist clients with community linkages  Yes  No
  - f) Expanded capability for family services, relationship restoration, and custody issues?  Yes  No
  - g) Providing employment assistance  Yes  No
  - h) Providing transportation to and from services  Yes  No
  - i) Educational assistance  Yes  No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

## Secret Shopper Surveys

AHCCCS conducts an annual, anonymous, secret shopper campaign that examines three contact points: access to care, adherence to state and federal regulations, and how to improve an individual/support networks experience.

AHCCCS internal staff anonymously call agencies that have frequent customer contact, such as the Medicaid Agency Applicant and Member Service Department, crisis agencies, health plans and a sample of individual providers who receive SABG funding. ? Each call captures the following items in an evaluation tool:

Caller Information,

RBHA,

Provider Information (i.e address, phone number,,

Level of Care,

Scenario,

Detail of call (i.e date, beginning and end time of call, wait time, name of person answering the phone, etc),

Were services answered within 48 hours,

Was the called offered an assessment, waitlist, transportation, childcare, treatment services, and

The culture of the call

The call data is aggregated to identify patterns and trends. ? The AHCCCS call team and subject matter experts debrief and determine a course of action to address opportunities for improvement.? AHCCCS provides feedback and data to contractors who receive SABG funding, who then work with their contracted service providers to improve access to care, adherence to state and federal regulations, and how to improve an individual/support networks experience.

## Independent Case Review

CFR 45 § 96.136 requires an annual independent peer review process referred to as the Independent Case Review (ICR) which reviews the quality and appropriateness of SABG-funded treatment services. The review focuses on treatment programs and the substance abuse service system within each Geographic Service Area, rather than on the individual practitioners. The intent of the ICR process is to continuously improve the treatment services to alcohol and drug users within the state system. "Quality," for purposes of this section, is the provision of treatment services which, within the constraints of technology, resources, and

individual/member circumstances, will meet accepted standards and practices which will improve individual/member health and safety status in the context of recovery. "Appropriateness," for purposes of this section, means the provision of treatment services consistent with the individual's identified clinical needs and level of functioning.

On an annual basis, AHCCCS contracts for ICR through a competitive process. A contractor is selected to review at least 200 case files with adequate sample sizes to meet the requirements for SABG. The project reviewers are individuals with expertise in the field of alcohol and drug use treatment. Because treatment services may be provided by multiple disciplines, AHCCCS makes every effort to ensure that individual case reviewers are representative of the various disciplines utilized by the SABG. Individual case reviewers are also knowledgeable about the modality being reviewed and its underlying theoretical approach to addictions treatment, and are sensitive to the cultural and environmental issues that may influence the quality of the services provided.

As part of the ICR, a representative sample of individual/member records are reviewed to determine quality and appropriateness of treatment services, while adhering to all federal and state confidentiality requirements, including 42 CFR part 2. The reviewers examine the following:

- Admission criteria/intake process,
- Assessments,
- Treatment planning, including appropriate referral, e.g., prenatal care and tuberculosis and HIV services,
- Documentation of implementation of treatment services,
- Discharge and continuing care planning, and
- Indications of treatment outcomes.

Data is aggregated and published in a formal report used for quality improvement efforts. Information specific to each contractor is provided, highlighting both strengths and opportunities for improvement. Contractors are expected to respond with an actionable plan to address areas of concern. AHCCCS compares data year over year to identify trends and patterns emerging for each contractor and statewide.

#### Operational Review

AHCCCS regularly reviews its Contractors to ensure that their operations and performance are in compliance with federal and state law; rules and regulations; and the AHCCCS contract. The reviewers use a process approved by the Centers for Medicare and Medicaid Services (CMS) based upon the terms of the contract with AHCCCS.

The primary objectives of the Operational Review are to:

- Determine if the Contractor satisfactorily meets AHCCCS' requirements as specified in Contract, AHCCCS policies, Arizona Revised Statute, the Arizona Administrative Code and 42 CFR Part 438, Managed Care,
- Increase AHCCCS knowledge of the Contractor's operational encounter processing procedures,
- Provide technical assistance and identify areas where improvements can be made, and identify areas of noteworthy performance and accomplishments,
- Review progress in implementing recommendations made during prior reviews,
- Determine if the Contractor is in compliance with its own policies and to evaluate the effectiveness of those policies and procedures,
- Perform Contractor oversight as required by the CMS in accordance with the AHCCCS 1115 Waiver, and
- Provide information to an External Quality Review Organization (EQRO) for its use as described in 42 CFR 438.364.

Contractors must complete a Corrective Action Plan (CAP) for any standard where the total score is less than 95 percent.

**Criterion 4,5&6****Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
  - a) 90 percent capacity reporting requirement  Yes  No
  - b) 14-120 day performance requirement with provision of interim services  Yes  No
  - c) Outreach activities  Yes  No
  - d) Syringe services programs, if applicable  Yes  No
  - e) Monitoring requirements as outlined in the authorizing statute and implementing regulation  Yes  No
2. Has your state identified a need for any of the following:
  - a) Electronic system with alert when 90 percent capacity is reached  Yes  No
  - b) Automatic reminder system associated with 14-120 day performance requirement  Yes  No
  - c) Use of peer recovery supports to maintain contact and support  Yes  No
  - d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?  Yes  No
3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

AHCCCS contracts with Regional Behavioral Health Authorities (RBHAs) to administer behavioral health services. RBHAs contract with a network of service providers similar to health plans to deliver a comprehensive array of services as outlined in the AHCCCS Medical Policy Manual (AMPM) detailing prevention, treatment, and recovery support services for both adults and children.

The overall goal of AHCCCS' management of the SABG is to ensure appropriate access to treatment services for persons who are eligible for the priority populations, including PWID. It also ensures that sufficient outreach, specialized treatment, and recovery supports are available to this population. Contracts between AHCCCS and the RBHAs include language for preferential access to care and provision of interim services, as needed. AHCCCS monitors the RBHAs for compliance with preferential access standards, including review of data reporting mechanisms, and corrective action as appropriate. Language continues to be expanded to specifically match the block grant requirements through contracts between AHCCCS and the RBHAs and referenced in the AHCCCS Contractors Operations Manual (ACOM), and AMPM.

RBHAs hold standing meetings with their providers about SUD. AHCCCS staff attends the meetings to monitor program compliance for the priority populations, and additional block grant requirements. These meetings serve as collaborative opportunities to disseminate information, address provider concerns, ensure that priorities of the block grant are met, and address any potential compliance issues promptly.

The SABG supports treatment services for persons with substance use disorders, and is used to plan, implement, and evaluate activities to prevent and treat substance use. SABG treatment services must support the long-term treatment and substance-free recovery needs of eligible persons. Behavioral health providers must also submit specific data elements to identify special populations and record specified clinical information. In addition to the compliance related activities mentioned above, AHCCCS monitors program compliance through the following mechanisms:

**Operational Review:** An annual requirement to ensure Contractors satisfactorily meet AHCCCS' requirements as specified in contract.

**AHCCCS Medical Policy Manual (AMPM):** Manual for covered services for NT-XIX/XXI populations, referenced by AHCCCS and Providers to ensure appropriate use of services. Updated annually.

**Contracts & Deliverables:** AHCCCS employs multiple contracts and service agreements to ensure appropriate use of SABG funds. Providers are required to regularly submit deliverables related to program progress, financial standing, and/or ad-hoc information as requested by AHCCCS.

**Secret Shopper:** Annually, designated staff at AHCCCS will conduct "secret shopper" calls,

Independent Peer Review: An annual requirement of the SABG, the Independent Peer Review assesses the quality, appropriateness, and efficacy of treatment services provided in the State.

## Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Business agreement/MOU with primary healthcare providers  Yes  No
  - b) Cooperative agreement/MOU with public health entity for testing and treatment  Yes  No
  - c) Established co-located SUD professionals within FQHCs  Yes  No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

AHCCCS tracks and ensures compliance with all identified TB strategies utilizing a variety of compliance monitoring tools. These tools include annual/ad hoc list of tuberculosis cases annually to determine if any individuals received substance use disorder or treatment or mental health services during the reporting fiscal year. This deliverable(s) from the Arizona Department of Health Services (ADHS) is specified through an Interagency Service Agreement (ISA). Additionally, AHCCCS utilizes the Independent Case Review (ICR) to review the quality, appropriateness, and efficacy of treatment services as documented in the client records. The intent of the independent peer review process is to continuously improve the treatment services provided to individuals diagnosed with substance use disorder (SUD) within the State (45 CFR § 96.136) in order to ultimately improve client outcomes and recovery. The ICR process examines multiple aspects of the treatment records as part of the review process, including treatment planning, including reviewing if the appropriate referrals, such as tuberculosis services, were included.

Utilizing the AHCCCS Medical Policy Manual Policy (AMPM) 302-T1, Block Grants and Discretionary Grants, subrecipients of SABG are held to the following standards for TB procedures:

As specified in 45 CFR Part 96 Sect. 127, providers shall routinely make available tuberculosis services as defined in 45 CFR 96.121 to each individual receiving treatment for substance use, implement infection control procedures including the screening of patients, and identify those individuals who are at high risk of becoming infected. As per 45 CFR 96.121, TB services include: Counseling the individual with respect to tuberculosis, Testing to determine whether the individual has been infected with mycobacteria tuberculosis to determine the appropriate form of treatment for the individual, and Providing for or referring the individuals infected by mycobacteria tuberculosis for appropriate medical evaluation and treatment.

The Contractor shall submit the SABG TB Services Treatment Procedure and Protocol as specified in Contract. This deliverable shall include the following information items:

At the time of intake, directly or through arrangements with other public or nonprofit private entities, routinely make available tuberculosis services as defined in [45 CFR 96.121] to each individual receiving treatment for such abuse, In the case of an individual in need of such treatment who is denied admission to the program on the basis of the lack of the capacity of the program to admit the individual, will refer the individual to another provider of tuberculosis services, Implement infection control procedures designed to prevent the transmission of tuberculosis, including the following: Screening of patients, Identifying those individuals who are at high risk of becoming infected, Meeting all state reporting requirements while adhering to federal and state confidentiality requirements, including 42 CFR part 2, and Conducting case management activities to ensure that individuals receive such services.

If compliance issues are identified through AHCCCS monitoring and reporting, AHCCCS initiates technical assistance sessions with sub-recipients to identify gaps, barriers, and/or any training needs that may need to be addressed. If warranted, AHCCCS will utilize procurement policies related to Corrective Action Planning (CAPs) and Corrective Action Letters to document deficiencies and identify steps to bring subrecipients back into compliance.

## Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Establishment of EIS-HIV service hubs in rural areas  Yes  No

- b) Establishment or expansion of tele-health and social media support services  Yes  No
- c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS  Yes  No

**Syringe Service Programs**

- 1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.C.Â§ 300x-31(a)(1)F)?  Yes  No
  - 2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?  Yes  No
  - 3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?  Yes  No
- If yes, please provide a brief description of the elements and the arrangement

## Criterion 8,9&10

### Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Workforce development efforts to expand service access  Yes  No
  - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services  Yes  No
  - c) Establish a peer recovery support network to assist in filling the gaps  Yes  No
  - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)  Yes  No
  - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations  Yes  No
  - f) Explore expansion of services for:
    - i) MAT  Yes  No
    - ii) Tele-Health  Yes  No
    - iii) Social Media Outreach  Yes  No

### Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services  Yes  No
  - b) Establish a program to provide trauma-informed care  Yes  No
  - c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education  Yes  No

### Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)?  Yes  No
2. Does your state provide any of the following:
  - a) Notice to Program Beneficiaries  Yes  No
  - b) An organized referral system to identify alternative providers?  Yes  No
  - c) A system to maintain a list of referrals made by religious organizations?  Yes  No

### Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Review and update of screening and assessment instruments  Yes  No
  - b) Review of current levels of care to determine changes or additions  Yes  No
  - c) Identify workforce needs to expand service capabilities  Yes  No

- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background  Yes  No

### Patient Records

1. Does your state have an agreement to ensure the protection of client records?  Yes  No
2. Has your state identified a need for any of the following:
- a) Training staff and community partners on confidentiality requirements  Yes  No
  - b) Training on responding to requests asking for acknowledgement of the presence of clients  Yes  No
  - c) Updating written procedures which regulate and control access to records  Yes  No
  - d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure:  Yes  No

### Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?  Yes  No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

To assess the quality and appropriateness of treatment services throughout Arizona, AHCCCS identified 63 block grant subrecipients to undergo the Independent Peer Review for State Fiscal Year 2020. The block grant subrecipients submitted a total of 310 treatment records for review, of which 200 were randomly selected to be included in the final review.

3. Has your state identified a need for any of the following:
- a) Development of a quality improvement plan  Yes  No
  - b) Establishment of policies and procedures related to independent peer review  Yes  No
  - c) Development of long-term planning for service revision and expansion to meet the needs of specific populations  Yes  No
4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?  Yes  No

If Yes, please identify the accreditation organization(s)

- i)  Commission on the Accreditation of Rehabilitation Facilities
- ii)  The Joint Commission
- iii)  Other (please specify)



**Criterion 7&11****Group Homes**

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service  Yes  No
  - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing  Yes  No

**Professional Development**

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
  - a) Recent trends in substance use disorders in the state  Yes  No
  - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services  Yes  No
  - c) Performance-based accountability:  Yes  No
  - d) Data collection and reporting requirements  Yes  No
2. Has your state identified a need for any of the following:
  - a) A comprehensive review of the current training schedule and identification of additional training needs  Yes  No
  - b) Addition of training sessions designed to increase employee understanding of recovery support services  Yes  No
  - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services  Yes  No
  - d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort  Yes  No
3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
  - a) Prevention TTC?  Yes  No
  - b) Mental Health TTC?  Yes  No
  - c) Addiction TTC?  Yes  No
  - d) State Targeted Response TTC?  Yes  No

**Waivers**

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C. § 300x-32 (f)).*

1. Is your state considering requesting a waiver of any requirements related to:
  - a) Allocations regarding women  Yes  No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
  - a) Tuberculosis  Yes  No
  - b) Early Intervention Services Regarding HIV  Yes  No
3. Additional Agreements
  - a) Improvement of Process for Appropriate Referrals for Treatment  Yes  No
  - b) Professional Development  Yes  No

c) Coordination of Various Activities and Services

Yes  No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

<https://www.azleg.gov/arsDetail/?title=36>

**Footnotes:**

December 30, 2020

The Honorable Douglas A. Ducey  
Governor of Arizona  
1700 W Washington  
Phoenix, Arizona 85007

The Honorable Karen Fann  
Arizona State Senate  
1700 W Washington  
Phoenix, Arizona 85007

The Honorable Russell Bowers  
Speaker of the House  
Arizona House of Representatives  
1700 W Washington  
Phoenix, Arizona 85007

Dear Governor Ducey, President Fann, and Speaker Bowers:

Pursuant to A.R.S. 36-2023(C)(6), AHCCCS is required to submit an annual report on its Substance Use Disorder (SUD) treatment programs by January 1 of each year. This submission represents the agency's 2020 report to comply with the requirement above. This report includes the names and locations of each program, the amount and sources of funding for each program, the number of clients who received services during the preceding fiscal year, the demographic descriptions of clients served, and a population description of client problems addressed by the programs, including the types of substances abused. This report also includes a summary of the numbers and types of services available and provided during the preceding fiscal year and an evaluation of the results achieved by the programs.

If you have any questions regarding this report, please feel free to contact me at (602) 417-4711.

Sincerely,



Jami Snyder  
Director

Cc: Christina Corieri, Governor's Office Senior Policy Advisor  
Matthew Gress, Director, Governor's Office of Strategic Planning and Budgeting  
Richard Stavneak, Director, Joint Legislative Budget Committee



**Annual Report:  
Substance Use Treatment Programs  
State Fiscal Year 2020**

**July 1, 2019 to June 30, 2020**

**January 2021  
Jami Snyder, Director**

## Background

The Arizona Health Care Cost Containment System (AHCCCS) is the single state Medicaid agency for the State of Arizona. In that capacity it is responsible for operating the Title XIX and Title XXI programs through the state's 1115 Research and Demonstration Waiver, which was granted by the Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). As of July 2020, AHCCCS provides coverage to over 2 million members in Arizona. AHCCCS also administers several Non-Title XIX programs through federal grant funds received from the Substance Abuse and Mental Health Services Administration (SAMHSA) under HHS.

AHCCCS has conducted an assessment of its Substance Use Disorder (SUD) treatment programs in accordance with the requirements outlined in Arizona Revised Statutes (A.R.S.) § 36-2023(C)(6):

*Prepare an annual report on drug abuse treatment programs in this state that receive monies from the administration to be submitted by January 1 of each year to the governor, the president of the senate and the speaker of the house of representatives and to be made available to the general public through the Arizona drug and gang prevention resource center. The report shall include:*

- (a) The name and location of each program.*
- (b) The amount and sources of funding for each program.*
- (c) The number of clients who received services during the preceding fiscal year.*
- (d) A description of the demographic characteristics of the client population served by each program, including age groups, gender and ethnicity.*
- (e) A description of client problems addressed by the programs, including the types of substances abused.*
- (f) A summary of the numbers and types of services available and provided during the preceding fiscal year.*
- (g) An evaluation of the results achieved by the programs.*

Utilization data used in this report are for dates of service in State Fiscal Year (SFY) 2020 from July 1, 2019 through June 30, 2020 and were extracted in November 2020. Due to the four-month lag from the last date of service, data may be slightly understated.

In a Special Session of the Legislature, members of the Arizona House and Senate unanimously passed the Arizona Opioid Epidemic Act, which Governor Ducey signed into law on January 26, 2018. The Arizona Opioid Epidemic Act included several key initiatives to combat the opioid epidemic in Arizona. Opioid use disorder (OUD) treatment was enhanced by identifying gaps in and improving access to treatment, including for uninsured or underinsured Arizonans, with a \$10 million Substance Use Disorder Services (SUDS) Fund appropriation to AHCCCS through the legislation.

On May 1, 2017, AHCCCS received an Opioid State Targeted Response (STR) grant from SAMHSA for prevention and treatment activities in the amount of \$24.3 million over the course of three years; the grant ended April 30, 2020. The objectives of the grant were to reduce the number of individuals with OUD and the number of opioid-related deaths. State partners included the Governor's Office of Youth, Faith and Family (GOYFF), Arizona Department of Health Services (ADHS), and the Department of Child Safety (DCS). Prevention activities included conducting Screening, Brief Intervention and Referral to Treatment (SBIRT) models;

increasing access to Naloxone for law enforcement; providing education and outreach to older adults; and implementing community-based awareness and education activities. Treatment activities were centered around increasing access, participation and retention in Medication Assisted Treatment (MAT) and recovery support services. Activities included 24/7 access to care sites for OUD treatment; increasing peer support networks; incarceration alternative projects; care coordination for individuals re-entering the community from correctional settings; and expanded options for residential services. More information on the grant can be found on the AHCCCS website: <https://www.azahcccs.gov/Resources/Grants/STR/>

On September 19, 2018, Arizona received the State Opioid Response (SOR) grant in the amount of \$20.3 million per year for two years to assist in combatting this nationwide epidemic and sustain the impactful programs that were developed through the STR grant. On May 2, 2019, Arizona received \$10.5 million to supplement first-year SOR funding. The project approach includes developing and supporting state, regional, and local level collaborations and service enhancements to develop and implement best practices. This work comprehensively addresses the full continuum of care related to opioid misuse, abuse and dependency. The funding is geared towards implementing, expanding and sustaining services that support the full continuum of care for an individual throughout their course of recovery. On August 27, 2020, Arizona received the State Opioid Response II (SOR II) grant in the amount of \$31.6 million per year for two years to continue and expand SOR programming to include stimulant use disorder. AHCCCS, as the single state agency for SUD Treatment, administers the grant and works with other state agencies and sub-recipients to implement the following activities:

- Sustaining and enhancing community Naloxone distribution;
- Increasing localized community opioid prevention efforts;
- Reducing stigma and increasing public awareness on the medical model of opioid dependency;
- Expanding trauma-informed prevention, treatment and recovery efforts;
- Expanding navigation and access to MAT through 24/7 access points;
- Expanding access to recovery support services (supportive housing, peer supports, job assistance and supportive recovery programming);
- Increasing public access to real-time prevention, treatment and recovery resources through the “no-wrong door” model;
- Equipping law enforcement and first responders with Naloxone;
- Promoting prescriber education and a statewide chronic pain self-management campaign;
- Collaborating with law enforcement, corrections, first responders and Emergency Departments for diversion and targeted care coordination efforts in high impact sectors;
- Collaborating with justice partners to integrate pre and post booking programs for those involved with the criminal justice system; and
- Targeted focus on treatment and recovery services for pregnant women and parents with OUD.

Lastly, the activities in the SOR program place a strong emphasis on comprehensive strategies to ensure a full continuum of care for this population. The objectives are geared towards addressing prevention, treatment and recovery supports for individuals suffering from an opioid use disorder. Focus is placed on integration efforts, and working to deliver services that are clinically indicated as best practices. In addition, the providers working within SOR were selected due to their person-centered approach and experience with addressing substance use, underlying and core issues, behavioral health disorders, trauma, family dynamics, lack of motivation and purpose, education or employment, life skills development, and aftercare support and housing.

Whether this occurs through a continuum of services from a single treatment provider or several providers, the cohesiveness within the SOR model ensures the provision of appropriate clinical services and has greater impact to retain those in services. More information on the grant can be found on the AHCCCS website: <https://www.azahcccs.gov/Resources/Grants/SOR/>

## Location of Substance Use Disorder Treatment Programs

The locations of the state’s SUD treatment programs are divided in three distinct geographic service areas (GSAs) throughout the state with oversight provided by Integrated Managed Care Organizations (MCOs), Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs). Like last year’s report, all AHCCCS contracted MCOs are included in this report due to the implementation of the AHCCCS Complete Care (ACC) program effective October 1, 2018. By adding the ACC MCOs, the number of programs and members in this report increased significantly from prior years’ reports. Significant growth is also observed when compared to last year’s report, which also included all ACC MCOs.

ACC, RBHA and TRBHA	GSA
Care 1 <sup>st</sup> - ACC	North & Central
Health Choice Arizona – RBHA/ACC	North & Central
Banner University Family Care - ACC	Central & South
Arizona Complete Health – RBHA/ACC	Central & South
UnitedHealthcare - ACC	Central & South
Magellan Complete Care - ACC	Central
Mercy Care – RBHA/ACC	Central
Navajo Nation - TRBHA	North
Pascua Yaqui Tribe - TRBHA	South
White Mountain Apache Tribe - TRBHA	North & South
Gila River Indian Community - TRBHA	Central & South

The ACCs, MCOs, RBHAs and TRBHAs are required to maintain a comprehensive network of behavioral health providers to deliver prevention, intervention, treatment and rehabilitative services to members enrolled in the AHCCCS program. This structure allows communities to provide services in a manner appropriate to meet the unique needs of members and families residing within their local areas. Appendix A lists the names and locations of providers throughout the state who had a Substance Use Treatment Program during SFY 2020. There were approximately 1,336 SUD programs in the State of Arizona, as summarized below.

ACC, RBHA and TRBHA	Number of Programs <sup>1</sup>
Care 1 <sup>st</sup> - ACC	697
Health Choice Arizona - RBHA/ACC	150
Banner University Family Care – ACC	189
Arizona Complete Health - RBHA/ACC	206
UnitedHealthcare – ACC	59
Magellan Complete Care - ACC	120

<sup>1</sup> More than 100 SUD programs serve more than one MCO, RBHA or TRBHA thus the data in the table will exceed 1,336 SUD programs.



Mercy Care - RBHA/ACC	563
Navajo Nation – TRBHA	6
Pascua Yaqui Tribe – TRBHA	76
White Mountain Apache Tribe - TRBHA	1
Gila River Indian Community - TRBHA	3

## Program Funding

During SFY 2020, AHCCCS expended over \$529 million in service funding for members and families with SUD. The single largest source of SUD treatment funding was Medicaid as reflected in Table I, followed by Federal Substance Abuse Block Grant (SABG) funds. Additional funding included Other Federal funding including Discretionary Funds, Substance Use Disorder Services funds (the appropriated monies included in the Arizona Opioid Epidemic Act), State Appropriated dollars, funds from Maricopa County for local detoxification services, funds available through intergovernmental agreements (IGA) with the City of Phoenix, and liquor fees.

**Table I: Substance Use Disorder Treatment Funding Summary  
SFY 2020 - July 1, 2019 to June 30, 2020**

Fund Source <sup>2</sup>	Dollar Amount	Percentage
Medicaid Funding (State Match and Title XIX)	\$463,471,270	88%
Federal: Substance Abuse Block Grant (SABG)	\$29,869,776	6%
Federal: Other (Discretionary Funds)	\$25,808,377	4%
State Appropriated	\$3,247,524	1%
Substance Use Disorder Services Fund	\$5,557,049	1%
Intergovernmental Agreements: Maricopa County; City of Phoenix Central City Addiction Recovery Center	\$1,489,871	0%
Liquor Fees	\$56,815	0%
<b>Total Funding:</b>	<b>\$529,500,682</b>	<b>100.00%</b>

## Enrolled and Served Demographics

AHCCCS policy requires that members with behavioral health needs undergo a clinical assessment, administered by a clinician through a mental health or substance use treatment

<sup>2</sup> Funding in Table I represents payments to TRBHAs/RBHAs, with the exception of the Medicaid Funding data which includes substance use funding for all AHCCCS programs including RBHA, ALTCS/EPD, ACC, and the American Indian Health Program. Funding includes administrative components and other amounts that will not be reflected in the provider level substance abuse utilization data in this report (Table VI). The State Appropriated line represents Crisis Services for individuals with a Substance Use Disorder which includes behavioral health services. Federal Discretionary funds include, but are not limited to, the STR grant and the MAT-PDOA grant.

program. The information gathered during this assessment process includes several identifiable factors, such as race and ethnicity, gender, and reasons for seeking treatment. Members identified in this report include those with a SUD who were enrolled in AHCCCS and received a service from a SUD program (Appendix A) during SFY 2020.

Tables II and III below detail the demographics of these members by RBHA GSA and provide statewide totals. In SFY 2020, there were 132,076 members enrolled in AHCCCS who received at least one service from a SUD program. The Central GSA has the largest AHCCCS population in the state and consistent with its overall AHCCCS membership, represents 60% of those receiving SUD treatment services.

**Table II: Members Served with a Substance Use Disorder by GSA SFY 2020 – July 1, 2019 to June 30, 2020**

GSA's	Count	Percentage
North	17,486	13.2%
South	35,289	26.7%
Central	79,301	60.1%
<b>Statewide</b>	<b>132,076</b>	<b>100.0%</b>

**Table III: Demographics of Members Served with a Substance Use Disorder by GSA SFY2020 – July 1, 2019 to June 30, 2020**

**Gender**

The percentage of males versus females served is consistent between GSAs and statewide, with the SUD treatment population comprised of more men than women—58% versus 42%, respectively. This statistic remains consistent with the data reported for the prior year.

Gender <sup>3</sup>	North		South		Central		Statewide	
	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage
Male	9,747	55.7%	20,434	57.9%	45,779	57.7%	75,960	57.5%
Female	7,739	44.3%	14,855	42.1%	33,522	42.3%	56,116	42.4%
<b>Totals</b>	<b>17,486</b>	<b>100.0%</b>	<b>35,289</b>	<b>100.0%</b>	<b>79,301</b>	<b>100.0%</b>	<b>132,076</b>	<b>100.0%</b>

**Race and Ethnicity**

The majority (53%) of members who were enrolled and received a SUD treatment service in SFY 2020 were White. As the table illustrates, approximately 8% of members enrolled and served were African American, 7% were American Indian, 1% were Asian and <1% were Native Hawaiian/Pacific Islander. Statewide, 3% of members enrolled and served identified as Hispanic/Latino.

<sup>3</sup> Data Source: AHCCCS enrollment data set.

Race/Ethnicity <sup>4</sup>	North		South		Central		Statewide	
	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage
American Indian	3,281	18.8%	2,586	7.3%	3,825	4.8%	9,692	7.3%
Asian	56	0.3%	211	0.6%	541	0.7%	808	0.6%
African American	265	1.5%	1,850	5.2%	8,126	10.2%	10,241	7.7%
Native Hawaiian/Pacific Islander	26	0.2%	55	0.2%	134	0.2%	215	0.2%
White	11,093	63.4%	19,090	54.1%	40,272	50.8%	70,455	53.3%
Hispanic	124	0.7%	816	2.3%	2,309	2.9%	3,249	2.5%
Multi-Racial	12	0.1%	18	0.1%	37	0.1%	67	0.1%
Data Unavailable	2,629	15.0%	10,663	30.2%	24,057	30.3%	37,349	28.3%
<b>Totals</b>	<b>17,486</b>	<b>100.0%</b>	<b>35,289</b>	<b>100.0%</b>	<b>79,301</b>	<b>100.0%</b>	<b>132,076</b>	<b>100.0%</b>

### Age

An aggregate review of the data detailing members' age indicates the vast majority of members with a SUD and served in SFY 2020 were adults, with those between the ages of 25 and 44 accounting for more than half of all members (51%). Additionally, 29% of members enrolled and served were between the ages of 45 – 64. Around two percent of members were under the age of 18. This data is similar to the age distribution reported for SFY 2019.

Age Distribution <sup>5</sup>	North		South		Central		Statewide	
	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage
Birth – 4	6	0.0%	20	0.5%	43	0.0%	69	0.1%
5 – 11	4	0.0%	17	0.0%	57	0.1%	78	0.1%
12 – 14	28	0.2%	78	0.2%	142	0.2%	248	0.2%
15 – 17	206	1.2%	696	2.0%	1,267	1.6%	2,169	1.6%
18 – 20	392	2.3%	847	2.4%	1,857	2.3%	3,096	2.3%
21 – 24	876	5.0%	1,788	5.1%	4,270	5.4%	6,934	5.2%
25 – 44	8,417	48.1%	18,557	52.6%	40,362	50.9%	67,336	51.0%
45 – 64	5,580	31.9%	9,669	27.4%	22,813	28.8%	38,062	28.8%
65+	1,977	11.3%	3,617	10.2%	8,490	10.7%	14,084	10.7%
<b>Totals</b>	<b>17,486</b>	<b>100.0%</b>	<b>35,289</b>	<b>100.0%</b>	<b>79,301</b>	<b>100.0%</b>	<b>132,076</b>	<b>100.0%</b>

### Substance Use Disorders Addressed by the Programs

Table IV below illustrates the number of substance types used, as reported by members.

<sup>4</sup> Data Source: AHCCCS enrollment data set

<sup>5</sup> Data Source: AHCCCS enrollment data set.

Members are allowed to report up to three substance types. Hallucinogens was the most common reported substance used statewide by those in treatment in SFY 2020 at 37%, followed by opiates at 27%. The next substance used was alcohol at 17%, and other stimulants at 12%. The least common substance reported was benzodiazepines (<1%).

The most common substance reported by GSA was hallucinogens. It was followed by alcohol (29%) in the North GSA and opiates in the South GSA (26%) and Central GSA (27%).

**Table IV: Substance Use Type by GSA  
SFY 2020 - July 1, 2019 to June 30, 2020**

Substance Type <sup>6</sup>	North		South		Central		Statewide	
	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage
Opiates	2,256	27.0%	4,233	25.8%	7,038	26.7%	13,527	26.5%
Alcohol	2,376	28.5%	2,314	14.1%	3,731	14.2%	8,421	16.5%
Marijuana/ Hashish	20	0.2%	51	0.3%	60	0.2%	131	0.3%
Methamphetamine	52	0.6%	380	2.3%	382	1.5%	814	1.6%
Cocaine/Crack	16	0.2%	21	0.1%	36	0.1%	73	0.1%
Other Stimulants	803	9.6%	2,454	14.9%	2,778	10.5%	6,035	11.8%
Benzodiazepines	8	0.1%	3	0.0%	13	0.1%	24	0.1%
Hallucinogens	2,412	28.9%	6,060	36.9%	10,543	40.0%	19,015	37.2%
Inhalants	16	0.2%	25	0.2%	39	0.2%	80	0.2%
Other Sedatives/ Tranquilizers	353	4.2%	843	5.1%	1,628	6.2%	2,824	5.5%
All Other	3	0.0%	6	0.0%	16	0.1%	25	0.1%
None/No Use	34	0.4%	41	0.3%	82	0.3%	157	0.3%
<b>Total</b>	<b>8,349</b>	<b>100.0%</b>	<b>16,431</b>	<b>100.0%</b>	<b>26,346</b>	<b>100.0%</b>	<b>51,126</b>	<b>100.0%</b>

## Summary of Services

AHCCCS maintains a comprehensive service delivery network providing primary prevention, treatment and rehabilitation programs to children and adolescents with Serious Emotional Disturbances (SED) and/or SUD, as well as adults with General Mental Health disorders (GMH) and/or SUD, and adults determined to have a Serious Mental Illness (SMI).

AHCCCS covers a variety of screenings through Medicaid for child members at a minimum of three different stages in which tobacco, alcohol, drug (including prescription drug) and inhalant use and misuse are screened beginning with the 9-12 years of age group, then during the 13 to 17 years of age group, and again during the 18-21 years of age group. Screening can occur at more frequent intervals depending upon need and practice preferences of providers.

<sup>6</sup> Data Source: AHCCCS Online Portal, Unique Member Characteristics (UMC). Not all members selected for this report had data in UMC. AHCCCS is working on streamlining the data and data collection process to improve data submissions. Data collection of UMC data started in October 2018

With respect to SUD treatment, AHCCCS works diligently with MCOs and TRBHAs to ensure the service delivery network presents individuals with a choice of multiple, highly-qualified providers, each offering varying levels of care spanning multiple treatment modalities.

Services can primarily be grouped into eight major categories: Inpatient, Support, Medical/Pharmacy, Residential Services, Behavioral Health Day Programs, Treatment, Crisis, and Rehabilitation. Table V details the array of SUD services offered.

**Table V: Services Available to Members  
SFY 2020 - July 1, 2019 to June 30, 2020**

Service Category <sup>7</sup>	Description
1. Inpatient Services	Inpatient detoxification and treatment services delivered in hospitals and sub-acute facilities, including Level I residential treatment centers that provide 24-hour supervision, an intensive treatment program, and on-site medical services.
2. Support Services	Case management, self-help/peer support services and transportation.
3. Medical and Pharmacy	Medications and medical procedures which relieve symptoms of addiction and/or promote or enhance recovery from addiction.
4. Residential Services	Residential treatment with 24-hour supervision
5. Behavioral Health Day Programs	Skills training and ongoing support to improve the individual’s ability to function within the community. Specialized outpatient substance abuse programs provided to a person, group of persons and/or families in a variety of settings.
6. Treatment Services	Individual and group counseling, therapy, assessment, evaluation, screening, and other professional services.
7. Crisis Intervention	Stabilization services provided in the community, hospitals and residential treatment facilities.
8. Rehabilitation Services	Living skills training, cognitive rehabilitation, health promotion, and ongoing support to maintain employment.

The services listed in Table V are available to all AHCCCS members and are delivered based on need per each member’s individualized treatment plan.

Table VI shows utilization of these service categories via the number of claims, and amounts paid to providers, for AHCCCS members served with a SUD. It should be noted that the data in Table VI represents all services included in Table V provided to members with a SUD diagnosis who received at least one paid service from any of the providers in Appendix A. As indicated in the Table, on a statewide basis Inpatient Services were utilized at the highest percentage (34%) based on paid amount, followed by Residential Services (16%), whereas Behavioral Health Day Program services were used the least (1%). Utilization by service category was consistent across GSAs.

<sup>7</sup> The Service Category Medical and Pharmacy is shown in two rows in Table VI to differentiate the expenditures for the Medical Services compared to the Pharmacy amounts. The Service Category Outpatient Services (UB92) is listed as an additional row in Table VI to represent the Outpatient Hospital Services expenditures.

**Table VI: Utilization by Service Category (Based on Number of Claims and Paid Amount)  
SFY 2020 - July 1, 2019 to June 30, 2020<sup>8</sup>**

Service Category	North		South		Central		Statewide	
	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount	Count	Paid Amount
Treatment Services	91,225	\$12,292,728	230,768	\$27,498,679	434,565	\$50,837,086	756,558	\$90,628,494
Rehabilitation Services	42,673	\$2,890,379	99,889	\$7,617,666	301,560	\$21,585,152	444,122	\$32,093,198
Medical Services	42,368	\$1,998,989	690,004	\$18,653,071	769,642	\$38,634,027	1,502,014	\$59,286,087
Support Services	228,005	\$11,640,385	518,419	\$24,440,545	1,888,090	\$77,340,220	2,634,514	\$113,421,150
Crisis Intervention Services	6,036	\$2,271,412	12,246	\$6,371,489	55,513	\$24,497,060	73,795	\$33,139,962
Inpatient Services	5,806	\$22,492,786	13,970	\$38,440,534	50,681	\$208,156,854	70,457	\$269,090,174
Residential Services	41,123	\$15,799,772	89,751	\$29,765,427	322,023	\$79,149,115	452,897	\$124,714,315
Behavioral Health Day Programs	1,609	\$755,705	30,495	\$2,784,551	17,164	\$1,626,215	49,268	\$5,166,472
Outpatient Services (UB92)	20,546	\$10,977,433	5,407	\$2,902,734	59,728	\$36,348,290	85,681	\$50,228,458
Pharmacy	31,119	\$2,311,083	67,548	\$5,935,212	102,399	\$10,534,574	201,066	\$18,780,869
<b>Totals</b>	510,510	\$83,430,675	1,758,497	\$164,409,913	4,001,365	\$548,708,595	6,270,372	\$796,549,184

### Summary of Medication Assisted Treatment Services

AHCCCS maintains a comprehensive network of MAT providers throughout the state. These treatment providers use a combination of counseling and ancillary support services with medications for the treatment of OUD. The medications used for OUD treatment are in the form of Methadone, Buprenorphine (Suboxone and/or Subutex) and Naltrexone. AHCCCS maintains a minimum list of medications to ensure the availability of necessary, safe and cost effective medications for persons with behavioral health disorders.

Through AHCCCS’ response to the opioid epidemic, efforts have been focused toward enhancing the state’s multi-sector strategic plan to address the gaps in prevention, treatment and recovery support. These specific initiatives include: increasing access to OUD treatment, expanding access to MAT, increasing public awareness through stigma reduction and education, enlisting new MAT providers, ensuring 24/7 access to care points, increasing access to peer support services and increasing recovery support options.

A key component of the Arizona strategy for preventing overdose deaths from opioids is through increasing community-based access to Naloxone, the overdose reversal medication. AHCCCS continues to partner with contracted network providers and first responders to enhance statewide Naloxone distribution and accessibility. AHCCCS has developed policies and contract

<sup>8</sup> Data Source: AHCCCS Encounter and Claims Data.

language for RBHAs and their network providers so they may implement a direct service, community Naloxone distribution network in order to meet the needs of the population. Providers are focusing specifically on the most vulnerable populations for opioid overdose, which include those living in poverty, transitioning out of the criminal justice system, and those with perceived barriers to obtaining a prescription for the medication. From July 1, 2019 through June 30, 2020, AHCCCS grant funding enabled local entities to distribute 123,207 doses of Naloxone throughout Arizona.<sup>9</sup> This was a reduction from SFY 2019, likely due to the COVID-19 Pandemic.

Table VII provides unique member counts for MAT medication utilization by GSA. Table VIII (on the following page) details unique member counts utilizing MAT services as well as the additional services listed. Members can, and do, move from one GSA to another, as well as receive more than one kind of behavioral health service. However, the summary lines are distinct in total.

**Table VII: MAT Medication Utilization<sup>10 11 12</sup>  
SFY 2020 - July 1, 2019 to June 30, 2020**

MAT Medication Utilization	North	South	Central	Statewide
	Count	Count	Count	Count
<b>Total</b>	2,403	8,239	19,074	29,289

<sup>9</sup> With State Targeted Response to the Opioid Crisis (Opioid STR) and State Opioid Response (SOR) funding, Arizona Department of Health Services has distributed 26,152 Naloxone doses dispensed in Arizona; With Arizona's Substance Abuse Block Grant (SABG) funding, Sonoran Prevention Works has distributed 97,055 doses throughout Arizona.

<sup>10</sup> Data Source: AHCCCS Encounter and Claims Data. The data methodology has been improved to more accurately reflect the utilization of MAT medication services and is not comparable to previous reports.

<sup>11</sup> Medication Assisted Treatment (MAT) refers to members diagnosed with Opiate Use Disorder (OUD) (diagnosed within 90 days of the MAT) who are receiving medication to treat opioid dependence and addiction.

<sup>12</sup> The Summary Count of members by County is distinct in total. A member may appear in more than one GSA if they move GSAs within the reporting period.

**Table VIII: Services in Conjunction with MAT Medications<sup>13 14</sup>**  
**SFY 2020 - July 1, 2019 to June 30, 2020**

Support Services Type	North	South	Central	Statewide
	Count	Count	Count	Count
Inpatient Services	652	3,379	7,028	10,921
Support Services	2,227	7,939	16,927	26,532
Residential Services	287	1,204	2,438	3,848
Medical Services	2,425	8,170	19,018	28,989
Treatment Services	2,037	7,606	16,886	26,104
Crisis Intervention Services	1,189	3,652	9,053	13,689
Behavioral Health Day Programs	12	240	117	367
Behavioral Health Residential Services	26	10	66	100
Rehabilitation Services	607	3,030	1,976	5,556
<b>Totals</b>	<b>2,491</b>	<b>8,320</b>	<b>19,244</b>	<b>29,297</b>

### Summary of Substance Use Disorder Services (SUDS) fund

The SUDS fund appropriation has supplied 51,907 services to 32,555 under and uninsured distinct, unduplicated individual with OUD in Arizona between February 1, 2018 and September 30, 2020. SUDS funding allows for additional direct service options including treatment, rehabilitation, medical services, medication-assisted treatment, peer and family supports, case management, crisis intervention, inpatient services, detoxification, residential services, day program services, transportation, and assistance with high co-pays or deductibles, which often serve as a barrier to accessing treatment and other support services. This year, the five most utilized services covered include: medical services (i.e. medication services; medical management; laboratory; radiology and medical imaging), methadone for medication assisted treatment, case management services, treatment services (i.e. behavioral health counseling and therapy; assessment, evaluation and screening services) and transportation services.

### Summary

AHCCCS continues to implement strategies to maximize the benefit to Arizonans who need treatment for SUD, including the recent establishment of the AHCCCS Health Equity Committee which is tasked with understanding health disparities and developing strategies to ensure health equity for all AHCCCS members across all programs. Continual efforts are being conducted in partnership with other state agencies, MCOs, providers and stakeholders committed to assisting those seeking recovery assistance in improving their quality of life and success in the community. The comprehensive array of services provided through the funding described in this

<sup>13</sup> Data Source: AHCCCS Encounter and Claims Data. The data methodology has been improved to more accurately reflect the utilization of services and is not comparable to previous reports.

<sup>14</sup> This table reports on behavioral health service categories for the members receiving MAT for Opiate use disorder.



report offer opportunities for each member in need of SUD services to be provided with treatment through the use of evidence based practices and individualized treatment planning. Services are available statewide and are tailored to be clinically and culturally appropriate for all age groups, genders, races, ethnic backgrounds and other areas of diversity.

## Appendix A: Name and Location of SUD Programs

Program Name	Service Address	City	State	Zip
2Nd Chance Treatment Centers PLLC	2450 E Guadalupe Rd Ste 103	Gilbert	AZ	85234
2Nd Chance Treatment Centers PLLC	6535 W Camelback Rd Ste 4	Phoenix	AZ	85033
2Nd Chance Treatment Centers, PLLC	101 North 7Th Street, Unit 219	Phoenix	AZ	85034
2Nd Chance Treatment Centers, PLLC	16620 North 40Th Street Suite I-5	Phoenix	AZ	85032
4C Medical Group PLC:	1208 East Broadway, Suite 215	Tempe	AZ	85282
4C Medical Group PLC:	2451 East Baseline Road, Suite 100	Gilbert	AZ	85234
4C Medical Group PLC:	2601 East Roosevelt Road	Phoenix	AZ	85008
A Brighter Day	264 North Exeter Street	Chandler	AZ	85225
AHCCMS- Crocus	3048 W Crocus Dr	Phoenix	AZ	85023
A New Leaf Dorothy B Mitchell Counseling Center	1655 E University Dr Ste 100 101	Mesa	AZ	85203
A New Leaf Family Care La Mesita	2254 W Main St	Mesa	AZ	85201
A New Leaf Pact	960 N Stapley Bldg 210	Mesa	AZ	85203
A New Leaf West Valley After School Program	8802 N 61St Ave	Glendale	AZ	85302
A New Leaf West Valley Behavioral Health Services	8581 N 61St Ave Bldg 102	Glendale	AZ	85302
A New Leaf:	12725 West Indian School Road, Suite F-109	Phoenix	AZ	85392
A New Leaf: The New Foundation	1200 N. 77Th St.	Scottsdale	AZ	85257
A Path Of Resilience	6102 S 37Th Ln	Phoenix	AZ	85041
A.I.A. Hospitalists LLC:	2680 South Val Vista Drive, Building 15, Suite 185	Gilbert	AZ	85295
A.I.A. Hospitalists LLC:	4530 East Muirwood Drive, Suite 105	Phoenix	AZ	85048
Abba Behavioral Health, LLC	21388 N 106Th Ln	Peoria	AZ	85382
Adelante Care Today Surprise	15317 W Bell Rd Ste 100	Surprise	AZ	85374
Adelante Health Peoria	15525 N 83Rd Ave Ste 104	Peoria	AZ	85382
Adelante Healthcare	500 W Thomas Rd Ste 870	Phoenix	AZ	85013
Adelante Healthcare Avondale	3400 N Dysart Rd Ste F121	Avondale	AZ	85392
Adelante Healthcare Buckeye	306 E Monroe	Buckeye	AZ	85326
Adelante Healthcare Gila Bend	100 N Gila Blvd	Gila Bend	AZ	85337
Adelante Healthcare Goodyear	13471 W Cornerstone Blvd	Goodyear	AZ	85395
Adelante Healthcare Mesa	1705 W Main St	Mesa	AZ	85201
Adelante Healthcare Phoenix	7725 N 43Rd Ave Ste 510	Phoenix	AZ	85051
Adelante Healthcare Surprise	15351 W Bell Rd	Surprise	AZ	85374
Adelante Healthcare Wickenburg	811 N Tegner St Ste 113	Wickenburg	AZ	85390
Advanced Behavioral Health Services	9417 North 17Th Place	Phoenix	AZ	85020
Affinity Behavioral Care	16800 W Roosevelt St	Goodyear	AZ	85338
Affinity Behavioral Care	1946 S 174Th Ln	Goodyear	AZ	85338
Affinity Behavioral Care	4349 N 161St Ave	Goodyear	AZ	85395
Affinity Behavioral Care	560 N 159Th Ln	Goodyear	AZ	85338
Affinity Behavioral Care LLC	16575 W Roosevelt St	Goodyear	AZ	85338
Agave Residential Care Home	3013 W Pollack St	Phoenix	AZ	85041

Program Name	Service Address	City	State	Zip
Ahccms Clearview Resid Pr	4301 W Windrose Dr	Glendale	AZ	85304
Ahccms- Hayward	7722 N 42Nd Ave	Phoenix	AZ	85051
Ahccms- Quail Creek	1829 E 2Nd St	Mesa	AZ	85203
Ahccms State House Residential	2022 W State	Phoenix	AZ	85021
Ahccms-110 W Camelback	110 W Camelback Rd	Phoenix	AZ	85013
Ahccms-Ironwood	10010 N 36Th Ave	Phoenix	AZ	85051
Ahccms-Keim	2208 W Keim	Phoenix	AZ	85015
Ahccms-Kings Residential Program	6627 W Kings Ave	Glendale	AZ	85306
Ahccms-Oregon Residential	6835 W Oregon	Glendale	AZ	85303
Ahccms-Six Pines	5344 N 40Th Ln	Phoenix	AZ	85019
Ahccms-Ward Manor Res	1018 E El Caminito	Phoenix	AZ	85020
Aid To Adoption Of Special Kids	2320 N 20Th St	Phoenix	AZ	85006
Ajo Community Health Center:	410 North Malacate Street	Ajo	AZ	85321
Albert Long Residential Program	993 Hermosa Dr B	Holbrook	AZ	86025
Alevea Mental Health LLC:	2034 East Southern Avenue, Suite D	Tempe	AZ	85282
Align Group Home LLC	1460 East Baker Drive	San Tan Valley	AZ	85410
Alium Health LLC	9440 E Ironwood Sq Dr	Scottsdale	AZ	85258
Allen Family Medicine PLLC:	1030 East Guadalupe Road	Tempe	AZ	85283
Alley Anesthesiology Consultants Inc.:	1850 North Central Avenue, Suite 1600	Phoenix	AZ	85004
Alliance Behavioral Care LLC	1024 North Ridge Circle	Mesa	AZ	85203
Alliance Behavioral Care LLC	1101 East Goldcrest Street	Gilbert	AZ	85297
Alliance Behavioral Care LLC	1469 East Ivanhoe Street	Gilbert	AZ	85295
Alliance Behavioral Care LLC	16781 West Hilton Avenue	Goodyear	AZ	85338
Alliance Behavioral Care LLC	2107 East Geneva Drive	Tempe	AZ	85282
Alliance Behavioral Care LLC	230 East Frances Lane	Gilbert	AZ	85295
Alliance Behavioral Care LLC	3447 E Dublin St	Gilbert	AZ	85295
Alpine Villa: Alpine villa	3113 W Port Au Prince	Phoenix	AZ	85053
Alpine Villa: Alpine villa LLC	3530 W Caribbean Ln	Phoenix	AZ	85053
Alpine Villa: Alpine villa Luke	2144 W Luke Ave	Phoenix	AZ	85015
Amity Foundation	10500 E. Tanque Verde Rd.	Tucson	AZ	85749
Anchored Hearts LLC	10428 East Osage Avenue	Mesa	AZ	85212
Angel Family Care LLC	28370 North Gold Lane	San Tan Valley	AZ	85143
Angel Heart	1114 West College Drive	Phoenix	AZ	85037
Angel Heart	7432 West Glendosa Avenue	Phoenix	AZ	85033
Angel Heart	9223 West Meadowcreek Road	Phoenix	AZ	85037
Angel Heart Behavioral Health LLC	11114 W College Dr	Phoenix	AZ	85037
Angelic Homes LLC	2869 East Isaiah Avenue	Gilbert	AZ	85298
Anthem Pain Management LLC:	41818 North Venture Drive, Suite 150	Anthem	AZ	85086
Anything Is Possible: Anything Is Possible Youth & Family Services LLC	793 N. Alma School Rd Suite D4	Chandler	AZ	85224
Applied Behavioral Health Interventions	10000 N 31St Ave Suite A	Phoenix	AZ	85051
Arizona Autism United	5025 E Washington St Ste 212	Phoenix	AZ	85034

Program Name	Service Address	City	State	Zip
Arizona Autism United Inc	4309 E Florian Ave	Mesa	AZ	85206
Arizona Behavioral Health Center (AZBHC)	2600 N 44Th St Ste B104	Phoenix	AZ	85008
Arizona Center For Change	4205 North 7Th Avenue, #311	Phoenix	AZ	85013
Arizona Community Physicians Pc:	1702 West Anklam Road, Suite 110	Tucson	AZ	85745
Arizona Digestive Health Pc:	10261 North 92Nd Street	Scottsdale	AZ	85258
Arizona Digestive Health Pc:	1950 West Frye Road	Chandler	AZ	85224
Arizona Digestive Health Pc:	3815 East Bell Road, Suite 4500	Phoenix	AZ	85032
Arizona Digestive Health Pc:	4545 East Chandler Blvd.	Phoenix	AZ	85048
Arizona Digestive Health Pc:	9201 West Thomas Road	Phoenix	AZ	85037
Arizona Digestive Health Pc:	9930 West Indian School Road	Phoenix	AZ	85037
Arizona Mentor	2700 N 3Rd St Ste 4000	Phoenix	AZ	85004
Arizona Mentor - Aztec	2413 N 92Nd Ln	Phoenix	AZ	85037
Arizona Mentor - Cactus	12002 N 28Th St	Phoenix	AZ	85028
Arizona Mentor - Chestnut	9287 W Belvoir Rd	Phoenix	AZ	85037
Arizona Mentor - Outpatient	3838 N Central Ave 12Th Fl	Phoenix	AZ	85012
Arizona Mentor Evergreen	9225 W Elm St	Phoenix	AZ	85037
Arizona Mentor Meadowbrook	8439 W Meadowbrook	Phoenix	AZ	85037
Arizona Mentor-Arizona City	8428 W Royal Blackheath Dr	Arizona City	AZ	85123
Arizona Mentor-Cambridge	9131 W Cambridge Ave	Phoenix	AZ	85037
Arizona Mentor-Curry	874 S Sunset Ct	Chandler	AZ	85225
Arizona Mentor-Desert Wind	7223 S 71St Ln	Laveen	AZ	85339
Arizona Mentor-Echo	8851 W Northview Ave	Glendale	AZ	85305
Arizona Mentor-Hawthorne	5621 S 51St Dr	Laveen	AZ	85339
Arizona Mentor-Horizon	3046 E Kingbird Pl	Chandler	AZ	85286
Arizona Mentor-Jasmine	12502 N. 85Th Lane	Peoria	AZ	85381
Arizona Mentor-Keats	7561 E Keats Ave	Mesa	AZ	85209
Arizona Mentor-Melissa	1668 E Melissa St	Casa Grande	AZ	85122
Arizona Mentor-Ocotillo	1918 S Ocotillo Dr	Apache Junction	AZ	85120
Arizona Mentor-Racine	621 W Racine Loop	Casa Grande	AZ	85122
Arizona Mentor-Union Hill	18244 N 39Th Dr	Glendale	AZ	85308
Arizona Mentor-Verlea	1316 E Verlea Dr	Tempe	AZ	85282
Arizona Rehab Campus LLC	6944 E Tanque Verde Rd	Tucson	AZ	85715
Arizona Rehab Campus LLC:	2435 North Castro Avenue	Tucson	AZ	85713
Arizona Youth & Family Services	3707 N 7Th St Ste 200	Phoenix	AZ	85014
Arizona's Children Association	111 E Monroe Ave Ste 102	Buckeye	AZ	85326
Arizona's Children Association	11321 W Bell Rd Ste 401	Surprise	AZ	85378
Arizona's Children Association	1445 W Chandler Blvd Bldg B 10 Ste A	Chandler	AZ	85225
Arizona's Children Association	2028 N Trell Rd Ste 102	Casa Grande	AZ	85122
Arizona's Children Association	2066 W Apache Trl Ste 101 111 112	Apache Junction	AZ	85120
Arizona's Children Association	225 S Orlando St	Florence	AZ	85132
Arizona's Children Association	3636 N Central Ave Ste 300	Phoenix	AZ	85012

Program Name	Service Address	City	State	Zip
Arizona's Children Association	375 E Elliot Rd Ste 11 12 13 14	Chandler	AZ	85225
Arizona's Children Association	7910 W Thomas Rd Ste 103	Phoenix	AZ	85033
Arizona's Children Association	7910 W Thomas Rd Ste 112	Phoenix	AZ	85033
Asap Adolescent Substance Abuse Program	2530 S Alma School Rd	Mesa	AZ	85210
Asap Adolescent Substance Abuse Program	3839 E Shea Blvd	Phoenix	AZ	85028
Asap Adolescent Substance Abuse Program	8607 N 59Th Ave Ste C6	Glendale	AZ	85302
Ascend Behavioral Health & Wellness	1812 W. Horsetail Trail	Phoenix	AZ	85085
Ascend Behavioral Health & Wellness	2432 W. Eagle Feather Rd.	Phoenix	AZ	85085
Ascend Behavioral Health & Wellness	3054 W. Leisure Road	Phoenix	AZ	85086
Ascend Behavioral Health & Wellness	35005 N. 27Th Lane	Phoenix	AZ	85086
Ascend Behavioral Health And Wellness	2029 W Caleb Road	Phoenix	AZ	85085
Ascend Behavioral Health And Wellness	2432 W Eagle Feather Road	Phoenix	AZ	85085
Ascend Behavioral Health And Wellness	27818 N 24Th Lane	Phoenix	AZ	85085
Ascend Behavioral Health And Wellness	33508 N 24Th Lane	Phoenix	AZ	85085
Ascend Behavioral Health And Wellness	35808 N 34Th Lane	Phoenix	AZ	85086
Ascend Behavioral Health And Wellness	36106 N 30Th Ave	Phoenix	AZ	85086
Ascend Behavioral Health And Wellness	512 W Yearling Road	Phoenix	AZ	85085
Aurora Behavioral Health System - Tempe	6350 S Maple Ave	Tempe	AZ	85283
Aurora Behavioral Health System LLC	6015 W Peoria Ave	Glendale	AZ	85302
Awakening Recovery Center	1204 E Baseline Rd	Tempe	AZ	85283
AZ Center For Change	4205 N 7Th Ave Ste 311	Phoenix	AZ	85013
AZ Comfort Home LLC	23832 W Tonto St	Buckeye	AZ	85326
Azi House LLC	6914 South Bittercress Road	Tucson	AZ	85756
Baart Behavioral Health Services Inc	908 W Chandler Blvd Ste A	Chandler	AZ	85225
Baljeet Singh Md	13820 N 51St Ave Ste 100	Glendale	AZ	85306
Banner Behavioral Health Hosp	7575 E Earll Dr	Scottsdale	AZ	85251
Banner Cancer Center Specialists LLC:	1900 North Higley Road	Gilbert	AZ	85234
Banner Cancer Center Specialists LLC:	2946 East Banner	Gilbert	AZ	85234
Banner Del E Webb Medical Center	14502 W Meeker Blvd	Sun City West	AZ	85375
Banner Desert Behavioral:	7301 East 2Nd Street, Suite 210	Scottsdale	AZ	85251
Banner Hospital Based Physicians Arizona LLC:	1111 East Mcdowell Road	Phoenix	AZ	85006
Banner Hospital Based Physicians Arizona LLC:	1400 South Dobson Road	Mesa	AZ	85202
Banner Hospital Based Physicians Arizona LLC:	1441 North 12Th Street	Phoenix	AZ	85006
Banner Hospital Based Physicians Arizona LLC:	9201 West Thomas Road	Phoenix	AZ	85037
Banner Physician Specialist Of Arizona:	925 East Mccdowell Road, Third Floor	Phoenix	AZ	85006
Banner Physician Specialist Of Arizona:	9305 West Thomas Road. Suite 405	Phoenix	AZ	85037
Banner Physician Super Specialists Arizona LLC:	1300 North 12Th Street, Suite 608	Phoenix	AZ	85006
Banner Physician Super Specialists Arizona LLC:	1432 South Dobson Road, Suite 107	Mesa	AZ	85202
Banner Primary Care:	1917 South Crimson Road	Queen Creek	AZ	85209
Banner Thunderbird BHC	5555 W Thunderbird Rd	Glendale	AZ	85306
Banner University Medical group:	1501 North Campbell Avenue	Tucson	AZ	85724

Program Name	Service Address	City	State	Zip
Banner University Medical group:	1501 North Campbell Avenue	Tucson	AZ	85724
Banner University Medical group:	2800 East Ajo Way	Tucson	AZ	85713
Banner University Medicine Crisis Response Center:	2802 East District Street	Tucson	AZ	85714
Banner University Medical Group	535 N. Wilmot Suite 201	Tucson	AZ	85711
Banner University Primary Care Physicians LLC:	117 East Main Street, Suite A-100	Payson	AZ	85441
Banner University Primary care Physicians LLC:	1300 South 12Th Street, Suite 608	Phoenix	AZ	85006
Banner Urgent Care Services:	10330 North Scottsdale Road, Suite 05	Phoenix	AZ	85004
Banner Urgent Care Services:	641 West Warner Road	Gilbert	AZ	85233
Banner Urgent Care Services:	707 North Alvernon Way, Suite 101	Tucson	AZ	85711
Banner Urgent Care Services:	7952 North 43Rd Avenue	Glendale	AZ	85301
Banner Urgent Care Services:	931 East Elliott Road	Mesa	AZ	85212
Baraka House	3740 W Caron	Phoenix	AZ	85051
Baraka House li	13619 N 36Th Ave	Phoenix	AZ	85029
Baraka House Iv	7445 W Cheryl Dr	Peoria	AZ	85345
Baraka House V	3302 W Mescal	Phoenix	AZ	85029
Bayless Integrated HealthCare	77 East Columbus Avenue Suite 210	Phoenix	AZ	85012
BBC Whitton	1106 E Whitton Ave	Phoenix	AZ	85014
Beautiful Beginnings	2819 South 73Rd Drive	Phoenix	AZ	85043
Beautiful Beginnings	5321 West Novak Way	Laveen	AZ	85339
Beautiful Beginnings	5427 West Novak Way	Laveen	AZ	85339
Beautiful Beginnings	7316 West Cordes Road	Phoenix	AZ	85043
Behavioral Awareness Center	2002 West Anklam Road	Tucson	AZ	85745
Benchmark Valley	6920 West Carson Road	Laveen	AZ	85339
Benchmark Valley Behavior	5625 Euclid Ave	Laveen	AZ	85339
Benchmark Valley Behavioral Home	5625 W Euclid Ave	Laveen	AZ	85339
Benchmark Valley Behavioral Home	5818 W Pedro Ln	Laveen	AZ	85339
Bentleys Transition Living	6432 S 23Rd Ave	Phoenix	AZ	85041
Best Care Behavioral	4161 North Cholla Drive	Prescott	AZ	85314
Better Horizons Ashridge	18491 E Ashridge Dr	Chandler Heights	AZ	85142
Better Horizons Fever Tree	1136 W Fever Tree Ave	Queen Creek	AZ	85140
Better Horizons LLC	146 E Elgin St	Gilbert	AZ	85295
Better Horizons LLC	2442 E Eleana Ln	Gilbert	AZ	85298
Better Horizons LLC	3030 E Sports Ct	Gilbert	AZ	85298
Better Horizons LLC	3800 E Lafayette Ave	Gilbert	AZ	85298
Better Horizons LLC - Firestone	2184 E Firestone Dr	Chandler	AZ	85249
Better Horizons LLC - Gilbert	910 E Frances Ln	Gilbert	AZ	85295
Better Horizons LLC - La Costa	2851 E La Costa Dr	Chandler	AZ	85249
Black Canyon Medical:	17301 East Spring Street, Suite F	Spring Valley	AZ	86333
Black Family & Child Services Substance Abuse Program	1522 E Southern Ave	Phoenix	AZ	85040
Body Soul Community Counseling Services LLC	5060 N 19Th Ave Ste 218	Phoenix	AZ	85015
Bridging The Hope Counseling Service	5320 N 16Th St Ste 102	Phoenix	AZ	85016

Program Name	Service Address	City	State	Zip
Buena Vista Recovery LLC	3033 S Arizona Ave	Chandler	AZ	85248
C P E S	324 S. Ocotillo Ave	Benson	AZ	85602
C P E S	4444 E. Grant Rd. #116	Tucson	AZ	85712
Cadens Health And Wellness	4114 W Desert Ln	Laveen	AZ	85339
Cadens Health And Wellness	810 N 6Th Ave	Phoenix	AZ	85003
Canyon Lands Community Health Care:	2016 West 16Th Street	Safford	AZ	85546
Canyon Medical Clinic LLC:	34501 South Old Black Canyon Highway	Black Canyon City	AZ	85324
Casa Grande Cpes Bhs	609 W Cottonwood Ln Ste 4	Casa Grande	AZ	85122
Catalina pediatrics:	3085 North Swan Road	Tucson	AZ	85712
Catholic Charities Counseling Program	5119 N. 19Th Ave Suite G	Phoenix	Az	85015
Cayonland Healthcare	10 A Ward Canyon Dr	Clifton	AZ	85533
Cayonland Healthcare	227 Main St	Duncan	AZ	85534
Cayonland Healthcare	3272 E Rio Virgin Rd	Beaver	AZ	86432
Cayonland Healthcare	467 Vista Ave	Page (And	AZ	86040
Cayonland Healthcare	5860 Hospital Dr Ste 102	Globe	AZ	85501
Ceb Capital LLC (Be healthy):	9150 West Indian School Road, Suite 111B	Phoenix	AZ	85037
Center For Behavioral Health Inc	2123 E Southern Ave	Tempe	AZ	85282
Center For Behavioral Health Phoenix Inc	1501 E Washington St	Phoenix	AZ	85034
Center For Pain And Supportive Care:	4611 East Shea Blvd., Building 3, Suite 190	Phoenix	AZ	85028
Change Point Integrated Health: Snowflake	423 S. Main Street	Snowflake	AZ	85937
Changepoint Integrated Health	1015 E Second St	Winslow	AZ	86047
Changepoint Integrated Health	103 N First Ave	Holbrook	AZ	86025
Changepoint Integrated Health	2500 E Show Low Lake Rd Bldg A	Show Low	AZ	85901
Changepoint Integrated Health	437 S Main St	Snowflake	AZ	85937
Changepoint Integrated Health - Psychiatric Hospital	1920 W Commerce Dr	Lakeside	AZ	85929
Changepoint Integrated Health:	1910 West Commerce Drive	Lakeside	AZ	85929
Cheers	1950 W Heatherbrae Suite 5	Phoenix	AZ	85015
Chicanos Por La Causa (CPLC)	Corazon 3639 W Lincoln St	Phoenix,	AZ	85009
Chicanos Por La Causa (CPLC) Maryvale Centro De La Familia	6850 W Indian School Rd	Phoenix,	AZ	85033
Chicanos Por La Causa Esperanza Op Clinic	325 N Stapley Dr	Mesa	AZ	85203
Chicanos Por La Causa Inc	3639 W Lincoln St	Phoenix	AZ	85009
Chicanos Por La Causa Op Clinic	1112 E Buckeye Rd	Phoenix	AZ	85034
Child And Family Support Services	10439 S 51St St Ste 100	Phoenix	AZ	85044
Child Crisis Arizona	170 W University Dr	Mesa	AZ	85201
Childhelp Inc	2120 N Central Ave Ste 130	Phoenix	AZ	85004
Children's Rehabilitative Services	3141 N 3Rd Ave	Phoenix	AZ	85013
Chinle Outpatient Treatment Center	Post Office Box 777	Chinle	AZ	86503
Chiricahua Community Health Centers:	155 Calle Portal, Suite 300	Sierra Vista	AZ	85635
Chiricahua Community Health Centers:	10566 Highway 191	Elfrida	AZ	85610
Choice Recovery Centers	2222 S Dobson Rd Ste 1002	Mesa	AZ	85202
Christian Family Care Agency Inc	2346 N Central Ave	Phoenix	AZ	85004

Program Name	Service Address	City	State	Zip
Cigna Health Care Of Arizona:	5891 West Eugie Avenue	Glendale	AZ	85304
Circle The City After Hrs	1125 W Clarendon Ave Ste 200	Phoenix	AZ	85013
Circle The City After Hrs	230 S 12Th Ave Ste 830	Phoenix	AZ	85007
Circle The City Downtown	220 S 12Th St	Phoenix	AZ	85007
Circle The City Fhc Umom	3333 E Van Buren St	Phoenix	AZ	85008
Circle The City Medical	210 S 12Th Ave	Phoenix	AZ	85007
Circle The City Medical	333 W Indian School Rd	Phoenix	AZ	85013
Circle the city:	3522 North 3Rd Avenue	Phoenix	AZ	85013
Clean Slate	7725 N. 43Rd Ave	Phoenix	AZ	85037
Cleanslate Medical Group Of Arizona PLLC	15255 N 40Th St Ste 135	Phoenix	AZ	85032
Cleanslate Medical Group Of Arizona PLLC	2451 E Baseline Rd Ste 430	Gilbert	AZ	85234
Cleanslate Medical Group Of Arizona PLLC	7725 N 43Rd Ave Ste 522	Phoenix	AZ	85051
Cleanslate Medical Group Of Arizona PLLC	8410 W Thomas Rd Ste 124	Phoenix	AZ	85037
Clear Choice Physicians LLC:	6328 East Brown Road, Suite 106	Mesa	AZ	85205
Clinica Familiar Bellavista Pc:	515 West Buckeye Road, Suite 303	Phoenix	AZ	85003
Codac - Gila House *	2482 N. Palo Verde Blvd.	Tucson	AZ	85716
Codac Behavioral Health Services Of Pima County Inc	1600 N Country Club Rd	Tucson	AZ	85716
Codac Health Recovery & Wellness	1075 E. Fort Lowell Rd	Tucson	AZ	85719
Codac Health Recovery & Wellness	380 E Fort Lowell Rd	Tucson	AZ	85716
Codac Health Recovery & Wellness	520 N. Silverbell Rd	Tucson	AZ	85745
Codac Health Recovery & Wellness	630 N. Alvernon Way, Suite 161	Tucson	AZ	85711
Codac Health Recovery And Wellness	2842 N Palo Verde Ave	Tucson	AZ	85716
Codac -Las Amigas (Women)	502 N Silverbell Rd	Tucson	AZ	85745
Comfort Care Celtic Homes	22509 North Celtic Avenue	Maricopa	AZ	85139
Community Bridges	2800 E. Ajo Way	Tucson	AZ	85713
Community Bridges	554 E. Bellview	Mesa	AZ	85204
Community Bridges	8541 E. Anderson Dr., Ste. 105	Scottsdale	AZ	85255
Community Bridges - Aspire	1012 S. Stapley Dr., Bldg. 5	Mesa	AZ	85204
Community Bridges Casa Grande Osc	675 E Cottonwood Ste 101	Casa Grande	AZ	85122
Community Bridges - Casa Grande Sru	675 E Cottonwood	Casa Grande	AZ	85122
Community Bridges - Payson Sru	803 W Main St	Payson	AZ	85541
Community Bridges - Payson Transition Point	220 S 12Th Ave	Phoenix	AZ	85007
Community Bridges - Payson Transition Point	250 S Toole Ave Ste B	Tucson	AZ	85701
Community Bridges - Payson Transition Point	803 W Main St Unit B	Payson	AZ	85541
Community Bridges - Payson Transition Point	995 Hermosa Dr Ste A	Holbrook	AZ	86025
Community Bridges - Winslow Sru	105 N Cottonwood	Winslow	AZ	86047
Community Bridges Center For Hope	544 S Bellview	Mesa	AZ	85204
Community Bridges Central City Addiction Recovery Center	2770 E Van Buren St	Phoenix	AZ	85008
Community Bridges Globe Outpatient Service	5734 E Hope Ln	Globe	AZ	85501
Community Bridges Inc	110 E Second St	Winslow	AZ	86047
Community Bridges Inc	1855 W Baseline Ste 101	Mesa	AZ	85202



Program Name	Service Address	City	State	Zip
Community Bridges Inc	240 O'Hara Ave	Bisbee	AZ	85603
Community Bridges Inc	250 S Toole Ave Ste 110	Tucson	AZ	85701
Community Bridges Inc	250 S Toole Ave Ste 130	Tucson	AZ	85701
Community Bridges Inc	250 S Toole Ave Ste C	Tucson	AZ	85701
Community Bridges Inc	2950 N Dodge Blvd Ste A	Tucson	AZ	85716
Community Bridges Inc	3250 E 40Th St # B	Yuma	AZ	85365
Community Bridges Inc	358 E Javelina Ave Ste 101	Mesa	AZ	85210
Community Bridges Inc	358 E Javelina Ave Ste 102	Mesa	AZ	85210
Community Bridges Inc	470 S Ocotillo Ave # 2	Benson	AZ	85602
Community Bridges Inc	560 S Bellview	Mesa	AZ	85204
Community Bridges Inc	646 W Union St	Benson	AZ	85602
Community Bridges Inc	675 E Cottonwood Ln Ste 140	Casa Grande	AZ	85122
Community Bridges Inc	824 N 99Th Ave Ste 105	Avondale	AZ	85323
Community Bridges Inc	824 N 99Th Ave Ste 108	Avondale	AZ	85323
Community Bridges Inc	824 N 99Th Ave Ste 109	Avondale	AZ	85323
Community Bridges Inc	993 Hermosa Dr Area B	Holbrook	AZ	86025
Community Bridges Inc - Aspire Outpatient	1012 S Stapley Dr Ste 117	Mesa	AZ	85204
Community Bridges Inc.	5734 E Hope Lane Suite 2	Globe	AZ	85501
Community Bridges West Valley Access Point	824 N 99Th Ave Ste 107 108	Avondale	AZ	85323
Community Bridges:	1301 West Beale Street	Kingman	AZ	86401
Community Bridges:	2601 East Roosevelt	Phoenix	AZ	85008
Community Bridges:	3759 North Morning Dove Circle	Mesa	AZ	85207
Community Bridges:	633 East Ray Road, Suite 131	Gilbert	AZ	85296
Community Bridges:	690 North Cofco Center Court	Phoenix	AZ	85008
Community Bridges:	9201 East Mountain View Road, Suite 220	Scottsdale	AZ	85258
Community Bridges: Cactus Integrated Care	1520 East Pima Street	Phoenix	AZ	85034
Community Bridges: Phoenix Rise	1125 West Jackson Street	Phoenix	AZ	85007
Community Bridges: Winslow Outpatient Services Center	110 E. 2Nd Street	Winslow	AZ	85607
Community Connections	18215 N 11Th Dr	Phoenix	AZ	85025
Community Connections	2301 E Greenway Rd	Phoenix	AZ	85022
Community Connections LLC	4025 W Bell Rd Ste 6	Phoenix	AZ	85053
Community Connections, LLC	17604 N 39Th Ave	Glendale	AZ	85308
Community Health Associates	1516 Ocotillo Ave.	Parker	AZ	85344
Community Health Associates	1667 N Trell Rd	Casa Grande	AZ	85122
Community Health Associates	1701 North Douglas	Douglas	AZ	85607
Community Health Associates	1773 W. St. Mary's Rd Suite 105	Tucson	AZ	85745
Community Health Associates	1923 N Trell Rd	Casa Grande	AZ	85122
Community Health Associates	1938 E. Juan Sanchez Blvd. Suite 4	San Luis	AZ	85349
Community Health Associates	2851 S Avenue B Bldg 4	Yuma	AZ	85364
Community Health Associates	32 Boulevard Del Rey David	Nogales	AZ	85621
Community Health Associates	410 S Maiden Ln	Yuma	AZ	85364

Program Name	Service Address	City	State	Zip
Community Health Associates (Cha)	1326 Highway 92 Suite J	Bisbee	AZ	85603
Community Health Associates (Cha)	1773 W. St. Mary's Rd Suite 102	Tucson	AZ	85745
Community Health Associates (Cha)	275 W. Continental Rd Suites 133 A B C D & 141	Green Valley	AZ	85622
Community Medical Services-Camelback	4527 N 27Th Ave	Phoenix	AZ	85017
Community Medical Services	102 E. Main St.	Safford	AZ	85546
Community Medical Services	302 El Camino Real, 10-C	Sierra Vista	AZ	85635
Community Medical Services	302 El Camino Real, Bldg 10, Suite C & D	Sierra Vista	AZ	85635
Community Medical Services - 23Rd Ave Clinic	7830 N 23Rd Ave	Phoenix	AZ	85021
Community Medical Services - Broadway Clinic	6802 E Broadway Blvd	Tucson	AZ	85710
Community Medical Services - Buckeye Clinic	213 E Monroe Ave	Buckeye	AZ	85326
Community Medical Services - Camelback Clinic	4527 N 27Th Ave	Phoenix	AZ	85017
Community Medical Services - Casa Grande	440 N Camino Mercado Ste 2	Casa Grande	AZ	85122
Community Medical Services - Casa Grande Medication Unit	440 N Camino Mercado Ste. B	Casa Grande	AZ	85122
Community Medical Services - Glendale	5002 W Glendale Ave Ste 101 And 102	Glendale	AZ	85301
Community Medical Services - Kingman Clinic	1115 Stockton Hill Rd Ste. 104	Kingman	AZ	86401
Community Medical Services - Mesa On Main Clinic	2940 E Main St	Mesa	AZ	85213
Community Medical Services - Nogales Medication Unit	274 W Viewpoint Drive	Nogales	AZ	85621
Community Medical Services - Northern Clinic	2301 W Northern Ave	Phoenix	AZ	85021
Community Medical Services - Peoria Clinic	10689 N 99Th Ave	Peoria	AZ	85345
Community Medical Services - Show Low Clinic	1500 E Woolford Road, Suite 101	Show Low	AZ	85901
Community Medical Services - Tucson On Park Clinic	3720 S Park Ave, Suite 601	Tucson	AZ	85704
Community Medical Services - Yuma Clinic	501 W 8Th St	Yuma	AZ	85364
Community Medical Services Arizona	2001 W Orange Grove Rd Ste 202	Tucson	AZ	85704
Community Medical Services Arizona	3825 N 24Th St	Phoenix	AZ	85016
Community Medical Services Arizona	6116 E Arbor Ave Ste 104	Mesa	AZ	85206
Community Medical Services Arizona	6626 E Carondelet Dr	Tucson	AZ	85710
Community Medical Services Private LLC:	1655 North Tegner Street	Wickenburg	AZ	85390
Community Medical Services Private LLC:	4103 East Hawthorne Street	Tucson	AZ	85711
Community Medical Services Tempe On Rural	2525 S Rural Ave Ste 9 -10 N	Tempe	AZ	85282
Community Partners Integrated Health:	3130 East Broadway	Tucson	AZ	85716
Community Partners Integrated Healthcare	1021 S Kofa Ave	Parker	AZ	85344
Community Partners Integrated Healthcare	1515 E Osborn Rd	Phoenix	AZ	85014
Community Partners Integrated Healthcare	20046 N John Wayne Pkwy Ste 102	Maricopa	AZ	85139
Community Partners Integrated Healthcare	2039 E Wilcox Dr Ste A	Sierra Vista	AZ	85635
Community Partners Integrated Healthcare	2039 E Wilcox Dr Ste B	Sierra Vista	AZ	85635
Community Partners Integrated Healthcare	2502 N Dodge Blvd Ste 130	Tucson	AZ	85716
Community Partners Integrated Healthcare	2545 S Arizona Ave Bldg A-D	Yuma	AZ	85364
Community Partners Integrated Healthcare	301 E 4Th St Ste A	Safford	AZ	85546
Community Partners Integrated Healthcare	301 E 4Th St Ste B	Safford	AZ	85546
Community Partners Integrated Healthcare	3939 S Park Ave Ste 150-190	Tucson	AZ	85714
Community Partners Integrated Healthcare	5055 E Broadway Blvd Ste A200	Tucson	AZ	85711

Program Name	Service Address	City	State	Zip
Community Partners Integrated Healthcare Inc	2273 E Wilcox Drive	Sierra Vista	AZ	85635
Community Provider Of Enrichment Services (Cpes)	4825 N Sabino Canyon Road	Tucson	AZ	85750
Community Provider Of Enrichment Services Winthrop	1509 S Winthrop	Mesa	AZ	85204
Community Support Services, Inc.	423 N Country Club Drive, Suite 36	Mesa	AZ	85201
Community Support Services, Inc.	5540 W Glendale Ave Suite B103	Glendale	AZ	85301
Community Bridges:	3548 East Renee Drive	Phoenix	AZ	85050
Community Medical Services Private LLC:	3844 West Van Buren Street	Phoenix	AZ	85009
Connections Access LLC	1135 N Jones Blvd	Tucson	AZ	85716
Connections Access LLC:	1475 West Saint Mary's Road	Tucson	AZ	85745
Connections access LLC:	One South Church Avenue	Tucson	AZ	85701
Connections AZ - Osborn Clinic	3333 7Th Ave.	Phoenix	AZ	85013
Connections AZ Inc	1201 S 7Th Ave Ste 150	Phoenix	AZ	85007
Continuum Recovery Center	3710 W Greenway Rd	Phoenix	AZ	85053
Cope - Lakeside Integrated Care	8050 E. Lakeside Parkway	Tucson	AZ	85730
Cope Mesquite Integrated Clinic:	2435 N. Castro Ave.	Tucson	AZ	85705
Cope - Villa Verde	1660 W. Commerce Point Place	Green Valley	AZ	85614
Cope Community Services	1501 W Commerce Court	Tucson	AZ	85746
Cope Community Services	3332 N Los Altos	Tucson	AZ	85705
Cope Community Services	5401 E 5Th St	Tucson	AZ	85712
Cope Community Services	620 N Craycroft Rd	Tucson	AZ	85711
Cope Community Services - Ocotillo	535 E Drachman Rd	Tucson	AZ	85705
Cope Community Services - Thrive Youth And Family Center	924 Alvernon Way	Tucson	AZ	85711
Cope Community Services, Inc.:	6810 South 39Th Place	Phoenix	AZ	85042
Cope- Craycroft Integrated Care Clinic:	620 N. Craycroft	Tucson	AZ	85711
Cope La Cholla Integrated Clinic:	1501 W. Commerce Court	Tucson	AZ	85746
Cope Northwest Integrated Clinic:	5840 N. La Cholla	Tucson	AZ	85741
Cope Thrive Clinic:	924 N. Alvernon Way, Suite 110	Tucson	AZ	85711
Cope Yavapai	105 E. Yavapai	Tucson	AZ	85705
Copper Springs Hospital, LLC	10550 W McDowell Rd	Avondale	AZ	85392
Corazon Behavioral Health Services:	2550 North Apache Drive	Kingman	AZ	86401
Corazon Inc	900 E Florence Blvd Ste G	Casa Grande	AZ	85122
Core Bella Health And Wellness LLC:	5700 West Olive Avenue, Suite 103	Glendale	AZ	85302
Corebella Health And Wellness LLC:	2600 East Southern Avenue, Suite E1	Tempe	AZ	85282
Cornerstone Behavioral Health	1400 North Wilmont Street	Tucson	AZ	85712
Coyote Task Force	66 E. Pennington Street	Tucson	AZ	85701
Cpes	2180 S. 4Th Ave. Suite H	Yuma	AZ	85364
Cpes	2525 W Huntington Ste 100	Tempe	AZ	85282
Crisis Preparation And Recovery	10799 N 90Th St Ste 100	Scottsdale	AZ	85260
Crisis Preparation And Recovery	1828 E Florence Blvd Ste 143	Casa Grande	AZ	85122
Crisis Preparation And Recovery	2120 S McClintock Dr Ste 105	Tempe	AZ	85282
Crisis Preparation And Recovery Inc Op Clinic	9321 W Thomas Rd Ste 100	Phoenix	AZ	85037

Program Name	Service Address	City	State	Zip
Crisis Response Network	1275 W Washington St Ste 201	Tempe	AZ	85281
Crossroads - East For Men	1845 E. Ocotillo Rd	Phoenix	AZ	85016
Crossroads - Extension For Women	244 N. Extension Rd	Mesa	AZ	85201
Crossroads - Flower For Women	1632 E. Flower St	Phoenix	AZ	85016
Crossroads Arcadia SABG	5116 E Thomas Rd	Phoenix	AZ	85018
Crossroads Inc	143 S Center St	Mesa	AZ	85210
Crossroads Inc	1700 E Thomas Rd	Phoenix	AZ	85016
Crossroads Inc	3702 N 13Th Ave	Phoenix	AZ	85013
Crossroads Inc	4201 N 16Th St Ste 110	Phoenix	AZ	85016
Crossroads Inc	7523 N 35Th Ave	Phoenix	AZ	85051
Crossroads Inc 360 Community Care Clinic	2002 E Osborn Rd	Phoenix	AZ	85016
Crossroads Inc.:	3306 West Roosevelt Street	Phoenix	AZ	85009
Crossroads Inc.:	500 North 3Rd Street, Suite 155	Phoenix	AZ	85004
Crossroads Mission	944 South Arizona Ave.	Yuma	AZ	85364
DEHP Therapeutic	3707 N 7Th St Ste 100B	Phoenix	AZ	85014
DEHP Therapeutic	3707 N 7Th St Ste 310	Phoenix	AZ	85014
Demo Community Services	2150 S Country Club Dr Suite 27	Mesa	AZ	85210
Desert Edge Mentoring Services	1950 W Heatherbrae Dr Ste 10	Phoenix	AZ	85015
Desert Edge Mentoring Services	1950 W Heatherbrae Dr Ste 4	Phoenix	AZ	85015
Desert Senita Community Health Center	410 N Malacate St	Ajo	AZ	85321
Desert West Obstetrics And Gynecology:	5601 West Eugie, Suite 100	Glendale	AZ	85304
Destiny Behavioral Health Residential	10313 West Hess Street	Tolleson	AZ	85353
Destiny Behavioral Health Residential	2911 South 87Th Drive	Tolleson	AZ	85353
Destiny Behavioral Health Residential	3427 South 84Th Lane	Tolleson	AZ	85353
Destiny Behavioral Health Residential	8755 West Pioneer Street	Tolleson	AZ	85353
Destiny Sober Living	11629 S 43Rd Ave	Laveen	AZ	85339
Destiny Sober Living	24032 W Antelope Trl	Buckeye	AZ	85326
Destiny Sober Living	5306 N 17Th Ave	Phoenix	AZ	85015
Devereux Adolescent Health And Wellness	1837 S Mesa Dr Ste A 201	Mesa	AZ	85210
Devereux Arizona CFS	11024 N 28Th Dr Ste 110	Phoenix	AZ	85029
Devereux Arizona Respite 2	6411 E Eugie Ter	Scottsdale	AZ	85254
Devereux Arizona Respite 3	6421 E Eugie Ter	Scottsdale	AZ	85254
Devereux Arizona Respite 4	6429 E Eugie Ter	Scottsdale	AZ	85254
Devereux Arizona Respite 5	6439 E Eugie Ter	Scottsdale	AZ	85254
Dilkon Outpatient Treatment Center	Post Office Box 7072 - Teesto Cpu	Winslow	AZ	86047
Direct Connect Ventures LLC (Desert Foothills Counselling)	1760 East Villa Drive, Ste #A	Cottonwood	AZ	86326
District Medical Group Inc.:	1201 South 7Th Avenue	Phoenix	AZ	85007
District Medical Group Inc.:	201 South 4Th Avenue	Phoenix	AZ	85003
District Medical Group Inc.:	21411 North 37Th Run	Phoenix	AZ	85050
District Medical Group Inc.:	2703 East Isabella Avenue	Mesa	AZ	85204
District Medical Group Inc.:	4011 North 51St Avenue	Phoenix	AZ	85031

Program Name	Service Address	City	State	Zip
District Medical Group Inc.:	7425 East Shea Blvd., Suite 102	Scottsdale	AZ	85260
District Medical Group Inc.:	8433 West Northview Avenue	Glendale	AZ	85305
District Medical Group Inc.: Valleywise Behavioral Health,	570 West Brown Road	Mesa	AZ	85201
District Medical Group INC.:	2601 East Roosevelt Street	Phoenix	AZ	85008
District Medical Group Inc.:	2929 East Thomas Road	Phoenix	AZ	85016
Divine Assurance Behavioral Health Residential	16040 West Vogel Avenue	Goodyear	AZ	85338
Dove In The Valley	6812 S. 21St Dr.	Phoenix	AZ	85041
Dove In The Valley	6821 South 21St Drive	Phoenix	AZ	85041
Dr. Chris Brooker:	7747 West Deer Valley Road, Suite 250	Peoria	AZ	85382
Dr. Kevin W. Cleary Ltd/ Clearpath:	7725 North 43Rd Avenue, Suite 720	Phoenix	AZ	85051
Dr. Mark Collins	5940 East Copper Hill, Suite B	Prescott Valley	AZ	86314
Dr. Rajivparikhpc	1964 East Baseline Road, Suite A-103	Tempe	AZ	85283
Dr. Robert Browns Berger:	705 North Leroux Street	Flagstaff	AZ	86001
Dyer Health PLLC:	4733 North 1St Avenue	Tucson	AZ	85736
Easter Seals Blake Foundation	3327 E Broadway Blvd	Tucson	AZ	85716
Easter Seals Blake Foundation	5120 E Alberta Dr	Tucson	AZ	85716
Easter Seals Blake Foundation	1115 E. Florence Blvd. Suite A,	Casa Grande,	AZ	85122
Easter Seals Blake Foundation	310 S. Meyer Ave.	Tucson	AZ	85701
Easter Seals Blake Foundation	3860 W. 24Th St. Suites 201	Yuma	AZ	85364
Easter Seals Blake Foundation	55 S. 5Th St.	Sierra Vista	AZ	85635
Easter Seals Blake Foundation	618 S. Central Ave.	Safford	AZ	85546
Easter Seals Blake Foundation	7750 E. Broadway Blvd. Suite A100	Tucson	AZ	85710
Easter Seals Blake Foundation	7756 E. Broadway Blvd. Suite C200	Tucson	AZ	85710
Ebony House - Elba House	8646 S 14Th Street	Phoenix	AZ	85042
Ebony House Children's	1616 E Indian School Rd Ste 100	Phoenix	AZ	85016
Ebony House Integrated Health	1616 E Indian School Rd Ste 250	Phoenix	AZ	85016
Ebony House Outpatient	6218 S 13Th St	Phoenix	AZ	85042
Ebony House, Inc.	6222 S 13Th St	Phoenix	AZ	85042
El Paso Family Mentoring And Counseling Services	3118 W. Thomas Rd. Suite 712	Phoenix	AZ	85017
El Rio Chc	1701 W. St Mary's Rd	Tucson	AZ	85745
El Rio Health	101 W. Irvington Rd. Building 10	Tucson	AZ	85714
El Rio Health	1230 S. Cherrybell Stravenue	Tucson	AZ	85713
El Rio Health	320 W. Prince Rd./340 W. Prince Rd.	Tucson	AZ	85705
El Rio Health	6950 E. Golf Links	Tucson	AZ	85730
El Rio Health	839 W. Congress St.	Tucson	AZ	85745
El Rio Santa Cruz Neighborhood Health Center, Inc	1230 South Cherrybell Strav	Tucson	AZ	85713
Elevation Health Services LLC	5333 N 7Th St Ste B310	Phoenix	AZ	85014
Embark Recovery	3727 Karicio Ln	Prescott	AZ	86303
Emerald Isle Health And Recovery	14188 W Hope Dr	Surprise	AZ	85379
Emerald Isle Health And Recovery	14407 W Desert Cove Rd	Sun City	AZ	85379
Emerald Isle Health And Recovery	10702 W Peoria Ave	Sun City	AZ	85351

Program Name	Service Address	City	State	Zip
Emmarie Behavioral Home Care	2976 West Wayland Drive	Phoenix	AZ	85014
Emmarie Behavioral Home Care	5748 W. Hidalgo Ave.	Phoenix	AZ	85339
Emmarie Behavioral Home Care	7725 West Wood Lane	Phoenix	AZ	85043
Emmarie Behavioral Home Care LLC	2926 W Wayland Dr	Phoenix	AZ	85041
Emmarie Behavioral Home Care LLC	3031 W Burgess Ln	Phoenix	AZ	85041
Emmerich, Jenlcs, Acsw, Ceds	6446 Sr 179 Ste 207B	Sedona	AZ	85351
Empact Spc San Tan Valley Op Clinic	2474 E Hunt Hwy Ste 100	Queen Creek	AZ	85143
Empact Suicide Prevention Op Clinic	914 S 52Nd St	Tempe	AZ	85281
Empowerment Behavioral Care LLC	6448 W Colter St	Glendale	AZ	85301
Empowerment Family Care LLC	8161 West Catalina Drive	Phoenix	AZ	85033
Encompass Health Services Inc	170 N Main	Fredonia	AZ	86022
Encompass Health Services Inc	32 N 10Th Ave, Ste 5	Page	AZ	86040
Encompass Health Services Inc	4103 E. Fleet, Ste 100	Littlefield	AZ	86432
Encompass Health Services Inc	463 S Lake Powell Blvd	Page	AZ	86040
Encompass Health Services	60 North Central	Colorado City	AZ	86022
Encourage Empowerment	1819 S Dobson Rd Ste 103	Mesa	AZ	85202
Equality Medical Group LLC	9020 W Thomas Rd	Phoenix	AZ	85037
Escalera Health And Wellness	2224 N. Craycroft Rd. Suite 100	Tucson	AZ	85712
Eureka Imperial Residence	1080 E. Clifton Ave.	Gilbert	AZ	85295
Eureka Imperial Residence	1740 S. Heritage Dr.	Gilbert	AZ	85295
Eureka Imperial Residence	2668 S. Heritage Dr.	Gilbert	AZ	85295
Exclusive Certified Residential Care LLC	3744 Martingale Drive	Kingman	AZ	86409
F J C M Group LLC	2710 East Valencia Drive	Phoenix	AZ	85042
Faith Behavioral Health Group	3101 West Larkspur Drive	Phoenix	AZ	850296
Family And Youth Interventions LLC	5037 S 24Th St Ste 2	Phoenix	AZ	85040
Family Involvement Center	5333 N 7Th St Ste A130	Phoenix	AZ	85014
Family Service Agency	10220 N 31St Ave Ste 103 105	Phoenix	AZ	85051
Family Service Agency	2400 N Central Ave Ste 101	Phoenix	AZ	85004
Family Service Agency - Mesa	1107 S. Gilbert Road, Suite 104	Mesa	AZ	85204
Five Star Medical Clinic:	3921 East Baseline Road	Gilbert	AZ	85234
Florence Crittenton Services	715 W Mariposa St	Phoenix	AZ	85013
Focused Family Services	1301 E. McDowell Rd Suite 204	Phoenix	AZ	85006
Focused Family Services	1634 N 19Th Ave	Phoenix	AZ	85009
Fort Defiance Outpatient Treatment Center	Post Office Box 1490	Fort Defiance	AZ	86504
Fresh Start Recovery LLC	28518 North 26Th Drive	Phoenix	AZ	85085
Fsl Pathways - Alice House	8744 W Alice Ave	Peoria	AZ	85345
Fsl Pathways - Cabot House	2420 E John Cabot Rd	Phoenix	AZ	85032
Fsl Pathways - Canyon House	13629 N 21St Dr	Phoenix	AZ	85029
Fsl Pathways - Cherry Hills House	7808 W Cherry Hills Dr	Peoria	AZ	85345
Fsl Pathways - Columbine House	3126 W Columbine Dr	Phoenix	AZ	85029
Fsl Pathways - Evans House	3916 W Evans Dr	Phoenix	AZ	85053

Program Name	Service Address	City	State	Zip
Fsl Pathways - Fogal House	925 W Fogal Way	Tempe	AZ	85282
Fsl Pathways - Garden House	3927 W Garden Dr	Phoenix	AZ	85029
Fsl Pathways - Hayward House	4023 W Hayward Ave	Phoenix	AZ	85051
Fsl Pathways - Hearn House	3615 W Hearn Rd	Phoenix	AZ	85053
Fsl Pathways - Meadowbrook House	8719 W Meadowbrook Ave	Phoenix	AZ	85037
Fsl Pathways - Peck House	8963 W Peck Dr	Glendale	AZ	85305
Fsl Pathways - Plata House	613 W Plata Ave	Mesa	AZ	85210
Fsl Pathways - Rios House	14633 N 55Th Ave	Glendale	AZ	85306
Fsl Pathways - Sierra Vista House	7145 W Sierra Vista Dr	Glendale	AZ	85303
Fsl Pathways - Surrey House	3367 W Surrey Ave	Phoenix	AZ	85029
Fsl Pathways - Watson House	916 E Watson Dr	Tempe	AZ	85283
Gateway Addictionology Services:	4862 East Baseline Road, Suite 108	Mesa	AZ	85206
Gatmal, LLC	2432 W Romley Rd	Phoenix	AZ	85041
Genesis Obgyn Pc:	2424 North Wyatt Drive, Second Floor	Tucson	AZ	85704
Genesis Obgyn Pc:	6261 North Cholla Blvd., Suite 277	Tucson	AZ	85741
Genesis Living	2839 East Courtney Street	Gilbert	AZ	85298
Gila River Behavioral Health - Oasis D3	291 W. Casa Blanca Road	Sacaton	AZ	85147
Gila River Behavioral Health - Oasis D5	3455 W. Casa Blanca Road	Bapchule	AZ	85339
Gila River Behavioral Health - Oasis D6	4577 W. Pecos Lane	Laveen	AZ	85339
Gila River Behavioral Health - Red Tail Hawk	3042 W. Queen Creek Rd.	Chandler	AZ	85286
Gila River Behavioral Health - Thwajik Ke	3850 N. 16Th Street	Laveen	AZ	85339
Globe Transition Point	5734 Hope Ln Ste 1	Globe	AZ	85501
Golden Cross Healthcare LLC	1523 W Colter St Unit 5	Phoenix	AZ	85015
Golden Heart Care	11939 W Columbine Dr	El Mirage	AZ	85335
Golden Heart Care	1929 West Spur Drive	Phoenix	AZ	85085
Good Care Network	2215 Ventura Drive	Bullhead City	AZ	86442
Good Health Medical Pc:	1050 South Terrance	Tempe	AZ	85281
Good Health Medical Pc:	9446 South Horned Lizard Circle	Tucson	AZ	85747
Good Hope Resources Inc	1320 W Angus Rd	San Tan Valley	AZ	85143
Good Samaritan Homes	494 East Daniella Drive	San Tan Valley	AZ	85140
Gross Man & Grossman, Ltd.	1300 N 12Th Street Ste 550	Phoenix	AZ	85006
Grossman & Grossman	1136 E Harmony Ave Ste 205	Mesa	AZ	85204
Grossman & Grossman	2345 E Thomas Rd Ste 360	Phoenix	AZ	85016
Grossman & Grossman	9635 W Peoria Ave Ste 107	Peoria	AZ	85345
Hallmark Behavioral Health At Lago LLC	688 S Lago Dr	Apache Junction	AZ	85120
Haven Senior Horizons	1201 S 7Th Ave Ste 200	Phoenix	AZ	85007
Health Squared LLC	10401 S 44Th Pl	Phoenix	AZ	85044
Heavens Medical Plc:	105 South Delaware Drive	Apache Junction	AZ	85120
Heavens Urgent Carellc:	105 South Delaware Drive, Suite 2	Apache Junction	AZ	85120
Helping Associates	1000 E. Racine Pl	Casa Grande	AZ	85122
Helping Associates Inc	1901 N Trezell Rd	Casa Grande	AZ	85122

Program Name	Service Address	City	State	Zip
Helping Hearts 12#2 House	9606 N 12Th Ave Ste 2	Phoenix	AZ	85021
Helping Hearts 57Th Ave	1500 E Thomas Rd Ste 104	Phoenix	AZ	85014
Helping Hearts Cambridge House	3829 E Cambridge Ave	Phoenix	AZ	85008
Helping Hearts College House	3302 W College Dr	Phoenix	AZ	85017
Helping Hearts Hatcher Outpatient Clinic	927 W Hatcher Ste 106	Phoenix	AZ	85021
Helping Hearts Indianola House	6129 W Indianola Ave	Phoenix	AZ	85033
Helping Hearts Meadowbrook House	1808 E Meadowbrook Ave	Phoenix	AZ	85016
Helping Ourselves Pursue Enrichment	2066 W Apache Trl Ste 111	Apache Junction	AZ	85120
Homamhaj Bandehmdp LLC:	255 South Dobson Road, Suite 1	Chandler	AZ	85224
Honor Family Health Care LLC:	300 West White Mountain Blvd., Suite D	Lakeside	AZ	85929
Hope Behavioral Health Residence	16870 West Desert Bloom	Goodyear	AZ	85338
Hope Behavioral Health Residential Care	16870 W Woodlands Ave	Goodyear	AZ	85338
Hope Community Services Inc	13760 N 93Rd Ave Ste 101	Peoria	AZ	85381
Hope Diabetes Center LLC:	13840 North Northsight Blvd., Suite 121	Scottsdale	AZ	85260
Hope Group LLC	4530 E Muirwood Dr Ste 103	Phoenix	AZ	85048
Hope Inc - Esperanza	4067 E. Grant Rd	Tucson	AZ	85712
Hope Inc.	1200 N. Country Club Rd	Tucson	AZ	85716
Hope Inc.	201 South 1St Avenue	Yuma	AZ	85364
Hope Inc.	2066 W Apache Trail	Apache Junction	AZ	85120
Hope Behavioral Health Residence	15985 West William Street	Goodyear	AZ	85338
Horizon Health & Wellness:	4601 East Fort Lowell Road, Suite 131	Tucson	AZ	85712
Horizon Health And Wellness	115 W 2Nd Street	Casa Grande	AZ	85122
Horizon Health And Wellness	120 W. Main St	Casa Grande,	AZ	85122
Horizon Health And Wellness	222 Cottonwood Ln	Casa Grande	AZ	85122
Horizon Health And Wellness	2271 S. Peart	Casa Grande	AZ	85122
Horizon Health And Wellness	3180 E. 40Th St.	Yuma	AZ	85365
Horizon Health And Wellness	374 Alden Rd.	Kearny	AZ	85137
Horizon Health And Wellness	415 W Baseline Spur	Globe	AZ	85501
Horizon Health And Wellness	447 E. Broadway Bldg 2	Apache Junction	AZ	85119
Horizon Health And Wellness	477 East Broadway	Apache Junction	AZ	85120
Horizon Health And Wellness	478 Hagen Road	Globe	AZ	85501
Horizon Health And Wellness	791 S 4Th Ave Suite A	Yuma	AZ	85364
Horizon Health And Wellness	210 E Cottonwood Ln	Casa Grande	AZ	85122
Horizon Health And Wellness	22713 South Ellsworth Road Bldg A St 101	Queen Creek	AZ	85142
Horizon Health And Wellness	625 N Plaza	Apache Junction	AZ	85120
Horizon Health And Wellness Florence	450 W Adamsville Rd Ste B	Florence	AZ	85132
Horizon Health And Wellness, Inc.	980 E. Mt. Lemmon Rd Bldg #1 & 2	Oracle	AZ	85623
Horizon Health Wellness - Casa Grande	2269 S Peart Rd	Casa Grande	AZ	85122
Horizon Health & Wellness: Yuma	791 S. 4Th Ave	Yuma	AZ	85364
House Of Hope Behavioral Agency LLC	406 West 11St Street	Eloy	AZ	85131
Hrt Parenting Skills Prog	2131 Broadway Rd 14	Tempe	AZ	85282



Program Name	Service Address	City	State	Zip
Human Services Consultants	4449 N 12Th St Ste A1	Phoenix	AZ	85014
Imara Orangewood Care Homes LLC	2134 W Orangewood Ave Unit 2	Phoenix	AZ	85021
Integro Health Systems Inc	1501 E Orangewood Ave Bldg A	Phoenix	AZ	85020
Integro Health Systems Inc	1501 E Orangewood Ave Bldg C	Phoenix	AZ	85020
Integro Health Systems Inc	2728 N 24Th St	Phoenix	AZ	85008
Intensive Treatment Systems	19401 N Cave Creek Rd Ste 18	Phoenix	AZ	85024
Intensive Treatment Systems	651 W Coolidge St	Phoenix	AZ	85013
Intensive Treatment Systems - Center Of Excellence	4136 North 75Th Avenue, Suite 116	Phoenix	AZ	85033
Intensive Treatment Systems LLC	36375 N Gantzel Rd Ste 101	San Tan Valley	AZ	85140
Intensive Treatment Systems, LLC:	9188 East San Salvador Drive, #201	Scottsdale	AZ	85258
Integrity pain and anesthesia PLLC	8997 East Cove Avenue, Floor 1	Scottsdale	AZ	85255
Intermountain	Tohono Plaza, Bia Route 19	Sells	AZ	85634
Intermountain	276 W. Viewpoint Drive	Nogales	AZ	85621
Intermountain - Admin Office	994 S Harrison Rd.	Tucson	AZ	85748
Intermountain - Summit	2200 S. Avenida Los Reyes	Tucson	AZ	85710
Intermountain Centers- Community Partners: Cpih Parker	1021 Kofa Ave.	Parker	AZ	85139
Intermountain Centers For Human Development	1821 N Trekall Rd Ste 1	Casa Grande	AZ	85122
Jcl Urgent care/ Honor health LLC:	6820 East Brown Road	Mesa	AZ	85207
Jewish Family & Children's Service – Mesa	1255 W. Baseline Road, Ste B258	Mesa	AZ	85202
Jewish Family & Children's Service – Michael R. Zent Healthcare Center	3001 N. 33Rd Avenue	Phoenix	AZ	85017
Jewish Family & Children's Service – West Valley	1840 N. 95Th Avenue Ste. 146	Phoenix	AZ	85037
Jewish Family & Children's Service	5701 W Talavi Blvd Ste 180	Glendale	AZ	85306
Jewish Family And Children's Service	2017 N 7Th St	Phoenix	AZ	85006
Jewish Family And Children's Service	2290 W Guadalupe Rd	Gilbert	AZ	85233
Jewish Family And Children's Service	4747 N 7Th St Ste 100	Phoenix	AZ	85014
Jewish Family And Children's Service	880 N Colorado St	Gilbert	AZ	85233
Jewish Family And Children's Service Inc Op Clinic	2033 N 7Th St Ste A100	Phoenix	AZ	85006
Joechris Home LLC	44349 W Bailey Dr	Maricopa	AZ	85138
John Baylock Jr- A New Hope Behavioral	9646 North 47Th Avenue	Glendale	AZ	85302
John C Lincoln LLC:	9191 West Thunderbird Road, Suite D-105	Peoria	AZ	85381
Joyful Behavioral Health Residential Care	16274 W Superior Ave	Goodyear	AZ	85338
Jussamal Manor li	641 S Karen Dr	Chandler	AZ	85224
Kaibeto Outpatient Treatment Center	Post Office Box 2147	Page	AZ	86053
Kaleidoscope Homes	41288 N Cambria Dr	San Tan Valley	AZ	85140
Kayenta Outpatient Treatment Center	Post Office Box 487	Kayenta	AZ	86033
Keep Right	1820 S Los Alamos	Mesa	AZ	85204
Kingman Regional Medical Center - Outpatient	2202 N Stockton Hill Road	Kingman	AZ	86401
Konadu Family	40030 West Coltin Way	Maricopa	AZ	85138
La Frontera	260 S. Scott Ave.	Tucson	AZ	85701
La Frontera	504 W 29Th St	Tucson	AZ	85713
La Frontera - Casa De Vida	1900 W. Speedway	Tucson	AZ	85745

Program Name	Service Address	City	State	Zip
La Frontera – Empact – Comunidad Office Phoenix	1035 E. Jefferson St.	Phoenix	AZ	85034
La Frontera - Grant Clinic	1141 W. Grant Rd, Suite 100	Tucson	AZ	85705
La Frontera Center New Life Clinic -	1082 E. Ajo Suite 100	Tucson	AZ	85713
La Frontera Center South Tucson Clinic -	502 W. 29Th St	Tucson	AZ	85713
La Frontera Center East Clinic -	4891 E. Grant Rd	Tucson	AZ	85712
La Frontera Center Hope Center -	360 S. Scott	Tucson	AZ	85701
La Frontera Center Inc:	1181 East Placita De Graciela	Tucson	AZ	85718
La Frontera Center Inc:	2499 East Ajo	Tucson	AZ	85713
La Frontera Center Inc:	7476 North Camino De La Tierra	Tucson	AZ	85741
La Frontera Center Menninger-	240 W. Navajo Rd.	Tucson	AZ	85705
La Frontera Center Mountain Clinic -	3620 N. Mountain Ave.	Tucson	AZ	85719
La Frontera Center Southwest Clinic -	1210 E. Pennsylvania,	Tucson	AZ	85714
La Frontera Center The Ranch-	10841 N. Thornydale Rd.	Tucson	AZ	85742
La Frontera Empact-Spc	11518 E. Apache Tail Suite 129	Apache Junction	AZ	85120
La Frontera Empact-Suicide Prevention	2474 E. Hunt Hwy. Ste. C100	San Tan Valley	AZ	85143
La Frontera – Empact – San Tan Valley Office	2474 E. Hunt Highway, Ste. A100	San Tan Valley	AZ	85143
La Paloma Living	12558 North 76Th Street	Scottsdale	AZ	85260
Lateef Behavioral Care Home	8613 S 7Th Dr	Phoenix	AZ	85041
Latino Care:	3140 North 35Th Avenue, Suite 7	Phoenix	AZ	85017
Life Change Family Services	20018 N Toledo Ave	Maricopa	AZ	85138
Lifeline Professional Counseling Inc	1423 South Higley Road #100	Mesa	AZ	85206
Lifeline Professional Counseling Inc	335 North Alma School Road	Chandler	AZ	85224
Lifeline Professional Counseling Inc	45 East Monterey Way #100	Phoenix	AZ	85012
Lifeline Professional Counseling Inc	17235 North 75Th Avenue, #F100	Glendale	AZ	85308
Lifeline Professional Counseling Inc	5040 East Shea Blvd #164	Scottsdale	AZ	85254
Lifewell Behavioral Wellness	119 W Highland	Phoenix	AZ	85013
Lifewell Behavioral Wellness	262 E University Dr	Mesa	AZ	85201
Lifewell Behavioral Wellness	2715 N 3Rd St	Phoenix	AZ	85004
Lifewell Behavioral Wellness	3222 N 37Th St	Phoenix	AZ	85018
Lifewell Behavioral Wellness	3301 E Pinchot Ave	Phoenix	AZ	85018
Lifewell Behavioral Wellness	3540 E Baseline Rd Ste 150	Phoenix	AZ	85042
Lifewell Behavioral Wellness	619 W Southern Ave	Mesa	AZ	85210
Lifewell Behavioral Wellness	621 W Southern Ave	Mesa	AZ	85210
Lifewell Behavioral Wellness	6915 E Main St	Mesa	AZ	85207
Lifewell Behavioral Wellness Oak	4451 E Oak St	Phoenix	AZ	85008
Lifewell Behavioral Wellness Op Clinic	2505 W Beryl Ave	Phoenix	AZ	85021
Lifewell Behavioral Wellness Op Clinic	40 E Mitchell Dr Ste 100 200	Phoenix	AZ	85012
Lifewell Behavioral Wellness Royal Palms	2311 W Royal Palm Rd	Phoenix	AZ	85021
Lifewell Behavioral Wellness:	1061 North 47Th Drive	Show Low	AZ	85901
Lighthouse Group Home	108 East 2Nd Avenue	Mesa	AZ	85210
Little Colorado Behavioral Health	470 W Cleveland	St Johns	AZ	85936

Program Name	Service Address	City	State	Zip
Little Colorado Behavioral Health	50 N Hopi	Springerville	AZ	85938
Little Colorado Behavioral Health Centers:	2500 East Show Low Lake Road	Show Low	AZ	85901
Live Well Assisted Living	12634 W Estero Ln	Litchfield Park	AZ	85340
Live Well Residential Care	10258 W Windsor Blvd	Glendale	AZ	85307
Live Well Residential Care	10258 W Windsor Blvd	Glendale	AZ	85307
Loloma House At Greenway	15259 N 67Th Dr	Peoria	AZ	85381
Marana Health Center Inc.:	8181 East Irvington Road	Tucson	AZ	85709
Marana Health Center, Inc.	13395 N Marana Main St.	Marana	AZ	85653
Marana Health Center, Inc.	3690 S. Park Ave., Ste 805	Tucson	AZ	85713
Marana Health Center, Inc.	435 E Glenn St	Tucson	AZ	85705
Marana Healthcare- Marana Main Health Center	13395 N. Marana Main Street, Bldg B	Marana	AZ	85653
Marana Healthcare- Wilmot Family Health	899 N. Wilmot Road	Tucson	AZ	85711
Marc Community Resources	3737 N 7Th St Ste 170	Phoenix	AZ	85014
Marc Community Resources Alder	4154 E Alder Ave	Mesa	AZ	85206
Marc Community Resources Hermosa Vista	2664 E Hermosa Vista Dr	Mesa	AZ	85213
Marc Community Resources Millett	918 E Millett Ave	Mesa	AZ	85204
Marc Community Resources Opc Florian	4250 E Florian Ave	Mesa	AZ	85206
Marc Community Resources Quartz	6433 E Quartz St	Mesa	AZ	85215
Maricopa Christian Psychiatry Group:	3130 North Arizona Avenue, Suite 101	Chandler	AZ	85225
Maricopa County Special Health Care:	2600 East Roosevelt Street	Phoenix	AZ	85008
Maricopa County Special Health Care:	74010 East Osborn Road	Scottsdale	AZ	85258
Maricopa County Special Healthcare:	2155 West Pinnacle Peak Road	Phoenix	AZ	85383
Maricopa Integrated Health Center Fqhc	10550 W Mariposa St Ste 1	Phoenix	AZ	85037
Maricopa Integrated Health System	1101 N Central Ave Ste 201	Phoenix	AZ	85004
Maricopa Integrated Health System	2619 E Pierce St	Phoenix	AZ	85008
Mariposa Community Health Center	101 Taylor Street	Patagonia	AZ	
Mariposa Community Health Center	1103 Circulo Mercado	Rio Rico	AZ	85648
Mariposa Community Health Center	1852 N Mastick Way	Nogales	AZ	
Mariposa Community Health Center	2239 E. Frontage Road	Tubac	AZ	
Mark Allen Foundation	2622 W State Ave	Phoenix	AZ	85051
Martha's Care LLC	22958 West Pima Street	Buckeye	AZ	85326
Mary's Mission And Developmental Center Inc.	736 W Country Club Dr	Mesa	AZ	85201
Max Behavioral Health LLC	405 West Burgell Lane	Laveen	AZ	85339
Mending Hearts Family Services Inc	17431 N 71St Dr Ste 103	Glendale	AZ	85308
Mesa Fhc Ihh Pir East Valley Center Fqhc	4330 E University Ste B	Mesa	AZ	85205
Mhc Healthcare Bh Substance Use Program	16701 N Oracle Rd #135	Catalina	AZ	85739
Michael B Bayless And Associates Pc	2204 S Dobson Rd Ste 102	Mesa	AZ	85202
Michael B Bayless And Associates Pc	2204 S Dobson Rd Ste 201	Mesa	AZ	85202
Michael B Bayless And Associates Pc	235 W Western Ave	Avondale	AZ	85323
Michael B Bayless And Associates Pc	3033 N Central Ave Ste 700	Phoenix	AZ	85012
Michael B Bayless And Associates Pc	3620 N 3Rd St	Phoenix	AZ	85012

Program Name	Service Address	City	State	Zip
Michael B Bayless And Associates Pc	77 E Columbus Ave Ste 210	Phoenix	AZ	85012
Michael B Bayless And Associates Pc	9014 S Central Ave	Phoenix	AZ	85042
MIKID- Phoenix	2642 E Thomas Rd	Phoenix	AZ	85016
MIKID-Casa Grande	901 E Cottonwood Ln Ste A An	Casa Grande	AZ	85122
Mingus Mountain Amber Hills	34218 N 26Th Ave	Phoenix	AZ	85085
Mingus Mountain Estates	3801 Robert Rd	Prescott Valley	AZ	86314
Mingus Mountain Ranch	100 Dewey Rd	Dewey	AZ	86327
Mingus Mountain Whitefeather House	2430 W White Feather Ln	Phoenix	AZ	85085
Mirasol, Inc	10490 E Escalante Rd	Tucson	AZ	85730
Mohave Mental Health Clinic	3505 Western Ave	Kingman	AZ	86004
Mohave Mental Health Clinic	1145 Marina Blvd	Bullhead City	AZ	86442
Mohave Mental Health Clinic	151 Riviera Ste B	Lake Havasu City	AZ	86403
Mohave Mental Health Clinic	2187 Swanson	Lake Havasu City	AZ	86403
Mohave Mental Health Clinic	2580 Hwy 95 Ste 209	Bullhead City	AZ	86442
Mohave Mental Health Clinic Inc.	1080 Sheldon Ave	Kingman	AZ	86409
Mohave Mental Health Clinic Inc.	1741 Sycamore Ave	Kingman	AZ	86409
Mohave Mental Health Clinic Inc.	3745 N Diamond Dr	Kingman	AZ	86409
Mohave Mental Health Clinic Inc.	915 Airway Ave	Kingman	AZ	86409
Mom Doc LLC:	1760 East Pecos Road, Suite 516A	Gilbert	AZ	85296
Mom Doc LLC:	2055 West Frye Road, Suite #9	Chandler	AZ	85224
Mom Doc LLC:	21300 North John Wayne Parkway, Suite 121	Maricopa	AZ	
Mom Doc LLC:	29675 North Valley Parkway, Unit 2031	Phoenix	AZ	85085
Mom Doc LLC:	8140 West Thomas Road, Suite 134	Phoenix	AZ	85037
Mom Doc LLC:	9897 West McDowell Road	Tolleson	AZ	85353
Mom Doc LLC:	37100 North Gantzel Road, Suite 106	Phoenix	AZ	85140
Monami Group Home LLC	9138 East Dennis Street	Mesa	AZ	85207
Morning Star Obstetrics And Gynecology:	3499 South Mercy Road	Gilbert	AZ	85297
Mountain Health & Wellness	22711 S Ellsworth Rd Bldg G Ste 105	Queen Creek	AZ	85142
Mountain Park Hc-Atkinson	4315 N Maryvale Pkwy	Phoenix	AZ	85031
Mountain Park Health	5517 N 17Th Ave	Phoenix	AZ	85015
Mountain Park Health Center	140 N Litchfield Rd Ste 200	Goodyear	AZ	85338
Mountain Park Health Center	1492 S Mill Ave Ste 312	Tempe	AZ	85281
Mountain Park Health Center	2702 N 3Rd St Ste 4020	Phoenix	AZ	85004
Mountain Park Health Center	690 N Cofco Ctr Ct Ste 230	Phoenix	AZ	85008
Mountain Park Health Center Maryvale	6601 W Thomas Rd	Phoenix	AZ	85035
Mountain Park Health Center:	3830 East Van Buren Street	Phoenix	AZ	85008
Mwangaza Residential Care	2226 N. Avenida El Capitan	Tucson	AZ	85705
Mwangaza Residential Care	2234 E. Calle Sierra Del Manantial	Tucson	AZ	85706
Mwangaza Residential Care	6330 S. Kolb Rd.	Tucson	AZ	85743
Mwangaza Residential Care	8421 E. Colette St.	Tucson	AZ	85710
NACAA Family Health Center	1500 East Cedar Avenue #26	Flagstaff	AZ	86004

Program Name	Service Address	City	State	Zip
National Council On Alcoholism And Drug Dependence	4201 N 16Th St Ste 140	Phoenix	AZ	85016
Native American Community Health Center	777 W Southern Ave Bldg E Ste 501	Mesa	AZ	85210
Native American Connections	4520 N Central Ave Ste 380	Phoenix	AZ	85012
Native American Connections Inc	337 E Virginia Ave	Phoenix	AZ	85004
Native American Connections-Patina Outpatient Ctr	4520 B. Central Ave #100/120	Phoenix	AZ	85012
Native Health	2423 West Dunlap Ave. Suite 100	Phoenix	AZ	85021
Native Health	4041 N. Central Ave. Bldg. C	Phoenix	AZ	85012
Nazcare, Inc. - El Bienestar	100 E. 24Th Street Suite 2.	Yuma	AZ	85364
Nazcare, Inc. - Rising Star	879 N. Plaza Dr, #101E.	Apache Junction	AZ	85120
Neema LLC	6607 E Hawk Dr	Tucson	AZ	85730
Neighborhood Outreach Access To Health:	8160 East Butherus Drive, Suite 9	Scottsdale	AZ	85260
Neighborhood Outreach Access to Health:	4720 East Greenway Road	Phoenix	AZ	85032
New Beginning Behavioral Health	3329 South 87Th Drive	Tolleson	AZ	85353
New Hope Behavioral Health Center Inc	215 S Power Rd Ste 114	Mesa	AZ	85206
New Hope Of Arizona Inc	11213 W Coronado Rd	Avondale	AZ	85392
New Hope Of Arizona Inc	12406 N 32Nd St Ste 101	Phoenix	AZ	85032
New Hope Of Arizona Inc	12834 W Sells Dr	Litchfield Park	AZ	85340
New Hope Of Arizona Inc	1881 S 235Th Ave	Buckeye	AZ	85326
New Hope Of Arizona Inc	21615 W Watkins St	Buckeye	AZ	85326
New Hope Of Arizona Inc	3120 W Pollack St	Phoenix	AZ	85041
New Horizon Community Care	6726 W Cholla	Peoria	AZ	85345
New Horizon Community Care	760 E Stottler	Chandler	AZ	85225
New Horizon Youth Home	774 E Buffalo St	Chandler	AZ	85295
New Horizon Youth Homes Commonwealth House	2504 Commonwealth Cir	Chandler	AZ	85225
New Horizon Youth Homes Inc	1102 W Dixon St	Mesa	AZ	85201
New Horizon Youth Homes Inc	11836 W Rosewood Dr	El Mirage	AZ	85335
New Horizon Youth Homes Inc	1810 W Palomino Dr	Chandler	AZ	85224
New Horizon Youth Homes Inc	5024 S Ash Ave Ste 106	Tempe	AZ	85282
New Horizon Youth Homes Inc	795 W Park Ave	Chandler	AZ	85225
New Horizon Youth Homes Inc	8731 N 83Rd Dr	Peoria	AZ	85345
New Life Counseling Services, LLC	8466 W. Peoria Ave. #6	Peoria	AZ	85345
Next Generation: Outpatient Sa	1702 South 65Th Avenue	Phoenix	AZ	85043
Next Generation: Outpatient Sa	2737 E Greenway Rd. Suite 8	Phoenix	AZ	85032
Next care Arizona LLC:	9250 North 3Rd Street, Suite 3015	Phoenix	AZ	85020
NHW Community Health Ctr Fqhc	2423 W Dunlap Ave Ste 140	Phoenix	AZ	85021
Noah Cholla Health Ctr	11130 E Cholla St Bldg 1	Scottsdale	AZ	85259
Noah Calavar Family Health Center	3525 W Calavar Rd	Phoenix	AZ	85053
Noah Copperwood Health Center	11851 N 51St Ave Ste B110	Glendale	AZ	85304
Noah Desert Mission	9201 N 5Th St	Phoenix	AZ	85020
Noah Heuser Family Medicine	7301 E 2Nd St Ste 210	Scottsdale	AZ	85251
Noah Midtown Health Center	4131 N 24Th St Ste B102	Phoenix	AZ	85016

Program Name	Service Address	City	State	Zip
Noah Palomino Health Center	16251 N Cave Creek Rd	Phoenix	AZ	85032
Noah Sierra Health Center	6206 W Bell Rd Ste 1	Glendale	AZ	85308
Noah Venado Valley Health Center	20440 N 27Th Ave	Phoenix	AZ	85027
North Country Health Care	708 S Coeur Dalene Ln Ste B	Payson	AZ	85541
North County Health Care	2920 North 4Th Street	Flagstaff	AZ	86004
North County Health Care:	2650 East Show Low Lake Road	Show Low	AZ	85901
North County Healthcare:	1301 South Crimson Road	Mesa	AZ	85209
North County Healthcare:	1510 Stockton Hill Road	Kingman	AZ	86401
Northern Arizona Pain Services:	708 South Coeur D'Alene Lance, Suite C	Payson	AZ	85541
Northwest Allied Physicians:	1551 East Tangerine Road	Oro Valley	AZ	85755
Northwest Allied Physicians:	1871 West Orange Grove Road, Suite 101	Tucson	AZ	85704
Oasis Behavioral Health	1120 E 6Th St	Casa Grande	AZ	85112
Oasis Behavioral Health	2190 N Grace Blvd	Chandler	AZ	85225
Open Hearts	3280 S Country Club Way Ste 110	Tempe	AZ	85282
Open Hearts	4414 N. 19Th Avenue	Phoenix	AZ	85015
Orion Homes Bloomfield li	6713 W Bloomfield Rd	Peoria	AZ	85381
Orion Homes Gelding	6764 W Gelding Dr	Peoria	AZ	85381
Orion Homes LLC	12022 N 49Th Ave	Glendale	AZ	85304
Orion Homes LLC	12427 N 39Th Ave	Phoenix	AZ	85029
Orion Homes LLC	142 E Joan De Arc	Phoenix	AZ	85022
Orion Homes LLC	3902 W Columbine Dr	Phoenix	AZ	85029
P S A Behavioral Health Agency / Resilient Health	2580 Highway 95 #116	Bullhead City	AZ	86442
Pacey Care LLC	2022 North Pacey Road	Phoenix	AZ	85037
Pain Centers Nationwide pc/Summa pain care:	8877 West Union Hills Drive, Suite 200	Peoria	AZ	85382
Palm Vein Center LLC:	7171 South 51St Avenue, Suite 100	Laveen	AZ	85339
Palo Verde Behavioral Health	2695 N Craycroft Rd	Tucson	AZ	85712
Paradise Valley Behavioral Health	13401 N 30Th St	Phoenix	AZ	85032
Paramount Behavioral Health Services:	1631 West Burnside Trail	Phoenix	AZ	85085
Paramount Behavioral Health Services:	5125 North 58Th Avenue	Glendale	AZ	85301
Park Place: Residential Program (BHRF)	13626 Del Rio	Arizona City	AZ	85123
Parkplace:Outpatient counseling program	3125 S Price Rd, Suite 120, Office 18	Chandler	AZ	85248
Parsons Family Health Center	3522 N 3Rd Ave	Phoenix	AZ	85013
Partners In Recovery Arrowhead Campus	5625 W Bell Rd Ste 100	Glendale	AZ	85308
Partners In Recovery East Valley Campus	4330 E University Dr	Mesa	AZ	85205
Partners In Recovery Gateway Campus	5222 E Baseline Rd Ste 101	Gilbert	AZ	85234
Partners In Recovery Hassayampa Campus Op Clinic	811 N Tegner St Ste 121	Wickenburg	AZ	85390
Partners In Recovery LLC	10240 N 31St Ave Ste 200	Phoenix	AZ	85051
Partners In Recovery LLC	14100 N 83Rd Ave Ste 100	Peoria	AZ	85381
Partners In Recovery LLC	14100 N 83Rd Ave Ste 150	Peoria	AZ	85381
Partners In Recovery LLC Op Clinic	9150 W Indian School Rd Ste 130	Phoenix	AZ	85037
Pathfinders Recovery Center LLC	7600 E Redfield Rd	Scottsdale	AZ	85260

Program Name	Service Address	City	State	Zip
Pathways Of Arizona	1161 N El Dorado Place #101	Tucson	AZ	85715
Pathways Of Arizona	1161 N. El Dorado Pl Suite 103	Tucson	AZ	85715
Pathways Of Arizona	3295 W. Ina Rd Suite 150 And 200	Tucson	AZ	85741
Pathways Of Arizona	3818 W. 16Th St Bldg 5	Yuma	AZ	85364
Pathways Of Arizona LLC	2830 W Glendale Ave Ste 16	Phoenix	AZ	85051
Penali Manor	3532 West Boston Street	Chandler	AZ	85226
Penali Manor LLC	3532 W Boston St	Chandler	AZ	85226
People Empowering People Of Arizona Inc	2428 E Apache Blvd Ste 123	Tempe	AZ	85281
PGF Medical Services:	5656 East Orange Blossom Lane, Suite 5	Phoenix	AZ	85018
Philia Home Care LLC	6431 West Branham Lane	Laveen	AZ	85339
Phoenician Medical Center Inc.:	2330 North 75Th Avenue, Suite 108	Phoenix	AZ	85035
Phoenician Medical Center Inc.:	963 North McQueen Road	Chandler	AZ	85225
Phoenix Children's Hospital:	3333 East Van Buren Street	Phoenix	AZ	85008
Phoenix Shanti Group	2345 W. Glendale Ave	Phoenix	AZ	85021
Phoenix Wellness Center LLC	2060 W Whispering Wind Dr Ste 270	Phoenix	AZ	85085
Phoenix Children's Hospital:	1919 East Thomas Road	Phoenix	AZ	85016
Physician Group Of Arizona Inc.:	4135 South Power Road, Suite 113	Mesa	AZ	85212
Pima Prevention Partnership/Sin Puertas	1346 N Stone	Tucson	AZ	85705
Pinal Hispanic Council	275 N. Grand Court Plaza	Nogales	AZ	85621
Pinal Hispanic Council (Op Clinic)	107 E 4Th St	Eloy	AZ	85131
Pinal Hispanic Council (Op Clinic)	330 N Picacho	Casa Grande	AZ	85122
Pinal Hispanic Council (Op Clinic)	556 S Arizona Blvd	Coolidge	AZ	85128
Planned Parenthood Arizona Inc./Optum:	4751 North 15Th Street	Phoenix	AZ	85014
Potters House Substance Abuse Center	4220 N 20Th Ave Ste 100	Phoenix	AZ	85015
PPEP Integrated Care	901 E. 46Th Street	Tucson	AZ	85713
Prescott Healthcare Solutions/ Optum: Family Medical Walk-In,	743 Miller Valley Road	Prescott	AZ	86301
Presidential Mansion care LLC	1647 S 170Th Ave	Goodyear	AZ	85338
Primary Care Practice Of Arizona/ Gateway Urgent Care:	920 East Williams Field, Suite 101	Gilbert	AZ	85296
Proghorn Psychiatry: Pronghorn Psychiatry	5940 E Copper Hill Drive Ste B	Prescott Valley	AZ	86314
Proghorn Psychiatry: Stoneridge Centers	5940 E Copper Hill Drive Ste E	Prescott Valley	AZ	86314
PSA Art Awakenings	309 W 2Nd St	Casa Grande	AZ	85122
PSA Art Awakenings	8152 N 23Rd Ave Ste A And B	Phoenix	AZ	85021
PSA Behavioral Health	1415 N 1St St	Phoenix	AZ	85004
PSA Behavioral Health Agency	1014 N 2Nd St	Phoenix	AZ	85004
PSA Behavioral Health Agency	1315 S. 4Th Ave, Ste. B&C	Yuma	AZ	85364
PSA Behavioral Health Agency	1326 Hwy 92, Suite K	Bisbee	AZ	85603
PSA Behavioral Health Agency	309 W. 2Nd Street	Casa Grande	AZ	85222
PSA Behavioral Health Agency	3271 E Queen Creek Rd Ste 105 110 111	Gilbert	AZ	85297
PSA Behavioral Health Agency	3341 E Queen Rd	Gilbert	AZ	85297
PSA Behavioral Health Agency	412 N. 6Th Avenue	Tucson	AZ	85705
PSA Behavioral Health Agency	4655 S Lakeshore Dr	Tempe	AZ	85282

Program Name	Service Address	City	State	Zip
PSA Behavioral Health Agency	541 10Th Street	Douglas	AZ	85607
PSA Behavioral Health Agency	820 California Avenue, Suite 104	Parker	AZ	85344
PSA Higley Integrated Care Center	3271 E Queen Creek Rd	Gilbert	AZ	85297
PSA Tempe Ash	4665 S Ash Ave Ste G	Tempe	AZ	85282
PTL Behavioral Health, LLC	10839 E Sonrisa Ave	Mesa	AZ	85212
RTL Behavioral Health	10839 East Sonrise Avenue	Mesa	AZ	85212
Purpose Healing Center LLC	9332 N 95Th Way Ste B203	Scottsdale	AZ	85258
Quality Of Life Medical Center:	5390 East Erickson Drive	Tucson	AZ	85712
Quality Care Residential Homes	4110 West Oregon Avenue	Phoenix	AZ	85019
Quick Med Center/ Akos LLC:	5104 North 67Th Avenue	Glendale	AZ	85301
Quick Med Center/ Akos LLC:	7615 West Thunderbird Road, Suite 106	Peoria	AZ	85381
Raghavllc/ More Md:	3769 Crossings Drive, Suite B	Prescott	AZ	86305
Rancho Del Pacifico	12378 E Via De Arboles	Chandler	AZ	85249
Recovery Innovations Inc	11361 N 99Th Ave Ste 200	Peoria	AZ	85345
Recovery Innovations Inc	11361 N 99Th Ave Ste 400 402	Peoria	AZ	85345
Recovery Innovations Inc	11361 N 99Th Ave Ste 600	Peoria	AZ	85345
Recovery Innovations Inc	1255 W Baselines Rd Ste C108	Mesa	AZ	85202
Recovery Innovations Inc	2701 N 16Th St Ste 122	Phoenix	AZ	85006
Recovery Innovations Inc Recovery Response Center Op Clinic	2701 N 16Th St Ste 316	Phoenix	AZ	85006
Recovery Innovations:	142 East Coronado Road, Suite 33	Phoenix	AZ	85004
Recovery Innovations: Respite	11361 N 99Th Avenue, Suite 107	Peoria	AZ	85345
Recovia LLC	1910 E Southern Ave	Tempe	AZ	85282
Recovia LLC	19636 N 27Th Ave Ste 106	Phoenix	AZ	85027
Recovia LLC	8322 E Hartford Dr Ste 100	Scottsdale	AZ	85255
Regional Center For Border Health	1130 E. Main St.	Somerton	AZ	85350
Regional Center For Border Health	1233 S. Main Street, Suite 1	San Luis	AZ	85349
Regional Center For Border Health	1896 E. Babbitt Lane	San Luis	AZ	85349
Regional Center For Border Health	214 W. Main St.	Somerton	AZ	85350
Regional Center For Border Health	950 E. Main St., Bldg B	Somerton	AZ	
Rehab Arizona LLC:	3048 East Baseline Road, Suite 122	Mesa	AZ	85204
Rehab Arizona LLC:	6116 East Arbor Avenue	Mesa	AZ	85206
Rehoboth LLC	19436 N Smith Drive	Maricopa	AZ	85139
Rehoboth LLC	41832 W Rosa Dr	Maricopa	AZ	85138
Rehoboth McKinley Christian Health Services Inc	2111 College Drive	Gallup	AZ	87301
Resilient Health	1023 F Ave.	Douglas,	AZ	85607
Resilient Health	1314 S. 4Th Ave. Ste B&C	Yuma	AZ	85364
Resilient Health	2255 W. Northern Ave. B100	Phoenix	AZ	85021
Resilient Health	309 W. 2Nd St.	Casa Grande	AZ	85122
Resilient Health	3271 E. Queen Creek Rd. Building 2, Suite. 101	Gilbert	AZ	85297
Resilient Health	412 N. 6Th Ave.	Tucson	AZ	85705
Resilient Health	4655 S. Lakeshore Dr	Tempe	AZ	85282



Program Name	Service Address	City	State	Zip
Resilient Health	4665 S. Ash Ave.	Tempe	AZ	85282
Richlin Regal Residency	2864 E. Bellerive Dr.	Gilbert	AZ	85298
Richlin Regal Residency	7872 S. Abbey Lane	Gilbert	AZ	85298
Right Of Way	3703 E Southern Ave Ste 1014	Mesa	AZ	85206
Rio Salado Bhs Inc	1308 W Camelback Rd	Phoenix	AZ	85013
Rosewood Ranch Lp	36075 S Rincon Rd	Wickenburg	AZ	85390
Rosewood Ranch Op Center Tempe	950 W Elliot Rd Ste 201	Tempe	AZ	85284
Roxbury Commons Residential, LLC	3847 West Port Royale	Phoenix	AZ	85053
Sage Counseling	2734 W Bell Rd Ste 1385 1390	Phoenix	AZ	85053
Sage Counseling	849 Cove Pkwy Ste A	Cottonwood	AZ	86326
Sage Counseling Inc	1830 S Alma School Rd Ste 101	Mesa	AZ	85210
Sage Counseling Inc	4435 S Rural Rd, Suite 5	Tempe	AZ	85282
Sage Counseling Inc	460 N Mesa Dr Ste 105	Mesa	AZ	85201
Sage Counseling Inc	460 N Mesa Dr Ste 207 209	Mesa	AZ	85201
Sage Counseling Inc	6610 N 47Th Ave Ste 6 7 8	Glendale	AZ	85301
Sage Counseling Inc	7375 E Stetson Dr, Unit 101	Scottsdale	AZ	85251
Sage Counseling Inc	8805 W Union Hills Dr Ste 100	Peoria	AZ	85382
Sage Counseling	1100 N Beeline Hwy, Suite F	Payson	AZ	85541
Sage Counseling	111 W 1St St	Casa Grande	AZ	85122
Sage Counseling	1132 E Broadway Blvd	Tucson	AZ	85719
Sage Counseling	1616 E Indian School Rd, Suite 135, 150, 160	Phoenix	AZ	85016
Sage Counseling	1700 Lakeside Dr, Suite 9	Bullhead City	AZ	86442
Sage Counseling	1849 Airfield	Kingman	AZ	86401
Sage Counseling	2164 McCullough, Suite C	Lake Havasu City	AZ	86403
Sage Counseling	2603 E 7Th Ave	Flagstaff	AZ	86004
Sage Counseling	281 W 24Th St, Suite 124	Yuma	AZ	85364
Sage Counseling	3001 W Main St, Suite 1D	Prescott	AZ	86314
Sage LLC:	4220 North 20Th Avenue	Phoenix	AZ	85015
Salama Behavioral Health	19665 E Carriage Way	Queen Creek	AZ	85142
Salt River Integrated Hc	10005 E Osborn Rd Hhs Bldg 30	Scottsdale	AZ	85256
San Tan Behavioral Health Services LLC	2671 E Vermont Ct	Gilbert	AZ	85234
San Tan Behavioral Health Services LLC	3970 Juanita Ave	Gilbert	AZ	85234
San Tan Behavioral Health Services LLC	459 North Gilbert Road #C-100	Gilbert	AZ	85234
Schweichler Adult Care Homes	7746 East Latham Street	Gilbert	AZ	85295
Scottsdale Center For Advanced Pain Management:	7401 West Villa Rita Drive	Glendale	AZ	85308
Scottsdale Center For Advanced Pain Management:	9500 East Ironwood Square Drive, Suite 125	Scottsdale	AZ	85258
SEABHS	1615 S. 1St Ave	Safford	AZ	85548
SEABHS	404 Rex Allen Dr	Willcox	AZ	85643
SEABHS	430 Coronado Blvd	Clifton	AZ	85533
SEABHS	4755 Campus	Sierra Vista	AZ	85635
SEABHS	590 S. Ocotillo Ave.	Benson	AZ	85602

Program Name	Service Address	City	State	Zip
SEABHS	936 F Avenue Suite B	Douglas	AZ	85607
Seek Arizona LLC	1830 S Alma School Rd Ste 130	Mesa	AZ	85210
Sequel Care Of Arizona	8800 Mary's Dr	Flagstaff	AZ	86004
Sequelcare Of Arizona	3170 Stillwater Dr.	Prescott	AZ	86305
Sequelcare Of Arizona	6070 N. Treadway Trail	Flagstaff	AZ	86004
Sequelcare Of Arizona LLC/ Syfs Intermediate Holdings	75 South Main Street, Suite B	Tuba City	AZ	86045
Shalom Behavioral Care LLC	35301 North Belgian Blue Court	San Tan Valley	AZ	85143
Sierra	18427 North 44Rd Avenue	Phoenix	AZ	85053
Silver Creek Medical Associate Spc:	2767 Silvercreek Road, Suite A	Bullhead City	AZ	86442
Ska-Shifra Group Home	7136 North 73Rd Drive	Glendale	AZ	85303
Social Work Associates LLC	14040 N Cave Creek Rd Ste 305 E	Phoenix	AZ	85022
Sonora Behavioral Health Hospital	2001 W Orange Grove Rd	Tucson	AZ	85704
Sonora Behavioral Health Hospital	6050 North Corona Road, #3	Tucson	AZ	85704
Southwest Behavioral - Chandler Care Center	777 E. Galveston St.	Chandler	AZ	85225
Southwest Behavioral - Desert Cove	1601 W. Desert Cove	Phoenix	AZ	85029
Southwest Behavioral - Haven	2313 W. Yuma St.	Phoenix	AZ	85009
Southwest Behavioral - Lake Havasu City Outpatient	1845 Mcculloch Blvd., Ste B-1	Lake Havasu	AZ	86403
Southwest Behavioral - Prescott Valley Opioid Replacement Services	7600 E. Florentine Rd. #101	Prescott Valley	AZ	86413
Southwest Behavioral - Recovery Transition Program	2042 N. 35Th Ave.	Phoenix	AZ	85008
Southwest Behavioral - Round Valley Residential	8985 W. Stageline Rd.	Payson	AZ	85541
Southwest Behavioral - Star	313 E. Willetta St.	Phoenix	AZ	85004
Southwest Behavioral - Villa Agave	7439 S. 7Th St.	Phoenix	AZ	85042
Southwest Behavioral & Health Services – Broadway Outpatient	4420 South 32Nd Street	Phoenix	AZ	85040
Southwest Behavioral & Health Services Inc.:	1125 East Blue Spruce Lane	Gilbert	AZ	85298
Southwest Behavioral & Health Services Inc.:	2619 East Pierce Street	Phoenix	AZ	85008
Southwest Behavioral :Bullhead City Outpatient	809/817 Hancock Rd.	Bullhead City	AZ	86442
Southwest Behavioral And Health Services	11221 N 28Th Drive Building E	Phoenix,	AZ	85029
Southwest Behavioral Health And Services	2580 Highway 95 Ste 120	Bullhead City	AZ	86442
Southwest Behavioral Health And Services	4015 S 7Th St	Phoenix	AZ	85040
Southwest Behavioral Health And Services	7600 E Florentine Rd, Ste 101, 201	Prescott Valley	AZ	86314
Southwest Behavioral Health And Services Cdr	401 Emery St	Bullhead City	AZ	86442
Southwest Behavioral Health Service Inc	1301 W Beale St	Kingman	AZ	86401
Southwest Behavioral Health Service Inc	1424 S 7Th Ave Bldg A	Phoenix	AZ	85007
Southwest Behavioral Health Service Inc	1424 S 7Th Ave Bldg B	Phoenix	AZ	85007
Southwest Behavioral Health Service Inc	1424 S 7Th Ave Bldg C	Phoenix	AZ	85007
Southwest Behavioral Health Service Inc	1515 E Cedar Ave Ste B-2	Flagstaff	AZ	86004
Southwest Behavioral Health Service Inc	1515 E Cedar Ave Ste B-3	Flagstaff	AZ	86004
Southwest Behavioral Health Service Inc	1515 E Cedar Ave Ste B-4	Flagstaff	AZ	86004
Southwest Behavioral Health Service Inc	1515 E Cedar Ave Ste E-1	Flagstaff	AZ	86004
Southwest Behavioral Health Service Inc	1515 E Cedar Ave Ste E-2	Flagstaff	AZ	86004
Southwest Behavioral Health Service Inc	2215 Hualapai Mountain Rd Ste E	Kingman	AZ	86401

Program Name	Service Address	City	State	Zip
Southwest Behavioral Health Service Inc	2215 Hualapai Mountain Rd Ste H	Kingman	AZ	86401
Southwest Behavioral Health Service Inc	2580 Hwy 95 Ste 119	Bullhead City	AZ	86442
Southwest Behavioral Health Service Inc	2580 Hwy 95 Ste 120	Bullhead City	AZ	86442
Southwest Behavioral Health Service Inc	2580 Hwy 95 Ste 121	Bullhead City	AZ	86442
Southwest Behavioral Health Service Inc	2580 Hwy 95 Ste 122	Bullhead City	AZ	86442
Southwest Behavioral Health Service Inc	2580 Hwy 95 Ste 123	Bullhead City	AZ	86442
Southwest Behavioral Health Service Inc	2580 Hwy 95 Ste 124	Bullhead City	AZ	86442
Southwest Behavioral Health Service Inc	2580 Hwy 95 Ste 125	Bullhead City	AZ	86442
Southwest Behavioral Health Service Inc	26426 W US Highway 85	Buckeye	AZ	85326
Southwest Behavioral Health Service Inc	5717 N 7Th St	Phoenix	AZ	85014
Southwest Behavioral Health Service Inc	7763 E Florentine Rd	Prescott Valley	AZ	86314
Southwest Behavioral Health Service Inc	809 Hancock Rd Ste 1	Bullhead City	AZ	86442
Southwest Behavioral Health Services Inc	2632 E Thomas Rd Ste 100 101 And 103	Phoenix	AZ	85016
Southwest Behavioral Health Services Inc	404 W Aero Dr	Payson	AZ	85541
Southwest Behavioral Health Services Toby House	303 W Willetta St	Phoenix	AZ	85003
Southwest Behavioral: Empowerment Center	302 W. Aero Dr.	Payson	AZ	85541
Southwest Behavioral: Mesa Outpatient	1255 W. Baseline Rd. Ste. 104, 124, & 138	Mesa	AZ	85202
Southwest Behavioral: Prescott Valley Outpatient	7600 E. Florentine Rd. Ste. 201	Prescott Valley	AZ	86314
Southwest Behavioral: Sheridan	7626 East Sheridan Street	Scottsdale	AZ	85257
Southwest Center For HIV Aids	1101 N Central Ave Ste 200	Phoenix	AZ	85004
Southwest Human Development	2850 N 24Th St	Phoenix	AZ	85008
Southwest Network Inc	1465 W Chandler Blvd Bldg A	Chandler	AZ	85224
Southwest Network Inc	1840 N 95Th Ave Ste 132	Phoenix	AZ	85037
Southwest Network Inc	2444 E University Dr Ste 150	Phoenix	AZ	85034
Southwest Network Inc	3140 N Arizona Ave Ste 113	Chandler	AZ	85225
Southwest Network Inc	3227 E Bell Rd Ste 170	Phoenix	AZ	85032
Southwest Network Inc	3640 W Osborn Rd Ste 1	Phoenix	AZ	85019
Southwest Network Inc	4160 N 108Th Ave	Phoenix	AZ	85037
Southwest Network Inc	460 N Mesa Dr Ste 201	Mesa	AZ	85201
Southwest Network Inc	4707 N 12Th St	Phoenix	AZ	85014
Southwest Network Inc	9051 W Kelton Ln Ste 13	Peoria	AZ	85382
Spectrum Healthcare Group	2880 Hopi Dr	Sedona	AZ	86336
Spectrum Healthcare Group	3633 Crossings Drive	Prescott	AZ	86305
Spectrum Healthcare Group	452 Finnie Flats Rd	Camp Verde	AZ	86322
Spectrum Healthcare Group	651 W Mingus Ave	Cottonwood	AZ	86326
Spectrum Healthcare Group Inc	8 E Cottonwood St Bldg A	Cottonwood	AZ	86326
Spectrum Healthcare Group Inc	8 E Cottonwood Street Bldg B	Cottonwood	AZ	86326
Spectrum Healthcare Group Inc	8 E Cottonwood Street Bldg C	Cottonwood	AZ	86326
Spectrum Healthcare Group:	2515 Blue Horizon Road	Sedona	AZ	86336
Spectrum Healthcare Group:	4212 East Mission Lane	Cottonwood	AZ	86326
Springs Of Joy LLC	613 S 125Th Ave	Avondale	AZ	85323

Program Name	Service Address	City	State	Zip
St Luke's Behavioral Health Center	1800 E Van Buren St	Phoenix	AZ	85006
St Luke's Behavioral Health Center	325 E Elliot Rd Ste 29	Chandler	AZ	85225
Star - Stand Together And Recover Centers Inc	1310 W University Dr	Mesa	AZ	85201
Star Stand Together & Recover Centers, Inc	2502 E Washington St	Phoenix	AZ	85034
Star Stand Together & Recover Centers, Inc	605 N Central Ave	Avondale	AZ	85323
Stoneridge Centers For Brain And Addiction Treatment	5940 E Copper Hill Dr Ste E	Prescott Valley	AZ	86314
Successful Journeys Integrated Care	20969 West Thomas Road	Buckeye	AZ	85396
Successful Journeys Integrated Care	2106 West Vista Avenue	Phoenix	AZ	85021
Successful Journeys Integrated Care	4434 North 153 Lane	Goodyear	AZ	85395
Successful Journeys Integrated Care LLC	8828 N Central Avenue, Ste 202-206	Phoenix	AZ	85020
Summit Behavioral Health Of Arizona	637 W Hillside Ave	Prescott	AZ	86301
Summit Behavioral Health Of Arizona	8183 East Florentine Road	Prescott Valley	AZ	86314
Summit Behavioral Health Of Arizona	8705 E. Eastridge Dr	Prescott Valley	AZ	86314
Summit Health Care Association:	151 North White Mountain Road, Suite E	Show Low	AZ	85901
Sun Life Family -Coolidge	1284 N Arizona Blvd	Coolidge	AZ	85128
Sun Life Family Health Center	150 S Main St	Florence	AZ	85132
Sun Life Family Health Center	2080 W Southern Ave Ste 10	Apache Junction	AZ	85120
Sun Life Family Health Center	865 N Arizona Rd	Casa Grande	AZ	85122
Sun Life Family Hlth-Eloy	205 N Stuart Blvd	Eloy	AZ	85131
Sun Life Family Oracle	1870 W American Ave	Oracle	AZ	85623
Sun Life Family-Maricopa	44572 W Bowlin Rd	Maricopa	AZ	85139
Sun Life Family-Pediatric	1856 E Florence Blvd	Casa Grande	AZ	85122
Sun Life Family-San Manuel	23 S Mcnab Pkwy	San Manuel	AZ	85631
Sunrise Behavioral Health	12930 W. Dreyfus Dr	El Mirage	AZ	85335
Sunrise Behavioral Health	8913 N 114Th Dr	Peoria	AZ	85345
Sunrise Behavioral Health	9280 W Sunnyslope Ln	Peoria	AZ	85345
Sunrise Behavioral Health LLC	9280 West Sunnyslope Drive	Peoria	AZ	85345
Team Physicians Arizona:	1955 West Frye Road	Chandler	AZ	85224
Tender Loving Care Home	509 S. Staunton Dr.	Tucson	AZ	85710
Tender Loving Care Home	6010 E. Seneca St.	Tucson	AZ	85712
Tender Loving Care Home	7232 E. Montecito Dr.	Tucson	AZ	85710
Terros Health	1232 E Broadway Road Bldg C, Suite 120	Tempe	AZ	85282
Terros Health	2445 W Indianola Ave	Phoenix	AZ	85015
Terros Health	4909 E McDowell Road	Phoenix,	AZ	85008
Terros Health	5153 W Olive Ave	Glendale	AZ	85302
Terros Health	3864 N 27Th Ave	Phoenix	AZ	85017
Terros Health	4616 N 51St Ave Ste 108	Phoenix	AZ	85012
Terros Health - 23Rd Ave	8804 N 23Rd Ave Bldg A Ste A01 A02	Phoenix	AZ	85021
Terros Health – HIV & Sti Services	333 E Indian School Rd.	Phoenix	AZ	85012
Terros Health – Stapley Drive Integrated Care & Ladder	1111 S. Stapley Dr.	Mesa	AZ	85204
Terros Inc Op Clinic	6153 W Olive Ave	Glendale	AZ	85302

Program Name	Service Address	City	State	Zip
Terros Inc Priest	1642 S Priest Dr Bldg 6 Ste 101	Tempe	AZ	85281
Terros, Inc	12835 N 32Nd St	Phoenix	AZ	85032
Terros, Inc	3033 N Central Ave	Phoenix	AZ	85012
Terros, Inc	3385 N Campbell Ave	Tucson	AZ	85719
Terros, Inc	4616 N 51St Ave Ste 201	Phoenix	AZ	85031
Terros, Inc	5801 N 51St Ave	Glendale	AZ	85301
Terros, Inc	8836 N 23Rd Ave Ste B1	Phoenix	AZ	85021
The Chalet House- Chalet North	6633 N Amahl Cir	Tucson	AZ	85704
The Chalet House- The Villas	6849 S Tackweed Way	Tucson	AZ	85756
The Guidance Center Inc	2187 N Vickey St	Flagstaff	AZ	86004
The Guidance Center Inc	220 W Grant Ave	Williams	AZ	86046
The Guidance Center Inc	2695 East Industrial Avenue	Flagstaff	AZ	86004
The Guidance Center Inc	2697 East Industrial Avenue	Flagstaff	AZ	86004
The Guidance Center Inc.:	8 East Cottonwood Street	Cottonwood	AZ	86326
The Hamptom House LLC	3638 West Denton Lane	Phoenix	AZ	85019
The Haven	1017, 1025 And 1107 E. Adelaide Dr.	Tucson	AZ	85719
The Haven	2601 N. Campbell Ave., Ste. 110	Tucson	AZ	85719
The Haven: Outpatient	2601 N. Campbell Ave, Ste 101	Tucson	AZ	85719
The Haven: Residential	1107 E Adelaide Dr.	Tucson	AZ	85719
The Havens Outpatient Clinic	2601 N Campbell Ave Ste 105	Tucson	AZ	85719
The Nile Health Network	1367 S Country Club Dr Unit 1011	Mesa	AZ	85210
The Oasis Home	78 E. Via Teresita	Sahuarita	AZ	85629
The Oasis Home	845 W. Calle Barbitas	Sahuarita	AZ	85629
The Oasis Home, LLC.	446 W Calle Franja Verde	Sahuarita	AZ	85629
The Pain Center Of Arizona:	650 East Indian School	Phoenix	AZ	85012
The Potters House Substance Abuse Center	1717 W Northern Ave Ste 101	Phoenix	AZ	85021
The Resolution Group Inc	1608 E Earll Dr	Phoenix	AZ	85016
The Resolution Group Inc	623 W Southern Ave Ste 7	Mesa	AZ	85210
The U-Turn Foundation	4005 E Edgewood Ave	Mesa	AZ	85206
The Wellness Center &P Prevention:	19841 North 27Th Avenue, Suite 204	Phoenix	AZ	85027
Thumb Butte Urgent Care LLC:	3124 Willow Creek Road	Prescott	AZ	86301
Thunderbird Obstetrics & Gynecology:	5757 West Thunderbird Road, Suite B-202	Glendale	AZ	85306
Tilda Manor	1404 N Ananea St	Mesa	AZ	85207
Tilda Manor	3228 E Isabella Ave	Mesa	AZ	85204
Tilda Manor	3583 E Wildhorse Dr	Gilbert	AZ	85297
Tilda Manor	5985 S Mack Ct	Gilbert	AZ	85298
Tilda Manor	6229 S Moccasin Trl	Gilbert	AZ	85298
TLC Transitional Living Communities	32 S Macdonald	Mesa	AZ	85210
Toole Inpatient	250 S Toole Ave Ste A	Tucson	AZ	85701
Touch Angels Behavioral Health	2018 West Morning Vista	Phoenix	AZ	85085
Touch Angels Behavioral Health	5045 South Tatum Lane	Gilbert	AZ	85298

Program Name	Service Address	City	State	Zip
Touchstone – Avondale Center	12409 W. Indian School Rd., Bld E	Avondale	AZ	85392
Touchstone – Main Center	15648 N. 35Th Ave.	Phoenix	AZ	85053
Touchstone – Mesa Center	2150 S. Country Club Dr. Ste 35 & 36	Mesa	AZ	85210
Touchstone – North Center	3602 E. Greenway Rd. Suite 102	Phoenix	AZ	85032
Touchstone Health Service	15820 N 35Th Ste 14	Phoenix	AZ	85053
Touchstone Health Services	12725 West Indian School Road #108	Phoenix	AZ	85053
Touchstone Health Services: Multi- Systemic Therapy	1430 E. Fort Lowell Rd, Suite 100	Tucson	AZ	85719
Track House Life	4205 N 7Th Ave Ste 307	Phoenix	AZ	85013
Transitional Living Center Recovery	1444 W 4Th St	Yuma	AZ	85364
Transitional Living Center Recovery Casa Grande	117 E 2Nd St	Casa Grande	AZ	85122
Transitional Living Center Recovery Yuma	1340 S 4Th Ave	Yuma	AZ	85364
Treatment Assessment Screening Center, Inc. (T A S C)	2080 Acoma Blvd. West, Ste. A	Lake Havasu	AZ	86403
Treatment Assessment Screening Center, Inc.(T A S C)	2302 N. 7Th Street, Ste. B	Phoenix	AZ	85006
Treatment Assessment Screening Center, Inc.(T A S C)	2364 Kingman Avenue	Kingman	AZ	86401
Treatment Assessment Screening Center, Inc.(T A S C)	244 W. Drachman	Tucson	AZ	85705
Treatment Assessment Screening Center, Inc.(T A S C)	281 W. 2Nd Street, Ste. 131	Flagstaff	AZ	86004
Treatment Assessment Screening Center, Inc.(T A S C)	423 N. Country Club Drive, Ste. 19	Mesa	AZ	85201
Treatment Assessment Screening Center, Inc.(TASC)	4016 N. Black Canyon Highway	Phoenix	AZ	85017
Tree Of Life Arizona	1659 E Draper Cir	Mesa	AZ	85203
Tri State Medical Specialists LLC:	1987 Mcculloch Blvd., Suite 101	Lake Havasu City	AZ	86403
Tripp Leppp	5201 W. Sunland Ave.	Laveen	AZ	85339
Tristate Medical Specialists LLC:	1510 Wagon Wheel Lane, Suite 110	Fort Mohave	AZ	86426
Tuba City Outpatient Treatment Center	Post Office Box 1350	Tuba City	AZ	86045
Tucson Medical Center:	7383 East Tanque Verde Road	Tucson	AZ	85715
UA Rise HWC/Camp Wellness	1030 N. Alvernon Way	Tucson	AZ	85711
Unhooked At The Heights	152 N 56Th St Ste B	Mesa	AZ	85205
Unhooked At The Heights	5801 E Main St	Mesa	AZ	85205
Unhooked LLC	3602 E Greenway Rd Ste 104B	Phoenix	AZ	85032
Unhooked Recovery Power Road	215 S Power Rd Bldg 1251	Tempe	AZ	85282
Unique Family Services	4801 S Lakeshore Dr Ste 101	Tempe	AZ	85282
Unique Family Services	5010 E Warner Rd Ste 107	Tempe	AZ	85284
Unique Family Srvcs Eagle	5010 E Warner Rd Ste 111	Phoenix	AZ	85044
Valle Del Sol	1209 S 1St Ave	Phoenix	AZ	85339
Valle Del Sol - 1510 Fqhc	1510 S 19Th Dr Ste 100	Phoenix	AZ	85009
Valle Del Sol – Avondale	10320 W. McDowell Rd. Ste. G-7024	Avondale	AZ	85392
Valle Del Sol – Central Phoenix	4117 N. 17Th St.	Phoenix	AZ	85014
Valle Del Sol – Southeast Valley	4135 S. Power Rd. Ste. 108	Mesa	AZ	85212
Valle Del Sol – West Phoenix	502 N. 27Th Ave.	Phoenix	AZ	85009
Valle Del Sol Inc	8410 W Thomas Rd Ste 116	Phoenix	AZ	85037
Valle Del Sol Inc.	509 S Rockford Dr	Tempe	AZ	85281
Valle Del Sol, Inc	3807 N 7Th St	Phoenix	AZ	85014

Program Name	Service Address	City	State	Zip
Valle Del Sol, Inc.	334 W 10Th Place Suite 100	Mesa,	AZ	85201
Valle Del Sol, Inc.:	2078 East Southern Avenue, Bldg. 1	Tempe	AZ	85282
Valley Hospital	3550 E Pinchot Ave	Phoenix	AZ	85018
Valley Perinatal Services LLC:	16611 South 40Th Street, Suite 180	Phoenix	AZ	85048
Valley Perinatal Services LLC:	2620 North 3Rd Street	Phoenix	AZ	85004
Valley Perinatal Services LLC:	9305 West Thomas Road	Phoenix	AZ	85037
Valley Perinatal Services LLC:	9440 East Ironwood Square Drive	Scottsdale	AZ	85258
Valley Vascular Consultants PLLC:	6120 West Bell Road, Suite 130	Glendale	AZ	85308
Valleywise Community Health Center Avondale	950 E Van Buren	Avondale	AZ	85323
Valleywise Community Health Center Chandler	811 S Hamilton	Chandler	AZ	85225
Valleywise Community Health Center Glendale	5141 W Lamar Rd	Glendale	AZ	85301
Valleywise Community Health Center Guadalupe	5825 E Calle Guadalupe Rd	Guadalupe	AZ	85283
Valleywise Community Health Center Maryvale	4011 N 51St Ave	Phoenix	AZ	85031
Valleywise Community Health Center McDowell	1101 N Central Ave Ste 204	Phoenix	AZ	85004
Valleywise Community Health Center Mesa	59 S Hibbert	Mesa	AZ	85210
Valleywise Community Health Center South Phoenix	33 W Tamarisk	Phoenix	AZ	85041
Valleywise Community Health Center Sunnyslope	934 W Hatcher Rd	Phoenix	AZ	85029
Valleywise Comprehensive Care Center Phoenix	2525 E Roosevelt St	Phoenix	AZ	85008
Valleywise Health	1205 S 7Th Ave	Phoenix	AZ	85007
Valleywise Health	12428 W Thunderbird Rd	El Mirage	AZ	85335
Valleywise Health	2601 E Roosevelt St	Phoenix	AZ	85008
Valleywise Health	5650 S 35Th Ave	Phoenix	AZ	85041
Valleywise Health	8088 W Whitney Dr	Peoria	AZ	85345
Vema Corporation	4482 West Peoria Avenue	Glendale	AZ	85302
Vema Corporation- Cholla Two	3927 West Cholla Street	Phoenix	AZ	85029
Vema Corporation- Sunnyslope	6026 West Sunnyslope Drive	Glendale	AZ	85304
Vema Corporation- West Cholla	4511 West Corrine Road	Glendale	AZ	85304
Vema Corporation- West Sierra	7032 West Sierra	Peoria	AZ	85345
Vema Corporation-Westcorrine	3822 West Cholla Street	Phoenix	AZ	85059
VHS Outpatient Clinics:	8383 East Nightingale Star Drive	Scottsdale	AZ	85266
Visions Of Hue	15213 W. Jackson St.	Goodyear	AZ	85338
Vogue Recovery Arizona LLC	4122 N 17Th St Bldg A	Phoenix	AZ	85016
Wagoner Care LLC	6127 West Wagoner Road	Glendale	AZ	85308
WD Recovery And Wellness Center LLC	7330 N 16Th St Ste B101	Phoenix	AZ	85020
Wellbeing Institute	3615 N. Prince Village Pl. #121	Tucson	AZ	85719
Wellness Connections - Safford	1025 South 1St St	Safford	AZ	85546
Wellness Connections - Sierra Vista	1201 E Fry Blvd	Sierra Vista	AZ	85635
Wesley Health Center	1300 S 10Th St	Phoenix	AZ	85034
Wesley Health Center	1625 N 39Th Ave	Phoenix	AZ	85009
West Yavapai Guidance Center:	3343 North Wind song Drive	Prescott Valley	AZ	86314
West Yavapai Guidance Center:	510 East Moeller Street	Prescott	AZ	86302

Program Name	Service Address	City	State	Zip
West Yavapai Guidance Center: Chino Valley	505 W. Road 3 North	Chino Valley	AZ	86323
West Yavapai Guidance Clinic	3347 N Windsong Dr	Prescott Valley	AZ	86314
West Yavapai Guidance Clinic	555 W Road 3 North	Chino Valley	AZ	86323
West Yavapai Guidance Clinic	642 Dameron Dr	Prescott	AZ	86301
West Yavapai Guidance Clinic	711 W Hillside Ave	Prescott	AZ	86301
West Yavapai Guidance Clinic	8655 E Eastridge Rd Ste B	Prescott Valley	AZ	86314
West Yavapai Guidance Clinic	3345 N Windsong Dr	Prescott Valley	AZ	86314
West Yavapai Guidance Clinic	505 S. Cortez	Prescott	AZ	86305
West Yavapai Guidance Clinic	625 Hillside Avenue	Prescott	AZ	86301
Whole Health Home Clinic Fqhc	10240 N 31St Ave Ste 210B	Phoenix	AZ	85051
Whole Health Home Clinic Fqhc	1035 E Jefferson Ste B	Phoenix	AZ	85034
Whole Health Home Clinic Fqhc	1465 W Chandler Blvd Bldg A Ste B	Chandler	AZ	85224
Whole Health Home Clinic Fqhc	1616 E Roeser Ste B	Phoenix	AZ	85040
Winslow Guidance Associates, Inc.	309 E Hopi Dr	Holbrook	AZ	86025
Winslow Memorial Hospital:	1500 North Williamson	Winslow	AZ	86047
Winslow Memorial Hospital:	500 North Indiana Avenue	Winslow	AZ	86047
Women's Health Innovations Of Arizona	3303 S Lindsay Rd Bldg 4 Ste 108	Gilbert	AZ	85297
X N R Inc:	3615 North Prince Village Place, Suite 121	Tucson	AZ	85641
XNR Inc:	2020 East Prince Road	Tucson	AZ	85719
XNR Inc:	3100 North First Avenue	Tucson	AZ	85719
XNR Inc:	5350 East Erickson Drive	Tucson	AZ	85712
Yavapai Regional Medical Center:	1003 Division Street, Suite 7	Prescott	AZ	86301
Yavapai Regional Medical Center:	1090 Commerce Drive	Prescott	AZ	86305
Youth Advocate Programs	4494 W Peoria Ave Ste 103	Glendale	AZ	85302
Youth Development Institute	1050 N 19Th St Bldg A	Phoenix	AZ	85006
Youth Development Institute	1050 N 19Th St Bldg B	Phoenix	AZ	85006
Youth Development Institute	1930 East Roosevelt Street	Phoenix	AZ	85006
Youth Development Institute Level Ii BHRF Ph1	1921 E Portland St	Phoenix	AZ	85006
Youth Development Institute Level Ii BHRF Ph2 Chaperone	1927 E Portland St	Phoenix	AZ	85006
Youth Development Institute Outpatient Clinic	1830 E Roosevelt St	Phoenix	AZ	85006
Youth Transition Service	1190 South Boulder Street, #D	Gilbert	AZ	85296
Zarephath Apache House	2060 E 37Th Ave	Apache Junction	AZ	85119
Zarephath Cactus House	1701 S Cactus Rd	Apache Junction	AZ	85119
Zarephath Chaparral House	3838 S Chaparral Rd	Apache Junction	AZ	85119
Zarephath Main Outpatient	4856 E Baseline Ste 103	Mesa	AZ	85206
Zarephath Milagro House	7247 E Milagro Ave	Mesa	AZ	85209
Zarephath Princess House	9310 E Princess Dr	Mesa	AZ	85207
Zarephath Sonrisa House	11358 E Sonrisa Ave	Mesa	AZ	85212
Zion Health Homes	19665 East Carriage Way	Queen Creek	AZ	85142



Substance Abuse Prevention and Treatment

# Case File Review

# Findings

# FY 2020

**Arizona Health Care Cost Containment System**  
**Division of Grants Administration**  
May 2021

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# 1

## Executive Summary

The State of Arizona (Arizona or State), Arizona Health Care Cost Containment System (AHCCCS) engaged Mercer Government Human Services Consulting (Mercer) to implement an independent case file review (ICR) for persons who received substance abuse treatment services through federal Substance Abuse Block Grant (SABG) funds between July 1, 2019–June 30, 2020. This report represents the most recent in an annual series of ICRs and the first conducted by Mercer.

The purpose of the annual review is to review the quality, appropriateness, and efficacy of treatment services as documented in the client records; the intent of the independent peer review process is to continuously improve the treatment services provided to individuals diagnosed with substance use disorder (SUD) within the State (see 45 CFR § 96.136) in order to ultimately improve client outcomes and recovery.

Consistent with statute, Mercer licensed clinicians (i.e., Licensed Clinical Social Worker, Doctor of Philosophy [PhD], Registered Nurse) examined the following aspects of the treatment records as part of the review process:

- Admission criteria/intake process
- Assessments
- Treatment planning, including appropriate referral, (e.g., prenatal care, tuberculosis, and HIV services)
- Documentation of implementation of treatment services
- Discharge and continuing care planning
- Indications of treatment outcomes

In addition to these statutorily required review components, Mercer also examined aspects of the treatment records related to Social Determinants of Health (SDoH), evidence-based treatment practices, peer support services, women's services, and opioid specific services.

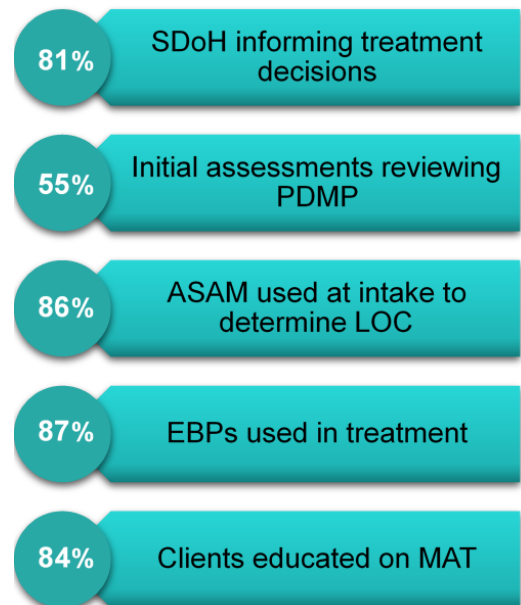
Mercer reviewed a total of 200 treatment records, provided by AHCCCS, from across the State. The files included in this review sample represented 37% of the providers in the State who receive SABG funds, which exceeds the minimum statutory requirement for this review (5%).

## Overview of Key Findings

Specific findings from the ICR are presented in the body of the report, broken down by Regional Behavioral Health Authority (RBHA): Arizona Complete Health (Southern Arizona), Health Choice Arizona (Northern Arizona), and Mercy Care (Central Arizona). Key findings identify how the documentation demonstrates the overall effectiveness and quality of the SABG service delivery system in Arizona. This includes how providers are performing in the identification, engagement, and response to client needs through the provision of SUD treatment services. The following bulleted list represents a summary of the major themes found across the system.

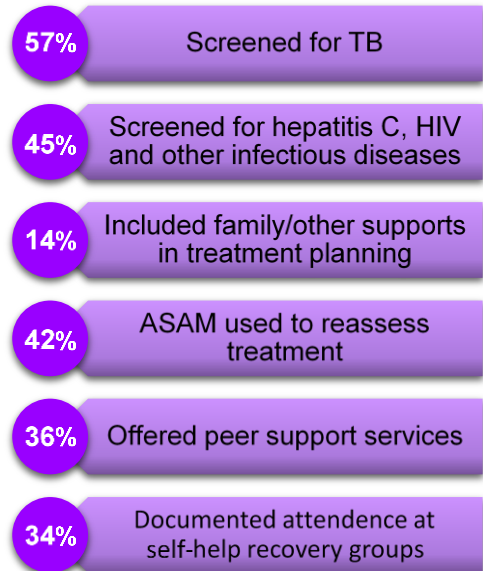
### Strengths

- Despite the fact that this is the first year the ICR has evaluated an item examining the providers' inclusion of SDoH in the initial assessment, 81% of providers are already using this important information to inform treatment decisions. Such a high percentage at the outset of tracking bodes well for future outcomes and suggests providers are incorporating emerging areas of research into current treatment approaches. Specific areas assessed include housing, employment, and education.
- An item related to the providers' review of the Prescription Drug Monitoring Program (PDMP) was also added for the first time in this year's ICR. Increased utilization of the PDMP has been a component of Federal efforts to address the opioid crisis, and primary care physicians (PCPs) and pharmacists are encouraged to review the PDMP for overutilization patterns. Fifty-five percent of the SUD charts reviewed in this year's ICR demonstrated provider review of the PDMP, which indicates room for improvement, but a promising start for the first year of evaluation.
- Adoption of the American Society of Addiction Medicine (ASAM) criteria in determining the appropriate level of care (LOC) appears to be going well, with 86% of cases documenting its use during the initial assessment.
- In 87% of cases reviewed, the providers documented the use of evidenced-based practices (EBPs) in the treatment of SUD clients. The most frequently used EBPs include Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Dialectical Behavioral Therapy, and Matrix Intensive Outpatient Treatment.
- For those clients diagnosed with an Opioid Use Disorder (OUD), 84% were educated on the benefits of Medication Assisted Treatment (MAT) and offered this intervention.



## Opportunities

- Documented screening for required medical conditions remains an area of needed improvement in the aggregate data. Screening for tuberculosis (TB or tuberculosis) was documented in only 57% of cases, and screening for hepatitis C, HIV, and other infectious diseases was present in only 45% of cases.
- Utilization of natural supports in the development of individual service plans (ISPs) was significantly lower than would be expected, with only 14% of cases documenting the inclusion of family or other supports in treatment planning. However, 46% (n = 87) of the reviewed files contained evidence that providers offered to include family or other supports in treatment planning, but the member declined.
- Forty-two percent of cases documented the use of ASAM criteria during the course of treatment to reassess the appropriate LOC. When compared to the use of ASAM criteria in initial assessments (86%), providers have room for additional improvement.
- For all cases reviewed, 36% (n = 71) documented that peer support services were offered as part of the treatment plan. Peer support services were actually delivered in 66% of the cases wherein they were offered (n = 47).
- The majority of cases (66%) failed to provide any documentation as to whether the client was attending self-help recovery groups (e.g., Alcoholics Anonymous or Narcotics Anonymous).



## Recommendations

The following recommendations are presented as potential areas of improvement to round out the evaluation of SABG programming and services, impact practice and outcomes for clients based upon the results of the ICR and associated analysis of findings. A more detailed outline of recommendations can be found in Section 6 of this report.

1. **Develop a mechanism for feedback to specific providers:** Although all SABG SUD providers have access to the findings of the ICR, the Mercer review team noted several instances where it would be beneficial to provide feedback to a specific provider (e.g., treatment concerns, missed opportunities for intervention, etc.). The ICR, in its present form, does not allow for provider-specific feedback to the RBHAs, with the intention of having that information passed along to the provider in question. AHCCCS should consider amending the ICR process to include a feedback mechanism that would allow for “lessons learned” to be disseminated or discussed, at a minimum, with the provider collective and specific providers as indicated in the results.

2. **Encourage the ongoing use of SDoH information in treatment:** As noted previously, providers are doing a good job of investigating SDoH concerns that could impact treatment, with 81% of cases having a documented assessment of these issues. The next step should be to incorporate the SDoH findings into the treatment planning and actively work to address existing obstacles to recovery. The ICR revealed that, with the exception of transportation, most providers did not incorporate SDoH issues during the course of treatment (i.e., after the initial assessment), even when SDoH concerns were revealed in the initial assessment. AHCCCS should encourage the RBHAs to develop mechanisms for addressing SDoH concerns in treatment and use the information they are now collecting to improve treatment outcomes. Such steps would likely assist in accomplishing the goals of the Whole Person Health Initiative.
3. **Consider the inclusion of interviews in future ICRs:** The ICR currently reveals useful information related to the use of best practices and procedures by SUD treatment providers. However, a file review only conveys the information as it is documented. By incorporating live interviews with the RBHAs, clients, and/or providers, AHCCCS could collect additional, valuable information that would round-out its understanding of what is working and what needs to be improved in SUD treatment services regionally and across the State. For example, although attendance at peer support groups is not currently documented consistently by providers, interviews could shed light on the true rate of participation in such groups.
4. **Consider formal statistical validation of the ICR Tool for future independent reviews.** As use of SABG funds continues, and additional ICRs are undertaken, AHCCCS could benefit from improved information that allows for year-to-year comparisons of ICR findings. Such comparisons can only be appropriately made when a statistically validated tool is used that increases confidence in the comparability of the different years' results. AHCCCS would have the option of performing such validation in-house, or leveraging the expertise of consultants trained in the validation of clinical review tools. As an additional option, AHCCCS could consider maintaining consistency in the independent review team that performs the ICR. Such consistency, together with the use of a statistically validated tool, would decrease variability from year-to-year, and increase the State's ability to compare results and assess large-scale trends within the SUD service system.
5. **Consider changes to sampling methodology for future reviews.** As an option in future reviews, AHCCCS should consider increasing validity and reliability by using a more randomized sampling methodology. One method for achieving this would be to have the independent reviewer randomly select the sample cases to be reviewed (from the entire population of files that meet inclusion criteria) and then ask the RBHAs to supply those specific records. This would add some time to the process (when compared to having the RBHAs select files to provide), but it would increase confidence in the results and contribute to overall project validity. An additional benefit of using this sampling methodology is that the independent reviewer would have the opportunity to stratify the sample and increase the number of cases from small sub-populations (e.g., pregnant women).

## 2

# Background and Introduction

AHCCCS serves as the single State authority to provide coordination, planning, administration, regulation, and monitoring of all facets of the State public behavioral health system. AHCCCS contracts with managed care organizations, known as RBHAs, to administer integrated physical health (to select populations) and behavioral health services, including SUD treatment, throughout the State. The current RBHAs are Arizona Complete Health (Southern Arizona), Health Choice Arizona (Northern Arizona), and Mercy Care (Central Arizona). Effective July 1, 2016, AHCCCS began to administer and oversee the full spectrum of services to support integration efforts at the health plan, provider and client levels.<sup>1</sup>

Consistent with the requirements of 45 CFR § 96.136, AHCCCS contracted with Mercer as the independent review contractor to perform the annual SABG ICR for State Fiscal Year 2020. Mercer does not have any reviewers who are employed as treatment providers with, or who have administrative oversight for, the programs under review. Further, Mercer's peer review personnel performed this review independent (i.e., separate) from SABG funding decision makers. The Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded a SABG to AHCCCS each year since the current program was established in 1993; the block grant requires that AHCCCS produce an independent review of the treatment services provided with SABG funds on an annual basis. For the current year, AHCCCS program goals for the SABG include<sup>2</sup>:

- Increase the availability and service utilization of MAT options for members with a SUD.
- Ensure women have ease of access to all specialty population related SUD treatment and recovery support services.
- Increase the number of tuberculosis screenings for members entering substance abuse treatment.

Below are results from the SABG chart review relating to each of the above AHCCCS program goals.

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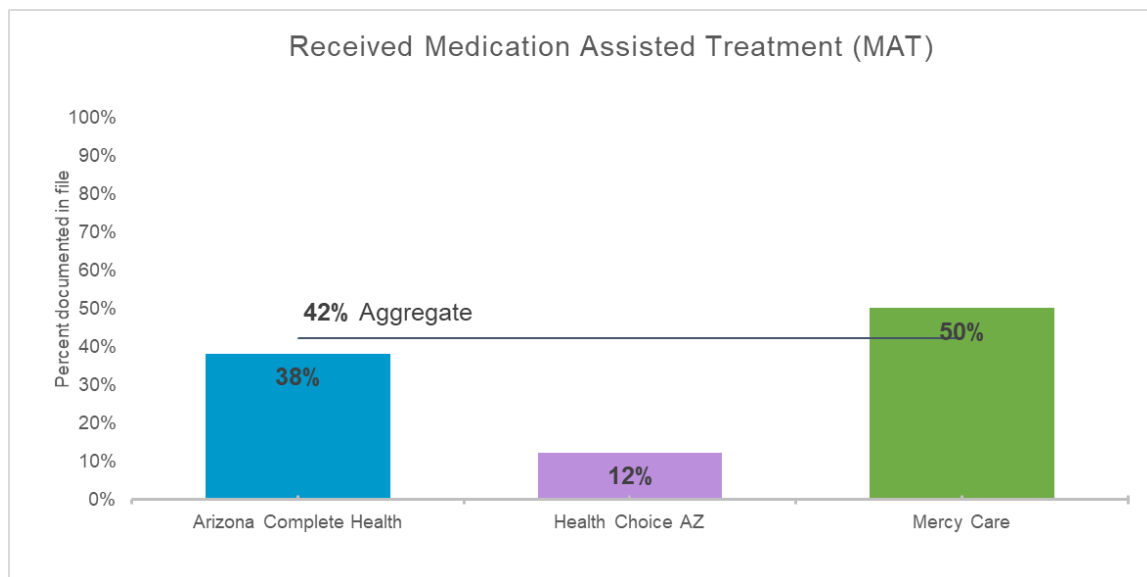
<sup>1</sup> State of Arizona. AHCCCS. (2020). Quality Service Review 2020.

<sup>2</sup> AHCCCS. (n.d.). *Substance Abuse Prevention and Treatment Block Grant (SABG)*. Available at: <https://www.azahcccs.gov/Resources/Grants/SABG/>

### Increase the availability and service utilization of MAT options for members with a SUD

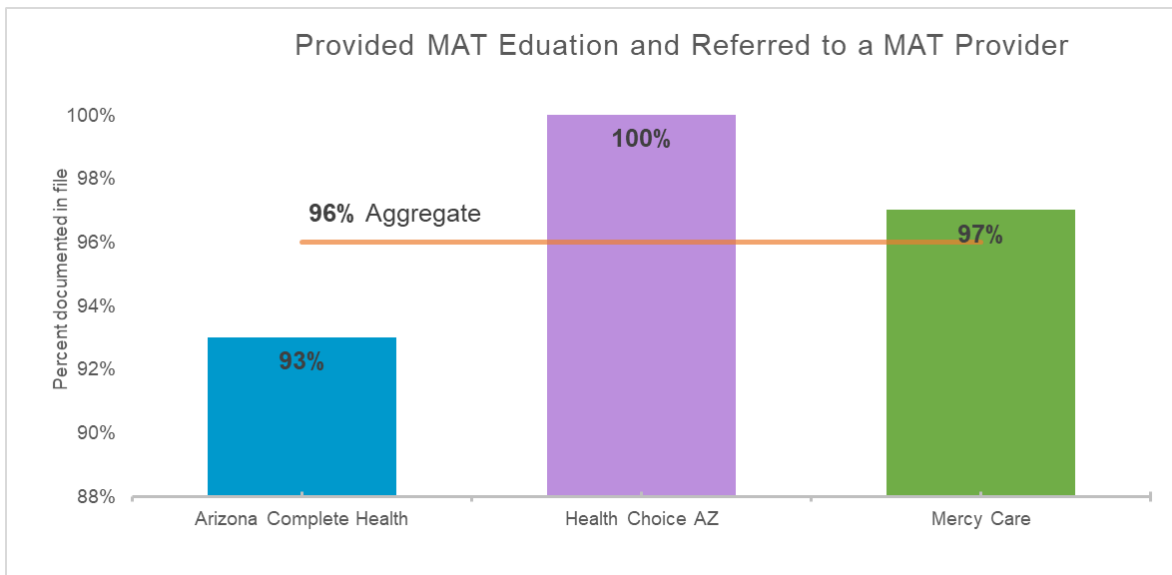
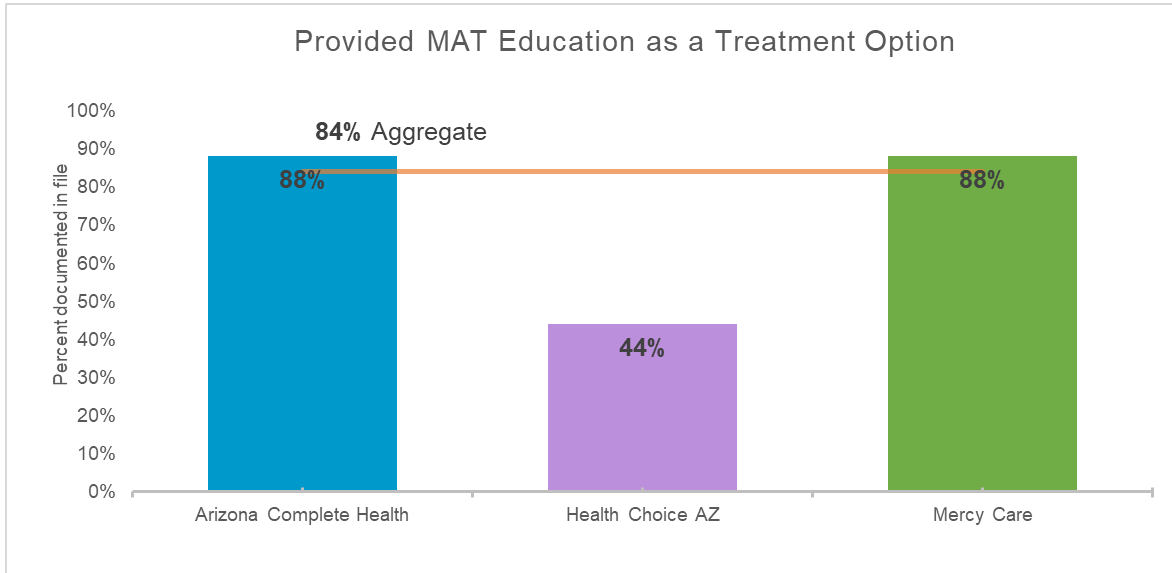
Offering MAT services promotes a “whole-patient” approach to the provision of substance use services.<sup>3</sup> Overall, 42% of sampled behavioral health case files (83 individuals) contained documentation that MAT was incorporated into treatment.

For members with a documented OUD, 84% were provided MAT education as a treatment option. Ninety-six percent of members receiving MAT education were referred to a MAT provider.



<sup>3</sup> SAMHSA, *Medication-Assisted Treatment (MAT)*, updated January 1, 2021. Available at: <https://www.samhsa.gov/medication-assisted-treatment>





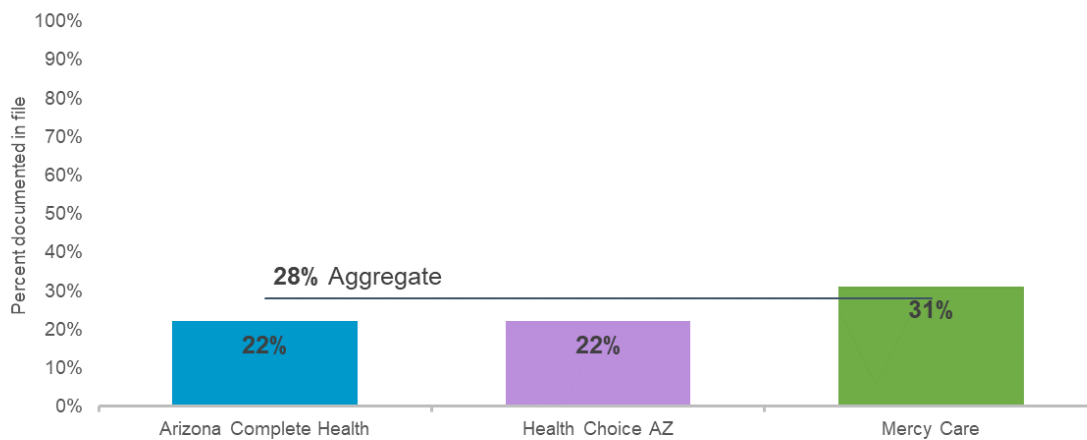
**Ensure women have ease of access to all specialty population related SUD treatment and recovery support services**

Women have different circumstances and experiences in regard to SUDs and treatment.<sup>4</sup> Allowing access to appropriate gender-based treatment can produce more favorable outcomes. One SABG

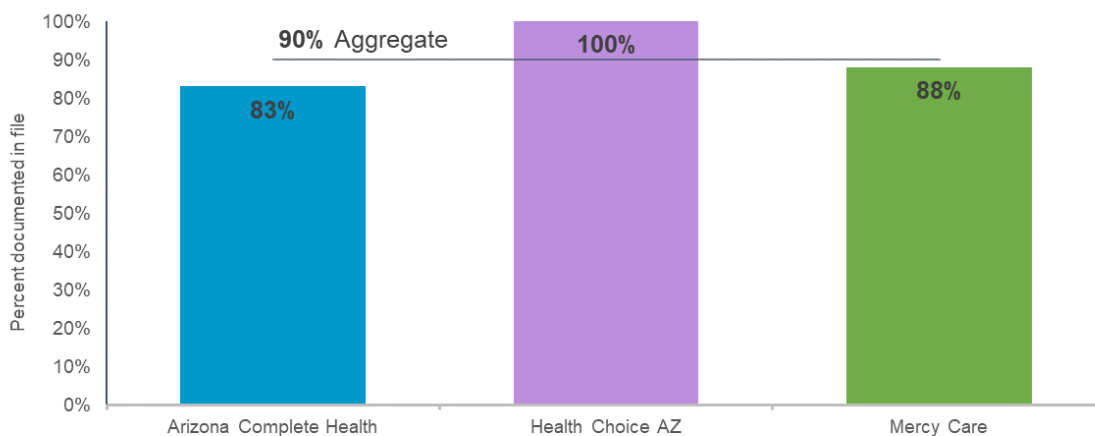
<sup>4</sup> National Institute on Drug Abuse, *What are the unique needs of women with substance use disorders?*, January 2018. Available at: <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/what-are-unique-needs-women-substance-use-disorders>

metric, *Was there evidence of gender-specific treatment services (e.g., women’s-only group therapy sessions)?*, showed that about a quarter of females in the aggregate sample had documented access to gender-specific services. A second metric, *If the female had dependent children, was there documentation to show that childcare was addressed?*, showed a higher percentage (90%) of mothers had childcare addressed by the provider. Addressing childcare removes one possible obstacle to treatment.

### Gender-specific Treatment Services

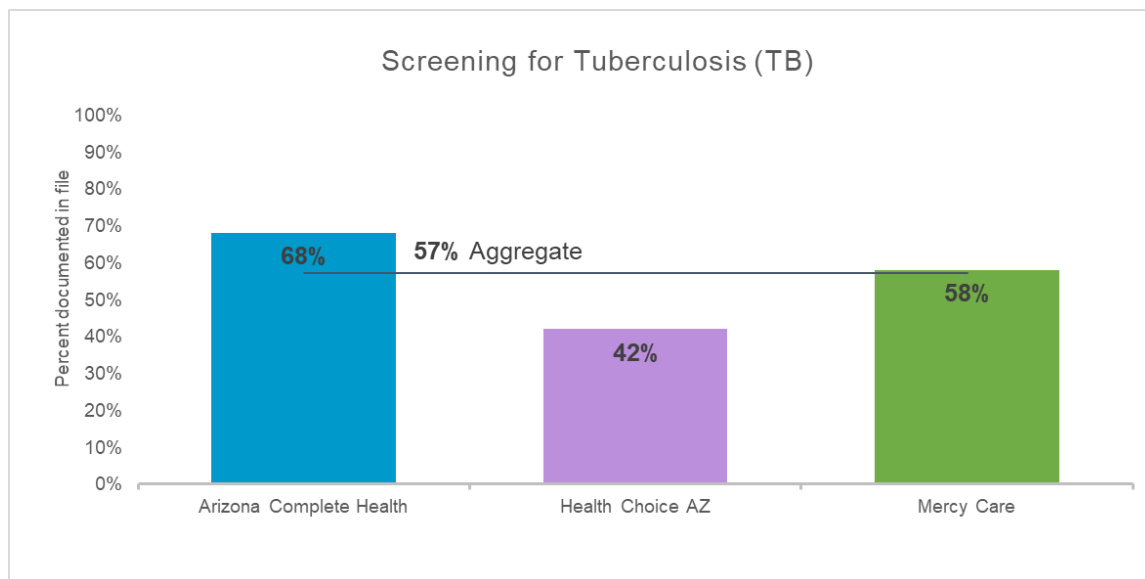


### Childcare Addressed for Women with Dependent Children



## Increase the number of tuberculosis screenings for members entering substance abuse treatment

A third program goal and requirement of the Code of Federal Regulations 45 CFR § 96.127<sup>5</sup>, requires entities providing substance use treatment to provide tuberculosis screening of individuals in order to prevent tuberculosis transmission. Fifty-seven percent of sampled charts documented providing tuberculosis screening for members.



## Goals of the Independent Case Review

The primary objective of this review is to determine the level of quality and appropriateness of care being provided through the use of SABG funds. According to State guidance, *quality* is the provision of treatment services that, within the constraints of technology, resources, and patient/client circumstances, will meet accepted standards and practices, which will improve patient/client health and safety status in the context of recovery. *Appropriateness* means the provision of treatment services consistent with the individual's identified clinical needs and level of functioning.<sup>6</sup>

AHCCCS decided to assess the level of quality and appropriateness of SUD treatment in the State through an examination of clinical records maintained by programs receiving SABG funds. A team of Mercer licensed clinicians, who have expertise in managed care, block grants, SUD treatment, ASAM,

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<sup>5</sup> eCFR, Title 45 Section 96.127 — 96.127 Requirements regarding tuberculosis. Available at: <https://ecfr.io/Title-45/Section-96.127>

<sup>6</sup> AHCCCS. (n.d.). *Substance Abuse Prevention and Treatment Block Grant (SABG)*. Available at: <https://www.azahcccs.gov/Resources/Grants/SABG/>

and clinical best practices systematically reviewed each of the files selected as part of the review sample. These independent clinicians examined SUD treatment records for the presence (or absence) of previously selected, evidence-based factors that would be expected to be present in high quality, appropriate treatment (which includes engagement, planning, and discharge).

The following domains were examined to determine the level of treatment quality and appropriateness (see Appendix A for specific review items in each domain):

- Intake and Treatment Planning
- Placement Criteria and Assessment
- Best Practices
- Treatment, Support Services, and Rehabilitation Services
- Gender Specific (Female Only)
- Opioid Specific
- Discharge and Continuing Care Planning
- Re-engagement
- National Outcome Measures (NOM)

## **Content of Records Reviewed**

Based upon the requirements of the annual ICR report to SAMHSA, AHCCCS sampled treatment records provided by the RBHAs. Behavioral health records vary from provider to provider, but typically include the following key documents and captured data elements:

- Demographic information
- Initial assessment
- Risk assessment and safety plan
- Crisis plan
- ISP
- ASAM Patient Placement Criteria
- Medication record
- Results of illicit substance use testing

- Progress notes (e.g., therapy [individual and group], case management, etc.)
- MAT documentation
- Evidence of outreach efforts
- Discharge or termination of treatment summary

Mercer used these documents, and any others contained in the individual records, to assess the level to which providers that receive SABG funds in Arizona are providing high quality engagement, planning, treatment, and discharge services to SUD clients.

## 3

# Methodology

The review team from Mercer consisted of four licensed clinicians (one registered nurse, two master's level behavioral health providers, and one clinical psychologist). A fifth member of the team provided data analytic services and ensured consistency in the application of project standards. Finally, Mercer included a Certified Peer as part of the team to review the findings and analysis through the peer lens. All feedback resulting from this additional review have been incorporated throughout the body of this report. The files reviewed by the evaluation team during the ICR were provided by AHCCCS and were stored and accessed on the State's Secure File Transfer Protocol site. Each Mercer reviewer received a secured sign in to ensure all file protected health information was protected. Due to the COVID-19 pandemic, and consistent with public health best practices, Mercer completed all ICR activities virtually, with no onsite reviews or in-person team meetings.

## Sampling

AHCCCS developed and implemented the sampling methodology for this review, and used the following inclusion criteria:

- Substance abuse clients with a substance abuse treatment service and episode of care (EOC) during fiscal year 2020: July 1, 2019, through June 30, 2020.
- Disenrolled/EOC end date before or on June 30, 2020.
- At least 18 years of age during the treatment episode.
- Were not diagnosed with a serious mental illness.
- Disenrolled due to completing treatment, declining further service, or lack of contact.
- Clients must have received substance abuse treatment during the treatment period.
- Clients must have received a counseling treatment during the treatment period.
- Clients must have been enrolled in a treatment center for at least 30 days.
- Clients must not be enrolled in a Tribal Behavioral Health Authority.

The sampling methodology used by AHCCCS excluded individuals who:

- Did not have any service encounters during the treatment episode.

- Only had assessment services during the treatment episode.
- Did not have any counseling encounters during the treatment episode.
- Only had a detoxification hospitalization encounter during the treatment episode.
- Only had services provided by an individual private provider.

Based upon these inclusion and exclusion criteria, AHCCCS supplied 310 treatment records to Mercer. Upon receipt of the review sample, Mercer randomly selected 200 files to be used in the initial review, with the remainder being held as an oversample. In 32 instances, files determined to be unusable for review purposes (e.g., an exclusion criterion was found in the file or the treatment dates were out of range) were removed from the original 200 records and replaced from the oversample.

## File Review Tool

AHCCCS collaboratively reviewed the existing State tool with Mercer. As a result of this review, the following AHCCCS approved changes to the ICR tool for the 2020 review were incorporated.

### New Tool Items

- Added an item to assess whether the service provider reviewed the PDMP website during the course of the treatment.
- Added an item to assess whether SDoHs were evaluated as part of the initial assessment.
- Added an item to assess whether the service provider explored the client's access to a PCP or other medical provider.

### Updated Tool Items

- Changed, for clarity, the wording of items related to application of the ASAM criteria. Specifically, "revised/updated" was changed to "reassessed" when reviewing for ongoing use of ASAM criteria during the course of treatment.
- Changed, for specificity, the wording of two items related to peer support services. Specifically, added the word "certified" to the term peer support to differentiate therapeutic peer support from social-support-based offerings.
- Changed, for clarity, the wording of an item related to pain management for individuals receiving treatment for an OUD. Specifically, identified chronic pain as the health issue of concern when assessing whether providers offered alternative interventions.
- Edited, for consistency, the wording and syntax of multiple items throughout the tool. For example, made the capitalization of medications more consistent, made changes for verb/tense agreement, etc.

Following the approval of these changes by AHCCCS, the Mercer team used the updated ICR tool as the source for development of an electronic format of the tool. The e-version of the tool, which was developed in Microsoft Access, allowed the review team to record review results in a format more conducive to analyzing the data and producing useful tables for presentation.

## **Inter-rater Reliability**

To ensure consistency in the use of the file review tool, the Mercer review team participated in two inter-rater reliability (IRR) training sessions followed by an IRR test prior to initiation of the review process. The test consisted of a vignette that approximated the information included in a SUD treatment record. Participants had the opportunity to review the clinical vignette, and were then asked to use the ICR tool to score the record consistent with the ICR Tool Instructions (Appendix A).

The Mercer project lead recorded the answers from each individual reviewer and then discussed with the team any items that yielded inconsistent results. As a result of this discussion, the team reached a consensus decision on how items would be scored. The initial review of the vignette yielded an IRR average score of 92%, while the team reached 100% agreement following discussion and consensus building.

Throughout the evaluation, which occurred during March 2021, the project lead maintained frequent contact with individual reviewers, answered questions regarding the application of the ICR Tool Instructions, and assured consistent application of the consensus methods for scoring. Additionally, in order to ensure fidelity to the scoring approach, the team met twice during the review process for group debriefs and problem solving related to the application of the ICR Tool Instructions.

## **Data Analysis**

Mercer selected sample data from the chart listing provided by AHCCCS. Each chart included in the sample was assigned a sample ID and uploaded into a customized, password-protected Microsoft Access review tool. After each reviewer finalized his or her assigned reviews, the data was exported and aggregated into a final dataset for analysis purposes in Microsoft Excel. Data checks were performed to ensure consistent and complete data was received; results were updated as necessary. Data tables reflecting required output tables were programmed with formulas reflecting the instructions for data entry (Appendix B). Results were technically peer reviewed for accuracy and reasonableness.

## **Limitations**

Mercer applied best practices in training and testing to foster optimal review findings for the ICR results. However, Mercer did not design the original ICR tool used in the file review process (although some modifications were made), nor did Mercer complete a separate and independent validation of the tool. Therefore, Mercer cannot attest to the reliability and validity of the tool.

Additionally, the period of review for this project (July 1, 2019–June 30, 2020) includes the advent of the worldwide COVID-19 pandemic (March 2020–present), which introduced multiple complicating



factors into the SUD treatment landscape (e.g., loss of in-person treatment, rapid implementation of telehealth practices, etc.). Although the review team was aware of these complicating factors, there is no reliable way to account fully for COVID-19's multiple impacts upon individual choices (e.g., reactions to the shift to telehealth interventions) and the resultant treatment outcomes.

Given these considerations, year-to-year results may include variability due to updates in the tool, which may have impacted validity or reliability. Further, orthogonal variables, such as the pandemic-driven shift from in-person treatment to telehealth, introduced unknown impacts on treatment outcomes that would not have been seen in any prior year's ICRs. Therefore, Mercer advises caution against the comparison of ICR findings across years without further validation and evaluation of the results.

## 4

# Aggregate Case File Review Findings

The SABG independent chart review findings are organized throughout this section in aggregate, by RBHA and by individual evaluation measure. This also includes sample demographics, records reviewed (broken down by RBHA), and gender and age of population sampled. Additionally, statistics on the reasons for case closure, referral to the program, and SABG-funded providers sampled are included for comparison purposes, as in past year's reports.

### Sample Demographics

Overall, 200 charts were reviewed for the ICR. Mercy Care provides services to the majority (67%) of the population, reflected in the number of sample cases chosen. Mercer received 65 charts from Arizona Complete Health and 58 from Health Choice AZ, which means 52% of the Arizona Complete Health charts and 57% of the Health Choice AZ charts were included in the review. This reflects a comparably sufficient sample for each of the RBHAs, based upon the records that were available for review.

RBHA	Sample Cases	Percent of Sample
Arizona Complete Health	34	17%
Health Choice AZ	33	17%
Mercy Care	133	66%
<b>Total</b>	<b>200</b>	<b>100%</b>

AHCCCS requires that at least 5% of the providers delivering SABG services are reviewed for quality and appropriateness of treatment services. This review ensured that over 5% of SABG providers from each RBHA were reviewed (distribution included in the table below).<sup>7</sup>

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<sup>7</sup> AHCCCS. (n.d.). *Substance Abuse Prevention and Treatment Block Grant (SABG)*. Available at: <https://www.azahcccs.gov/Resources/Grants/SABG/>

RBHA	SABG-Funded Treatment Providers	SABG-Funded Treatment Providers included in the ICR	Percentage of SABG Treatment providers included in the ICR
Arizona Complete Health	24	4	17%
Health Choice AZ	17	11	65%
Mercy Care	22	8	36%
<b>Total</b>	<b>63</b>	<b>23</b>	<b>37%</b>

Table 1-3 shows the female and male distribution by sample by RBHA. Overall, the mean age served in the sample was 36.5 years, with a median of 34.3.

RBHA	Gender				Age	
	Female		Male		Mean	Median
	N	%	N	%		
Arizona Complete Health	9	26%	25	74%	35.2	33.2
Health Choice AZ	18	55%	15	45%	38.6	35.4
Mercy Care	49	37%	84	63%	36.2	33.9
<b>Total</b>	<b>76</b>	<b>38%</b>	<b>124</b>	<b>62%</b>	<b>36.5</b>	<b>34.3</b>

## Sample Characteristics

To be included in the sample, clients must have been disenrolled or have had an episode of care with a closure date within fiscal year 2020 (July 1, 2019 to June 30, 2019) with a final case closure date no later than June 30, 2020. Closure reasons include *Client Declined Further Service*, *Lack of Contact*, *Treatment Completion*, and *Missing*.

The most frequent reason for case closure was *Lack of Contact* (46%), followed closely by *Treatment Completion* (40%). Reasons for case closure are included in the table below.

RBHA	Sample cases	Client declined further service		Lack of contact		Treatment completion		Missing	
		N	%	N	%	N	%	N	%
Arizona Complete Health	34	3	9%	17	50%	13	38%	1	3%
Health Choice AZ	33	3	9%	19	58%	11	33%	0	0%
Mercy Care	133	22	17%	56	42%	55	41%	0	0%

**Table 1-4 — Distribution Based on Case Closure Reason**

RBHA	Sample cases	Client declined further service		Lack of contact		Treatment completion		Missing	
		N	%	N	%	N	%	N	%
<b>Total</b>	<b>200</b>	<b>28</b>	<b>14%</b>	<b>92</b>	<b>46%</b>	<b>79</b>	<b>40%</b>	<b>1</b>	<b>1%</b>

Table 1-5 shows the most frequent source of referral to SUD treatment. “Criminal Justice/Correctional” includes Administrative Office of the Courts, Arizona Department of Corrections, Arizona Department of Juvenile Corrections, Jail/Prison, and Probation. “Other” includes physical health providers, State agencies, crisis, and unknown sources. Overwhelmingly, self-referral or referral by family or friends was the most frequent referral source (57%).

**Table 1-5 — Source for Referral**

	Criminal Justice/Correctional		Other Behavioral Health Provider		Self/Family/Friend		Other		Grand Total
	N	%	N	%	N	%	N	%	N
Arizona Complete Health	6	18%	13	38%	13	38%	2	6%	34
Health Choice AZ	15	45%	2	6%	14	42%	2	6%	33
Mercy Care	17	13%	17	13%	87	65%	12	9%	133
<b>Grand Total</b>	<b>38</b>	<b>19%</b>	<b>32</b>	<b>16%</b>	<b>114</b>	<b>57%</b>	<b>16</b>	<b>8%</b>	<b>200</b>

## Aggregate Review Findings

The tables (2-1 through 2-9) below represent the aggregate chart review findings. As noted in the Methodology section, although the measures remain primarily the same as those used in previous years, certain measures were updated and several are new during this round of review. The denominators primarily consisted of the sum of “Yes” and “No” responses and, as such, differ across the measures. The denominators of certain indicators were based on the number of “Yes” responses from a prior question when applicable. For example, the denominators for I.A.1 through 9 equate to the numerator for I.A. *Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?* Certain measures allowed for a response of “Not Applicable” (N/A); N/As are not included in any denominator, consistent with prior years’ analyses. Measures marked with an asterisk in the “N/A” column indicate that “N/A” was not a valid response option for that particular measure. Additionally, certain measures included an option for missing documentation.

Additional narrative information was collected on the following measures (See full set and description of measures in Appendix A) and is incorporated into the Findings section prior to the table.

- II.D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?
- III.A.1. The following evidence-based practices were used in treatment...Other Practices or Programs (please list in box below).
- VIII.C. Were other attempts made to re-engage the individual, such as...Other, please list other identified outreach efforts in the box below.

## Measure I — Intake/Treatment Planning Key Findings

### Initial Behavioral Health Assessment

Mercer reviewed 200 total records for the State, as a whole, and found 99% of the charts contained evidence that an initial behavioral health assessment was completed within 45 days of the initial appointment. As part of the initial assessment, providers successfully documented compliance with the required components of the assessment (Items A1–9) with a range of 45% to 100%. The areas of lowest performance were hepatitis C, HIV, and other infectious disease screening (45%), documentation of review of the PDMP (55%), and tuberculosis screening (57%).

### Individual Service Plan (ISP)

Providers developed an ISP for the client’s treatment (within 90 days of the initial appointment) in 97% of the reviewed cases. In 96% of these cases, the providers developed the ISP in congruence with the presenting concerns. Fourteen percent of ISPs were developed with the participation of the client’s family or other supports (when the client consented to allow participation from these sources). Eighty-seven clients declined participation from family and other supports, or supports did not exist.

**Table 2-1 — Aggregate Case File Review Findings**

I.	Intake/Treatment Planning	Denominator	# of Yes	% of Yes	# of N/A
A.	Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	199	197	99%	1
	Did the behavioral health assessment:				
A.	Address substance-related disorder(s)?	197	197	100%	*
	Describe the intensity/frequency of substance use?	197	187	95%	*
	Include the effect of substance use on daily functioning?	197	154	78%	*
	Include the effect of substance use on interpersonal relationships?	197	156	79%	*
	Include a completed risk assessment?	197	196	99%	*
	Document screening for tuberculosis (TB)?	197	112	57%	*

**Table 2-1 — Aggregate Case File Review Findings**

Table 2-1 — Aggregate Case File Review Findings					
I.	Intake/Treatment Planning	Denominator	# of Yes	% of Yes	# of N/A
	Document screening for Hepatitis C, HIV, and other infectious diseases?	197	89	45%	*
	Document screening for emotional and/or physical abuse/trauma issues?	197	187	95%	*
	Documentation that review of the Prescription Drug Monitoring Program (PDMP) was completed?	108	59	55%	92
B.	Was there documentation that charitable choice requirements were followed, if applicable?	1	1	100%	199
C.	Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	193	188	97%	7
	Was the ISP:				
A.	Developed with participation of the family/support network?	101	14	14%	87
	Congruent with the diagnosis(es) and presenting concern(s)?	188	180	96%	*
	Measurable objectives and timeframes to address the identified needs?	188	165	88%	*
	Addressing the unique cultural preferences of the individual?	188	161	86%	*
	Were social determinants of health issues considered as part of, and incorporated into, the ISP?	187	152	81%	*

**Measure II — Placement Criteria/Assessment Key Findings**

ASAM Patient Placement Criteria were used at intake to determine the appropriate level of service in 86% of the cases reviewed. Of these cases, documentation showed that 90% received the LOC identified by the ASAM criteria. Providers documented the use of the ASAM criteria to reassess the proper LOC during treatment in 42% of cases. In 22% of the reviewed case files, providers documented the use of other (or additional) assessment tools during the course of treatment. These tools included:

- Clinical Outcomes in Routine Evaluation (CORE) (Used one time)
- Daily Living Activities–20 (DLA-20) (Used three times)
- Drug Abuse Screening Test (DAST) (Used three times)
- Clinical Institute Withdrawal Assessment (CIWA) (Used two times)

- Opioid Withdrawal Scale (OWS) (Used one time)
- UNCOPE Screening Instrument for Substance Abuse (Used three times)
- Outcome Rating Scale (ORS) (Used one time)

**Table 2-2 — Aggregate Case Review Findings**

II.	Placement Criteria/Assessment				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?	200	171	86%	*
	A. If the ASAM Patient Placement Criteria were used, the level of service identified was:				
	a. Level 0.5: Early Intervention	149	1	1%	*
	b. OMT: Opioid Maintenance Therapy	149	1	1%	*
	c. Level I: Outpatient Treatment	167	80	48%	*
	d. Level II: Intensive Outpatient Treatment/Partial Hospitalization	150	37	25%	*
	e. Level III: Residential/Inpatient Treatment	152	49	32%	*
	f. Level IV: Medically Managed Intensive Inpatient Treatment	149	3	2%	*
	A. Did the member receive the level of services identified by the placement criteria/assessment?	171	154	90%	*
	B. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	200	83	42%	*
	C. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	200	44	22%	*

### Measure III — Best Practices Key Findings

Eighty-seven percent of sampled behavioral health case files contained documentation that EBPs were used in treatment. Of these, CBT was the most widely used EBP (72%). MAT was documented in 42% percent of the behavioral health case files. Of the 83 individuals who received MAT, methadone was the most frequently used medication (52%). Three interventions were not documented as having been used during this review period: Adolescent Community Reinforcement Approach (ACRA), Beyond Trauma: A Healing Journey for Women, and Trauma Recovery and Empowerment Model (TREM).

Additional interventions used by providers included:

- Eye Movement Desensitization and Reprocessing (EMDR) (Used two times)
- STOP Program (Domestic Violence) (Used one time)
- Acceptance and Commitment Therapy (ACT) (Used three times)
- Accelerated Resolution Therapy (ART) (Used two times)
- Rational Emotive Behavior Therapy (REBT) (Used five times)
- Mindfulness (Used four times)
- Living In Balance (Used two times)
- Brene Brown Shame-Resilience Curriculum (Used four times)

In 36% of cases, providers offered peer support services and, in 66% of those cases, the services were provided as part of treatment. Seventeen individuals declined peer support services when the provider offered. The EBP of screening for ongoing substance use during treatment occurred in 79% of the reviewed cases.

**Table 2-3 — Aggregate Case Review Findings**

III.	Best Practices				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Were evidence-based practices used in treatment?	200	173	87%	*
	1. The following evidence-based practices were used in treatment:				
	a. Adolescent Community Reinforcement Approach (ACRA)	173	0	0%	*
	b. Beyond Trauma: A Healing Journey for Women	173	0	0%	*
	c. Cognitive Behavioral Therapy (CBT)	173	124	72%	*
	d. Contingency management	173	1	1%	*
	e. Dialectal Behavioral Therapy (DBT)	173	28	16%	*
	f. Helping Women Recover	173	8	5%	*
	g. Matrix	173	22	13%	*
	h. Moral Re-connection Therapy (MRT)	173	1	1%	*
	i. Motivational Enhancement/Interviewing Therapy (MET/MI)	173	66	38%	*
	j. Relapse Prevention Therapy (RPT)	173	11	6%	*



**Table 2-3 — Aggregate Case Review Findings**

Table 2-3 — Aggregate Case Review Findings					
III.	Best Practices	Denominator	# of Yes	% of Yes	# of N/A
	k. Seeking Safety	173	4	2%	*
	l. SMART Recovery	173	10	6%	*
	m. Thinking for a Change	173	1	1%	*
	n. Trauma Recovery and Empowerment Model (TREM)	173	0	0%	*
	o. Trauma-Informed Care (TIC)	173	17	10%	*
	p. Wellness Recovery Action Plan (WRAP)	173	1	1%	*
	q. Other Practices or Programs(please list in box below):	173	30	17%	*
	B. Medication Assisted Treatment (MAT)	200	83	42%	*
	1. The following medication was used in treatment:				
	a. Alcohol-related				
	i. Acamprostate (Campral)	83	1	1%	*
	ii. Disulfiram (Antabuse)	83	1	1%	*
	b. Opioid-related				
	i. Subutex (buprenorphine)	83	8	10%	*
	ii. Methadone/Levo-Alpha-Acetylmethadol (LAAM)	83	43	52%	*
	iii. Narcan (naloxone)	83	5	6%	*
	iv. Vivitrol (long-acting naltrexone)	83	9	11%	*
	v. Suboxone (buprenorphine-naloxone)	83	30	36%	*
	C. Was screening for substance use/abuse conducted during the course of treatment?	200	158	79%	*
	D. Was certified peer support offered as part of treatment?	200	71	36%	17
	E. If yes to III.D, were certified peer support services used as a part of treatment?	71	47	66%	*

**Measure IV — Treatment/Support Services/Rehabilitation Services Key Findings**

Providers used case management as the most common service provided in the sample (72%), followed by individual therapy (71%), group therapy (67%), and family counseling (3%). For those individuals who received counseling, 46% attended more than 11 sessions; 42% attended five or fewer sessions.

Sixty-six percent of behavioral health case files did not contain documentation regarding the number of self-help or recovery group sessions completed during treatment. Of those that did document this metric (34%), 14% of cases documented zero attendance at the self-help or recovery group sessions.

**Table 2-4 — Aggregate Case Review Findings**

Table 2-4 — Aggregate Case Review Findings					
IV.	Treatment/Support Services/Rehabilitation Services	Denominator	# of Yes	% of Yes	# of N/A
	A. The following services were used in treatment:				
	1. Individual counseling/therapy	200	141	71%	*
	2. Group counseling/therapy	199	134	67%	*
	3. Family counseling/therapy	200	5	3%	*
	4. Case management	199	143	72%	*
	B. Was there clear documentation of progress or lack of progress toward the identified ISP goals?	169	146	86%	31
	C. The number of completed counseling/therapy sessions during treatment was:				
	• 0–5 sessions	193	81	42%	*
	• 6–10 sessions	193	23	12%	*
	• 11 sessions or more	193	89	46%	*
	D. Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:				
	• No documentation	200	132	66%	*
	• 0 times during treatment	200	28	14%	*
	• 1–4 times during treatment	200	14	7%	*
	• 5–12 times during treatment	200	10	5%	*
	• 13–20 times during treatment	200	13	7%	*
	• 21 or more times during treatment	200	3	2%	*
	E. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?	80	34	43%	118
	F. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	117	107	91%	81

Table 2-4 — Aggregate Case Review Findings					
IV.	Treatment/Support Services/Rehabilitation Services	Denominator	# of Yes	% of Yes	# of N/A
	G. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	101	74	73%	97
	H. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	140	81	58%	58
	I. Does the documentation reflect that substance abuse services were provided?	198	194	98%	*
	J. Was member's access to a primary care physician (PCP) or other medical provider explored?	191	149	78%	4

### Measure V — Gender Specific (female only) Key Findings

Providers documented 25 women's case files with a history of domestic violence; of these, 72% contained a safety plan. Providers documented two pregnant women in this sample; coordination of care with the PCP or obstetrician occurred in one case (50%) and education on the effects of substance use on fetal development occurred in one case (50%). This sample did not contain any women who had given birth in the past year. Of the case files for women who had dependent children, 90% documented an examination of childcare. Gender-specific services were documented in 28% of cases.

Table 2-5 — Aggregate Case Review Findings					
V.	Gender Specific (female only)	Denominator	# of Yes	% of Yes	# of N/A
	A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	25	18	72%	51
	B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	2	1	50%	74
	C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?	2	1	50%	74

Table 2-5 — Aggregate Case Review Findings					
V.	Gender Specific (female only)				
		Denominator	# of Yes	% of Yes	# of N/A
	D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?	0	0	–	76
	E. If the female had dependent children, was there documentation to show that childcare was addressed?	31	28	90%	45
	A. Was there evidence of gender-specific treatment services (e.g., women’s-only group therapy sessions)?	75	21	28%	45

### Measure VI — Opioid Specific Key Findings

For this sample, providers documented OUD in 65% of the cases. Of these cases, providers educated 84% of the clients on MAT as a treatment option, and 96% of those were referred to a MAT provider. Documentation showed MAT providers educated the client on overdose, naloxone, and steps to take in the event of an overdose in 44% of the cases. Education on the effects of polysubstance abuse with opioids was provided in 54% of the cases. In 90% of cases, providers referred clients with withdrawal symptoms to a medical provider.

Table 2-6 — Aggregate Case Review Findings					
VI.	Opioid Specific				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?	155	100	65%	*
	B. Was there documentation that the member was provided MAT education as a treatment option?	100	84	84%	*
	C. If yes to VI. B, were they referred to a MAT provider?	84	81	96%	58
	D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	50	45	90%	94
	E. If a physical health concern related to pain was identified, were alternative pain management options addressed?	39	22	56%	105
	F. If member is a pregnant female; did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?	1	0	0%	199

Table 2-6 — Aggregate Case Review Findings					
VI.	Opioid Specific				
		Denominator	# of Yes	% of Yes	# of N/A
	G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?	100	44	44%	*
	H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	100	54	54%	*

**Measure VII — Discharge and Continuing Care Planning (completed only if the individual completed treatment or declined further services) Key Findings**

In 55% of the reviewed cases, providers documented completion of a relapse prevention plan for clients who completed treatment or declined further services. Providers documented offering resources pertaining to community supports in 73% of these cases. For those clients engaged with other agencies, providers actively coordinated with these agencies at the time of discharge in 70% of the cases.

Table 2-7 — Aggregate Case Review Findings					
VII.	Discharge and Continuing Care Planning <i>Completed if member completed treatment or declined further services</i>				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Was there documentation present that a relapse prevention plan completed?	170	94	55%	*
	B. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g. crisis line)?	170	124	73%	*
	C. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?	116	81	70%	55

**Measure VIII — Re-engagement (completed only if the individual declined further services or chose not to appear for scheduled services) Key Findings**

In 63% of cases where the client declined further services or chose not to appear for scheduled services, providers followed up with a phone call at times when the member was expected to be available. In 56% of these cases, providers mailed a letter to the client requesting contact. Other activities taken by providers to make contact included contacting other involved agencies (54%), calling the client’s emergency contact (31%), and visiting the client’s home (23%). Other methods of outreach were documented in 19% of cases reviewed and include:

- Visiting the client while the individual was incarcerated.
- Visiting the client while the individual was receiving services at an agency contacting the client’s attorney (for whom there was a signed release of information).
- Visiting the client while the individual was in an inpatient facility and sending an email to the client.

Table 2-8 — Aggregate Case Review Findings					
VIII.	Re-engagement <i>Completed if member declined further services or chose not to appear for scheduled services</i>				
		Denominator	# of Yes	% of Yes	# of N/A
The following efforts were documented:					
A.	Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?	158	99	63%	*
A.	If telephone contact was unsuccessful, was a letter mailed requesting contact?	134	75	56%	24
B.	Were other attempts made to re-engage the individual, such as:				
1.	Home visit?	26	6	23%	*
2.	Call emergency contact(s)?	26	8	31%	*
3.	Contacting other involved agencies?	26	14	54%	*
4.	Street Outreach?	26	0	0%	*
5.	Other?	26	5	19%	*

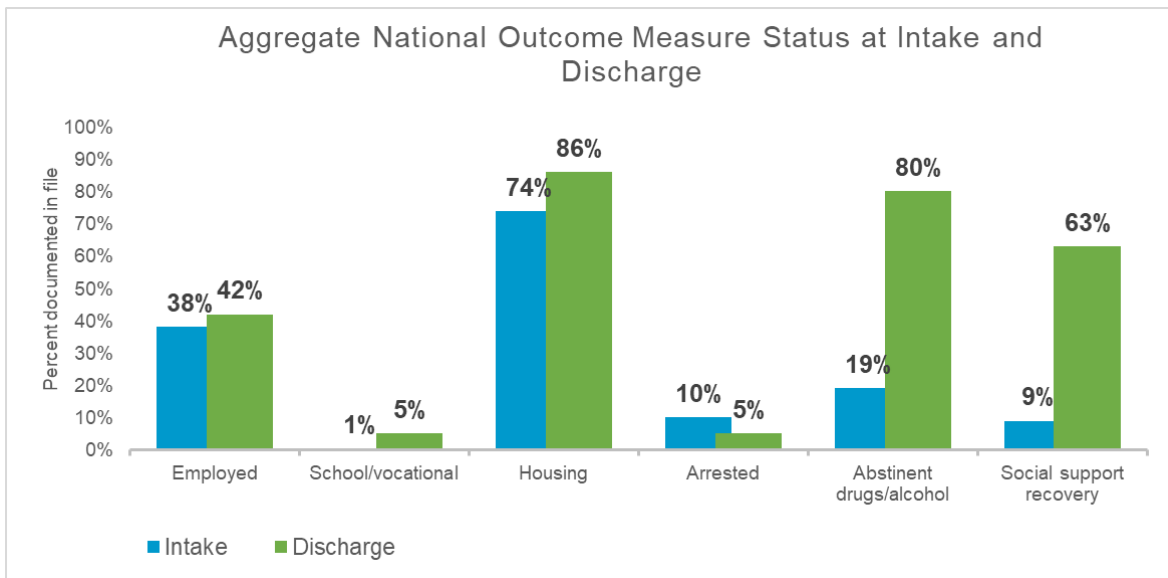
### Measure IX — NOMs Key Findings

Each of the six NOMs for Measure IX are depicted in Table 2-9. Denominators reflect missing documentation of status at intake and discharge, if applicable. In general, documentation was more complete at intake than at discharge, other than *Participated in social support recovery in the preceding 30 days?* (missing information 44% of the time). This measure was absent in general in two-thirds of the files at discharge; other NOMs were not documented almost 45% at discharge.

Note that a lower number and percentage are desired for the NOM *Arrested in the preceding 30 days?* measure.

The graphs below show the results for each NOM at intake and discharge. Results for each RBHA for each NOM improved at discharge.

Table 2-9 — Aggregate Case File Review Findings						
Measure IX National Outcome Measures						
NOMs	Intake			Discharge		
	Denominator	# Yes	% Yes	Denominator	# Yes	% Yes
A. Employed?	198	75	38%	118	50	42%
B. Enrolled in school or vocational educational program?	195	1	0.5%	112	6	5%
C. Lived in a stable housing environment (e.g., not homeless)?	198	147	74%	114	98	86%
D. Arrested in the preceding 30 days? <sup>8</sup>	195	19	10%	111	6	5%
E. Abstinent from drugs and/or alcohol?	197	38	19%	110	88	80%
F. Participated in social support recovery in the preceding 30 days?	199	18	9%	68	43	63%



<sup>8</sup> Note that a lower number and percentage is desired for the NOM *Arrested in the preceding 30 days?*

## 5

# Case File Review Findings

The narratives and tables below represents the chart review findings for each RBHA. The methodology is identical to the Aggregate Findings section and is repeated here. As noted in the Methodology Section, although the measures remain primarily the same as those used in previous years, certain measures were updated and several are new during this year's review. The denominators primarily consisted of the sum of "Yes" and "No" responses and, as such, differ across the measures. The denominators of certain indicators were based on the number of "Yes" responses from a prior question when applicable. For example, the denominators for I.A.1 through 9 equate to the numerator for I.A. *Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?* Certain measures allowed for a response of "Not Applicable" (N/A); N/As are not included in any denominator, consistent with prior years' analyses. Measures marked with an asterisk in the "N/A" column indicate that "N/A" was not a valid response option for that particular measure. Additionally, certain measures included an option for missing documentation.

Additional narrative information was collected on the following measures and are incorporated into the Findings section prior to the table.

- II.D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?
- III.A.1. The following evidence-based practices were used in treatment...Other Practices or Programs (please list in box below).
- VIII.C. Were other attempts made to re-engage the individual, such as...Other, please list other identified outreach efforts in the box below.

## Arizona Complete Health (AzCH)

AzCH has responsibility for AHCCCS clients in the southern region of the State. Mercer reviewed provider treatment records from four separate clinics under AzCH's area of responsibility. The following highlights were observed within the data collected from these cases.

- Providers addressed SDoH issues during the initial assessment in 100% of the cases that contained an ISP, which was well above average for the State (81%).
- Although providers reassessed ASAM criteria during the course of treatment for only 50% of cases, this was above average for the State as a whole (42%).



- Screening for tuberculosis within this region, which was documented in 68% of cases, was above the average for the State (57%).
- Forty-Six percent of cases reviewed documented the involvement of natural supports in the treatment planning process, which was well above the average for the State (14%).
- AzCH produced results above the State average (36%) for clients offered certified peer support services; the providers in this region offered certified peer support to 82% of clients.

### Measure I — Intake/Treatment Planning Key Findings

#### Initial Behavioral Health Assessment

Mercer reviewed 34 total records for AzCH and found 100% of the charts contained evidence that an initial behavioral health assessment was completed within 45 days of the initial appointment. As part of the initial assessment, providers successfully documented compliance with the required components of the assessment (Items A1–9) with a range of 36% to 100%. The areas of lowest performance were documentation of review of the PDMP (36%); hepatitis C, HIV, and other infectious disease screening (44%); and tuberculosis screening (68%).

#### Individual Service Plan (ISP)

Providers developed an ISP for the client’s treatment (within 90 days of the initial appointment) in 89% of the reviewed cases. In 96% of these cases, the providers developed the ISP in congruence with the presenting concerns. Forty-six percent of ISPs were developed with the participation of the client’s family or other supports (when the client consented to allow participation from these sources). Twelve clients declined participation from family and other supports, or supports did not exist.

**Table 3-1 — AzCH Case File Review Findings**

Table 3-1 — AzCH Case File Review Findings					
I.	Intake/Treatment Planning				
	Denominator	# of Yes	% of Yes	# of N/A	
A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	34	34	100%	0	
Did the behavioral health assessment:					
Address substance-related disorder(s)?	34	34	100%	*	
Describe the intensity/frequency of substance use?	34	33	97%	*	
Include the effect of substance use on daily functioning?	34	34	100%	*	
Include the effect of substance use on interpersonal relationships?	34	34	100%	*	
Include a completed risk assessment?	34	34	100%	*	
Document screening for tuberculosis (TB)?	34	23	68%	*	

**Table 3-1 — AzCH Case File Review Findings**

Table 3-1 — AzCH Case File Review Findings					
I.	Intake/Treatment Planning	Denominator	# of Yes	% of Yes	# of N/A
	Document screening for Hepatitis C, HIV, and other infectious diseases?	34	15	44%	*
	Document screening for emotional and/or physical abuse/trauma issues?	34	30	88%	*
	Documentation that review of the Prescription Drug Monitoring Program (PDMP) was completed?	11	4	36%	23
B.	Was there documentation that charitable choice requirements were followed, if applicable?	0	0	–	34
C.	Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	28	25	89%	6
	Was the ISP:				
	Developed with participation of the family/support network?	13	6	46%	12
	Congruent with the diagnosis(es) and presenting concern(s)?	25	24	96%	*
	Measurable objectives and timeframes to address the identified needs?	25	25	100%	*
	Addressing the unique cultural preferences of the individual?	25	25	100%	*
	Were social determinants of health issues considered as part of, and incorporated into, the ISP?	25	25	100%	*

### Measure II — Placement Criteria/Assessment Key Findings

ASAM Patient Placement Criteria were used at intake to determine the appropriate level of service in 82% of the cases reviewed. Of these cases, documentation showed that 71% received the LOC identified by the ASAM criteria. Providers documented the use of the ASAM criteria to reassess the proper LOC during treatment in 50% of cases. In 26% of the reviewed case files, providers documented the use of other (or additional) assessment tools during the course of treatment. These tools included:

- CORE (Used one time)
- DLA-20 (Used three times)
- DAST (Used one time)

Table 3-2 — AzCH Case File Review Findings					
II.	Placement Criteria/Assessment	Denominator	# of Yes	% of Yes	# of N/A
	A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?	34	28	82%	*
	1. If the ASAM Patient Placement Criteria were used, the level of service identified was:				
	a. Level 0.5: Early Intervention	28	0	0%	*
	b. OMT: Opioid Maintenance Therapy	28	0	0%	*
	c. Level I: Outpatient Treatment	28	2	7%	*
	d. Level II: Intensive Outpatient Treatment/Partial Hospitalization	28	15	54%	*
	e. Level III: Residential/Inpatient Treatment	28	9	32%	*
	f. Level IV: Medically Managed Intensive Inpatient Treatment	28	2	7%	*
	B. Did the member receive the level of services identified by the placement criteria/assessment?	28	20	71%	*
	C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	34	17	50%	*
	D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	34	9	26%	*

### Measure III — Best Practices Key Findings

Seventy-nine percent of sampled behavioral health case files contained documentation that EBP's were used in treatment. Of these, CBT was the most widely used EBP (74%). MAT was documented in 38% percent of the behavioral health case files. Of the 13 individuals who received MAT, Suboxone® was the most frequently used medication (54%). Seven interventions were not documented as having been used during this review period: ACRA, Beyond Trauma: A Healing Journey for Women, Helping Women Recover, Matrix, Moral Re-connection Therapy (MRT), Thinking for a Change, and TREM.

In 82% of cases, providers offered certified peer support services and, in 89% of those cases, the services were provided as part of treatment. Three individuals declined peer support services when the provider offered. The EBP of screening for ongoing substance use during treatment occurred in 94% of the reviewed cases.

Table 3-3 — AzCH Case File Review Findings					
III.	Best Practices				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Were evidence-based practices used in treatment?	34	27	79%	*
	1. The following evidence-based practices were used in treatment:				
	a. Adolescent Community Reinforcement Approach (ACRA)	27	0	0%	*
	b. Beyond Trauma: A Healing Journey for Women	27	0	0%	*
	c. Cognitive Behavioral Therapy (CBT)	27	20	74%	*
	d. Contingency management	27	1	4%	*
	e. Dialectal Behavioral Therapy (DBT)	27	3	11%	*
	f. Helping Women Recover	27	0	0%	*
	g. Matrix	27	0	0%	*
	h. Moral Re-connection Therapy (MRT)	27	0	0%	*
	i. Motivational Enhancement/Interviewing Therapy (MET/MI)	27	7	26	*
	j. Relapse Prevention Therapy (RPT)	27	1	4%	*
	k. Seeking Safety	27	2	7%	*
	l. SMART Recovery	27	3	11%	*
	m. Thinking for a Change	27	0	0%	*
	n. Trauma Recovery and Empowerment Model (TREM)	27	0	0%	*
	o. Trauma-Informed Care (TIC)	27	1	4%	*
	p. Wellness Recovery Action Plan (WRAP)	27	1	4%	*
	q. Other Practices or Programs(please list in box below):	27	4	15%	*
	B. Medication Assisted Treatment (MAT)	34	13	38%	*
	1. The following medication was used in treatment:				
	a. Alcohol-related				
	i. Acamprosate (Campral)	13	0	0%	*
	ii. Disulfiram (Antabuse)	13	0	0%	*
	b. Opioid-related				
	i. Subutex (buprenorphine)	13	3	23%	*

Table 3-3 — AzCH Case File Review Findings					
III.	Best Practices				
		Denominator	# of Yes	% of Yes	# of N/A
	ii. Methadone/Levo-Alpha-Acetylmethadol (LAAM)	13	5	38%	*
	iii. Narcan (naloxone)	13	2	15%	*
	iv. Vivitrol (long-acting naltrexone)	13	2	15%	*
	v. Suboxone (buprenorphine-naloxone)	13	7	54%	*
	C. Was screening for substance use/abuse conducted during the course of treatment?	34	32	94%	*
	D. Was certified peer support offered as part of treatment?	34	28	82%	3
	E. If yes to III.D, were certified peer support services used as a part of treatment?	28	25	89%	*

### Measure IV — Treatment/Support Services/Rehabilitation Services Key Findings

Providers used individual therapy as the most common service provided in the sample (82%), followed by case management (79%) and group therapy (70%). Providers did not document the provision of family counseling in any of the reviewed cases (0%). For those individuals who received counseling, 57% attended more than 11 sessions; 36% attended five or fewer sessions.

Fifty-three percent of behavioral health case files did not contain documentation regarding the number of self-help or recovery group sessions completed during treatment. Of those that did document this metric, 26% of cases documented zero attendance at the self-help or recovery group sessions.

Table 3-4 — AzCH Case File Review Findings					
IV.	Treatment/Support Services/Rehabilitation Services				
		Denominator	# of Yes	% of Yes	# of N/A
	A. The following services were used in treatment:				
	1. Individual counseling/therapy	34	28	82%	*
	2. Group counseling/therapy	33	23	70%	*
	3. Family counseling/therapy	34	0	0%	*
	4. Case management	33	26	79%	*
	B. Was there clear documentation of progress or lack of progress toward the identified ISP goals?	22	20	91%	12

Table 3-4 — AzCH Case File Review Findings					
IV.	Treatment/Support Services/Rehabilitation Services				
		Denominator	# of Yes	% of Yes	# of N/A
	C. The number of completed counseling/therapy sessions during treatment was:				
	• 0–5 sessions	28	10	36%	*
	• 6–10 sessions	28	2	7%	*
	• 11 sessions or more	28	16	57%	*
	D. Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:				
	• No documentation	34	18	53%	*
	• 0 times during treatment	34	9	26%	*
	• 1–4 times during treatment	34	4	12%	*
	• 5–12 times during treatment	34	1	3%	*
	• 13–20 times during treatment	34	2	6%	*
	• 21 or more times during treatment	34	0	0%	*
	E. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?	15	10	67%	18
	F. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	26	22	85%	7
	G. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	16	10	63%	17
	H. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	29	23	79%	4
	I. Does the documentation reflect that substance abuse services were provided?	33	29	88%	*
	J. Was member's access to a primary care physician (PCP) or other medical provider explored?	30	27	90%	1

### Measure V — Gender Specific (female only) Key Findings

Providers documented three women’s case files with a history of domestic violence; of these, 67% contained a safety plan. This sample did not contain any pregnant women or women who had given birth in the past year. Of the case files for women who had dependent children, 83% documented an examination of childcare. Gender-specific services were documented in 22% of cases.

Table 3-5 — AzCH Case File Review Findings					
V.	Gender Specific (female only)				
		Denominator	# of Yes	% of Yes	# of N/A
	A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	3	2	67%	6
	B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	0	0	–	9
	C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?	0	0	–	9
	D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?	0	0	–	9
	E. If the female had dependent children, was there documentation to show that childcare was addressed?	6	5	83%	3
	F. Was there evidence of gender-specific treatment services (e.g., women’s-only group therapy sessions)?	9	2	22%	0

### Measure VI — Opioid Specific Key Findings

For this sub-sample, providers documented OUD in 47% of the cases. Of these cases, providers educated 88% of the clients on MAT as a treatment option, and 93% of those were referred to a MAT provider. Documentation showed MAT providers educated the client on overdose, naloxone, and steps to take in the event of an overdose in 69% of the cases. Education on the effects of polysubstance abuse with opioids was provided in 56% of the cases. In 100% of cases, providers referred clients with withdrawal symptoms to a medical provider.

Table 3-6 — AzCH Case File Review Findings					
VI.	Opioid Specific	Denominator	# of Yes	% of Yes	# of N/A
	A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?	34	16	47%	*
	B. Was there documentation that the member was provided MAT education as a treatment option?	16	14	88%	*
	C. If yes to VI. B, were they referred to a MAT provider?	14	13	93%	20
	D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	15	15	100%	19
	E. If a physical health concern related to pain was identified, were alternative pain management options addressed?	4	4	100%	30
	F. If member is a pregnant female; did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?	0	0	—	34
	G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?	16	11	69%	*
	H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	16	9	56%	*

**Measure VII — Discharge and Continuing Care Planning (completed only if the individual completed treatment or declined further services) Key Findings**

In 58% of the reviewed cases, providers documented completion of a relapse prevention plan for clients who completed treatment or declined further services. Providers documented offered resources pertaining to community supports in 61% of these cases. For those clients engaged with other agencies, providers actively coordinated with these agencies at the time of discharge in 66% of the cases.

Table 3-7 — AzCH Case File Review Findings					
VII.	Discharge and Continuing Care Planning <i>Completed if member completed treatment or declined further services</i>	Denominator	# of Yes	% of Yes	# of N/A
	A. Was there documentation present that a relapse prevention plan completed?	33	19	58%	*



Table 3-7 — AzCH Case File Review Findings					
VII.	Discharge and Continuing Care Planning <i>Completed if member completed treatment or declined further services</i>				
		Denominator	# of Yes	% of Yes	# of N/A
	B. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g. crisis line)?	33	20	61%	*
	C. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?	32	21	66%	2

**Measure VIII — Re-engagement (completed only if the individual declined further services or chose not to appear for scheduled services) Key Findings**

In 30% of cases where the client declined further services or chose not to appear for scheduled services, providers followed up with a phone call at times when the member was expected to be available. In 23% of these cases, providers mailed a letter to the client requesting contact. Other activities taken by providers to make contact included, visiting the client’s home (57%), contacting other involved agencies (43%), calling the client’s emergency contact (29%), and, in one case, visiting the client while the individual was incarcerated.

Table 3-8 — AzCH Case File Review Findings					
VIII.	Re-engagement <i>Completed if member declined further services or chose not to appear for scheduled services</i>				
		Denominator	# of Yes	% of Yes	# of N/A
	The following efforts were documented:				
	A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?	33	10	30%	*
	B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	31	7	23%	2
	C. Were other attempts made to re-engage the individual, such as:				
	1. Home visit?	7	4	57%	0
	2. Call emergency contact(s)?	7	2	29%	0
	3. Contacting other involved agencies?	7	3	43%	0
	4. Street Outreach?	7	0	0%	0

Table 3-8 — AzCH Case File Review Findings					
VIII. Re-engagement					
<i>Completed if member declined further services or chose not to appear for scheduled services</i>					
		Denominator	# of Yes	% of Yes	# of N/A
	5. Other?	7	1	14%	0

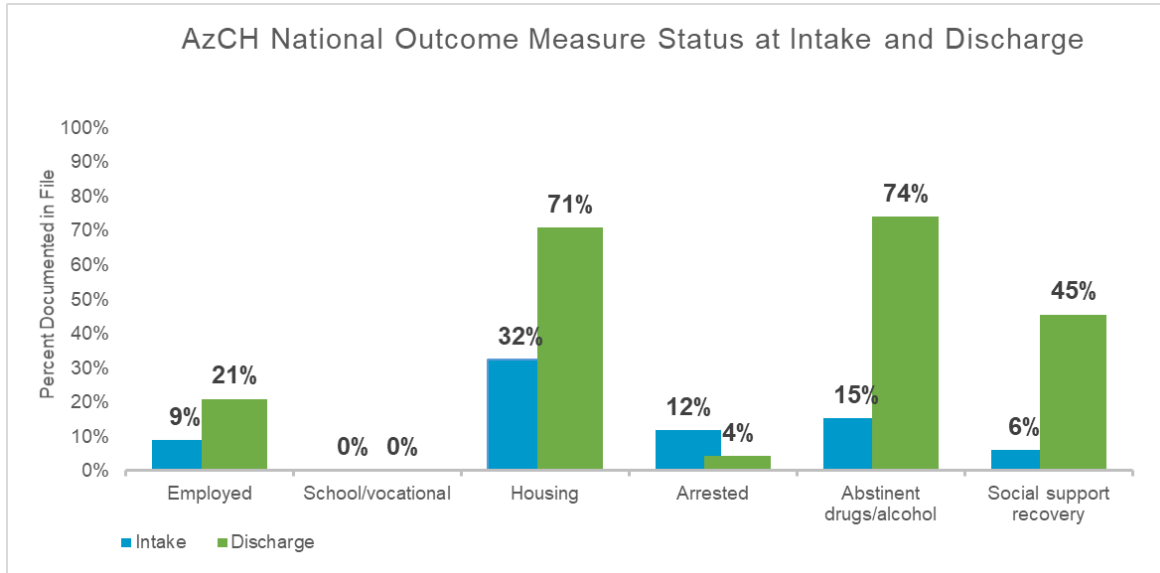
### Measure IX — NOMs Key Findings

Each of the six AzCH NOMs for Measure IX are depicted in Table 3-9. The denominator is determined and compared for both intake and discharge. Denominators are impacted by missing documentation of status at intake and discharge if applicable. Approximately 40% of NOMs documentation was missing from files at discharge.

The table and graph below shows the client’s status for each NOM at intake and discharge, results for AzCH for each NOM improved at discharge.

Table 3-9 — AzCH Case File Review Findings						
Measure IX National Outcome Measures						
NOMs	Intake			Discharge		
	Denominator	# Yes	% Yes	Denominator	# Yes	% Yes
A. Employed?	34	3	9%	24	5	21%
B. Enrolled in school or vocational educational program?	34	0	0%	24	0	0%
C. Lived in a stable housing environment (e.g., not homeless)?	34	11	32%	24	17	71%
D. Arrested in the preceding 30 days? <sup>9</sup>	34	4	12%	24	1	4%
E. Abstinent from drugs and/or alcohol?	33	5	15%	23	17	74%
F. Participated in social support recovery in the preceding 30 days?	34	2	6%	22	10	45%

<sup>9</sup> Note that a lower number and percentage is desired for the NOM *Arrested in the preceding 30 days?*



## Health Choice (HC)

HC has responsibility for AHCCCS clients in the northern region of the State. Mercer reviewed provider treatment records from 11 separate clinics under HC’s area of responsibility. The following highlights were observed within the data collected from these cases.

- Providers developed an ISP that was congruent with the diagnosis in 100% of the cases that contained an ISP.
- Although providers reassessed ASAM criteria during the course of treatment for only 52% of cases, this was above average for the State as a whole (42%).
- Referral to a medical provider for clients with withdrawal symptoms occurred in 100% of the cases reviewed within this region.
- Ninety-five percent of cases reviewed documented coordination with other involved agencies at the time of discharge, which was above the average for the State.

### Measure I — Intake/Treatment Planning Key Findings

#### Initial Behavioral Health Assessment

Mercer reviewed 33 total records for HC and found 100% of the charts contained evidence that an initial behavioral health assessment was completed within 45 days of the initial appointment. As part of the initial assessment, providers successfully documented compliance with the required components of the assessment (Items A1–9) with a range of 18% to 100%. The areas of lowest performance were documentation of hepatitis C, HIV, and other infectious disease screening (18%), tuberculosis screening (42%), and review of the PDMP (43%).

#### Individual Service Plan (ISP)

Providers developed an ISP for the client’s treatment (within 90 days of the initial appointment) in 100% of the reviewed cases. In 100% of these cases, the providers developed the ISP in congruence with the presenting concerns. Ten percent of ISPs were developed with the participation of the client’s family or other supports (when the client consented to allow participation from these sources). Four clients declined participation from family and other supports, or supports did not exist.

**Table 4-1 — Substance Abuse Prevention and Treatment**

HC Case File Review Findings					
I.	Intake/Treatment Planning				
		Denominator	# of Yes	% of Yes	# of N/A
A.	Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	33	33	100%	0
	Did the behavioral health assessment:				

Table 4-1 — Substance Abuse Prevention and Treatment					
HC Case File Review Findings					
I.	Intake/Treatment Planning				
		Denominator	# of Yes	% of Yes	# of N/A
A.	Address substance-related disorder(s)?	33	33	100%	*
	Describe the intensity/frequency of substance use?	33	33	100%	*
	Include the effect of substance use on daily functioning?	33	33	100%	*
	Include the effect of substance use on interpersonal relationships?	33	33	100%	*
	Include a completed risk assessment?	33	32	97%	*
	Document screening for tuberculosis (TB)?	33	14	42%	*
	Document screening for Hepatitis C, HIV, and other infectious diseases?	33	6	18%	*
	Document screening for emotional and/or physical abuse/trauma issues?	33	32	97%	*
	Documentation that review of the Prescription Drug Monitoring Program (PDMP) was completed?	7	3	43%	26
B.	Was there documentation that charitable choice requirements were followed, if applicable?	0	0	—	33
C.	Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	33	33	100%	0
	Was the ISP:				
	Developed with participation of the family/support network?	29	3	10%	4
	Congruent with the diagnosis(es) and presenting concern(s)?	33	33	100%	*
	Measurable objectives and timeframes to address the identified needs?	33	32	97%	*
	Addressing the unique cultural preferences of the individual?	33	21	64%	*
	Were social determinants of health issues considered as part of, and incorporated into, the ISP?	33	21	64%	*

## Measure II — Placement Criteria/Assessment Key Findings

ASAM Patient Placement Criteria were used at intake to determine the appropriate level of service in 79% of the cases reviewed. Of these cases, documentation showed that 96% received the LOC identified by the ASAM criteria. Providers documented the use of the ASAM criteria to reassess the proper LOC during treatment in 52% of cases. In 39% of the reviewed case files, providers documented the use of other (or additional) assessment tools during the course of treatment. These tools included:

- CIWA (Used two times)
- OWS (Used one time)
- ORS (Used one time)

Table 4-2 — Substance Abuse Prevention and Treatment					
HC Case File Review Findings					
II.	Placement Criteria/Assessment				
		Denominator	# of Yes	% of Yes	# of N/A
A.	Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?	33	26	79%	*
B.	If the ASAM Patient Placement Criteria were used, the level of service identified was:				
a.	Level 0.5: Early Intervention	26	0	0%	*
b.	OMT: Opioid Maintenance Therapy	26	0	0%	*
c.	Level I: Outpatient Treatment	26	12	46%	*
d.	Level II: Intensive Outpatient Treatment/Partial Hospitalization	26	6	23%	*
e.	Level III: Residential/Inpatient Treatment	26	7	27%	*
f.	Level IV: Medically Managed Intensive Inpatient Treatment	26	1	4%	*
C.	Did the member receive the level of services identified by the placement criteria/assessment?	26	25	96%	*
D.	Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	33	17	52%	*
E.	Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	33	13	39%	*

### Measure III — Best Practices Key Findings

Eighty-five percent of sampled behavioral health case files contained documentation that EBPs were used in treatment. Of these, CBT was the most widely used EBP (71%). MAT was documented in 12% percent of the behavioral health case files. Of the four individuals who received MAT, Suboxone was the most frequently used medication (50%). Six interventions were not documented as having been used during this review period: ACRA, Beyond Trauma: A Healing Journey for Women, Contingency Management, MRT, TREM, and Wellness Recovery Action Plan (WRAP).

Additional interventions used by providers included:

- ART (Used two times)
- ACT (Used three times)
- EMDR (Used two times)
- STOP Program (Domestic Violence) (Used one time)

In 33% of cases, providers offered certified peer support services and, in 45% of those cases, the services were provided as part of treatment. Three individuals declined peer support services when the provider offered. The EBP of screening for ongoing substance use during treatment occurred in 70% of the reviewed cases.

Table 4-3 — Substance Abuse Prevention and Treatment					
HC Case File Review Findings					
III.	Best Practices				
		Denominator	# of Yes	% of Yes	# of N/A
A.	Were evidence-based practices used in treatment?	33	28	85%	*
1.	The following evidence-based practices were used in treatment:				
a.	Adolescent Community Reinforcement Approach (ACRA)	28	0	0%	*
b.	Beyond Trauma: A Healing Journey for Women	28	0	0%	*
c.	Cognitive Behavioral Therapy (CBT)	28	20	71%	*
d.	Contingency management	28	0	0%	*
e.	Dialectal Behavioral Therapy (DBT)	28	6	21%	*
f.	Helping Women Recover	28	1	4%	*
g.	Matrix	28	4	14%	*
h.	Moral Re-connection Therapy (MRT)	28	0	0%	*

Table 4-3 — Substance Abuse Prevention and Treatment					
HC Case File Review Findings					
III.	Best Practices				
		Denominator	# of Yes	% of Yes	# of N/A
	i. Motivational Enhancement/Interviewing Therapy (MET/MI)	28	15	54%	*
	j. Relapse Prevention Therapy (RPT)	28	8	29%	*
	k. Seeking Safety	28	1	4%	*
	l. SMART Recovery	28	2	7%	*
	m. Thinking for a Change	28	1	4%	*
	n. Trauma Recovery and Empowerment Model (TREM)	28	0	0%	*
	o. Trauma-Informed Care (TIC)	28	4	14%	*
	p. Wellness Recovery Action Plan (WRAP)	28	0	0%	*
	q. Other Practices or Programs(please list in box below):	28	9	32%	*
	<b>B. Medication Assisted Treatment (MAT)</b>	<b>33</b>	<b>4</b>	<b>12%</b>	<b>*</b>
	1. The following medication was used in treatment:				
	a. Alcohol-related				
	i. Acamprosate (Campral)	4	0	0%	*
	ii. Disulfiram (Antabuse)	4	1	25%	*
	b. Opioid-related				
	i. Subutex (buprenorphine)	4	1	25%	*
	ii. Methadone/Levo-Alpha-Acetylmethadol (LAAM)	4	0	0%	*
	iii. Narcan (naloxone)	4	0	0%	*
	iv. Vivitrol (long-acting naltrexone)	4	0	0%	*
	v. Suboxone (buprenorphine-naloxone)	4	2	50%	*
	<b>C. Was screening for substance use/abuse conducted during the course of treatment?</b>	<b>33</b>	<b>23</b>	<b>70%</b>	<b>*</b>
	<b>D. Was certified peer support offered as part of treatment?</b>	<b>33</b>	<b>11</b>	<b>33%</b>	<b>2</b>
	<b>E. If yes to III.D, were certified peer support services used as a part of treatment?</b>	<b>11</b>	<b>5</b>	<b>45%</b>	<b>*</b>



### Measure IV — Treatment/Support Services/Rehabilitation Services Key Findings

Providers used individual therapy and case management as the most common services provided in the sample (91% each), followed by group therapy (64%), and family counseling (9%). For those individuals who received counseling, 39% attended more than 11 sessions; 45% attended five or fewer sessions.

Fifty-five percent of behavioral health case files did not contain documentation regarding the number of self-help or recovery group sessions completed during treatment. Of those that did document this metric, 9% of cases documented zero attendance at the self-help or recovery group sessions.

Table 4-4 — Substance Abuse Prevention and Treatment					
HC Case File Review Findings					
IV.	Treatment/Support Services/Rehabilitation Services				
		Denominator	# of Yes	% of Yes	# of N/A
A.	The following services were used in treatment:				
1.	Individual counseling/therapy	33	30	91%	*
2.	Group counseling/therapy	33	21	64%	*
3.	Family counseling/therapy	33	3	9%	*
4.	Case management	33	30	91%	*
B.	Was there clear documentation of progress or lack of progress toward the identified ISP goals?	32	32	100%	1
C.	The number of completed counseling/therapy sessions during treatment was:				
	• 0–5 sessions	33	15	45%	*
	• 6–10 sessions	33	5	15%	*
	• 11 sessions or more	33	13	39%	*
D.	Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:				
	• No documentation	33	18	55%	*
	• 0 times during treatment	33	3	9%	*
	• 1–4 times during treatment	33	6	18%	*
	• 5–12 times during treatment	33	6	18%	*
	• 13–20 times during treatment	33	0	0%	*
	• 21 or more times during treatment	33	0	0%	*

Table 4-4 — Substance Abuse Prevention and Treatment					
HC Case File Review Findings					
IV.	Treatment/Support Services/Rehabilitation Services				
		Denominator	# of Yes	% of Yes	# of N/A
	E. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?	24	16	67%	9
	F. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	23	23	100%	10
	G. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	22	22	100%	11
	H. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	30	26	87%	3
	I. Does the documentation reflect that substance abuse services were provided?	33	33	100%	*
	J. Was member's access to a primary care physician (PCP) or other medical provider explored?	29	25	86%	3

### Measure V — Gender Specific (female only) Key Findings

Providers documented nine women's case files with a history of domestic violence; of these, 78% contained a safety plan. This sample did not contain any pregnant women or women who had given birth in the past year. Of the case files for women who had dependent children, 100% documented an examination of childcare. Gender-specific services were documented in 22% of cases.

Table 4-5 — Substance Abuse Prevention and Treatment					
HC Case File Review Findings					
V.	Gender Specific (female only)				
		Denominator	# of Yes	% of Yes	# of N/A
	A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	9	7	78%	9
	B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	0	0	—	18
	C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?	0	0	—	18
	D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?	0	0	—	18
	E. If the female had dependent children, was there documentation to show that childcare was addressed?	9	9	100%	9
	F. Was there evidence of gender-specific treatment services (e.g., women’s-only group therapy sessions)?	18	4	22%	0

### Measure VI — Opioid Specific Key Findings

For this sub-sample, providers documented OUD in 47% of the cases. Of these cases, providers educated 44% of the clients on MAT as a treatment option, and 100% of those were referred to a MAT provider. Documentation showed MAT providers educated the client on overdose, naloxone, and steps to take in the event of an overdose in 22% of the cases. Education on the effects of polysubstance abuse with opioids was provided in 22% of the cases. In 100% of cases, providers referred clients with withdrawal symptoms to a medical provider.

Table 4-6 — Substance Abuse Prevention and Treatment					
HC Case File Review Findings					
VI.	Opioid Specific				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?	19	9	47%	*
	B. Was there documentation that the member was provided MAT education as a treatment option?	9	4	44%	*

Table 4-6 — Substance Abuse Prevention and Treatment					
HC Case File Review Findings					
VI.	Opioid Specific				
		Denominator	# of Yes	% of Yes	# of N/A
	C. If yes to VI. B, were they referred to a MAT provider?	4	4	100%	13
	D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	4	4	100%	15
	E. If a physical health concern related to pain was identified, were alternative pain management options addressed?	6	5	83%	13
	F. If member is a pregnant female; did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?	0	0	—	33
	G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?	9	2	22%	*
	H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	9	2	22%	*

**Measure VII — Discharge and Continuing Care Planning (completed only if the individual completed treatment or declined further services) Key Findings**

In 54% of the reviewed cases, providers documented completion of a relapse prevention plan for clients who completed treatment or declined further services. Providers documented offered resources pertaining to community supports in 69% of these cases. For those clients engaged with other agencies, providers actively coordinated with these agencies at the time of discharge in 95% of the cases.

Table 4-7 — Substance Abuse Prevention and Treatment					
HC Case File Review Findings					
VII.	Discharge and Continuing Care Planning <i>Completed if member completed treatment or declined further services</i>				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Was there documentation present that a relapse prevention plan completed?	26	14	54%	*

Table 4-7 — Substance Abuse Prevention and Treatment					
HC Case File Review Findings					
VII.	Discharge and Continuing Care Planning <i>Completed if member completed treatment or declined further services</i>				
		Denominator	# of Yes	% of Yes	# of N/A
	B. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g. crisis line)?	26	18	69%	*
	C. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?	19	18	95%	7

**Measure VIII — Re-engagement (completed only if the individual declined further services or chose not to appear for scheduled services) Key Findings**

In 86% of cases where the client declined further services or chose not to appear for scheduled services, providers followed up with a phone call at times when the member was expected to be available. In 67% of these cases, providers mailed a letter to the client requesting contact. Other activities taken by providers to make contact included, contacting other involved agencies (55%), calling the client’s emergency contact (45%), and visiting the client’s home (9%). In one case, the provider visited the client while the individual was receiving services at an agency and, in one other case, the provider contacted the client’s attorney (for whom there was a signed release of information).

Table 4-8 — Substance Abuse Prevention and Treatment					
HC Case File Review Findings					
VIII.	Re-engagement <i>Completed if member declined further services or chose not to appear for scheduled services</i>				
		Denominator	# of Yes	% of Yes	# of N/A
	The following efforts were documented:				
	A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?	21	18	86%	*
	B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	18	12	67%	3
	Were other attempts made to re-engage the individual, such as:				
	1. Home visit?	11	1	9%	0

Table 4-8 — Substance Abuse Prevention and Treatment					
HC Case File Review Findings					
VIII.	Re-engagement <i>Completed if member declined further services or chose not to appear for scheduled services</i>				
		Denominator	# of Yes	% of Yes	# of N/A
	2. Call emergency contact(s)?	11	5	45%	0
	3. Contacting other involved agencies?	11	6	55%	0
	4. Street Outreach?	11	0	0%	0
	5. Other?	11	2	18%	0

### Measure IX — NOMs Key Findings

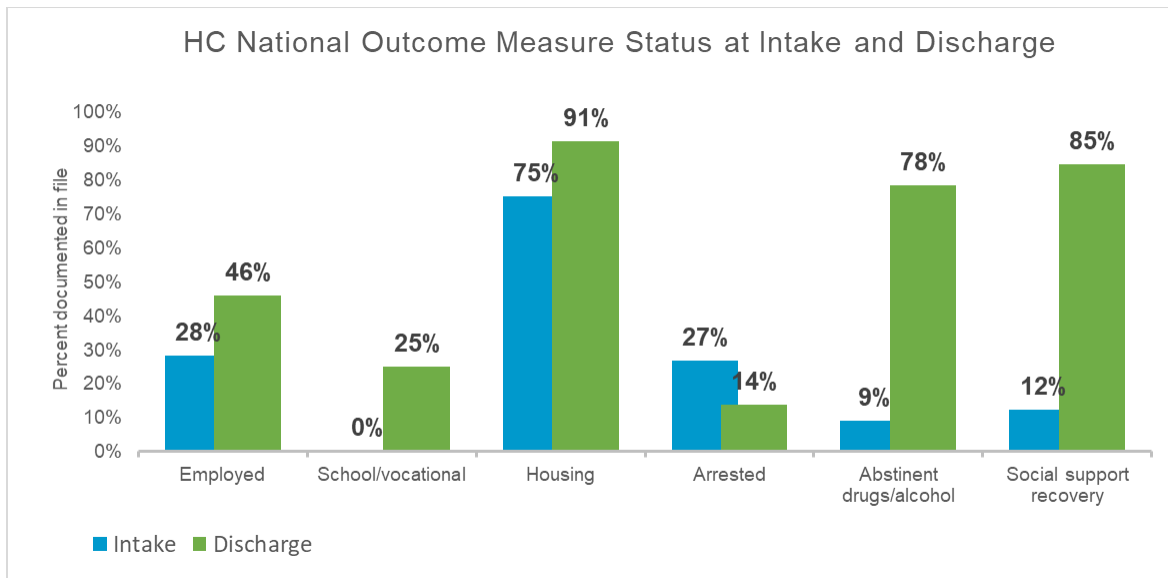
Each of the six HC NOMs for Measure IX are depicted in Table 4-9. Denominators are impacted by missing documentation of status at intake and discharge if applicable. Approximately half of the NOM documentation for *Participated in social support recovery in the preceding 30 days?* was not present in the file for intake and two-thirds was missing at discharge. Approximately a third of NOMs documentation was missing from files at discharge.

The graphs below show the client’s status for each NOM at intake and discharge. Results for HC for each NOM improved at discharge.

Table 4-9 — HC Case File Review Findings						
Measure IX National Outcome Measures						
NOMs	Intake			Discharge		
	Denominator	# Yes	% Yes	Denominator	# Yes	% Yes
A. Employed?	32	9	28%	24	11	46%
B. Enrolled in school or vocational educational program?	31	0	0%	20	5	25%
C. Lived in a stable housing environment (e.g., not homeless)?	32	24	75%	23	21	91%
D. Arrested in the preceding 30 days? <sup>10</sup>	30	8	27%	22	3	14%

<sup>10</sup> Note that a lower number and percentage is desired for the NOM *Arrested in the preceding 30 days?*

Table 4-9 — HC Case File Review Findings						
Measure IX National Outcome Measures						
E. Abstinent from drugs and/or alcohol?	33	3	9%	23	18	78%
F. Participated in social support recovery in the preceding 30 days?	33	4	12%	13	11	85%



## **Mercy Care (MC)**

MC has responsibility for AHCCCS clients in the central region of the State. Mercer reviewed provider treatment records from eight separate clinics under MC's area of responsibility. The following highlights were observed within the data collected from these cases.

- Providers educated OUD clients on the benefits of MAT in 88% of the cases reviewed, which was above average for the State (84%).
- Although the only pregnant women within this year's review sample came from this region, 100% received education on the effects of substance use on fetal development.
- One-hundred percent of charitable choice providers in this region documented that the requirements of this program were followed during the course of treatment.
- Providers in this region completed an appropriate risk assessment for 100% of the clients reviewed.

## **Measure I — Intake/Treatment Planning**

### **Initial Behavioral Health Assessment**

Mercer reviewed 133 total records for MC and found 98% of the charts contained evidence that an initial behavioral health assessment was completed within 45 days of the initial appointment (one case was scored "N/A", which indicates there was no documentation of an initial assessment, but the case was closed within 45 days of the first appointment). As part of the initial assessment, providers successfully documented compliance with the required components of the assessment (Items A1–9) with a range of 52% to 100%. The areas of lowest performance were documentation of hepatitis C, HIV, and other infectious disease screening (52%), review of the PDMP (58%), and tuberculosis screening (58%).

### **Individual Service Plan (ISP)**

Providers developed an ISP for the client's treatment (within 90 days of the initial appointment) in 98% of the reviewed cases. In 95% of these cases, the providers developed the ISP in congruence with the presenting concerns. Eight percent of ISPs were developed with the participation of the client's family or other supports (when the client consented to allow participation from these sources). Seventy-one clients declined participation from family and other supports, or supports did not exist.



Table 5-1 — Substance Abuse Prevention and Treatment					
MC Case File Review Findings					
I.	Intake/Treatment Planning				
		Denominator	# of Yes	% of Yes	# of N/A
A.	Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	132	130	98%	1
	Did the behavioral health assessment:				
	Address substance-related disorder(s)?	130	130	100%	*
	Describe the intensity/frequency of substance use?	130	121	93%	*
	Include the effect of substance use on daily functioning?	130	87	67%	*
	Include the effect of substance use on interpersonal relationships?	130	89	68%	*
	Include a completed risk assessment?	130	130	100%	*
	Document screening for tuberculosis (TB)?	130	75	58%	*
	Document screening for Hepatitis C, HIV, and other infectious diseases?	130	68	52%	*
	Document screening for emotional and/or physical abuse/trauma issues?	130	125	96%	*
	Documentation that review of the Prescription Drug Monitoring Program (PDMP) was completed?	90	52	58%	43
B.	Was there documentation that charitable choice requirements were followed, if applicable?	1	1	100%	132
C.	Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	132	130	98%	1
	Was the ISP:				
	Developed with participation of the family/support network?	59	5	8%	71
	Congruent with the diagnosis(es) and presenting concern(s)?	130	123	95%	*
	Measurable objectives and timeframes to address the identified needs?	130	108	83%	*
	Addressing the unique cultural preferences of the individual?	130	115	88%	*
	Were social determinants of health issues considered as part of, and incorporated into, the ISP?	129	106	82%	*

## Measure II — Placement Criteria/Assessment Key Findings

ASAM Patient Placement Criteria were used at intake to determine the appropriate level of service in 88% of the cases reviewed. Of these cases, documentation showed that 93% received the LOC identified by the ASAM criteria. Providers documented the use of the ASAM criteria to reassess the proper LOC during treatment in 37% of cases. In 17% of the reviewed case files, providers documented the use of other (or additional) assessment tools during the course of treatment. These tools included:

- CIWA (Used more than ten times)
- DAST (Used two times)
- OWS (Used more than five times)
- UNCOPE Screening Instrument for Substance Abuse (Used three times)

Table 5-2 — Substance Abuse Prevention and Treatment					
MC Case File Review Findings					
II.	Placement Criteria/Assessment				
		Denominator	# of Yes	% of Yes	# of N/A
A.	Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?	133	117	88%	*
B.	If the ASAM Patient Placement Criteria were used, the level of service identified was:				
a.	Level 0.5: Early Intervention	95	1	1%	*
b.	OMT: Opioid Maintenance Therapy	95	1	1%	*
c.	Level I: Outpatient Treatment	113	66	58%	*
d.	Level II: Intensive Outpatient Treatment/Partial Hospitalization	96	16	17%	*
e.	Level III: Residential/Inpatient Treatment	98	33	34%	*
f.	Level IV: Medically Managed Intensive Inpatient Treatment	95	0	0%	*
C.	Did the member receive the level of services identified by the placement criteria/assessment?	117	109	93%	*
D.	Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	133	49	37%	*
E.	Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	133	22	17%	*

### Measure III — Best Practices Key Findings

Eighty-nine percent of sampled behavioral health case files contained documentation that EBPs were used in treatment. Of these, CBT was the most widely used EBP (71%). MAT was documented in 50% percent of the behavioral health case files. Of the 66 individuals who received MAT, methadone was the most frequently used medication (58%). Six interventions were not documented as having been used during this review period: ACRA, Beyond Trauma: A Healing Journey for Women, Contingency Management, Thinking for a Change, TREM, and WRAP.

Additional interventions used by providers included:

- Brene Brown Shame-Resilience Curriculum (Used four times)
- Living In Balance (Used three times)
- Mindfulness (Used four times)
- REBT (Used five times)

In 24% of cases, providers offered certified peer support services and, in 53% of those cases, the services were provided as part of treatment. Twelve clients declined the use of peer support services when providers offered. The EBP of screening for ongoing substance use during treatment occurred in 77% of the reviewed cases.

Table 5-3 — Substance Abuse Prevention and Treatment					
MC Case File Review Findings					
III.	Best Practices				
		Denominator	# of Yes	% of Yes	# of N/A
A.	Were evidence-based practices used in treatment?	133	118	89%	*
	1. The following evidence-based practices were used in treatment:				
	a. Adolescent Community Reinforcement Approach (ACRA)	118	0	0%	*
	b. Beyond Trauma: A Healing Journey for Women	118	0	0%	*
	c. Cognitive Behavioral Therapy (CBT)	118	84	71%	*
	d. Contingency management	118	0	0%	*
	e. Dialectal Behavioral Therapy (DBT)	118	19	16%	*
	f. Helping Women Recover	118	7	6%	*
	g. Matrix	118	18	15%	*
	h. Moral Re-connection Therapy (MRT)	118	1	1%	*

Table 5-3 — Substance Abuse Prevention and Treatment					
MC Case File Review Findings					
III.	Best Practices				
		Denominator	# of Yes	% of Yes	# of N/A
	i. Motivational Enhancement/Interviewing Therapy (MET/MI)	118	44	37%	*
	j. Relapse Prevention Therapy (RPT)	118	2	2%	*
	k. Seeking Safety	118	1	1%	*
	l. SMART Recovery	118	5	4%	*
	m. Thinking for a Change	118	0	0%	*
	n. Trauma Recovery and Empowerment Model (TREM)	118	0	0%	*
	o. Trauma-Informed Care (TIC)	118	12	10%	*
	p. Wellness Recovery Action Plan (WRAP)	118	0	0%	*
	q. Other Practices or Programs(please list in box below):	118	17	14%	*
	B. Medication Assisted Treatment (MAT)	133	66	50%	*
	1. The following medication was used in treatment:				
	a. Alcohol-related				
	i. Acamprosate (Campral)	66	1	2%	*
	ii. Disulfiram (Antabuse)	66	0	0%	*
	b. Opioid-related				
	i. Subutex (buprenorphine)	66	4	6%	*
	ii. Methadone/Levo-Alpha-Acetylmethadol (LAAM)	66	38	58%	*
	iii. Narcan (naloxone)	66	3	5%	*
	iv. Vivitrol (long-acting naltrexone)	66	7	11%	*
	v. Suboxone (buprenorphine-naloxone)	66	21	32%	*
	C. Was screening for substance use/abuse conducted during the course of treatment?	133	103	77%	*
	D. Was certified peer support offered as part of treatment?	133	32	24%	12
	E. If yes to III.D, were certified peer support services used as a part of treatment?	32	17	53%	*

### Measure IV — Treatment/Support Services/Rehabilitation Services Key Findings

Providers used group therapy as the most common service provided in the sample (68%), followed by case management (65%), individual therapy (62%), and family counseling (2%). For those individuals who received counseling, 45% attended more than 11 sessions; 42% attended five or fewer sessions.

Seventy-two percent of behavioral health case files did not contain documentation regarding the number of self-help or recovery group sessions completed during treatment. Of those that did document this metric, 12% of cases documented zero attendance at the self-help or recovery group sessions.

When there was a documented lack of progress in treatment, providers sought consultation or changed the treatment approach in 20% of the cases reviewed.

Table 5-4 — Substance Abuse Prevention and Treatment					
MC Case File Review Findings					
IV.	Treatment/Support Services/Rehabilitation Services				
		Denominator	# of Yes	% of Yes	# of N/A
	A. The following services were used in treatment:				
	1. Individual counseling/therapy	133	83	62%	*
	2. Group counseling/therapy	133	90	68%	*
	3. Family counseling/therapy	133	2	2%	*
	4. Case management	133	87	65%	*
	B. Was there clear documentation of progress or lack of progress toward the identified ISP goals?	115	94	82%	18
	C. The number of completed counseling/therapy sessions during treatment was:				
	• 0–5 sessions	132	56	42%	*
	• 6–10 sessions	132	16	12%	*
	• 11 sessions or more	132	60	45%	*
	D. Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:				
	• No documentation	133	96	72%	*
	• 0 times during treatment	133	16	12%	*
	• 1–4 times during treatment	133	4	3%	*
	• 5–12 times during treatment	133	3	2%	*

Table 5-4 — Substance Abuse Prevention and Treatment					
MC Case File Review Findings					
IV.	Treatment/Support Services/Rehabilitation Services				
		Denominator	# of Yes	% of Yes	# of N/A
	• 13–20 times during treatment	133	11	8%	*
	• 21 or more times during treatment	133	3	2%	*
	E. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?	41	8	20%	91
	F. If the member was unemployed during intake, was there evidence that the individual’s interest in finding employment was explored?	68	62	91%	64
	G. If the member was not involved in an educational or vocational training program, was there evidence that the individual’s interest in becoming involved in such a program was explored?	63	42	67%	69
	H. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual’s interest in such an activity was explored?	81	32	40%	51
	I. Does the documentation reflect that substance abuse services were provided?	132	132	100%	*
	J. Was member’s access to a primary care physician (PCP) or other medical provider explored?	132	97	73%	0

### Measure V — Gender Specific (female only) Key Findings

Providers documented nine women’s case files with a history of domestic violence; of these, 69% contained a safety plan. Providers documented two pregnant women in this sample; coordination of care with the PCP or obstetrician occurred in one case (50%) and education on the effects of substance use on fetal development occurred in one case (50%). This sample did not contain any women who had given birth in the past year. Of the case files for women who had dependent children, 88% documented an examination of childcare. Gender-specific services were documented in 31% of cases.

Table 5-5 — Substance Abuse Prevention and Treatment					
MC Case File Review Findings					
V.	Gender Specific (female only)				
		Denominator	# of Yes	% of Yes	# of N/A
	A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	13	9	69%	36
	B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	2	1	50%	47
	C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?	2	1	50%	47
	D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?	0	0	—	49
	E. If the female had dependent children, was there documentation to show that childcare was addressed?	16	14	88%	33
	F. Was there evidence of gender-specific treatment services (e.g., women’s-only group therapy sessions)?	48	15	31%	1

### Measure VI — Opioid Specific Key Findings

For this sub-sample, providers documented OUD in 74% of the cases. Of these cases, providers educated 88% of the clients on MAT as a treatment option, and 97% of those were referred to a MAT provider. Documentation showed MAT providers educated the client on overdose, naloxone, and steps to take in the event of an overdose in 41% of the cases. Education on the effects of polysubstance abuse with opioids was provided in 57% of the cases. In 84% of cases, providers referred clients with withdrawal symptoms to a medical provider.

Table 5-6 — Substance Abuse Prevention and Treatment					
MC Case File Review Findings					
VI.	Opioid Specific				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?	102	75	74%	*
	B. Was there documentation that the member was provided MAT education as a treatment option?	75	66	88%	*

Table 5-6 — Substance Abuse Prevention and Treatment					
MC Case File Review Findings					
VI.	Opioid Specific				
		Denominator	# of Yes	% of Yes	# of N/A
	C. If yes to VI. B, were they referred to a MAT provider?	66	64	97%	25
	D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	31	26	84%	60
	E. If a physical health concern related to pain was identified, were alternative pain management options addressed?	29	13	45%	62
	F. If member is a pregnant female; did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?	2	1	50%	88
	G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?	75	31	41%	*
	H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	75	43	57%	*

**Measure VII — Discharge and Continuing Care Planning (completed only if the individual completed treatment or declined further services) Key Findings**

In 55% of the reviewed cases, providers documented completion of a relapse prevention plan for clients who completed treatment or declined further services. Providers documented offered resources pertaining to community supports in 77% of these cases. For those clients engaged with other agencies, providers actively coordinated with these agencies at the time of discharge in 65% of the cases.

Table 5-7 — Substance Abuse Prevention and Treatment					
MC Case File Review Findings					
VII.	Discharge and Continuing Care Planning <i>Completed if member completed treatment or declined further services</i>				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Was there documentation present that a relapse prevention plan completed?	111	61	55%	*



Table 5-7 — Substance Abuse Prevention and Treatment					
MC Case File Review Findings					
VII.	Discharge and Continuing Care Planning				
<i>Completed if member completed treatment or declined further services</i>					
		Denominator	# of Yes	% of Yes	# of N/A
	B. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g. crisis line)?	111	86	77%	*
	C. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?	65	42	65%	46

**Measure VIII — Re-engagement (completed only if the individual declined further services or chose not to appear for scheduled services) Key Findings**

In 68% of cases where the client declined further services or chose not to appear for scheduled services, providers followed up with a phone call at times when the member was expected to be available. In 66% of these cases, providers mailed a letter to the client requesting contact. Other activities taken by providers to make contact included, contacting other involved agencies (63%), visiting the client’s home (13%), and calling the client’s emergency contact (13%). In one case, the provider visited the client while the individual was in an inpatient facility and, in one other case, the provider sent an email to the client.

Table 5-8 — Substance Abuse Prevention and Treatment					
MC Case File Review Findings					
VIII.	Re-engagement				
<i>Completed if member declined further services or chose not to appear for scheduled services</i>					
		Denominator	# of Yes	% of Yes	# of N/A
The following efforts were documented:					
	A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?	104	71	68%	*
	B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	85	56	66%	19
	C. Were other attempts made to re-engage the individual, such as:				
	1. Home visit?	8	1	13%	0
	2. Call emergency contact(s)?	8	1	13%	0

Table 5-8 — Substance Abuse Prevention and Treatment					
MC Case File Review Findings					
VIII.	Re-engagement				
	<i>Completed if member declined further services or chose not to appear for scheduled services</i>				
		Denominator	# of Yes	% of Yes	# of N/A
	3. Contacting other involved agencies?	8	5	63%	0
	4. Street Outreach?	8	0	0%	0
	5. Other?	8	2	25%	0

### Measure IX — NOMs Key Findings

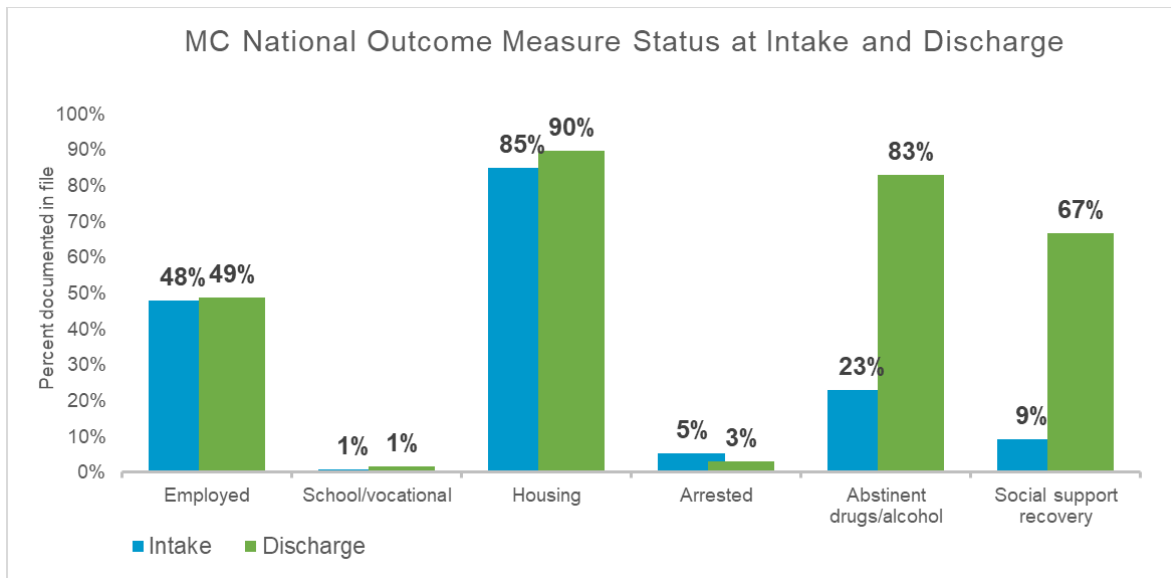
Each of the six MC NOMs for Measure IX are depicted in Table 5-9. The denominator is determined and compared for both intake and discharge. Denominators are impacted by missing documentation of status at intake and discharge if applicable. Half of the NOM documentation for *Participated in social support recovery in the preceding 30 days?* was not present in the file for intake and three-quarters were missing at discharge. For NOMs other than this measure, NOMs documentation was about 99% complete at intake and almost half complete at discharge.

The table and graph below shows the client’s status for each NOM at intake and discharge. Results for MC for each NOM improved at discharge.

Table 5-9 — MC Case File Review Findings						
Measure IX National Outcome Measures						
NOMs	Intake			Discharge		
	Denominator	# Yes	% Yes	Denominator	# Yes	% Yes
A. Employed?	132	63	48%	70	34	49%
B. Enrolled in school or vocational educational program?	130	1	1%	68	1	1%
C. Lived in a stable housing environment (e.g., not homeless)?	132	112	85%	67	60	90%
D. Arrested in the preceding 30 days? <sup>11</sup>	131	7	5%	65	2	3%

<sup>11</sup> Note that a lower number and percentage is desired for the NOM *Arrested in the preceding 30 days?*

Table 5-9 — MC Case File Review Findings						
Measure IX National Outcome Measures						
E. Abstinent from drugs and/or alcohol?	131	30	23%	64	53	83%
F. Participated in social support recovery in the preceding 30 days?	132	12	9%	33	22	67%



## 6

# Recommendations

Based upon the results of the ICR and associated analysis of findings, Mercer recommends the following areas of improvement for AHCCCS' consideration.

1. **Develop a mechanism for feedback to providers:** Although all SABG SUD providers have access to the findings of the ICR, the Mercer review team noted several instances where it would be beneficial to provide feedback to a specific provider (e.g., treatment concerns, missed opportunities for intervention, etc.). The ICR, in its present form, does not allow for provider-specific feedback to the RBHAs; such feedback could be provided with the intention of having that information passed along to the provider in question. AHCCCS should consider amending the ICR process to include a feedback mechanism that would allow for "lessons learned" to be disseminated to specific providers.

A potential vehicle for this feedback could be the ICR tool. AHCCCS could amend the ICR tool to include an additional section that would allow reviewers to identify important information related to the documented care in the record (e.g., treatment issues, missed opportunities, quality of care concerns, etc.). At the conclusion of the ICR, the comments could be compiled (by provider) and given to the RBHAs to pass along to the individual agencies, with the intent of having the providers make necessary adjustments in practices and procedures. When feedback is provided with specific examples, which are relevant to the receiver of the feedback, the recommendation is more likely to lead to improvements in behavior.<sup>12</sup>

The addition of a comment and feedback process would likely add to the ICR timeline, but such additional time could lead to desired improvements in provider treatment to the SUD population. Mercer suggests the benefits of this additional work may be worth the added effort.

2. **Encourage the ongoing use of SDoH information in treatment:** As noted previously, providers are doing a good job of investigating SDoH concerns that could impact treatment, with 81% of cases having a documented assessment of these issues. The next step should be to incorporate the SDoH findings into treatment and actively work to address existing obstacles to recovery. The ICR revealed that, with the exception of transportation, most providers did not address SDoH issues during the course of treatment (i.e., after the initial assessment), even when SDoH concerns were revealed in the initial assessment. AHCCCS should encourage the RBHAs to develop mechanisms for addressing SDoH concerns in treatment and use the information they are

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<sup>12</sup> Westberg, J. & Jason, H. (2001). *Fostering Reflection and Providing Feedback*. New York, NY: Springer Publishing Company.

now collecting to improve treatment outcomes. Such steps would likely assist in accomplishing the goals of the Whole Person Health Initiative.

As with all emerging trends within behavioral health care, provider education will play an important role in making SDoH an integral part of SUD treatment planning. One option for AHCCCS to consider is requiring (at a minimum encouraging) the RBHAs to make the integration of SDoH a priority in any educational offerings provided to their respective networks. The RBHAs should be encouraged to continue or leverage any SDoH focused trainings they may have already begun offering.

As mentioned previously, an item related to the examination of SDoH factors in the initial assessment was included in this year's ICR for the first time. Another option for AHCCCS to consider is expanding the number of items that focus on SDoH treatment considerations in future ICRs. This will provide a fuller understanding of how providers are addressing these issues throughout each phase of the service delivery process (e.g., engagement, planning, treatment, and discharge) and the system, and will provide the opportunity to track potential improvements over time.

- 3. Consider the inclusion of interviews in future ICRs:** The ICR currently reveals useful information related to the use of best practices and procedures by SUD treatment providers. However, a file review only conveys the information as it is documented. By incorporating live interviews with the RBHAs, clients, and providers, AHCCCS could collect additional, valuable information that would round-out its understanding of what works and what needs to be improved in SUD treatment services within the State. For example, although attendance at peer support groups is not currently documented consistently by providers, interviews could shed light on the true rate of participation in such groups.

Other AHCCCS-sponsored projects that focus on the improvement of behavioral health care service delivery have used live interviews to great effect. The Quality Services Review, which focuses on behavioral health care service delivery to the Serious Mental Illness population, has included individual interviews with service recipients and other stakeholders for the past eight years. This project could serve as a model for the ICR and provide valuable insight into potential areas of improvement for the SUD treatment system.

- 4. Consider formal statistical validation of the ICR Tool for future independent reviews.** As use of SABG funds continues, and additional ICRs are undertaken, AHCCCS could benefit from improved information that allows for year-to-year comparisons of ICR findings. Such comparisons can only be appropriately made when a statistically validated tool is used that increases confidence in the comparability of the different years' results. AHCCCS would have the option of performing such validation in-house, or leveraging the expertise of consultants trained in the validation of clinical review tools. As an additional option, AHCCCS could consider maintaining consistency in the independent review team that performs the ICR. Such consistency, together with the use of a statistically validated tool, would decrease variability from year-to-year, and increase the State's ability to compare results and assess large-scale trends within the SUD service system.

5. **Consider changes to sampling methodology for future reviews.** As an option in future reviews, AHCCCS should consider increasing validity and reliability by using a more randomized sampling methodology. One method for achieving this would be to have the independent reviewer randomly select the sample cases to be reviewed (from the entire population of files that meet inclusion criteria) and then ask the RBHAs to supply those specific records. This would add some time to the process (when compared to having the RBHAs select files to provide), but it would increase confidence in the results and contribute to overall project validity. Mercer currently uses this sampling methodology in support of the Priority Mental Health Services review, which is conducted annually for AHCCCS.

An additional benefit of using this sampling methodology is that the independent reviewer would have the opportunity to stratify the sample and increase the number of cases from small sub-populations that are reviewed. For example, this year's review included only two pregnant women (only one of which was diagnosed with an OUD). This small representation within the sample makes it difficult to draw conclusions for this group. By using appropriate sampling methodology, the independent reviewer could increase the representation of sub-populations in the sample while maintaining the randomness necessary for increased validity and reliability.

## Appendix A

# Case File Review Tool

Table 6-1 — Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	# of Yes	% of Yes	# of N/A	# of No Documentation
I	Intake/Treatment Planning					
	A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?					
	Did the behavioral health assessment:					
	1. Address substance-related disorder(s)?					
	2. Describe the intensity/frequency of substance use?					
	3. Include the effect of substance use on daily functioning?					
	4. Include the effect of substance use on interpersonal relationships?					
	5. Was a risk assessment completed?					
	6. Document screening for tuberculosis (TB)?					
	7. Document screening for Hepatitis C, HIV and other infectious diseases?					
	8. Document screening for emotional and/or physical abuse/trauma issues?					
	9. Documentation that review of the Prescription Drug Monitoring Program (PDMP) was completed?					

Table 6-1 — Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	# of Yes	% of Yes	# of N/A	# of No Documentation
	B. Was there documentation that charitable choice requirements were followed, if applicable?					
	C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?					
	Was the ISP:					
	1. Developed with participation of the family/support network?					
	2. Congruent with the diagnosis(es) and presenting concern(s)?					
	3. Measurable objectives and timeframes to address the identified needs?					
	4. Addressing the unique cultural preferences of the individual?					
	5. Were social determinants of health issues considered as part of, and incorporated into, the ISP?					
<b>II</b>	<b>Placement Criteria/Assessment</b>					
	A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?					
	1. If the ASAM Patient Placement Criteria were used, the level of service identified was:					
	Level 0.5: Early Intervention					
	OMT: Opioid Maintenance Therapy					
	Level I: Outpatient Treatment					
	Level II: Intensive Outpatient Treatment/Partial Hospitalization					
	Level III: Residential/Inpatient Treatment					



Table 6-1 — Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	# of Yes	% of Yes	# of N/A	# of No Documentation
	Level IV: Medically Managed Intensive Inpatient Treatment					
	B. Did the member receive the level of services identified by the placement criteria/assessment?					
	C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?					
	D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment? If yes, please list in box below:					
<b>III</b>	<b>Best Practices</b>					
	A. Were evidence-based practices used in treatment?					
	1. The following evidence-based practices were used in treatment:					
	Adolescent Community Reinforcement Approach (ACRA)					
	Beyond Trauma: A Healing Journey for Women					
	Cognitive Behavioral Therapy (CBT)					
	Contingency management					
	Dialectical Behavioral Therapy (DBT)					
	Helping Women Recover					
	Matrix					
	Moral Re-connection Therapy (MRT)					
	Motivational Enhancement/Interviewing Therapy (MET/MI)					
	Relapse Prevention Therapy (RPT)					
	Seeking Safety					
	SMART Recovery					
	Thinking for a Change					

Table 6-1 — Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	# of Yes	% of Yes	# of N/A	# of No Documentation
	Trauma Recovery and Empowerment Model (TREM)					
	Trauma-Informed Care (TIC)					
	Wellness Recovery Action Plan (WRAP)					
	Other Practices or Programs (please list in box below):					
	<b>B. Medication Assisted Treatment (MAT)</b>					
	1. The following medication was used in treatment:					
	❖ <u>Alcohol-related</u>					
	Acamprosate (Campral)					
	Disulfiram (Antabuse)					
	❖ <u>Opioid-related</u>					
	Subutex (buprenorphine)					
	Methadone/Levo-Alpha-Acetylmethadol (LAAM)					
	Narcan (naloxone)					
	Vivitrol (long-acting naltrexone)					
	Suboxone (buprenorphine-naloxone)					
	C. Was screening for substance use/abuse conducted during the course of treatment?					
	D. Was certified peer support offered as part of treatment?					
	If yes to III.I.D, were certified peer support services used as a part of treatment?					
<b>IV</b>	<b>Treatment/Support Services/Rehabilitation Services</b>					
	A. The following services were used in treatment:					

**Table 6-1 — Substance Abuse Prevention and Treatment**

**Case File Review Findings for Measure I-IX**

	Denominator	# of Yes	% of Yes	# of N/A	# of No Documentation
Individual counseling/therapy					
Group counseling/therapy					
Family counseling/therapy					
Case management					
B. Was there clear documentation of progress or lack of progress toward the identified ISP goals?					
C. The number of completed counseling/therapy sessions during treatment was:					
0–5 sessions					
6–10 sessions					
11 sessions or more					
D. Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:					
No documentation					
0 times during treatment					
1–4 times during treatment					
5–12 times during treatment					
13–20 times during treatment					
21 or more times during treatment					
E. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?					
F. If the member was unemployed during intake, was there evidence that the individual’s interest in finding employment was explored?					
G. If the member was not involved in an educational or vocational training program, was there evidence that the individual’s interest in becoming involved in such a program was explored?					

Table 6-1 — Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	# of Yes	% of Yes	# of N/A	# of No Documentation
	H. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual’s interest in such an activity was explored?					
	I. Does the documentation reflect that substance abuse services were provided?					
	J. Was member’s access to a primary care physician (PCP) or other medical provider explored?					
<b>V</b>	<b>Gender Specific (female only)</b>					
	A. If there was a history of domestic violence, was there evidence that a safety plan was completed?					
	B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?					
	C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?					
	D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?					
	E. If the female had dependent children, was there documentation to show that childcare was addressed?					
	F. Was there evidence of gender-specific treatment services (e.g., women’s-only group therapy sessions)?					
<b>VI</b>	<b>Opioid Specific</b>					
	A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?					

<b>Table 6-1 — Substance Abuse Prevention and Treatment</b>						
<b>Case File Review Findings for Measure I-IX</b>						
		<b>Denominator</b>	<b># of Yes</b>	<b>% of Yes</b>	<b># of N/A</b>	<b># of No Documentation</b>
	B. Was there documentation that the member was provided MAT education as a treatment option?					
	C. If yes to VI B, were they referred to a MAT provider?					
	D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?					
	E. If a physical health concern related to pain was identified, were alternative pain management options addressed?					
	F. If member is a pregnant female; did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?					
	G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?					
	H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?					
<b>VII</b>	<b>Discharge and Continuing Care Planning</b>					
	<b>(completed only if member completed treatment or declined further services)</b>					
	A. Was there documentation present that a relapse prevention plan completed?					
	B. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g. crisis line)?					
	C. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?					
<b>VIII</b>	<b>Re-engagement</b>					

Table 6-1 — Substance Abuse Prevention and Treatment							
Case File Review Findings for Measure I-IX							
		Denominator	# of Yes	% of Yes	# of N/A	# of No Documentation	
(completed only if member declined further services or chose not to appear for scheduled services)							
	The following efforts were documented:						
	A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?						
	B. If telephone contact was unsuccessful, was a letter mailed requesting contact?						
	C. Were other attempts made to re-engage the individual, such as:						
	Home visit?						
	Call emergency contact(s)?						
	Contacting other involved agencies?						
	Street Outreach?						
	Other, <i>please list other identified outreach efforts in the box below</i>						
IX	National Outcome Measures						
		At Intake			At Discharge		
		Yes	No	Missing	Yes	No	Missing
	A. Employed?						
	B. Enrolled in school or vocational educational program?						
	C. Lived in a stable housing environment (e.g., not homeless)?						
	D. Arrested in the preceding 30 days?						
	E. Abstinent from drugs and/or alcohol?						
	F. Participated in social support recovery in the preceding 30 days?						

## Appendix B

# Case File Review Methodology

The methodology for making review determinations is comparable to prior years to promote consistency over the continuum of the SABG periods. Methodology was slightly updated based on consultation with AHCCCS. Review team members used this methodology to perform the primary IRR and review process. This methodology was also used to program the formulas used for the analysis.

Indicator	Instructions
<b>I. Intake/Treatment Planning</b>	
<p>A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?</p>	<ul style="list-style-type: none"> <li>• Yes: A comprehensive behavioral health assessment has been performed within 45 days of the initial appointment.</li> <li>• No: No comprehensive behavioral health assessment has been performed within 45 days of the initial appointment.</li> <li>• No: A behavioral health assessment has been performed within 45 days of the initial appointment but is not present in the file.</li> <li>• N/A: No comprehensive behavioral health assessment is present in the file and the case.</li> </ul>
<p>Did the behavioral health assessment:</p>	
<p>1. Address substance-related disorder(s)</p>	<ul style="list-style-type: none"> <li>• Yes: The assessment addressed substance-related disorder(s) within 45 days of the initial appointment.</li> <li>• No: The assessment addressed substance-related disorder(s) within 45 days of the initial appointment.</li> </ul>
<p>2. Describe the intensity/frequency of substance use?</p>	<ul style="list-style-type: none"> <li>• Yes: The assessment described the intensity/frequency of substance use within 45 days of the initial appointment.</li> <li>• No: The assessment did not describe the intensity/frequency of substance use within 45 days of the initial appointment.</li> </ul>
<p>3. Include the effect of substance use on daily functioning?</p>	<ul style="list-style-type: none"> <li>• Yes: The assessment included the effect of substance use on daily functioning within 45 days of the initial appointment.</li> <li>• No: The assessment did not include the effect of substance use on daily functioning within 45 days of the initial appointment.</li> </ul>
<p>4. Include the effect of substance use on interpersonal relationships?</p>	<ul style="list-style-type: none"> <li>• Yes: The assessment addressed the intensity/frequency of substance use within 45 days of the initial appointment.</li> <li>• No: The assessment did not address the intensity/frequency of substance use within 45 days of the initial appointment.</li> </ul>

Indicator	Instructions
5. Was a risk assessment completed?	<ul style="list-style-type: none"> <li>• Yes: The assessment included a completed risk assessment. The risk assessment may be part of the behavioral health assessment or exist on separate RBHA- or provider-specific forms. The risk assessment must be completed within the first 45 days of the initial appointment.</li> <li>• No: The assessment or file did not include a completed risk assessment or the risk assessment was not completed within 45 days of the initial appointment.</li> </ul>
6. Document screening for tuberculosis (TB)?	<ul style="list-style-type: none"> <li>• Yes: The assessment included documentation of screening for TB. Acceptable documentation includes information on testing, education, referrals for screening and services, follow-up counseling addressing identified services, or an evaluation of history, risk factors, and/or screening tools. The screening must be completed within the first 45 days of the initial appointment.</li> <li>• No: The assessment did not include documentation for screening of TB or the documentation was not completed within 45 days of the initial appointment.</li> </ul>
7. Document screening for Hepatitis C, HIV and other infectious diseases?	<ul style="list-style-type: none"> <li>• Yes: The assessment included documentation of screening for Hepatitis C, HIV, and other infectious diseases. Acceptable documentation includes information on testing, education, referrals for screening and services, follow-up counseling addressing identified services, an evaluation of history, risk factors, and/or screening tools.</li> <li>• No: The assessment did not include documentation of screening for Hepatitis C, HIV, and other infectious diseases.</li> </ul>
8. Document screening for emotional and/or physical abuse/trauma issues?	<ul style="list-style-type: none"> <li>• Yes: The assessment documented screening for emotional and/or physical abuse/trauma issues within 45 days of the initial appointment.</li> <li>• No: The assessment did not document screening for emotional and/or physical abuse/trauma issues within 45 days of the initial appointment.</li> </ul>
9. Document that review of the Prescription Drug Monitoring Program (PDMP) was completed?	<ul style="list-style-type: none"> <li>• Yes: The assessment documented that a review of the PDMP was completed for those clients receiving MAT or other medication services.</li> <li>• No: The assessment did not document that a review of the PDMP was completed for those clients receiving MAT or other medication services.</li> <li>• N/A: The client was not receiving MAT or other medications as part of SUD treatment services.</li> </ul>
B. Was there documentation that charitable choice requirements were followed, if applicable?	<ul style="list-style-type: none"> <li>• Yes: The assessment documented within 45 days of the initial appointment that charitable choice requirements were followed and applicable.</li> <li>• No: The assessment did not include documentation that charitable choice requirements were followed when applicable or were not followed within 45 days of the initial appointment.</li> <li>• N/A: Charitable choice requirements were not applicable for the provider.</li> </ul>



Indicator	Instructions
C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	<ul style="list-style-type: none"> <li>• Yes: An ISP was completed within 90 days of the initial appointment and in the file. Note: an interim ISP is not acceptable documentation for this measure.</li> <li>• No: An ISP was not completed within 90 days of the initial appointment or was not contained in the file.</li> <li>• N/A: No ISP was completed and the case was closed within 90 days of the initial appointment.</li> </ul>
Was the ISP:	Measures below apply only if there is an ISP completed within 90 days of the initial appointment.
1. Developed with participation of the family/support network?	<ul style="list-style-type: none"> <li>• Yes: There is documentation that the ISP was developed with active input of the client's family/support network. Documentation may include verbal or written efforts to solicit their input.</li> <li>• No: There is no documentation that staff tried to seek input from the client's family/support network.</li> <li>• N/A: There is no family/support network and/or the client chose not to engage others in the process.</li> </ul>
2. Congruent with the diagnosis(es) and presenting concern(s)?	<ul style="list-style-type: none"> <li>• Yes: The scope, intensity, and duration of services offered are congruent with the diagnosis(es).</li> <li>• No: The scope, intensity, and duration of services offered are not congruent with the diagnosis(es).</li> </ul>
3. Measurable objectives and timeframes to address the identified needs?	<ul style="list-style-type: none"> <li>• Yes: The objectives and timeframes on the ISP are measurable and address the identified needs.</li> <li>• No: The objectives and timeframes on the ISP are not measurable and do not address the identified needs.</li> </ul>
4. Addressing the unique cultural preferences of the individual?	<ul style="list-style-type: none"> <li>• Yes: The ISP addresses one or more unique cultural preferences of the individual including language, customs, traditions, family, age, gender identity, ethnicity, race, sexual orientation, and socioeconomic class.</li> <li>• No: The ISP does not address any cultural preferences of the individual.</li> </ul>
5. Were social determinants of health issues considered as part of, and incorporated into, the ISP?	<ul style="list-style-type: none"> <li>• Yes: The ISP addresses one or more social determinants of health issues (e.g., housing, employment, health, etc.).</li> <li>• Yes: The ISP does not address social determinants of health issues.</li> </ul>
<b>II. Placement Criteria/Assessment</b>	
A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?	<ul style="list-style-type: none"> <li>• Yes: An ASAM tool was completed to determine the level of care at intake. A provider-created tool is acceptable.</li> <li>• No: No ASAM tool or evidence of an ASAM tool was completed at intake or found in the file.</li> </ul>

Indicator	Instructions
1. If the ASAM Patient Placement Criteria were used, the level of service identified was:	<p>If an ASAM tool was completed at intake, choose the level of service identified by the tool. At least one level must be chosen.</p> <ul style="list-style-type: none"> <li>• Level 0.5: Early Intervention</li> <li>• OMT: Opioid Maintenance Therapy</li> <li>• Level I: Outpatient Treatment</li> <li>• Level II: Intensive Outpatient Treatment/Partial Hospitalization</li> <li>• Level III: Residential/Inpatient Treatment</li> <li>• Level IV: Medically Managed Intensive Inpatient Treatment</li> </ul>
B. Did the member receive the level of services identified by the placement criteria/assessment?	<ul style="list-style-type: none"> <li>• Yes: An ASAM tool was completed at intake and the member received the level of services identified by the placement criteria/assessment.</li> <li>• No: An ASAM tool was completed at intake but the member did not receive the level of services identified by the placement criteria/assessment.</li> </ul>
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	<ul style="list-style-type: none"> <li>• Yes: An ASAM tool was updated and the dimensions reassessed after intake and during the course of treatment. The tool results (level of care) may remain the same as long as it has been reassessed.</li> <li>• No: An ASAM tool was not updated after intake/during the course of treatment.</li> </ul>
D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	<ul style="list-style-type: none"> <li>• Yes: One or more non-ASAM multi-dimensional placement criteria were used after intake and during treatment.</li> <li>• No: No other assessment tool was used after intake/during the course of treatment.</li> </ul>
If yes, please list in box below:	List the name(s) of the other assessment tool(s) used during the course of treatment.
<b>III. Best Practices</b>	
A. Were evidence-based practices used in treatment?	<ul style="list-style-type: none"> <li>• Yes: Documentation exists that evidence-based practices were incorporated into treatment.</li> <li>• No: No documentation exists that evidence-based practices were used in treatment.</li> <li>• No documentation: There is indication that evidence-based practices were used in treatment but not enough documentation available to confirm. For example, the specific treatment intervention was not mentioned in progress notes.</li> </ul>

Indicator	Instructions
1. The following evidence-based practices were used in treatment:	<p>Select which evidence-based practice were used in treatment. Choose all that apply.</p> <ul style="list-style-type: none"> <li>• Adolescent Community Reinforcement Approach (ACRA)</li> <li>• Beyond Trauma: A Healing Journey for Women</li> <li>• Cognitive Behavioral Therapy (CBT)</li> <li>• Contingency management</li> <li>• Dialectal Behavioral Therapy (DBT)</li> <li>• Helping Women Recover</li> <li>• Matrix</li> <li>• Moral Re-conation Therapy (MRT)</li> <li>• Motivational Enhancement/Interviewing Therapy (MET/MI)</li> <li>• Relapse Prevention Therapy (RPT)</li> <li>• Seeking Safety</li> <li>• SMART Recovery</li> <li>• Thinking for a Change</li> <li>• Trauma Recovery and Empowerment Model (TREM)</li> <li>• Trauma-Informed Care (TIC)</li> <li>• Wellness Recovery Action Plan (WRAP)</li> </ul>
Other Practices or Programs (please list in box below):	<ul style="list-style-type: none"> <li>• Yes: An evidence-based practice not listed in the above question was incorporated into treatment.</li> <li>• No: No other evidence-based practice other than those listed above were incorporated into treatment.</li> </ul>
Listed other practices/programs	List the name(s) of the other evidence-based practice(s) indicated in the question above.
B. Medication Assisted Treatment (MAT)	<ul style="list-style-type: none"> <li>• Yes: For individuals undergoing substance abuse treatment, documentation exists that MAT was incorporated into treatment.</li> <li>• No: No documentation exists that MAT was incorporated into treatment.</li> </ul>
1. The following medication was used in treatment:	<p>If MAT was used in treatment, select which alcohol-related medication(s) were used in treatment. Choose all that apply.</p> <ul style="list-style-type: none"> <li>• Acamprosate (Campral)</li> <li>• Disulfiram (Antabuse)</li> </ul>
	<p>If MAT was used in treatment, select which opioid-related medication(s) were used in treatment. Choose all that apply.</p> <ul style="list-style-type: none"> <li>• Subutex (buprenorphine)</li> <li>• Methadone/Levo-Alpha-Acetylmethadol (LAAM)</li> <li>• Narcan (naloxone)</li> <li>• Vivitrol (long-acting naltrexone)</li> <li>• Suboxone (buprenorphine-naloxone)</li> </ul>

Indicator	Instructions
C. Was screening for substance use/abuse conducted during the course of treatment?	<ul style="list-style-type: none"> <li>• Yes: Documentation exists that screening for substance use/abuse occurred during the course of treatment.</li> <li>• No: No documentation exists that screening for substance use/abuse occurred during the course of treatment.</li> </ul>
D. Was certified peer support offered as part of treatment?	<ul style="list-style-type: none"> <li>• Yes: Documentation exists that certified peer support (e.g., coaches, peer specialists) was offered as part of treatment. Evidence of certification is not required but the peer support offered should be more formal and less of a social support group.</li> <li>• No: No documentation exists that certified peer support (e.g., coaches, peer specialists) was offered as part of treatment.</li> <li>• N/A: Peer support was offered to the client and the client declined.</li> </ul>
If yes to III.I.D, were certified peer support services used as a part of treatment?	<ul style="list-style-type: none"> <li>• Yes: Certified peer support services were offered and were accepted and used.</li> <li>• No: Certified peer support services were offered and accepted, but not used.</li> </ul>
<b>IV. Treatment/Support Services/Rehabilitation Services</b>	
A. The following services were used in treatment:	<p>Select which service(s) were used in treatment. Choose all that apply.</p> <ul style="list-style-type: none"> <li>• Individual counseling/therapy</li> <li>• Group counseling/therapy</li> <li>• Family counseling/therapy</li> <li>• Case management</li> </ul>
B. Was there clear documentation of progress or lack of progress toward the identified ISP goals?	<ul style="list-style-type: none"> <li>• Yes: Documentation of progress or lack of progress toward the identified ISP goals exists in the record.</li> <li>• No: No documentation exists that screening for substance use/abuse occurred during the course of treatment.</li> <li>• N/A: No ISP exists or services provided are recent but no change in progress is indicated.</li> </ul>
C. The number of completed counseling/therapy sessions during treatment was:	<p>Select the number of completed counseling/therapy sessions during treatment. Choose one response only.</p> <ul style="list-style-type: none"> <li>• 0–5 sessions</li> <li>• 6–10 sessions</li> <li>• 11 sessions or more</li> </ul>
D. Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:	<p>Select the number of instances the client reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.). Choose No Documentation when the client was referred to a group but did not attend.</p> <ul style="list-style-type: none"> <li>• 0 times during treatment</li> <li>• 1–4 times during treatment</li> <li>• 5–12 times during treatment</li> <li>• 13–20 times during treatment</li> <li>• 21 or more times during treatment</li> </ul>

Indicator	Instructions
<p>E. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?</p>	<ul style="list-style-type: none"> <li>• Yes: The chart showed documentation of lack of progress towards the identified goal and evidence that the provider revised the treatment approach and/or sought consultation in order to enact symptomatic improvement.</li> <li>• No: The chart showed documentation of lack of progress towards the identified goal but no evidence that the provider revised the treatment approach and/or sought consultation in order to enact symptomatic improvement.</li> <li>• N/A: Documentation of symptomatic improvement exists in the file.</li> </ul>
<p>F. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?</p>	<ul style="list-style-type: none"> <li>• Yes: The client was unemployed at intake and the chart showed documentation of employment opportunity discussion(s).</li> <li>• No: The client was unemployed at intake and the chart did not show documentation of employment opportunity discussions(s).</li> <li>• N/A: The client was employed at intake or unemployed but an employment discussion was irrelevant (i.e. client participates in a vocational program or is retired).</li> </ul>
<p>G. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?</p>	<ul style="list-style-type: none"> <li>• Yes: The client was not involved in an educational or vocational training program at intake but involvement in such a program was explored.</li> <li>• No: The client was not involved in an educational or vocational training program at intake and the chart did not show documentation of such a discussions.</li> <li>• N/A: The client was involved in an educational or vocational training program at intake or not involved but a discussion was irrelevant (i.e. client is employed).</li> </ul>
<p>H. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?</p>	<ul style="list-style-type: none"> <li>• Yes: The client was not involved in a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation) at intake but involvement in such a program was explored.</li> <li>• No: The client was not involved in a meaningful community activity at intake and involvement in such a program was not discussed with the client.</li> <li>• N/A: The client was involved in a community activity at intake or not involved but a discussion was irrelevant (i.e. client is employed).</li> </ul>
<p>I. Does the documentation reflect that substance abuse services were provided?</p>	<ul style="list-style-type: none"> <li>• Yes: Documentation exists that substance abuse services were provided.</li> <li>• No: No documentation exists of the provision of substance abuse services.</li> </ul>
<p>J. Was member's access to a primary care physician (PCP) or other medical provider explored?</p>	<ul style="list-style-type: none"> <li>• Yes: A discussion about the client's access to a PCP or other medical provider(s) was documented.</li> <li>• No: No documentation exists about whether the client's access to a PCP or other medical provider(s) was discussed.</li> </ul>

Indicator	Instructions
<b>V. Gender Specific (female only)</b>	
A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	<ul style="list-style-type: none"> <li>• Yes: Client is female, a history of domestic violence exists, and documentation of a safety plan is contained in the file.</li> <li>• No: Client is female, a history of domestic violence exists, but no documentation of a safety plan is contained in the file.</li> <li>• N/A: Client is female but a history of domestic violence does not exist.</li> </ul>
B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	<ul style="list-style-type: none"> <li>• Yes: Client is a pregnant female and documentation exists showing efforts at coordination with the client's PCP and/or obstetrician.</li> <li>• No: Client is a pregnant female and documentation does not exist showing coordination with the client's PCP and/or obstetrician.</li> <li>• N/A: Client is female but not pregnant.</li> </ul>
C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?	<ul style="list-style-type: none"> <li>• Yes: Client is a pregnant female and documentation exists showing client was educated on the effects of substance use on fetal development.</li> <li>• No: Client is a pregnant female and documentation does not exist showing client was educated on the effects of substance use on fetal development.</li> <li>• N/A: Client is female but not pregnant.</li> </ul>
D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?	<ul style="list-style-type: none"> <li>• Yes: Client is a female with a child less than one year of age and documentation exists showing a screening was completed for postpartum depression/psychosis.</li> <li>• No: Client is a female with a child less than one year of age and no documentation exists showing a screening was completed for postpartum depression/psychosis.</li> <li>• N/A: Client is female but does not have a child less than one year of age.</li> </ul>
E. If the female had dependent children, was there documentation to show that childcare was addressed?	<ul style="list-style-type: none"> <li>• Yes: Client is a female with dependent children and documentation exists showing that childcare was addressed.</li> <li>• No: Client is a female with dependent children but no documentation exists showing that childcare was addressed.</li> <li>• N/A: Client is female with no dependent children.</li> </ul>
F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	<ul style="list-style-type: none"> <li>• Yes: Client is a female and documentation exists showing female-specific treatment services were offered and/or provided (i.e. women's-only group therapy sessions, female peer support).</li> <li>• No: Client is a female but no documentation exists showing female-specific treatment services were offered and/or provided.</li> <li>• N/A: Client is female and turned down female-specific services.</li> </ul>
<b>VI. Opioid Specific</b>	
A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?	<ul style="list-style-type: none"> <li>• Yes: Documentation exists showing client had an OUD diagnosis.</li> <li>• No: No documentation exists showing an OUD diagnosis.</li> </ul>

Indicator	Instructions
B. Was there documentation that the member was provided MAT education as a treatment option?	<ul style="list-style-type: none"> <li>• Yes: Client has a documented OUD diagnosis and documentation exists showing client was offered MAT education.</li> <li>• No: Client has a documented OUD diagnosis but no documentation exists showing client was offered MAT education.</li> </ul>
C. If yes to VI B, were they referred to a MAT provider?	<ul style="list-style-type: none"> <li>• Yes: Client has a documented OUD diagnosis and documentation exists showing client was offered MAT and referred to a MAT provider.</li> <li>• No: Client has a documented OUD diagnosis and documentation exists showing client was offered MAT but was not referred to a MAT provider.</li> <li>• N/A: Client has a documented OUD diagnosis and documentation exists showing client was not offered MAT.</li> </ul>
D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	<ul style="list-style-type: none"> <li>• Yes: Client has a documented OUD diagnosis and documentation exists showing client had withdrawal symptoms that were addressed by referral and/or intervention by a medical provider.</li> <li>• No: Client has a documented OUD diagnosis but no documentation exists showing client's withdrawal symptoms were addressed by referral and/or intervention by a medical provider.</li> <li>• N/A: Client has a documented OUD diagnosis but no withdrawal symptoms.</li> </ul>
E. If a physical health concern related to pain was identified, were alternative pain management options addressed?	<ul style="list-style-type: none"> <li>• Yes: Client has a documented OUD diagnosis and documentation exists showing client received alternative pain management options for an identified physical health concern related to pain.</li> <li>• No: Client has a documented OUD diagnosis and documentation exists showing client had an identified physical health concern related to pain but did not receive alternative pain management options.</li> <li>• N/A: Client has a documented OUD diagnosis but no pain-related physical health concerns.</li> </ul>
F. If member is a pregnant female; did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?	<ul style="list-style-type: none"> <li>• Yes: Client is a pregnant female with a documented OUD diagnosis and documentation exists showing client received education about the safety of methadone and/or buprenorphine during the course of pregnancy.</li> <li>• No: Client is a pregnant female with a documented OUD diagnosis but no documentation exists showing client received education about the safety of methadone and/or buprenorphine during the course of pregnancy.</li> <li>• N/A: Client has a documented OUD diagnosis but is not a pregnant female.</li> </ul>
G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?	<ul style="list-style-type: none"> <li>• Yes: Client has a documented OUD diagnosis and documentation exists showing client received relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose.</li> <li>• No: Client has a documented OUD diagnosis but no documentation exists showing client received relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose.</li> </ul>

Indicator	Instructions
<p>H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?</p>	<ul style="list-style-type: none"> <li>• Yes: Client has a documented OUD diagnosis and documentation exists showing client received information on the effects of polysubstance use with opioids.</li> <li>• No: Client has a documented OUD diagnosis but no documentation exists showing client received information on the effects of polysubstance use with opioids.</li> </ul>
<b>VII. Discharge and Continuing Care Planning</b>	
<p>A. Was there documentation present that a relapse prevention plan completed?</p>	<ul style="list-style-type: none"> <li>• Yes: Client completed treatment or declined further services and documentation of a completed relapse prevention plan exists.</li> <li>• No: Client completed treatment or declined further services but no documentation of a completed relapse prevention plan exists.</li> </ul>
<p>B. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g. crisis line)?</p>	<ul style="list-style-type: none"> <li>• Yes: Client completed treatment or declined further services and documentation exists that staff offered at least one resource pertaining to community supports, including recovery self-help, and/or other individualized support services (e.g. crisis line).</li> <li>• No: Client completed treatment or declined further services but no documentation exists that staff offered at least one resource pertaining to community supports, including recovery self-help, and/or other individualized support services (e.g. crisis line).</li> </ul>
<p>C. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?</p>	<ul style="list-style-type: none"> <li>• Yes: Client completed treatment or declined further services and documentation exists that staff actively coordinated with other involved agencies at the time of discharge.</li> <li>• No: Client completed treatment or declined further services but no documentation exists that staff actively coordinated with other involved agencies at the time of discharge.</li> <li>• N/A: Client completed treatment or declined further services and there were no other involved agencies at the time of discharge.</li> </ul>
<b>VIII. Re-engagement</b>	
<p>A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?</p>	<ul style="list-style-type: none"> <li>• Yes: Client declined further services or chose not to appear for scheduled services and documentation exists that the client (or legal guardian) was contacted by telephone at times when the client was expected to be available (e.g., after work or school).</li> <li>• No: Client declined further services or chose not to appear for scheduled services but was not contacted by telephone at times when the client was expected to be available (e.g., after work or school).</li> </ul>
<p>B. If telephone contact was unsuccessful, was a letter mailed requesting contact?</p>	<ul style="list-style-type: none"> <li>• Yes: Client declined further services or chose not to appear for scheduled services and documentation exists that telephone contact was unsuccessful but a letter was mailed requesting contact.</li> <li>• No: Client declined further services or chose not to appear for scheduled services and documentation exists that although telephone contact was unsuccessful, no letter was mailed requesting contact.</li> <li>• N/A: Client declined further services or chose not to appear for scheduled services and documentation exists that client was contacted successfully through means other than a telephone call or letter.</li> </ul>

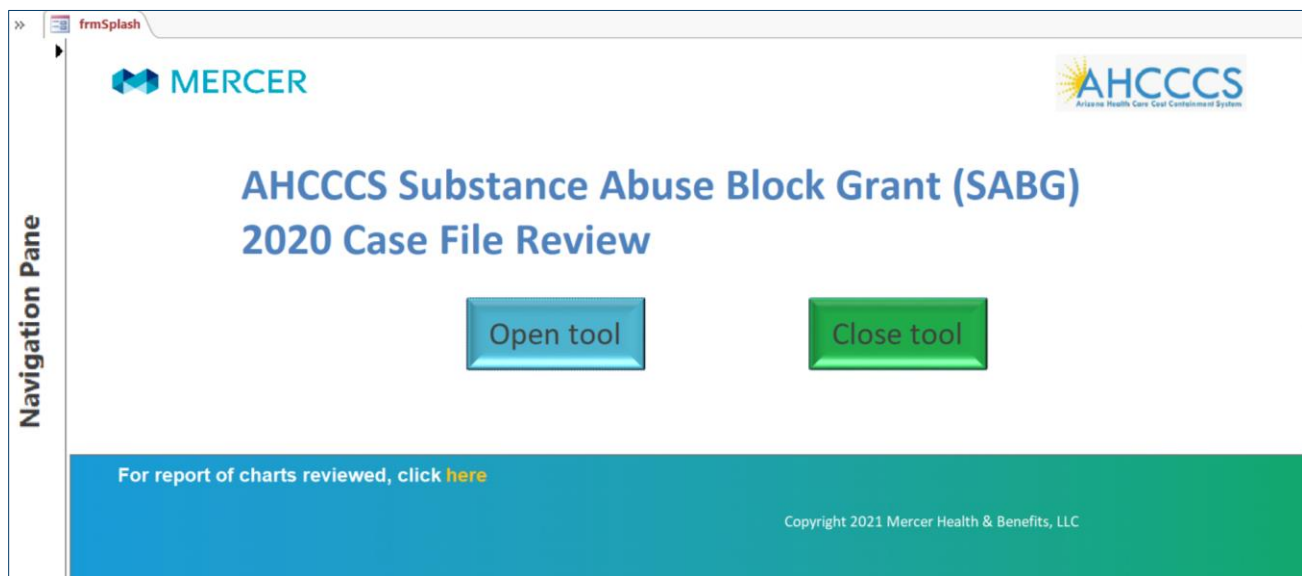


Indicator	Instructions
C. Were other attempts made to re-engage the individual, such as:	<ul style="list-style-type: none"> <li>• Yes: Client declined further services or chose not to appear for scheduled services and documentation exists that the following attempts at re-engaging were made. Select all that apply.                             <ul style="list-style-type: none"> <li>- Home visit</li> <li>- Call emergency contact(s)</li> <li>- Contacting other involved agencies</li> <li>- Street Outreach</li> <li>- Other</li> </ul> </li> <li>• N/A: Other means of re-engagement not listed above were successful or not applicable to the client.</li> </ul>
Other, please list other identified outreach efforts in the box below	List other identified outreach efforts.
<b>IX. National Outcome Measures (NOMs)</b>	
A. Status at Intake	<ul style="list-style-type: none"> <li>• Yes: For each NOM, client's status at intake.                             <ul style="list-style-type: none"> <li>- Employed?</li> <li>- Enrolled in school or vocational educational program?</li> <li>- Lived in a stable housing environment (e.g., not homeless)?</li> <li>- Arrested in the preceding 30 days?</li> <li>- Abstinent from drugs and/or alcohol?</li> <li>- Participated in social support recovery in the preceding 30 days?</li> </ul> </li> <li>• Missing: No documentation of the NOM at intake</li> </ul>
B. Status at Discharge	<ul style="list-style-type: none"> <li>• Yes: For each NOM, client's status at discharge.                             <ul style="list-style-type: none"> <li>- Employed?</li> <li>- Enrolled in school or vocational educational program?</li> <li>- Lived in a stable housing environment (e.g., not homeless)?</li> <li>- Arrested in the preceding 30 days?</li> <li>- Abstinent from drugs and/or alcohol?</li> <li>- Participated in social support recovery in the preceding 30 days?</li> </ul> </li> <li>• Missing: No documentation of the NOM at discharge.</li> </ul>

## Appendix C

# Case File Electronic Review Tool

Reviewers used an Access review tool pre-populated with relevant chart data. Below are sample screen shots of the tool.



2021 AZ SABG C2021 AZ SABG CMR review tool for screen shots - Database- C:\Users\Jeanie-Aspiras\Desktop\AZ SABG Tool and analysis\2021...

File Home Create External Data Database Tools Tell me what you want to do... Aspiras, Jeanie

frmSplash tblReviewDetails

### Chart review collection tool

Choose chart to be reviewed:

Reviewer  Date  RBHA  Provider

DOB  Age  Gender  Intake Date  Closure Date  Sample Period

Reason for closure  Closure from file  SUD  Chart status

5. Gender Specific 6. Opioid Specific 7. Discharge/Cont Care Planning 8. Re-engagement 9. NOMs 10. Comments

1. Intake/Treatment Planning 2. Plcmt Criteria/Assessment 3. Best Practices 4. Treatment/Support Svcs/Rehab

**Intake/Treatment Planning**

A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?

**Did the behavioral health assessment:**

Address substance-related disorder(s)?

Describe the intensity/frequency of substance use?

Include the effect of substance use on daily functioning?

Include the effect of substance use on interpersonal relationships?

Was a risk assessment completed?

Document screening for tuberculosis (TB)?

Document screening for Hepatitis C, HIV and other infectious diseases?

Document screening for emotional and/or physical abuse/trauma issues

Documentation that review of the Prescription Drug Monitoring Program (PDMP) was completed?

B. Was there documentation that charitable choice requirements were followed, if applicable?

C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?

**Was the ISP:**

Developed with participation of the family/support network?

Congruent with the diagnosis(es) and presenting concern(s)?

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# Environmental Factors and Plan

## 11. Quality Improvement Plan- Requested

### Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

### Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2020-FFY 2021?  Yes  No

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

### Footnotes:



# Quality Strategy

## *Draft*

**July 1, 2021**



# AHCCCS Quality Strategy

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# AHCCCS Quality Strategy

## Executive Summary

In accordance with Code of Federal Regulations (CFR) 42 CFR 438.340 et. seq., the Arizona Health Care Cost Containment System (AHCCCS) Quality Strategy was first established in 2003. It has since been revised, as appropriate, to reflect innovative approaches to member care and continuous quality improvement efforts. AHCCCS' Quality Strategy is a coordinated, comprehensive, and proactive approach to drive improved health outcomes by utilizing creative initiatives, ongoing assessment and monitoring, and results-based performance improvement. It is designed to ensure that services provided to members meet or exceed established standards for access to care, quality of care, and service delivery. In addition, the Quality Strategy supports the identification and documentation of issues related to those standards.

The agency's Quality Strategy has shifted emphasis from process measurements to more comprehensive outcome-based measurements and innovative delivery system design. The Quality Strategy provides a framework for improving and/or maintaining members' health status as well as fostering the increased resilience and functional health status of members with chronic conditions. Members, the public, and stakeholders provide input and recommendations regarding the content and direction of the Quality Strategy through stakeholder presentations and public comments.

Through internal and external collaborations with partners, the agency is able to develop and implement key initiatives and address identified issues. AHCCCS has established the following Quality Strategy goals and objectives applicable to Arizona's managed care program (inclusive of Medicaid and CHIP members):

**Quality Goal 1:** Improve the member's experience of care, including quality and satisfaction.

### Objectives:

- Enrich the member experience through an integrated approach to service delivery,
- Improve information retrieval and reporting capability by establishing new, and upgrading existing, information technologies, thereby increasing responsiveness and productivity,
- Enhance current performance measures, PIPs, and best practice activities by creating a comprehensive quality of care assessment and improvement plan across AHCCCS programs, and
- Drive the improvement of member-centered outcomes using nationally recognized protocols, standards of care, and benchmarks, as well as the practice of collaborating with MCOs to reward providers based on clinical best practices and outcomes (as funding allows).

**Quality Goal 2:** Improve the health of AHCCCS populations.

### Objectives:

- Increase member access to integrated care that meets the member's individual needs within their local community,
- Support innovative reimbursement models, such as Alternative Payment Models (APMs), while promoting increased quality of care and services, and
- Build upon prevention and health maintenance efforts through targeted medical management:
  - o Emphasizing disease and chronic care management,
  - o Improving functionality in activities of daily living,
  - o Planning patient care for special needs populations,

## AHCCCS Quality Strategy

- o Identifying and sharing best practices, and
- o Expanding provider development of Centers of Excellence (COEs).

### Quality Goal 3: Reduce the growth in healthcare costs and lower costs per person.

#### Objectives:

- Increase analytical capacity to make more informed clinical and policy making decisions, and
- Develop collaborative strategies and initiatives with state agencies and other external partners, such as:
  - o Strategic partnerships to improve access to health care services and affordable health care coverage,
  - o Partnerships with sister government agencies, MCOs, and providers to educate Arizonans on health issues,
  - o Effective medical management for at-risk and vulnerable populations, and
  - o Building capacity in rural and underserved areas to address both professional and paraprofessional shortages.

### Quality Goal 4: Enhance data system and performance measure reporting capabilities.

#### Objectives:

- Evaluate current data system infrastructure,
- Identify system and process limitations impacting performance measure reporting and analysis,
- Leverage various data sources to produce comprehensive reliable data,
  - o Collaborate with external stakeholders to facilitate access to supplemental data sources, and
  - o Explore means for collecting and reporting performance measure data utilizing electronic health record (EHR) methodologies, and
- Drive continuous delivery system performance through advanced data analytics and disparity analyses.

A comprehensive and thoughtful Quality Strategy is a key priority for AHCCCS. AHCCCS continues to collaborate with stakeholders to optimize both the experience and health outcomes of Arizonans accessing Medicaid managed care.

# AHCCCS Quality Strategy

## 1. AHCCCS Overview

As a delivery system that serves more than 2.2 million Arizonans with a budget of more than \$18.3 billion, it is critical that AHCCCS pursue a broad array of strategies that are focused on creating a sustainable program while maintaining its member-centered focus. AHCCCS has established the following to demonstrate its commitment to serving members and providing high quality care and services:

**Agency Vision:** Shaping tomorrow's managed care... from today's experience, quality, and innovation.

**Agency Mission:** Reaching across Arizona to provide comprehensive, quality health care for those in need.

**Agency Values:** Passion, Community, Quality, Respect, Accountability, Innovation, Teamwork, Leadership, and Courage.

**Agency Credo:** Our first care is your health care.

### 1.1 AHCCCS Strategic Plan Goals

The AHCCCS Strategic Plan identifies four multi-year strategies. These are:

**Strategic Goal 1:** Pursue and implement long-term strategies that bend the cost curve while improving member health outcomes.

**Strategic Goal 2:** Pursue continuous quality improvement.

**Strategic Goal 3:** Reduce fragmentation driving toward an integrated sustainable healthcare system.

**Strategic Goal 4:** Maintain core organizational capacity, infrastructure, and workforce planning that effectively serve AHCCCS operations.

### 1.2 Background

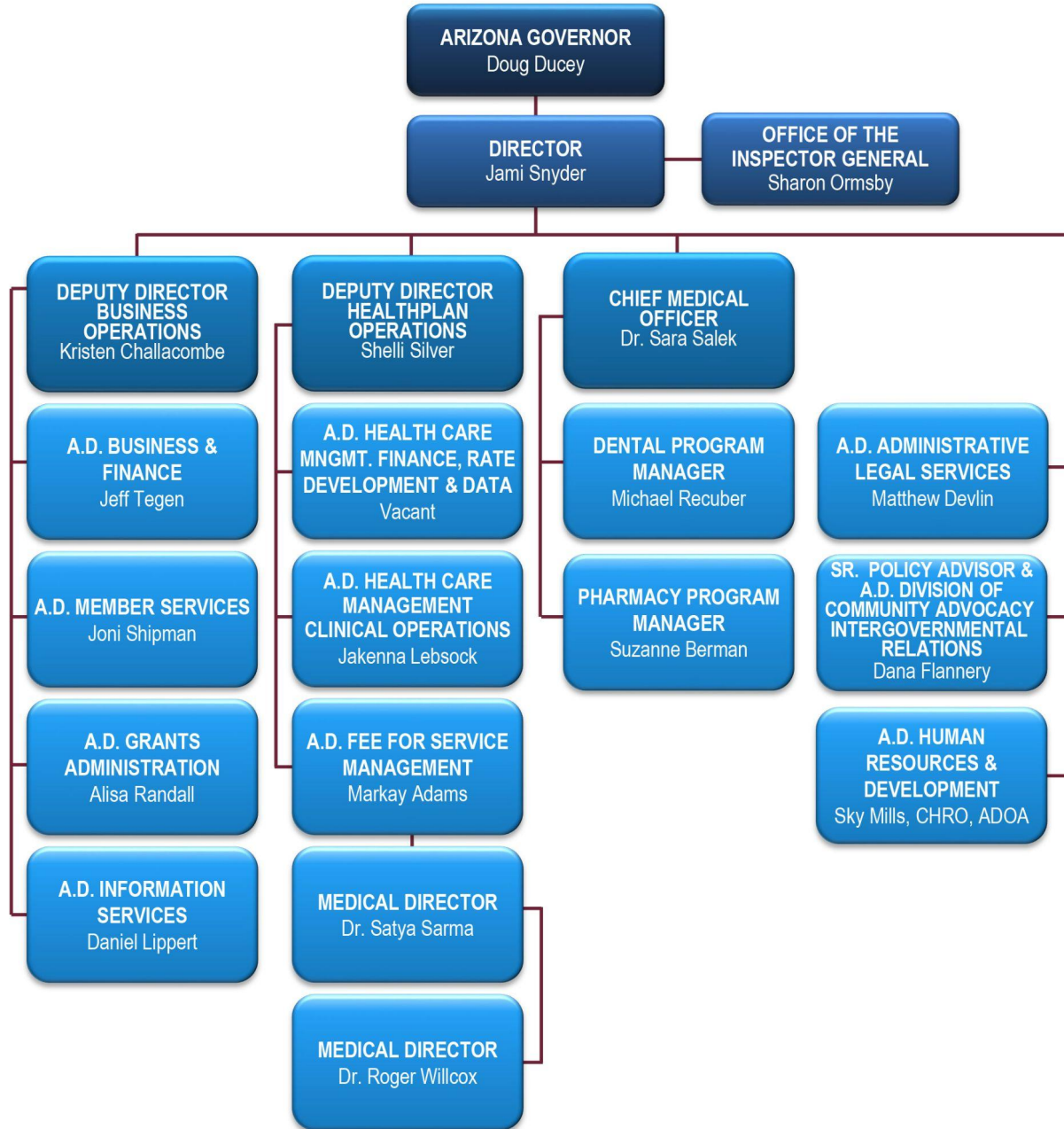
Since 1982, AHCCCS has been delivering high-quality, cost-effective health care services to Arizonans. The State of Arizona has the unique distinction of being the first state in the country to operate under a statewide managed care 1115 Waiver, and the only state to have done so from the start of its Medicaid program. This public-private partnership ensures that members receive high-quality care and that the agency maximizes efficiency and contains costs. In 1988, the 1115 Waiver was amended to add the Arizona Long Term Care System (ALTCSS) program, a fully integrated, managed care health plan for physical and behavioral health services, Long-Term Services and Supports (LTSS), serving individuals with intellectual and/or developmental disabilities, as well as those who are elderly and/or have a physical disability. AHCCCS believes that this health care delivery system design is essential to providing quality care that improves members' health outcomes while eliminating barriers to care and containing costs. By integrating physical and behavioral health services under a single MCO, AHCCCS is better able to address the whole health needs of the state's Medicaid population, reduce fragmentation within the system, and simultaneously improve service delivery to members. On October 1, 2018, AHCCCS fully integrated physical and behavioral health managed care contracts for 1.5 million managed care members. AHCCCS promotes integration at the provider level as well, supporting efforts to deliver integrated services through primary care, integrated clinics, health homes, and other models, and using innovative reimbursement models to improve health outcomes.

### 1.3 AHCCCS Organizational Overview

The AHCCCS organizational structure is designed to effectively implement and oversee various programs that serve its members. The executive management team, and specifically the Chief Medical Officer

## AHCCCS Quality Strategy

(CMO), oversees the Division of Health Care Management’s (DHCM) implementation of the Quality Strategy, as outlined in the agency administration and management organizational chart below.



- Director and the Executive Management Team: the director of AHCCCS has overall responsibility for ensuring that the agency meets the established goals of its Strategic Plan and maintains the administrative infrastructure to meet its needs. The director leads the executive management team (the deputy directors, CMO, and senior policy advisor) and the leadership team (agency assistant directors) to manage the business, develop and implement administrative policies and procedures, and support the delivery of quality health care services to more than 2 million Medicaid members.

## AHCCCS Quality Strategy

- Chief Medical Officer: the CMO is a key position within AHCCCS, working collaboratively across divisions to provide oversight and guidance of the quality and delivery of health care services as well as to develop and approve medical policy.
- Division of Health Care Management: the DHCM is responsible for developing policy, procuring MCO contracts, and overseeing and monitoring MCOs. All units within the DHCM play a role in development of and adherence to the agency's Quality Strategy. Key units include Clinical, Contract & Policy Unit, Finance & Reinsurance, Operations, and AHCCCS Office of Data Analytics.

### 1.4 Investigations - QM/OIG Relationship

The AHCCCS Office of Inspector General (OIG) coordinates with the DHCM on different aspects of the quality strategy. Any potential quality of care issues are forwarded from the OIG to the DHCM, Quality Management (QM) unit for its review. The OIG also receives referrals for any matters that QM identifies, which may indicate fraud, waste, or abuse. The OIG coordinates with the DHCM for any areas of concern, operational reviews (ORs) of the MCO for program integrity requirements, and MCO compliance with technical assistance.

Once the OIG notifies the QM unit of the need to suspend and/or terminate a provider, the QM unit contacts each MCO to identify how many members are assigned and/or receiving services from the provider. MCOs are also queried regarding network capacity to transition members to an appropriate provider that can meet their needs as well as the anticipated time frames for safe member transition. AHCCCS QM tracks all MCO notifications and member transitions; the OIG and QM provide bi-directional updates throughout the process. The OIG also coordinates the same questions and processes through the Division of Fee-for-Service Management (DFSM) for populations not served by the MCOs.

### 1.5 Populations Served

#### *a. AHCCCS Complete Care (ACC)*

The ACC program provides physical and behavioral health care services to Arizona residents who are eligible, based on the Federal Poverty Level (FPL) categories. To qualify, children and/or adults must:

- Be a citizen or qualified immigrant,
- Have a social security number or apply for one, and
- Apply for all cash benefits that one may be entitled to, such as pensions or Veteran Assistance benefits.

#### *b. CHIP (KidsCare)*

To qualify, an individual must:

- Be under 19 years of age,
- Live in a household with an income under 200 percent of the FPL,
- Be a citizen or qualified immigrant, and
- Have a social security number or apply for one.

#### *c. Arizona Long Term Care System (ALTCS)*

ALTCS provides long-term care services and supports to financially and medically eligible Arizona residents who are elderly, blind, have a disability, or those who have an intellectual/developmental disability. Financial eligibility compares the individual's income to 300% of the Federal Benefit Rate (FBR) and involves a resources test. To qualify for ALTCS, in addition to meeting financial and medical eligibility criteria, the individual must:

## AHCCCS Quality Strategy

- Be in need of a nursing home level of care as determined by AHCCCS,
- Be a citizen or qualified immigrant,
- Have a social security number or apply for one,
- Be a resident of Arizona and apply for all cash benefits that one may be entitled to, such as pensions or Veteran Assistance benefits, and
- Live in an approved setting, such as one's own home, an AHCCCS certified nursing facility, or assisted living facility.

### *d. AHCCCS Fee-for-Service (FFS)*

While the vast majority of the AHCCCS populations are managed under a MCO, approximately 12 percent of AHCCCS membership is under FFS management. The DFSM is responsible for the clinical, administrative, and claims functions of the FFS population of more than 275,000 members. This includes American Indians enrolled in the American Indian Health Program (AIHP) for integrated acute physical and behavioral health services, members enrolled with the Tribal Regional Behavioral Health Authorities (TRBHAs) for behavioral health care coordination services, members enrolled with the Tribal Long Term Care programs (Tribal ALTCS), and individuals in the Federal Emergency Service (FES) program.

#### **AHCCCS American Indian Health Program (AIHP)**

AIHP is a FFS program that provides medically necessary physical and behavioral health services. Enrolled members may receive health care services from IHS/638 health programs and Urban Indian health clinics and from other AHCCCS-registered providers. Members are not limited to a network and may switch their enrollment between the AIHP and an MCO at any time; however, a member can change from one MCO to another only once a year. AIHP members must meet the same eligibility requirements in either sections a or b as outlined above.

#### **Tribal ALTCS**

Tribal ALTCS is a FFS program that provides medically necessary physical health, behavioral health, and long term care services. An AI/AN member will be enrolled with a Tribal ALTCS Program if he/she lives on or lived on a reservation prior to admission into an off-reservation facility. Enrolled AI/AN members may receive health care services from IHS/638 health programs and Urban Indian health clinics and from other AHCCCS-registered providers. Members must meet the same eligibility requirements as outlined in section c above.

#### **Federal Emergency Services (FES)**

AHCCCS provides emergency health care services through the FES program for qualified and nonqualified individuals, as specified in 8 USC 1611 et seq. who meet all requirements for Title XIX eligibility as specified in the State Plan except for citizenship. All services for FES must undergo medical review conducted by DFSM.

The DFSM contracts with a Pharmacy Benefits Manager (PBM) for its FFS programs. In April 2019, Indian Health Service (IHS) and Tribal 638 (IHS/638) pharmacies began submitting their claims through the PBM, which provides AHCCCS with more data on American Indian/Alaska Native (AI/AN) members filling a prescription with an IHS/638 facility, including both FFS and MCO enrolled AI/ANs. AHCCCS is also able to implement point of sale safety edits, as well as perform concurrent and retrospective utilization review, to assist in ensuring coordination of care and best practices in prescribing for FFS members and comply with the opioid drug utilization review provisions.

# AHCCCS Quality Strategy

## 2. Population Management

Population management looks at the structures and processes in place to enhance clinical health outcomes through improved care coordination and member engagement. As part of the agency's population management efforts, the agency has implemented the following:

### 2.1 State Procedures for Identifying Race, Ethnicity, and Primary Language of Each Member

AHCCCS receives member race, ethnicity, and primary language information through the eligibility screening process, which collects such information at the time of application. This information, along with other demographics, is systematically updated on the AHCCCS member record file and transmitted daily to the MCO on the member enrollment roster. Changes to this information are also updated and transmitted to the MCO. MCOs are responsible for providing any updated information to AHCCCS that differs from the initial documentation provided for each member. AHCCCS updates the member information, as appropriate. Member information is included on the data exchange file received from the Social Security Administration. If any information is missing, the system will default to unknown or unspecified. If the member does not provide or does not wish to provide this information, the member will be designated as unknown/unspecified.

Currently, there are codes for 40 languages that can be captured electronically. AHCCCS periodically assesses the language data to determine any need to expand possible language categories. In addition, AHCCCS evaluates prevalent languages for the AHCCCS populations at the state and MCO levels.

### 2.2 Disability Status

AHCCCS utilizes its Medicaid Management Information System records of eligibility to identify disability status. Individuals defined by the state as having a disability include the following:

- A person who has been determined to have a qualifying disability by the Social Security Administration or the Department of Economic Security (DES), Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E),
- A person who has been determined to meet the criteria for blindness by the Social Security Administration or the DES, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(2),
- A person who is determined by an authorized entity contracted with AHCCCS to have a serious mental illness (SMI) as defined in Arizona Revised Statutes (A.R.S.) § 36-501,
- A person who at the time of a regularly scheduled continuing disability review is determined by the DES, Disability Determination Services Administration to no longer have a qualifying disability, but continues to have a severe medically determinable impairment, as determined under Social Security Act section 42 U.S.C. 1396a(a)(10)(A)(ii)(XVI),
- A person who is determined eligible for services by the DES Division of Developmental Disabilities (DDD) and determined by AHCCCS through a Pre-Admission Screening assessment to be at immediate risk of institutionalization in either a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), and
- A person who is determined by AHCCCS through a Pre-Admission Screening assessment to be at immediate risk of institutionalization in either a nursing facility or an ICF/IID.



# AHCCCS Quality Strategy

## 2.3 Health Equity

AHCCCS seeks to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status.

### *a. AHCCCS Health Equity Committee*

Formally established in July 2020, the [Health Equity Committee](#) is tasked with understanding health disparities and developing strategies to ensure health equity for all AHCCCS members. The committee is responsible for overseeing and managing health equity considerations as they relate to policy, data, MCO oversight, and emerging health care innovation strategies for over 2 million Arizonans.

[Healthy People 2030](#) defines health equity as the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”

This committee is responsible for identifying health disparities among AHCCCS-eligible individuals and members by using AHCCCS utilization and quality improvement data to advance policy and/or contracting strategies to improve the health equity of AHCCCS’ populations and programs. This committee will communicate existing health equity strategies currently being implemented by the agency, identify needed improvements to existing strategies (if appropriate), develop and/or evaluate key metrics, and articulate future interventions aimed at eliminating health disparities.

### *b. Health Disparity Summary & Evaluation Report*

Beginning CYE 2021, MCOs shall be required to annually submit a Health Disparity Summary & Evaluation Report intended to provide:

- An analysis of the effectiveness of implemented strategies and interventions in meeting health equity goals and objectives during the previous calendar year,
- A detailed overview of the MCO’s identified health equity goals/objectives for the upcoming calendar year, and
- Targeted strategies/interventions planned for the upcoming calendar year to achieve health equity goals.

## 2.4 Transition of Care

AHCCCS has a Member Transition policy that applies to all AHCCCS MCOs and FFS programs. The policy provides detailed requirements to ensure that member access to services remains consistent throughout the transition process. Requirements for member transitions are identified for the following:

- Transitions between MCOs and FFS programs and FFS members,
- Transitions between ALTCS and non-ALTCS MCOs [ACC, Regional Behavioral Health Authorities (RBHA)],
- Transitions between ALTCS Elderly and Physical Disabilities (ALTCS EPD) and ALTCS Developmental Disabilities (ALTCS DD),
- Transitions across Geographic Service Areas (GSAs), and
- Transition age youth to adult delivery systems.

Contractors are required to have policies and procedures to address transitions for members with special circumstances including, but not limited to:

## AHCCCS Quality Strategy

- Pregnancy,
- Major organ or tissue transplantation services that are in process,
- Chronic illness, for members in a high-risk category, currently hospitalized or place in nursing or other facilities,
- Significant medical or behavioral health conditions,
- Chemo or radiation therapy,
- Dialysis,
- Members with ongoing needs (e.g., ventilator, pain management, durable medical equipment, and prescriptions),
- Human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), and
- Members with an SMI designation.

MCOs are required to ensure that care is coordinated between MCOs as well as between the providers that are involved in member care. MCOs and providers are expected to provide appropriate notifications of enrollment changes via a standardized Enrollment Transition Information (ETI) form which includes information, such as pending authorizations, for services or medications, outpatient treatment, and disposition of medical equipment and supplies. AHCCCS provides an Electronic Transfer for capturing key pieces of information for the transition process. AHCCCS also shares Medicaid claims data from IHS and Tribal facilities for AI/AN members enrolled with the health plans and requires that each health plan employ a Tribal Liaison in order to work through any continuity of care issues that may arise.

### 2.5 AHCCCS Initiatives and Best Practices

AHCCCS has deemed several initiatives as best practices for populations served. These efforts show a committed focus to stakeholder engagement, system accountability, and reducing service fragmentation with the ultimate goal of improving member experiences and health outcomes. AHCCCS highlights current ongoing initiatives on the [AHCCCS Initiatives and Best Practices](#) web page that includes links to more detailed information.

### 2.6 Integrated Health Care

One of the primary strategic goals of AHCCCS is to reduce system fragmentation and develop systems of care that are easy for members to navigate.

#### *a. AHCCCS Complete Care*

The ACC program was implemented October 1, 2018 to ensure that MCOs deliver integrated physical and behavioral health services to address whole health needs of AHCCCS members and improve member experience. The MCOs are expected to continuously add value to the program by exhibiting recognition of the following:

- The importance of an integrated delivery system for physical and behavioral health services,
- The critical importance of care coordination through organizational design and operational processes,
- Medicaid members entitled to care and assistance in navigating the service delivery system,
- Health care providers as an essential partner in the delivery of physical and behavioral health care services,

## AHCCCS Quality Strategy

- Performance improvement is both clinical and operational in nature,
- The program is publicly funded and is subject to public scrutiny, and
- The importance of the system values and guiding principles.

In addition, MCOs are expected to continuously add value to the program by implementing the following:

- Focused strategies and approaches to ensure coordinated service delivery to members,
- Organizational design and operational processes that demonstrate the critical importance of care coordination,
- Special efforts throughout their operations to assure members receive necessary services,
- Care coordination to Medicaid members with special health care needs (SHCN) or chronic health conditions requiring care coordination,
- Operation of the health plans in a manner that is efficient and effective for health care providers as well as the MCO,
- Self-monitoring and self-correcting as necessary to improve contract compliance and/or operational excellence, and
- Operating in a manner that promotes cost containment and efficiency.

### *b. ALTCS*

Since its inception in 1989, the ALTCS EPD program has been a fully integrated product. EPD members receive all services through their MCOs, and many are aligned to receive their Medicare benefits through the MCO's D-SNP plan, which allows for enhanced care coordination. Beginning October 2020, the ALTCS MCO for individuals with intellectual and developmental disabilities created a partially integrated health program by sub-contracting with health plans to provide physical and behavioral health services, Children's Rehabilitation Services (CRS), and limited LTSS while maintaining the responsibility for the provision of the majority of LTSS, including case management support coordination. In serving ALTCS members, the case managers shall promote the values of dignity, independence, individuality, privacy, choice and self-determination, and adhere to the following guiding principles:

- Member-centered case management,
- Member directed options,
- Person-centered planning,
- Consistency of services,
- Accessibility of network,
- Most integrated setting, and
- Collaboration with stakeholders.

### *c. Members Living with an SMI*

Members enrolled in managed care that are not eligible for the ALTCS program and have an SMI designation receive all their acute care and behavioral health services through a RBHA. Members with an SMI designation who reside in Maricopa County (central region) began receiving integrated care on April

## AHCCCS Quality Strategy

1, 2014. Integration efforts expanded to northern and southern regions on October 1, 2015, transitioning members with an SMI designation into an integrated delivery system.

### *d. Medicare and Medicaid Dually Eligible Members*

As of October 1, 2015, dually eligible members (individuals eligible for both Medicaid and Medicare) enrolled in managed care but not eligible for the ALTCS program began receiving behavioral health services from their enrolled Acute Care MCO. In addition to integration of Medicaid services, AHCCCS promoted extensive alignment efforts between Medicaid and Medicare. As of November 2020, approximately 47 percent of full benefit dually enrolled members are in aligned plans.

### *e. American Indian Medical Home (AIMH)*

Arizona is home to over 350,000 AI/AN individuals, approximately half of whom are enrolled in AHCCCS. Significant health disparities exist for the AI/AN population. For instance, the average age of death for American Indians is 17.5 years lower than the general population, and American Indians experience higher death rates from preventable diseases. Whereas the American Indian population accounts for less than 2 percent of the national population and 4 percent of the Arizona population, it accounts for approximately 10 percent of the AHCCCS population. Recognizing its unique role in addressing the health needs of Arizona's AI/AN population, AHCCCS launched a relatively new effort to improve the health outcomes of tribal members by identifying critical population needs and collaborating with tribes, tribal health partners, community organizations, and state and federal agencies to enhance care coordination.

To that end, CMS approved Arizona's State Plan Amendment for the American Indian Medical Home (AIMH) program for the AI/AN members enrolled in the AIHP. The AIMH program supports Primary Care Case Management (PCCM), diabetes education, and care coordination for the AIHP enrolled members. The AIMHs help address health disparities between American Indians and other populations in Arizona by enhancing case management and care coordination. IHS/638 facilities that choose to become an AIMH must obtain Primary Care Medical Home (PCMH) status through an appropriate accreditation body or provide an annual attestation of its participation in the IHS Improving Patient Care (IPC) model, in addition to providing 24-hour telephonic access to the care team. The AIMH PCCM program is a voluntary program. AIHP enrolled members can select an AIMH site by accessing a participating AIMH provider or by contacting AHCCCS Member Services, where they will be enrolled through the AHCCCS online portal. The AIMH Member Sign-Up forms are available at AIMH sites and on the AHCCCS website and are processed by AHCCCS on a monthly basis. The AIMH member sign-up form identifies benefits of the program, the right to disenroll or select a different AIMH provider at any time, and any other information required by federal and state regulations including 42 CFR 438.54(c)(3). As of May 2021, approximately 25% of AIHP members are empaneled in an AIMH.

### *e. Targeted Investments (TI) Program*

The Targeted Investments (TI) Program is AHCCCS' strategy to provide financial incentives to eligible AHCCCS providers to develop systems for integrated care. In accordance with 42 CFR 438.6(c) and the 1115 Waiver, managed care plans will provide financial incentives to eligible Medicaid providers who meet certain benchmarks for integrating and coordinating physical and behavioral health care for Medicaid beneficiaries. The TI Program aims to:

- Reduce fragmentation between acute and behavioral health care,
- Increase efficiencies in service delivery for members with behavioral health needs by improving integration at the provider level, and
- Improve health outcomes for members with physical health and behavioral health needs.

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## 2.7 Long Term Care Supports and Services

### *a. Long Term Care Case Management*

Each member enrolled in ALTCS receives case management services provided by a qualified case manager. ALTCS case managers utilize a person-centered approach and maximize member/family self-determination while promoting the values of dignity, independence, individuality, privacy, and choice. Case managers conduct regular on-site, face-to-face visits with members to:

- Ensure quality services are provided without gaps,
- Determine the services necessary to meet the member’s needs,
- Provide member specific education to the member and their family, and
- Introduce alternative models of care delivery, when appropriate.

The person-centered planning meetings conducted by the case managers are intended to result in a mutually agreed upon, appropriate, and cost-effective individualized, person-centered service plan that meets the medical, functional, social, and behavioral health needs of the member in the most integrated and least restrictive setting. The following are examples of how case managers execute the roles and responsibilities included above:

- **Member-Directed Options Information:** case managers regularly inform members about member-directed options and assist members and their families to make informed decisions about the service delivery model of care.
- **Cost Effectiveness Analysis:** case managers assess the continued suitability, appropriateness, and cost effectiveness of the member’s in-home services. Home and community based services placement is the goal for ALTCS members, as long as cost effectiveness standards and the member’s medical, functional, social, and behavioral health needs can be met in that setting. The case manager regularly assesses the cost of the home and community based services and compares them to the estimated cost of institutionalized care. Home and community based services placement is considered cost-effective if the cost of home and community based services for a member does not exceed 100 percent of the net cost of institutional care.
- **Non-Medicaid Service Coordination:** case managers identify and integrate non-ALTCS covered community resources/services as appropriate, based on the member’s needs. Case managers are also responsible for assisting members to identify independent living/personal goals while providing them with local resources that may help transition members towards greater self-sufficiency in the areas of housing, education, employment, recreation, and socialization.
- **End of Life (EOL) Care:** case managers are required to educate members/family on EOL care which encompasses all health care and support services provided at any age or stage of an illness. EOL care goals focus on comfort and quality of life. Services include advance care planning, palliative care, supportive care, and hospice.
- **Person-Centered Service Planning (PCSP):** in an effort to enhance the person-centered approach and further maximize member/family self-determination, AHCCCS initiated a process to:
  - o Create alignment of practices, forms, and monitoring of PCSP approach and personal goal development,
  - o Support members to have the information and supports to maximize member-direction and determination, and

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- o Develop processes to document health and safety risks, and safeguard against unjustified restrictions of member rights, in accordance with the Home and Community Based Settings Rules (HCBS Rules).

### *b. Home and Community Based Services*

AHCCCS has maintained a consistent trend of home and community based services member placements (considering increases in population) either plateauing or increasing yearly. Specifically, over a decade ago (2009) the proportion of members residing in their own homes was as low as 49 percent and has currently grown to 72 percent, while the proportion of the members residing in institutions declined from 31 percent (2009) to the current 9 percent. The proportion of members residing in alternative residential settings remains stable at 19 percent. These placement rates are largely attributable to the service options and HCBS Rules activities available which demonstrates the program's commitment to advancing initiatives which result in the shift of placement for members to community-based placements.

The HCBS Rules afford Arizona the opportunity to reinforce the priority of serving members in the least restrictive setting while formalizing a new priority to ensure members are actively engaged and participating in their communities. On January 16, 2014, CMS released final rules regarding requirements for HCBS operated under section 1915 of the Social Security Act. The rules mandate certain requirements for residential and non-residential settings where Medicaid members receive long-term care services and supports. Specifically, the rules establish requirements for settings to ensure that individuals receiving services are integrated into their communities and have full access to the benefits of community living. In Arizona, these requirements impact ALTCS program members receiving services in the following residential and non-residential settings:

#### Residential

- Assisted Living Facilities,
- Group Homes,
- Adult and Child Development Homes, and
- Behavioral Health Residential Facilities.

#### Non-Residential

- Adult Day Health Programs,
- Day Treatment and Training Programs,
- Center-Based Employment Programs, and
- Group-Supported Employment Programs.

Between November 2014 and May 2015, AHCCCS conducted a systemic assessment of Arizona's HCBS to determine current level of compliance, provide recommendations for identified variances, and outline a process for continuous monitoring. The systemic assessment process included a review of A.R.S., Arizona Administrative Code (A.A.C.) (licensing rules), and AHCCCS and MCO policies and contracts.

AHCCCS engaged various stakeholders in the assessment process and in the development of the transition plan. The purpose of these meetings was to dialogue with, and solicit input from, stakeholders regarding the preliminary assessment findings and draft recommendations to ensure compliance with the HCBS Rules. AHCCCS revised the Assessment and Transition Plan based upon the input received. The meetings also served as an orientation for stakeholders and a strategy to support stakeholders in

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providing informed public comment during August 2015. Following the stakeholder meetings, AHCCCS enacted an official public comment period from August 1, 2015 through August 31, 2015, which included eight public forums hosted by AHCCCS throughout the state. AHCCCS published the draft Systemic Assessment of Arizona's HCBS and the draft Transition Plan for bringing the settings into compliance. After review and consideration of all public comments, AHCCCS finalized the Assessment and Transition Plan and submitted it to CMS for approval in October 2015. The final Transition Plan is available on the AHCCCS [Home and Community Based Settings Rules](#) web page.

The Transition Plan outlines strategies the state will use to make sure all HCBS settings come into compliance by March 2022. AHCCCS engaged in multiple meetings and/or correspondence with CMS, pertaining to the Transition Plan, for the period of September 2017 through February 2019. The updated Transition Plan posted on the AHCCCS website contains revisions to the Transition Plan made in response to CMS feedback during that period. In February 2019, CMS confirmed the current revisions to the Transition Plan to-date are satisfactory. CMS will not officially approve Arizona's Systemic Assessment and Transition Plan until after the first round of site-specific assessments have been completed, a public comment period is held, and the State's reports to CMS are satisfactory. In March 2019 through May 2019, AHCCCS held a public comment period including stakeholder forums, statewide, to provide information on updates made to the Transition Plan and solicit comments that will be used to help inform the implementation of the Transition Plan.

AHCCCS is currently working in partnership with the MCOs, the provider community, and CMS to modify the quality monitoring tools and process that accommodates COVID-19 mitigation strategies while also ensuring the integrity of the HCBS Rules. Consistent with AHCCCS' ongoing efforts to be transparent and accountable to the general public during the implementation of the Assessment and Transition Plan, AHCCCS will post reports on the [Home and Community Based Settings Rules](#) web page to delineate progress with quarterly and annualized milestones. AHCCCS will continue to solicit, receive, and incorporate public input regarding progress made on the Transition Plan implementation.

With respect to individual member experiences, the case manager will play a critical role in assessing and addressing barriers to members accessing community living benefits. The Person-Centered Service Plan has been modified to support the case manager in ascertaining the member experience and feedback regarding provider compliance with the HCBS Rules requirements. MCOs shall also assess the member experience through member interviews conducted as a part of annual quality and contract monitoring of the settings noted above.

### *c. Electronic Visit Verification (EVV)*

Pursuant to Section 1903 of the Social Security Act (42 U.S.C. 1396b), AHCCCS is mandated to implement Electronic Visit Verification (EVV) for non-skilled in-home services (attendant care, personal care, homemaker, habilitation, respite), and for in-home skilled nursing services (home health) by January 1, 2023. The EVV system must, at a minimum, electronically verify the:

- Type of service performed,
- Individual receiving the service,
- Date of the service,
- Location of service delivery,
- Individual providing the service, and
- Time the service begins and ends.

AHCCCS' goals for instituting EVV include:

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- Helping to make sure that members get the services they need, when they need them, through the use of scheduling, contingency planning, and reporting,
- Supporting provider business choices and reducing administrative burden associated, and
- Preventing, detecting, and recovering improper payments due to fraud, waste, and abuse.

AHCCCS is employing a number of strategies/activities to ensure the EVV system meets both federally mandated and AHCCCS requirements. In order to make an informed decision on the EVV system requirements, AHCCCS engaged in a number of stakeholder engagement and public comment activities, including the formation of a multi-disciplinary steering committee composed of internal and external parties (members, providers, MCOs, etc.). Additionally, AHCCCS has engaged stakeholders to provide public comment. In-person forums were facilitated for members and their families, while providers simultaneously had an opportunity to submit public comments through a Request for Information process. AHCCCS implemented EVV on January 1, 2021 (for both personal care and home health services) with the state-wide EVV vendor and data aggregator through Sandata Technologies. AHCCCS continues to meet with several provider cohorts and MCOs to discuss operational issues and will continue to meet to analyze the data and create performance measures to evaluate and incentivize provider compliance.

### 2.8 Centers of Excellence

Starting October 1, 2015, AHCCCS required all contracted MCOs to develop approaches for identifying and contracting with COEs. The Centers are facilities that are recognized as providing the highest levels of leadership, quality, and service. They align physicians and other providers to achieve higher value through greater focus on appropriateness of care, clinical excellence, and patient satisfaction. Designation as a COE is based on criteria, such as procedure volumes, clinical outcomes, treatment planning, and coordination. Each MCO was required to submit a report identifying why it selected a procedure or condition, how it identified and selected providers to address them, how the MCO shall drive utilization to the providers, and any barriers or challenges in the development of the COE.

MCOs employed a variety of approaches in developing and maintaining their COEs. All seven ACC plans formed a COE Collaborative Workgroup to establish a set of standardized criteria for COE statewide with the intent of avoiding provider abrasion in responding to seven different sets of criteria for each of the COE to be developed/established. As a result, the workgroup criteria were developed for the following COE: autism spectrum disorder (ASD), integrated pain management, substance use, adolescents, and transition aged youth. The workgroup will next work to complete the COE for members aged birth to five years.

Once an MCO has designated a provider a COE, the MCO takes steps to ensure the COE maintains quality standards. For example, one MCO identified a variety of COEs with diverse specializations offering services such as ASD, peer and family support, and sleep disorders. While the MCO originally planned to implement standardized criteria and reporting across its COE network, it determined it needed to develop specialized metrics for each COE type. After implementing these metrics, the MCO is currently meeting quarterly with each COE to review performance concerns, and annually makes decisions about the COE designation.

Another MCO incorporates monitoring through incorporating COEs into its Value-Based Purchasing (VBP) arrangements. COEs sign a Value-Based contract, which allows the MCO's Value-Based department to monitor the COEs, along with all other Value-Based contracts on a monthly or quarterly basis. Quality and utilization metrics outlined in the contract are measured in graphical format and reviewed with the COE at monthly/quarterly Joint Operating Committee (JOC) meetings. COE performance is reviewed and areas for improvement are discussed in order to meet minimum performance standards. Depending on



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the nature of the service, providers receive some or all of the following reporting: Quality performance trend graphs, daily discharges, monthly gaps in care, newborn report, inpatient census, and quarterly utilization. Some partners also receive claims, pharmacy, and lab data monthly.

AHCCCS continues to improve its COE program. Starting in 2017, rather than submitting a separate update for its COE program, AHCCCS required the MCOs to incorporate COE program updates with their Annual Network Development and Management Plan. It is AHCCCS' intent that these programs be integrated into the context of each MCO's overall network strategy.

### 2.9 Residential Facilities and Oversight

AHCCCS monitors residential facilities in a variety of ways. One way is to provide oversight of MCO adherence to network standard requirements, as outlined in the AHCCCS Contractor Operations Manual (ACOM) Policy 436. Another way is to ensure a general assessment of network adequacy for member service needs. AHCCCS has partnered with MCOs to undertake a network analysis in order to identify the specialized treatment and program options for various populations to better understand the capacity for treating individuals with complex needs. The network is validated by the AHCCCS External Quality Review Organization (EQRO). AHCCCS also closely evaluates monitoring of treatment settings for clinical and quality performance. AHCCCS regularly monitors MCO prior authorization requirements and issues requests to MCOs with specific requirements for auditing and reporting.

To further enhance monitoring efforts, AHCCCS collaborates with the Arizona Department of Health Services (ADHS) for those facilities licensed by the ADHS. AHCCCS has continued to engage with MCOs to better clarify the expectations around treatment provided within residential facilities and to align with licensure requirements by the ADHS.

The AHCCCS Office of Human Rights (OHR) and the Office of Individual Family Affairs (OIFA) both engage with community members on an ongoing basis. It is through this work that many system concerns are identified. Once identified, these issues are brought forward for resolution within the appropriate AHCCCS division.

### 2.10 Prevention Efforts and Attention to the Overuse of Opioids

Arizona, like most states in the country, has witnessed the rising tide of opioid-related deaths. In 2018, more than three Arizonans died each day due to opioid-related causes, with a quadrupling in the number of deaths due to heroin since 2012. In an effort to combat the opioid epidemic, AHCCCS developed an Opioid Strategic Plan in 2016 and has been implementing three major strategies with MCOs, providers, and community champions across several impacted sectors. The overarching goals of the AHCCCS Opioid Initiative are as follows:

- Enhance harm reduction strategies to prevent overdose,
- Enhance access to Medication Assisted Treatment (MAT) for individuals with opioid use disorder (OUD), and
- Promote responsible prescribing and dispensing policies and practices.

The implementation plan includes a blend of objectives designed to increase coordinated and integrated care, recovery support services, and prevention activities to reduce the prevalence of OUDs and opioid-related overdose deaths. The project approach includes developing and supporting state, regional, and local level collaborations as well as service enhancements to develop and implement best practices to comprehensively address the full continuum of care related to opioid misuse, abuse, and dependency.

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### Strategies to Combat Opioid Abuse:

- **Increase access to Naloxone:** Conduct community-based education and naloxone distribution; encourage co-prescribing of Naloxone for all members prescribed greater than 90 Morphine Equivalent Daily Doses and for any situations involving combinations of opioids and benzodiazepines.
- **Increase access, participation, and retention in Medication Assisted Treatment (MAT):** Increase provider capacity among Opioid Treatment Programs, Office Based Opioid Treatment providers, and Residential settings that allow all three forms of MAT; increase 24/7 access to care sites through identified 24/7 Access Points, previously known as Centers of Excellence; increase navigation to treatment and retention in treatment through expansion of peer supports and care coordinators; increase the ability to identify and assist with the navigation of justice-involved individuals, pregnant and parenting women to MAT.
- **Promote responsible prescribing and dispensing policies and practices:** Reduce the number of opioid-naïve members unnecessarily started on opioid treatment by limiting initial opioid fills for first acute episodes to no more than five (5) days; promoting the Arizona Opioid Prescribing Guidelines and opioid prescribing education; non-opioid best practices for effective pain management; use of mental health, trauma, and substance use screenings prior to prescribing opioids; and opioid risk education materials for members; improve care processes for chronic pain and high-risk members by using data to identify problematic prescribing patterns and coordinating provider education; using data to identify high-risk members and coordinating to appropriate care; use of the Controlled Substance Prescription Monitoring Program; promote e-prescribing of controlled substances; increase access to non-opioid methods for managing chronic pain; incentivize for integrated behavioral health and pain management; increase options for complex case consults.

### 2.11 Foster Care Youth

AHCCCS is committed to providing comprehensive, quality health care for children in foster, kinship, and adoptive care. Children in foster/kinship placements are eligible for medical and dental care, behavioral health, and other services through the Department of Child Safety Comprehensive Health Plan (DCS CHP). Adoptive children are typically AHCCCS eligible and are enrolled into an integrated health plan, similar to any Medicaid-eligible child. On April 1, 2021, physical and behavioral health were integrated under Mercy Care DCS CHP as the single sub-contractor providing services to members in DCS CHP.

System improvements include availability of frequently asked questions documents and behavioral health and crisis services flyers for foster and kinship caregivers, as well as the streamlining of MCO deliverables. AHCCCS created a dashboard to track and trend utilization for children in foster care. This dashboard report is posted to the AHCCCS website. Furthermore, AHCCCS hired Mercer Government Human Services Consulting (Mercer) to perform an analysis for implementing an integrated health plan for children in foster care. The analysis was designed to identify the necessary operational and ongoing infrastructure requirements of an integrated health plan administered through DCS CHP.

AHCCCS ACOM Policy 449: Behavioral Health Services for Children in Department of Child Safety Custody and Adopted Children, was developed to implement House Bill 2442 (also known as Jacob's Law) legislative requirements. Additionally, a dedicated web page hosts helpful information and resources to support the families, community, and providers involved in the care and treatment of foster and adoptive children. Jacob's Law mandates include the following:

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- Designated points of health plan and AHCCCS contacts,
- An assessment of the child (must be conducted within 72 hours after being notified that a child has been placed out of home),
- A mobile team assessment within two hours, as indicated, in the event of a crisis or urgent need,
- An initial evaluation of the child must be completed within seven calendar days after a referral or request for services,
- The health plan must respond to a request for residential placement due to threatening behavior within 72 hours,
- If a foster child is moved to a different county, they may continue to receive treatment in the previous county or seek treatment in the new county, and
- An initial behavioral health appointment must be provided within 21 calendar days after the initial evaluation.

In the event the initial behavioral health appointment is not provided within 21 calendar days, the out of home placement or adoptive parent must notify the health plan and AHCCCS, and the guardian may access the service directly from any AHCCCS-registered provider regardless of whether the provider is contracted with the health plan. The AHCCCS Foster Care Liaison also conducts Jacob's Law training sessions for the public.

### 2.12 Justice Population

Approximately 120,000 individuals are released from Arizona jails and prisons each year and over 70 percent have a substance use and/or mental health disorder. The volume of complex needs within this population makes it difficult to provide high-touch care to all who need it. Despite the challenges, AHCCCS is actively engaged with the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR) and most of Arizona's county jails, including Maricopa and Pima, in a data exchange process which suspends health plan enrollment upon incarceration, instead of terminating AHCCCS coverage. This data exchange agreement allows the ADCRR and county jails to electronically transmit custody dates for AHCCCS members, which simplifies the process of transitioning members directly back into care following release. Additionally, AHCCCS MCOs (including RBHAs) are required to provide "reach-in" care coordination to identify incarcerated members with complex health needs and connect them with case managers, prerelease, to provide information and schedule appointments with Primary Care Physicians (PCP) and behavioral health providers, as appropriate.

AHCCCS has intergovernmental agreements implemented with the ADCRR and most Arizona counties, to provide services to incarcerated individuals temporarily admitted into an inpatient hospital setting outside the correctional institution. This process involves the correctional institution, or its designee, assisting the incarcerated individual with submitting an application for temporary AHCCCS coverage and an expedited review from specialized units which determine eligibility and the specific period of the hospital stay. When determined eligible, the medical services performed during the hospital stay will be covered by AHCCCS.

AHCCCS has additional agreements with the ADCRR and most Arizona counties, including Maricopa and Pima, granting special permissions in the AHCCCS online application portal [Health-e-Arizona Plus (HEAplus)] to assist uninsured individuals in applying for AHCCCS coverage prior to release. The application is submitted in HEAplus approximately 30 days prior to release and will be reviewed by a specialized eligibility unit. The eligibility determination process is expedited to help ensure that qualified individuals who need critical care may be enrolled in AHCCCS immediately following release.

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Incarcerated individuals at risk of needing an institutional level of care upon release may receive a Pre-admission Screening assessment while incarcerated and, when eligible, may apply for ALTCS upon release.

### 2.13 Suicide Prevention in Arizona

As ADHS reported on its website, suicide was the 10th leading cause of death nationally and the eighth leading cause of death in Arizona in 2018. Of the 1,432 deaths by suicide in Arizona, 55.9 percent of the methods used were firearms. When stratified, communities most impacted were males, Native Americans, rural areas, those aged 45 and older, and veterans. AHCCCS publishes an annual [Suicide Prevention Action Plan](#) highlighting populations at risk and community partnerships. AHCCCS works with the Arizona Coalition for Suicide Prevention to disseminate information and resources regarding suicide prevention. Additionally, all MCOs are required to address suicide prevention in their policies and to provide suicide prevention training to their front-line staff. The suicide prevention team includes a suicide prevention specialist, an epidemiologist, and two grant-funded positions. One grant specialist works with the Arizona Department of Education (ADE) on the Substance Abuse and Mental Health Services Administration (SAMHSA)-funded Project AWARE. The five-year grant targets school districts with suicide prevention and behavioral health resources. The second grant-funded position works on a SAMHSA-funded suicide prevention/domestic violence project in Pima County. Since the creation of the team in 2018, Arizona has seen a 41 percent decrease of youth suicides, and a decrease among all ages in 2020 (Arizona Child Fatality Review Team 35).

### 2.14 System of Care Oversight

The System of Care team is responsible for oversight of AHCCCS MCOs adherence to contract and policy requirements to ensure services are delivered in line with the Arizona Vision (12 Principles and Adult Service Delivery System and 9 Guiding Principles), as well as the integration of physical and behavioral health services at the point of care. These oversight activities include monitoring of contract and policy requirements that ensure adequate, timely, and effective service delivery to aid members to achieve success in school/work, to live independently within their community, to avoid delinquency, and to achieve their vision of recovery.

#### *a. Fidelity Review*

The Western Interstate Commission for Higher Education (WICHE), a national expert in the four SAMHSA evidence-based practices (EBP), conducts annual fidelity monitoring of services provided to individuals with an SMI designation. These reviews focus on four service types: Assertive Community Treatment, Supported Employment, Supportive Housing, and Peer and Family Services. Fidelity reviews include fidelity scales and review of all EBP materials including interview guides, scoring protocols and forms, fidelity report templates, provider notification, and preparation letters. These tools continue to be utilized.

- Reviews are conducted in a team of two reviewers. Each team has a lead reviewer in charge of preparation correspondence, provider scheduling, and writing the report.
- Following the one-to-four-day reviews, each team member completes individual scores, and the team then consolidates final consensus scores.
- A detailed fidelity report with scoring rationale and recommendations is drafted by the review team.
- Following discussion and any needed input from respective expert consultant(s), the report with the fidelity scale score sheet is delivered to providers.

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- A follow-up call with providers and the RBHA may be scheduled to discuss the review findings and answer specific questions regarding the report upon request by the provider.

Mercer Government Human Services Consulting (Mercer) conducts an annual quality service review (QSR) and conducts an annual evaluation of individuals with an SMI designation. The purpose of the review is to identify strengths, service capacity and gaps in areas where members receive their services. The QSR includes an evaluation of nine targeted behavioral health services that includes the following: Case Management, Peer Support, Family Support, Supported Housing, Living Skills Training, Supported Employment, Crisis Services, Medication and Medication Services and Assertive Community Treatment Services. Mercer conducts the QSR of the targeted services using a number of evaluation techniques.

### *b. Behavioral Health Clinical Chart Audit*

The Behavioral Health Clinical Chart Audit has historically been utilized to audit provider charts, with the focus on processes related to initial and ongoing assessment and service planning. Each of the RBHAs conducted its audits utilizing its own unique tool that comported with required AHCCCS policies. However, the use of distinct audit tools did not allow for data analysis at a statewide level. Therefore, beginning in 2018 and with the advent of the ACC plans, AHCCCS began working with the RBHAs and ACC plans to develop a unified tool for utilization throughout Arizona by all MCOs. The audit tool was formally implemented on October 1, 2019. The first round of results was reported as of April 2020, but further auditing was suspended due to the COVID-19 Public Health Emergency (PHE). AHCCCS intends to continue evaluation of the Behavioral Health Chart Audit process to ensure a more focused view of the outcomes of members who have received behavioral health services.

### 2.15 Division of Grants Administration

The Division of Grants Administration has applied for, and been awarded, several key grants that help achieve the agency's mission and vision for individuals who are either under or uninsured. The federal grants received by AHCCCS have a narrowly defined purpose for a demonstrated need. The current grants focus on substance use disorders (SUDs), mental health, homelessness, OUD, Crisis Counseling Program, suicide prevention, COVID-19, and ongoing prevention and treatment for adolescents and adults.

### 2.16 Housing

AHCCCS recognizes the importance of housing as a social risk factor to health and is working to integrate housing strategies into its larger health management strategies. Housing is currently one of the three primary focus areas in AHCCCS' Whole Person Care Initiative (WPCI) to address social risk factors to health. Additionally, AHCCCS provides housing subsidies and supports for persons with an SMI designation [and a smaller number of members with general mental health/substance use (GMHSU) needs] through Non-Title XIX/XXI funds and through Title XIX/XXI funding for those support services which are Medicaid compensable. To implement its housing strategies, AHCCCS follows the Permanent Supportive Housing (PSH) model endorsed by SAMHSA, Housing and Urban Development (HUD), and CMS.

Under the PSH model, there are two components to an effective housing strategy: provision of safe, appropriate, and affordable housing that meets the member's/resident's need, and the availability of effective, individualized wrap around supportive services to assist the individual or household attain and maintain their housing placement while addressing other service plan goals. These services are provided to help a member secure appropriate housing and stay housed in a stable environment.

In addition to Title XIX/XXI funding, AHCCCS receives a state funded annual allocation of approximately \$28 million for non-Medicaid compensable housing subsidies and supports. Since 2014, AHCCCS utilizes

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housing funds in all Arizona GSAs and uses a small portion of housing funds to serve persons diagnosed as GMHSU. AHCCCS prioritizes persons experiencing homelessness for housing subsidy. At present, AHCCCS housing funds provide housing subsidies to an average of 2,800 households statewide each month. Housing funds also support operating expenses for an additional 1,500 persons with an SMI designation and who were experiencing homelessness but now reside in HUD Continuum of Care subsidized PSH units. AHCCCS housing funding is currently awarded to the RBHA in each GSA based on the submission and approval of an annual Housing Spending Plan that documents local housing needs, waitlists, projects to be funded, service coordination strategies, and an annual housing budget. The RBHAs must also provide monthly utilization/vacancy and housing inventory reports, as well as other ad hoc reports as required in contract, which are used to monitor housing performance. Contracts require each RBHA to employ at least one (1) Housing Administrator to coordinate the RBHA housing activities related to AHCCCS funds including monitoring of housing providers, ensuring performance of key housing operational activities (e.g., inspections, rent subsidy determinations, service coordination, grievances, and reporting), and the RBHA housing policy maintenance.

Additionally, the Arizona State Legislature allocates \$2 million annually to a SMI Housing Trust Fund. With these dollars, the RBHAs and TRBHAs can purchase and renovate properties (with some limitations) for individuals with a SMI designation. Properties purchased or renovated with these dollars are limited to the use of those individuals with an SMI designation through Covenants, Conditions, and Restrictions (CC&Rs) on the funded projects for a period ranging from 15-30 years.

Statewide, Arizona is in the midst of an affordable housing crisis. Arizona's dramatically increasing population, limited development of affordable units, and a strong job market, has left rental vacancies at historic lows. Some cities report less than a three percent vacancy rate for all units. This has put upward pressure on rents. In Maricopa County, according to the HUD Office of Policy Development and Research, Fair Market Rents for an efficiency unit have increased over 25 percent (from \$744 to \$933 a month) and one-bedroom rates have increased almost 19 percent (from \$868 to \$1,032). The current COVID-19 crisis does not seem to have reduced the lack of affordable housing, to date. Other Arizona counties have shown rent increases as well. This is more complicated in Arizona's rural communities that may lack traditional rental units or where affordable housing may not be near other necessary resources. AHCCCS works closely with RBHAs, ALTCS providers, and MCOs to ensure adherence to follow national best practices regarding assessment and placement of homeless individuals. MCOs are required to use the Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) to assess a member's housing needs and rank members accordingly on a housing wait list. Priority is given to persons experiencing homelessness. Housing staff are expected to be familiar with the Housing Quality Standard (HQS) inspection process to make sure members are being housed in safe environments. The RBHAs work closely with landlords and with developers to ensure available housing units are matched with members. Once matched, the member is provided supportive services to help keep him/her successfully housed. For chronically homeless individuals, the first 30 days are critical for supportive services to prevent eviction. The RBHAs work with other community housing providers when possible, including local Public Housing Authority, the three Arizona HUD approved Continua of Care, and other state agencies to secure both housing subsidies, as well as to develop additional affordable housing units for AHCCCS members.

Beginning October 2021, AHCCCS will consolidate administration of its housing funding with a statewide Housing Administrator. Arizona Behavioral Health Corporation (ABC) was selected through the Request for Proposals (RFP) process to standardize housing processes including referrals, waitlist management prioritization, voucher management, resident pre-tenancy briefings, landlord engagement, housing quality inspections, legal compliance, rent determinations, and subsidy payments. As part of this

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process, AHCCCS will increase accountability and reporting for housing performance including use of HUD and other PSH evaluation standards and benchmarks. Additionally, AHCCCS will continue to work on the quality of services provided by standardizing programmatic language and reporting, implementing the permanent supportive housing fidelity review statewide, reducing barriers to housing, strengthening relationships with homeless outreach teams, and encouraging developers to be mindful of the Medicaid and vulnerable populations when developing new properties. AHCCCS has created an internal Housing Workgroup that will coordinate these efforts.

### 2.17 Workforce Development

Workforce Development (WFD) is the process of recruiting, selecting, developing, deploying, and retaining a sufficiently staffed, qualified, and capable workforce. Within the AHCCCS system, the WFD function is described in ACOM Policy 407. The policy differentiates the responsibilities of the three types of organizations (AHCCCS, MCOs, and providers) comprising the system and describes the collaborative approach to WFD:

- Providers directly acquire, develop, deploy, and retain a qualified and capable workforce,
- MCOs monitor and ensure that providers maintain a workforce that possesses the required qualifications, staffing capacity, and skill capability needed to deliver AHCCCS services. In addition, MCOs must develop detailed WFD plans to strengthen the workforce capacity and capability of providers within their networks. These network specific plans often include specific assistance MCOs provide to their provider organizations. MCOs also participate in joint WFD planning with AHCCCS and other MCOs designed to address statewide WFD challenges.
- AHCCCS analyzes current and future healthcare workforce trends, forecasts and describes workforce requirements, and generates policies to manage the development and deployment of the healthcare workforce.

Monitoring the activities and intended accomplishments described in the Annual WFD Plan is the primary way AHCCCS evaluates the productivity and success of the MCOs' WFD programs. Workforce development directly affects the health care members receive, as well as the health outcomes they experience. Services must be provided by a sufficiently skilled workforce who is capable of meeting member needs in the most interpersonally, clinically, and culturally appropriate manner possible. AHCCCS, MCOs, and leaders from the provider community and industry groups are working collaboratively to strategize, develop measures and methods for analyzing the needs, and action planning on how to attract and retain the desired workforce. Specifically, AHCCCS is working towards:

- Increasing its capacity to collect workforce data, analyze workforce trends, facilitate workforce planning, and mobilize human, educational, and community resources needed to both attract and prepare qualified workers to deliver contracted services,
- Enabling MCOs to better assist providers to enhance their WFD programs by strengthening the internal relationship and collaboration between networks, quality, customer service, and culturally competent units, and
- Developing partnerships with communities, industry group, and educational resources to develop regional approaches to recruit talented individuals (including current AHCCCS members), to join the integrated healthcare workforce, preventing, reducing or eliminating health professional shortages in key areas and to improve the efficacy of the state's education, training, and development programs.

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### 2.18 Employment Support

AHCCCS believes that every individual with a disability can work competitively in the community when the right kind of job and work environment is found. Competitive Integrated Employment is work that is performed on a full-time or part-time basis for which an individual is: compensated at or above minimum wage and comparable to the customary rate paid to persons without disabilities performing similar duties and with similar training and experience; receiving the same level of benefits provided to other employees without disabilities in similar positions; at a location where the employee interacts with other individuals without disabilities; and presented opportunities for advancement similar to other employees without disabilities in similar positions. Self-employment, in many cases, is also considered Competitive Integrated Employment.

The RBHAs are required to maintain subcontracted arrangements with at least one fully dedicated employment/rehabilitation provider staff at each clinic whose only duties include employment and rehabilitation-related activities, such as meaningful community involvement activities. AHCCCS tracks the utilization of covered services.

For individuals with an SMI designation, AHCCCS and the Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA) [which includes the State Vocational Rehabilitation (ADES/VR) program], have an established Interagency Service Agreement (ISA) to provide specialty employment services and supports. AHCCCS provides funds toward this agreement that the ADES/RSA uses as a state match to draw down additional federal monies. The overall funding is used toward client services, staffing, and training. The VR submits quarterly deliverables that include client progress statuses and staffing capacity. Some of the special requirements within the ISA are:

- Vocational Rehabilitation Counselors (VRCs) have specialized caseloads consisting of individuals with psychiatric disabilities. ADES/VR counselors are cross-trained in the area of psychiatric disabilities to effectively serve the individual needs of the clients,
- The federally mandated, 60-day eligibility requirement for ADES/VR applicants is modified to 30-days; ADES/VR Counselors and RBHA provider employment staff have weekly consultations regarding the progress of mutual program participants, and
- The ISA also requires quarterly ISA Advisory Committee meetings with AHCCCS, RBHAs, and RSA/VR and bi-annual regional ISA Coordination meetings for collaboration with all stakeholders in efforts to enhance program delivery methods and increase successful employment outcomes. The AHCCCS contract with the RBHA mandates its adherence to the ISA.

AHCCCS is expanding employment requirements beyond the RBHAs by including employment requirements for MCOs more generally. AHCCCS is educating MCOs on the usage of Medicaid covered employment services. For the ALTCS and DCS CHP contracts, plans are required to employ staff designated as the subject matter expert (SME) on employment and employment services. Their role is to assist case managers with up-to-date information designed to aid members in making informed decisions about their independent living options, including employment. For ACC (effective October 1, 2018), the integrated MCOs shall be required to maintain subcontracted arrangements with at least one fully dedicated employment/rehabilitation provider staff at each clinic whose only duties are to include employment and rehabilitation-related activities. Deliverables will be attached to the ACC contract around employment.

AHCCCS has also begun efforts to help transform the employment system by coming into compliance with the CMS HCBS Rules specific to employment services (Center-Based Employment and Group Supported Employment). The purpose of the rule is to ensure that individuals receiving home and



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community-based services are integrated into their communities and have full access to the benefits of community living, including employment settings. By March 17, 2023, through the help of a workgroup facilitated by the AHCCCS Employment Administrator, Arizona will need to be compliant with HCBS Rules, so that all members have the opportunity to seek competitive employment in the most integrated setting and to the same degree of access as individuals not receiving home and community-based services.

### 3. AHCCCS Quality Strategy and Evaluation

AHCCCS performs most of the External Quality Review (EQR) functions at the MCO level using an EQRO to evaluate whether the work that AHCCCS completes complies with federal requirements. The EQRO is tasked with preparing independent Annual EQR Technical Reports that summarize each MCO's compliance, strengths, weaknesses, implementation of corrective actions, identification of best practices, and improvement opportunities. The Quality Strategy is considered a companion document to the EQR reports.

#### 3.1 External Quality Review (EQR)

Over the past 35 years, AHCCCS has developed significant in-house resources, processes, and expertise in monitoring its MCOs. EQRO feedback is used to assess effectiveness of the current quality goals and strategies, as well as provide a roadmap for considerations and potential changes to the agency's Quality Strategy. This Quality Strategy is closely aligned and interfaces with the EQR mandatory requirements defined in 42 CFR 438.358, which includes:

- Review of MCO compliance with specified standards for quality program operations,
- Validation of state-required performance measures,
- Validation of state-required performance improvement projects (PIPs), and
- Validation of MCO compliance with network adequacy requirements.

AHCCCS utilizes Operational Reviews (ORs) to evaluate MCO operations and performance related to compliance with federal and state laws, rules and regulations, and AHCCCS contract and policy. These ORs provide information to the EQRO for its use in its annual report of AHCCCS and MCO compliance. EQR reports are posted on the AHCCCS website and made available in accordance with 42 CFR 438.364.

##### *a. Non-Duplication of Efforts*

42 CFR 438.360 allows the use of information from a Medicare or private accreditation review of a MCO to provide information for the annual EQR instead of conducting one or more of the EQR activities. As part of the agency's direction in requiring its MCOs to obtain National Committee for Quality Assurance (NCQA) Accreditation specific to their Medicaid line of business by October 1, 2023, AHCCCS will review and evaluate which NCQA Accreditation activities are considered deemable and able to be used for the purpose of providing information for the annual EQR reporting (in lieu of the EQRO conducting one or more of the mandatory EQR activities).

##### *b. EQRO Process*

Through the procurement process, AHCCCS ensures the qualifications of its CMS-required EQRO for both competence and independence as outlined in 42 CFR 438.354. This review provides an outside analysis and assessment of the MCOs' performance as well as recommendations to improve the MCOs' performance, as applicable. The technical reports provide the following elements by line of business (e.g., ACC and ALTCS):

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- A description of the EQR activities,
- An overview of the AHCCCS program history and a summary of AHCCCS' Quality Strategy goals and objectives,
- An overview of AHCCCS' statewide quality initiatives across its Medicaid managed care programs and those specific to each MCO,
- An overview of the MCOs' best and emerging practices,
- Network adequacy,
- Organizational assessment and structure performance,
- Performance measure results and analysis, and
- Performance improvement project results and analysis.

### 3.2 Quality Strategy Scope and Objectives

The AHCCCS Quality Strategy is a coordinated, comprehensive, and proactive approach designed to drive quality throughout the AHCCCS delivery system. AHCCCS achieves goals outlined in the Quality Strategy through:

- Combined methods of partnership with and regulatory oversight of contracted MCOs,
- Value-based program development, and
- Focus on outcomes and optimized member health.

AHCCCS clearly outlines expectations for quality care/service delivery and has structured a thorough, multi-faceted approach for monitoring compliance to expectations, including on-going member and stakeholder feedback/engagement and numerous MCO-based activities.

The scope of the Quality Strategy is designed to incorporate the requirements outlined in 42 CFR 438.340 and 42 CFR 457.1240(e). AHCCCS requires transparency for the quality of health care and services it provides to its members, the community, and its stakeholders. AHCCCS has developed quality initiatives and strategies for evidence-based outcomes that:

- Reward quality of care, integrated service delivery, member safety, and member satisfaction outcomes,
- Support best practices in disease management and chronic care,
- Provide feedback on quality and outcomes to MCOs and providers, and
- Provide comparative information to potential members, members, and stakeholders.

The agency's Quality Strategy is focused on continuous quality improvement based on the Triple Aim framework of healthcare. The Triple Aim was developed by the Institute for Healthcare Improvement (IHI) in 2007 and has been widely adopted by governmental and commercial organizations as a mechanism to improve both the member's healthcare experience and the system performance simultaneously. In order to achieve the Triple Aim, AHCCCS has formulated strategies intended to simultaneously improve care, improve population health, and reduce costs. With these concepts in mind, AHCCCS has established the following Quality Strategy goals and objectives applicable to Arizona's managed care program (inclusive of Medicaid and CHIP members):

**Quality Goal 1:** Improve the member's experience of care, including quality and satisfaction.

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### Objectives:

- Enrich the member experience through an integrated approach to service delivery,
- Improve information retrieval and reporting capability by establishing new and upgrading existing information technologies, thereby increasing responsiveness and productivity,
- Enhance current performance measures, PIPs, and best practice activities by creating a comprehensive quality of care assessment and improvement plan across AHCCCS programs, and
- Drive the improvement of member-centered outcomes using nationally recognized protocols, standards of care, and benchmarks, as well as the practice of collaborating with MCOs to reward providers based on clinical best practices and outcomes (as funding allows).

### Quality Goal 2: Improve the health of AHCCCS populations.

#### Objectives:

- Increase member access to integrated care that meets the member's individual needs within their local community,
- Support innovative reimbursement models, such as Alternative Payment Models (APMs), while promoting increased quality of care and services, and
- Build upon prevention and health maintenance efforts through targeted medical management:
  - o Emphasizing disease and chronic care management,
  - o Improving functionality in activities of daily living,
  - o Planning patient care for special needs populations,
  - o Identifying and sharing best practices, and
  - o Expanding provider development of COE.

### Quality Goal 3: Reduce the growth in healthcare costs and lower costs per person.

#### Objectives:

- Increase analytical capacity to make more informed clinical and policy making decisions, and
- Develop collaborative strategies and initiatives with state agencies and other external partners, such as:
  - o Strategic partnerships to improve access to health care services and affordable health care coverage,
  - o Partnerships with sister government agencies, MCOs, and providers to educate Arizonans on health issues,
  - o Effective medical management for at-risk and vulnerable populations, and
  - o Building capacity in rural and underserved areas to address both professional and paraprofessional shortages.

### Quality Goal 4: Enhance data system and performance measure reporting capabilities.

#### Objectives:

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- Evaluate current data system infrastructure,
- Identify system and process limitations impacting performance measure reporting and analysis,
- Leverage various data sources to produce comprehensive reliable data,
  - o Collaborate with external stakeholders to facilitate access to supplemental data sources, and
  - o Explore means for collecting and reporting performance measure data utilizing EHR methodologies, and
- Drive continuous delivery system performance through advanced data analytics and disparity analyses.

A comprehensive and thoughtful Quality Strategy is a key priority for AHCCCS as the agency continues to collaborate with stakeholders to optimize both the experience and health outcomes of Arizonans accessing Medicaid managed care.

### 3.3 Methods and Processes for Quality Strategy Development

AHCCCS strives to ensure that the voice of the community is heard. Quality is a community process that is continuously informed and shaped by the voices and choices made by internal and external stakeholders. AHCCCS ensures agency transparency and incorporates community feedback into its Quality Strategy development through support of the following structures.

#### *a. Public Information*

The AHCCCS Public Information Officer (PIO) is the information messenger to the public. This office distributes public-facing information about the agency's programs using traditional external communication techniques, including press releases, website content, public and media relations, email newsletters, and social media. In addition, the PIO interfaces with external stakeholders including businesses, students, and AHCCCS members.

AHCCCS employs a social media strategy to increase public access to information, generate positive public relations, interface with the media, support MCO community efforts, gather information to increase business intelligence, and bolster employee recruiting efforts. Twitter posts at @AHCCCS.gov amplify external messages, support partner organizations, answer member questions, and drive traffic to the AHCCCS blog and website. Posts on LinkedIn promote agency business initiatives. The AHCCCS Facebook page is a source for member-directed content. Public video content is posted on the agency's YouTube channel.

A public-facing blog profiles successful AHCCCS employees, health care initiatives, legislative updates, human interest stories about Medicaid issues, and health care-related community events. To increase transparency and information sharing, AHCCCS divisions publish various e-newsletters to which stakeholders and the public may subscribe.

#### *b. Division of Community Advocacy and Intergovernmental Relations (DCAIR)*

AHCCCS has a dedicated division that interfaces with members, peers, family members, and other stakeholders receiving physical and behavioral health services in Arizona's Medicaid managed care delivery system. Dedicated teams within the DCAIR include:

- **Office of Human Rights (OHR)**

The Office of Human Rights (OHR) is the State Advocacy Office, established by the A.A.C., R9-21-104, that focuses on direct advocacy to a population designated as Special Assistance.

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Special Assistance is a clinical designation that occurs when a member cannot participate effectively in his/her own treatment planning processes due to a cognitive or intellectual impairment and/or medical condition. Currently in Arizona, there are over 3,200 members who receive Special Assistance. The OHR also provides advocacy to individuals with an SMI designation. Staff provide assistance to help members understand and learn how to protect and exercise their rights, facilitate self-advocacy through education, and obtain access to behavioral health services within Arizona's publicly funded system.

### ▪ **Office of Individual and Family Affairs (OIFA)**

The Office of Individual and Family Affairs (OIFA) is staffed by peers and family members of persons receiving services in Arizona's behavioral health system. They bring their lived experiences to the forefront when making decisions, incorporating recovery and resiliency into all aspects of service delivery. Moreover, the OIFA:

- o Builds partnerships with individuals, families of choice, youth, communities, and organizations to promote recovery, resiliency, and wellness,
- o Collaborates with key leadership and community members in the decision-making process at all levels of the behavioral health system,
- o Advocates for the development of culturally inclusive environments that are welcoming to individuals and families,
- o Establishes structures to promote diverse youth, family, and individual voices in leadership positions throughout Arizona,
- o Deliver training, technical assistance, and instructional materials for individuals and their families, and
- o Ensures peer support and family support is available to all persons receiving services and their families and monitors MCO performance and measure outcomes.

### *c. Arizona State Medicaid Advisory Committee (SMAC)*

The State Medicaid Advisory Committee (SMAC) reviews and advises on the operations, programs, and planning for Arizona's Medicaid program. The Committee advises the Director of AHCCCS on policy, operations, and administrative issues of the Medicaid program, including issues of concern to the community. SMAC operates in accordance with 42 CFR 431.12 and the Medicaid State Plan. The bylaws for the committee were created in September 1992 and are reviewed annually, or as needed. The Committee is composed of the AHCCCS Director, the Director of the ADHS or a designee, the Director of the Arizona Department of Economic Security or a designee, and no less than 17 health care providers or professionals with a direct interest in the AHCCCS program. Members are appointed for two-year terms with appointments made on a staggered basis with half the public and professional/provider members completing their terms annually. SMAC meets quarterly, chaired by the AHCCCS Director, and meetings are open to the public with a public comment period at the end of the agenda.

### *d. Behavioral Health Planning Council*

The Arizona Behavioral Health Planning Council is required by 42 U.S. Code § 300x-3 to review Arizona's Mental Health Block Grant (MHBG) and the Arizona Behavioral Health Planning Council elects to review the Substance Abuse Block Grant (SABG) Services Plans for children and adults. This review must occur before it is submitted to the United States Department of Health and Human Services (DHHS). The council's membership reflects the diverse cultures in Arizona and includes behavioral health recipients,

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family members, advocates, state agencies, and community providers. The council and its committees meet monthly, either in-person or online, as appropriate.

The council is tasked with reviewing the MHBG and the SABG plans provided by AHCCCS and submitting to the state any council recommendations for modifications to the plans. It also serves as an advocate for adults with an SMI designation, children with a severe emotional disturbance, and other individuals with mental health or emotional problems. The council reviews and evaluates the allocation and adequacy of behavioral health services within the state, not less than once each year.

### *e. ALTCS Advisory Council*

The ALTCS Advisory Council consists of ALTCS members, their family members/representatives, ALTCS MCOs, providers, state and advocacy agencies, and advocacy program representatives. The council assists the ALTCS program to develop a work plan that addresses opportunities for new service innovations or systemic issues impacting ALTCS members. Council members advise on activities directed at system improvements. Individual council members provide input and feedback on ALTCS program activities from their own personal or professional experience, expertise, and/or perspective.

### *f. Tribal Consultation*

AHCCCS recognizes the unique government-to-government relationship that exists between American Indian tribes and federal and state governments. At minimum, AHCCCS conducts tribal consultation on a quarterly basis to strengthen the special relationship between tribal nations and the AHCCCS administration. The goal is to ensure that AHCCCS provides reasonable notice and opportunity for consultation with tribal nations prior to implementing policy changes that may be likely to have a direct effect on one or more tribal communities and its members, on the relationship between the State of Arizona and tribal nations, or on the distribution of responsibilities between the State of Arizona and tribal nations. AHCCCS has a designated tribal liaison who is responsible for tribal consultation and serves as the primary point of contact for tribal issues.

### *g. AHCCCS Community Quality Forum*

The AHCCCS Community Quality Forum occurs once every four months and focuses on the evaluation of health system performance for physical and behavioral health care in alignment with the agency's integrated care model and drives system improvement through collaboration and consultation with community stakeholders. Participants include CMOs and Quality Management staff from all MCOs, tribal affiliates, consumers representing the community of members, and mental health advocacy organizations, such as National Alliance on Mental Illness (NAMI) and Mental Health America (MHA).

### *h. Liaison to Independent Oversight Committees (IOC)*

The Independent Oversight Committees (IOCs) were created by the Arizona Legislature to assist AHCCCS, DDD, and the RBHAs in promoting and protecting the rights of children and adults diagnosed with special health care conditions [i.e. members with intellectual and developmental disabilities (I/DD)] and/or who receive publicly funded behavioral health services. The committees provide independent oversight to ensure members' rights are protected.

The IOCs are composed of volunteers with an array of expertise, including providers, members, family members, tribal representatives, advocates, I/DD professionals and/or mental health professionals, and representatives from state agencies. The IOCs review, monitor, and evaluate the adequacy of relevant services as well as agency handling of significant incidents and quality of care concerns. These volunteers are supported by the Community Affairs Liaison within DHCM as required by the A.A.C.

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### 3.4 Process for Quality Strategy Review and Update

AHCCCS established the 2021 Quality Strategy Workgroup with the goal of updating its Quality Strategy to:

- Develop and draft the Quality Strategy Evaluation,
- Outline significant changes faced by the agency over the past three years,
- Outline future goals and objectives, and
- Incorporate the updated Medicaid and CHIP managed care regulations.

This workgroup consisted of a core team tasked with the oversight and management of the organization's efforts to update this document by providing a robust and comprehensive program description and evaluation that supports the quality focused managed care regulations, with necessary approvals and posting on the AHCCCS website, completed no later than July 1, 2021. AHCCCS executive management provided essential guidance and feedback related to the structure and contents of the document, serving as the 2021 Quality Strategy Workgroup authority. In addition, an extended team composed of AHCCCS personnel, identified as SMEs, was established to document and highlight key aspects for meeting the aforementioned goals.

Throughout the 2021 Quality Strategy Workgroup efforts, AHCCCS engaged and solicited feedback from external stakeholders and, when possible, incorporated the feedback offered into the development, review, and revision efforts used to create the finalized AHCCCS 2021 Quality Strategy. Examples of external stakeholder feedback opportunities built into the project management timeline included, but were not limited to, tribal consultation meetings, ALTCS advisory council, SMAC, and public comment period (30-day public comment period seeking public input, as posted online, with notification and distribution occurring through a list serve public notice system). In addition, AHCCCS involved the MCOs throughout the Quality Strategy development process via written communication and discussion at various meetings which included:

- **Quality Management/Maternal Child Health (QM/MCH) Contractor Meeting:** meetings conducted in collaboration with the AHCCCS QM and Quality Improvement staff that involve ongoing participation of the MCO quality-focused staff members.
- **Community Quality Forum:** meetings conducted every four months to evaluate health system performance for physical and behavioral healthcare, in alignment with the agency's integrated care model, and drive system improvement through collaboration and consultation with community stakeholders.
- **AHCCCS MCO Update Meeting:** meetings to interact with AHCCCS leadership; the agency hosts the AHCCCS MCO Update Meetings with contracted MCOs, state agencies, and RBHAs/TRBHAs. These meetings are typically held quarterly.
- **AHCCCS Medical Directors Meeting:** meetings conducted every month with the AHCCCS MCO CMOs; topics vary with each meeting and include updates by agency area leads to proposed topics from the medical directors.

### 3.5 Quality Strategy Evaluation

The Quality Strategy is reviewed, at a minimum, once every three years or as needed, based on significant program changes. Significant changes would include revisions to delivery system models, fundamental shifts in quality approaches, and/or changes that significantly impact the manner in which members receive care and services. The review process focuses on the previous three years or less.

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Within the quality review structure, the Quality Strategy Evaluation team members seek to determine if a substantial change was made toward meeting the identified target area(s). The results of the Quality Strategy Evaluation and the updated Quality Strategy are submitted to CMS for comment and feedback prior to adopting the changes. In addition, these documents are posted on the [AHCCCS Quality Strategy](#) web page and made available in accordance with 42 CFR 438.340 and 42 CFR 457.1240(e).

### 3.6 Quality Strategy Effectiveness

Data collection and analysis, in addition to other evaluation activities, are utilized to assess the value of the strategies described in this Quality Strategy. The analysis includes trends and comparisons with established goals and benchmarks. Examples of these data include results of performance measures and PIPs, as well as other data reported by MCOs, such as quality of care concerns.

The Quality Strategy is considered a companion document to the EQR reports. As mentioned above, the EQR reports encompass specific details of the assessment, results, and recommendations related to the goals and strategies found in this document. This information is used to assess the efficacy of current goals and strategies, and to provide a roadmap for potential changes and development of new goals/strategies. Quality Strategy effectiveness, progress, and updates are also reported in the AHCCCS 1115 Waiver Quarterly Report. AHCCCS' quarterly quality assurance/monitoring activities are described in this report, as well as summarized in the agency's annual report to CMS, as required by the state's 1115 Waiver.

## 4. MCO Program Requirements

The purpose of the contract between AHCCCS and the MCO is to delineate MCO requirements. The MCOs shall be responsible for the performance of all contract requirements as it implements and operates the ACC, DCS CHP, ALTCS EPD, ALTCS DD, and/or RBHA Programs pursuant to A.R.S. and 42 CFR 438 Managed Care.

### 4.1 State Verification that Sub-Part E Provisions of the Managed Care Regulations are Included in Medicaid Contract Provisions

In its contracts with MCOs, AHCCCS incorporates the CFR requirements regarding MCO establishment and implementation of ongoing comprehensive Quality Management/Performance Improvement (QM/PI) programs for services provided to members. The contracts between AHCCCS and its MCOs define the standards for access, structure, operations, quality measurement, and quality improvement. The AHCCCS Medical Policy Manual (AMPM), the ACOM, and other AHCCCS policies and manuals are incorporated by reference as part of the MCO contracts and provide more detailed standards, information, and requirements. MCO contract provisions require all MCOs to:

- Establish and implement an ongoing comprehensive QM/PI Program,
- Implement mechanisms to assess the quality and appropriateness of care furnished to members with SHCN, as defined by the state in the Quality Strategy,
- Conduct PIPs,
- Collect and submit performance measurement data,
- Implement mechanisms to detect both underutilization and overutilization of services,
- Collect data from providers in standardized formats (to the extent feasible and appropriate), including secure information exchanges/technologies utilized for state Medicaid quality improvement and care coordination efforts,



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- Track and trend member and provider issues, and
- Implement written policies regarding member rights and responsibilities.

In addition to the requirements outlined above, contract provisions for MCOs providing LTSS require the MCO to:

- Implement mechanisms to assess the quality and appropriateness of care provided to members utilizing LTSS, including the assessment of care between care settings as well as a comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable, and
- Participate in efforts by the state to prevent, detect, and remediate critical incidents.

### 4.2 Quality Management/Performance Improvement (Quality Assessment and Performance Improvement) Requirements

Within its MCO contracts, AHCCCS outlines QM/PI Program requirements. The MCO's QM/PI Program shall be designed to achieve and sustain, through ongoing measurements and intervention, significant improvement in the areas of clinical care and nonclinical care, which is expected to have a favorable effect on health outcomes and member satisfaction. These QM/PI requirements include, but are not limited to:

- Implementation, monitoring, evaluation, and compliance with applicable program requirements,
- Provision of quality care and services to eligible members, regardless of payor source and eligibility category,
- Contractor written policies and training in regards to preventing abuse, neglect, and exploitation, ensuring incident stabilization (member(s) immediate health and safety is secured, and immediate care and recovery needs are identified and provided), reporting incidents, and conducting investigations,
- Monitoring for provider compliance with policies, training, and signage requirements aimed at preventing and reporting abuse, neglect, and exploitation,
- Mechanisms to assess the quality and appropriateness of care furnished to members with SHCN,
- Demonstration of improvement in the quality of care and services provided to members through established QM/PI processes,
- Analysis of the effectiveness of implemented interventions, including targeted interventions, to address the unique needs of populations and subpopulations served,
- Participation in community initiatives, events, and/or activities, as well as implementation of specific interventions to address overarching community concerns, including applicable activities of the Medicare Quality Improvement Organization (QIO),
- Written policies regarding member rights and responsibilities,
- Protection of medical records, any other personal health, and enrollment information that identifies a particular member, or subset of members, in accordance with federal and state privacy requirements,
- Development and maintenance of mechanisms to solicit feedback and recommendations from key stakeholders, subcontractors, members, and family members to monitor service quality, and

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develop strategies to improve member outcomes and quality improvement activities related to quality of care and system performance,

- Tracking and trending of member and provider issues, which includes, but is not limited to, investigation and analysis of quality of care issues, abuse, neglect, exploitation, and unexpected deaths,
- QM/PI Program monitoring and evaluation activities, which include Peer Review and Quality Management Committees that are chaired by the MCO's local CMO, and
- Performance measurement and PIPs.

MCOs are required to develop a written QM/PI Program Plan that specifies the objectives of the MCOs' QM/PI Programs and addresses the MCOs' proposed approaches to meet or exceed the performance standards and requirements specified in the contract and AHCCCS policy. The QM/PI Program Plans (inclusive of program narrative, work plan, and work plan evaluation) are submitted annually and describe how program activities shall improve the quality of care, service delivery, and satisfaction for members.

### 4.3 Assessment of Quality and Appropriateness of Care/Services for Routine and Special Health Care Needs Members

The MCOs are required by contract to identify children and adults with special health care needs (SHCN). The qualifying criteria is defined in the contract as, "Members who have serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally." A member is considered as having SHCN if the medical condition simultaneously meets one or more of the following criteria:

- Actively engaged in a transplant process plus one-year post transplant,
- ALTCS DD,
- ALTCS EPD,
- Autism/at risk for Autism,
- Arizona Early Intervention Program (AzEIP),
- Mercy Care DCS CHP and up to one year after transition from Mercy Care DCS CHP,
- CRS,
- Early Childhood Service Intensity Instrument (ECSII)/Child and Adolescent Level of Care Utilization System score of 4 or higher,
- High needs and high costs HIV/AIDS,
- Severe Combined Immunodeficiency (SCID),
- SED/Neonatal Abstinence Syndrome (NAS), or
- An SMI designation.

#### *a. Identification*

Members with SHCN are identified through a review of utilization data to identify diagnoses, services, and medications specific to a member with SHCN, new member health risk assessments, concurrent review, prior authorization, and/or a review of Early and Periodic Screening Diagnosis and Treatment (EPSDT) tracking forms. The identification (not available for all categories of SHCN) that designates a

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member as having SHCN is entered into the Pre-paid Medical Management Information System (PMMIS) mainframe database.

### *b. Assessment*

MCOs are required to comprehensively assess each member identified as having SHCN, in order to identify any ongoing special conditions of the member that require a course of treatment, regular care management, or transition to another AHCCCS program [42 CFR 438.208(c)(2) and 42 CFR 438.240(b)(4)]. The assessment mechanisms must use appropriate health care professionals with the appropriate expertise [42 CFR 438.240(c)(2) and 42 CFR 438.208(c)(2)]. The MCO must share the results of its identification and assessment of that member's needs with other entities providing services to that member to avoid unnecessary duplication of effort [42 CFR 438.208(b)(4) and 42 CFR 438.208(c)(3)].

The MCO must ensure that members with special health care needs have an individualized clinical and behavioral treatment or service plan. Further, the MCO shall conduct multidisciplinary staffing for members with challenging behaviors or health care needs [42 CFR 438.208(c)(3)].

### *c. Access to Care*

Recognizing that Medicaid members with SHCN or chronic health conditions require care coordination, AHCCCS requires MCOs to provide appropriate coordination. The contracts between AHCCCS and its MCOs require and define standards for access to specialists (e.g., through a standing referral or an approved number of visits), and structure of programs and operations in order to serve the member's condition and identified needs in accordance with 42 CFR 438.208(c)(4). Additionally, the MCOs must have a methodology to identify providers willing to provide medical home services and make reasonable efforts to offer access to these members.

### *d. Monitoring*

AHCCCS monitors quality and appropriateness of care and services for members, including members with SHCN, through annual MCO ORs, review of required MCO deliverables set forth in contract, program specific performance measures, and PIPs. AHCCCS tracks and trends member grievances to identify potential access to care issues and/or the need for corrective actions and monitors the outcomes of required corrective actions.

## 4.4 Member Information Requirements

AHCCCS requires MCOs, as specified in the contract and in AHCCCS policy, to provide members with information including, but not limited to the following:

- Covered services,
- How to obtain services,
- How to choose a provider,
- A member's rights with respect to grievances and state fair hearings,
- Prior authorization processes and requirements,
- Advance directives,
- What constitutes an emergency,
- Language and cultural competency requirements, and
- Member financial responsibilities.

This information is required to be included in each MCO Member Handbook.

## AHCCCS Quality Strategy

The contracts between AHCCCS and its MCOs define the standards for access, structure, operations, and quality measurement and improvement. The AMPM and ACOM, as well as other AHCCCS Policies and Manuals, are incorporated by reference as part of the MCO contracts and provide more detailed standards information and requirements.

Requirements for enrollee information dissemination (42 CFR 438.10 and 42 CFR 457.110) as set forth for both AHCCCS and its MCOs are required to be adhered to; moreover, AHCCCS processes and protocols ensure that:

- The Application for Benefits complies with the information requirements for potential enrollees,
- The eligibility staff has access to the provider listing by MCO for their Geographic Service Area (GSA) and will share the MCOs' websites with the applicant,
- All enrollees and potential enrollees are informed of their enrollment rights as they pertain to their specific GSA and circumstances, and
- The beneficiary support system is available for all enrollees and potential enrollees to assist in making an informed decision when selecting their MCOs.

When enrollees and potential enrollees need help selecting a health plan, they may:

- Visit [www.azahcccs.gov/choice](http://www.azahcccs.gov/choice), or
- Speak to a Beneficiary Support Specialist by calling 602-417-7100 from area codes 480, 602, and 623 or 1-800-334-5283 from area codes 520 and 928.

AHCCCS also provides links to the AHCCCS MCO websites, member handbooks, provider searches, and drug formularies. This enables applicants to view the MCO networks from the AHCCCS website.

A variety of language assistance services, as well as auxiliary aids and related services, are available to individuals at no cost. Written materials for the AHCCCS program are available in both English and Spanish. In addition, bilingual staff are employed throughout AHCCCS to assist individuals who speak Spanish, to answer their questions and provide information. AHCCCS also utilizes a vendor to provide oral interpretation services for all languages. Additional communication accommodations, such as large print eligibility letters, are provided for applicants and members who have visual, auditory, and/or other impairments. All vital materials include taglines, printed in a conspicuously visible font size, in a variety of the most common non-English languages spoken in the state. Vital documents also provide information about the availability of written translation and oral interpretation services, how to request auxiliary aids and services, and how to obtain information in alternative formats.

With regard to MCOs, AHCCCS imposes stringent requirements regarding availability of language assistance services and auxiliary aids and services at no cost. Written materials that are critical to obtaining services are made available in each prevalent non-English language in the MCO's service area and oral interpretation services are available in all languages. Tagline documents and information describing availability of auxiliary aids and services are also mandatory requirements for MCOs.

### 4.5 Evidence-Based Clinical Practice Guidelines

AHCCCS requires MCOs, as specified in the contract, to develop, manage, and monitor provider use of the Evidence Based Programs and Practices (EBPP), including but not limited to the following:

- Intake, assessment, engagement, treatment planning, harm reduction efforts, data and outcome collection, and post discharge engagement,

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- EBPPs used by all providers for the treatment of SUD and MAT integrated into services as appropriate,
- Trauma informed care,
- Gender-based treatment,
- Lesbian, Gay, Bisexual, Transgender, and/or Queer/Questioning (LGBTQ),
- Culturally appropriate,
- Criminal involvement,
- Adolescent specific, and
- Development and use of promising practices, if no EBPP is available.

AHCCCS requires MCOs, as specified in AHCCCS AMPM Policy 1020, to develop or adopt and disseminate practice guidelines for physical and behavioral health services that are based on valid and reliable clinical evidence, consider the needs of the MCOs' members, and adopt in consultation with MCOs and National Practice Guidelines. MCOs must disseminate EBPP to all affected providers upon request to members/Health Care Decision Makers and potential members upon request. AHCCCS requires MCOs to annually evaluate the guidelines through the Medical Management Committee to determine if the guidelines remain applicable, represent the best practice standards, and reflect current medical standards [42 CFR 457.1233(c) and 42 CFR 438.236(b)(4)].

### 4.6 Sharing Best Practices

AHCCCS actively seeks to identify local, state, and national evidence-based best practices that promote and support member health outcomes. This includes MCO initiated programs and practices as identified by AHCCCS or self-reported by the MCO annually via the Contractor Best Practices & Follow Up on Previous Year's EQR Report Recommendations submission. Identified best practices are shared with the EQRO for inclusion within the Annual EQR Technical Reports.

The MCO representatives are invited to share best practices at the QM/MCH Contractor Meetings and the Community Quality Forum to facilitate discussion and system wide process improvement efforts within the practice area being addressed. In addition, AHCCCS routinely invites external SMEs to present information and best practices that pertain to key AHCCCS initiatives. Technical assistance is offered upon MCO request or upon AHCCCS direction based on MCO performance.

### 4.7 Sanction Philosophy and Notice to Cure

AHCCCS collaborates closely with its MCOs to ensure compliance with contractual and policy requirements and provides technical assistance whenever necessary to educate and train MCOs on specific requirements. AHCCCS does have the authority to issue administrative actions and sanctions to a MCO for failing to demonstrate compliance with contractual requirements. Each occurrence of non-compliance will be evaluated for possible administrative action. Administrative actions may include issuing of any of the following: Notice of Concern, mandate for Corrective Action Plan (CAP), Notice to Cure, and/or Sanctions.

With few exceptions, the AHCCCS Compliance Committee evaluates recommendations for proposed sanctions, considers relevant factors, and determines the appropriate sanction to be imposed. The Compliance Committee may also consider less severe administrative actions that do not include a sanction, such as a Notice of Concern, a Notice to Cure, or a requirement of a CAP as part of their review process. ACOM Policy 408, Sanctions, describes the types of sanctions and subsequent monetary penalties or other actions that may result if an MCO fails to adhere to the provisions of the Medicaid

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managed care program or contract requirements. The policy also identifies the committee membership and considerations for determination of appropriate sanctions.

AHCCCS may impose monetary sanctions, suspend any or all further member enrollment, and/or suspend, deny, refuse to renew, or terminate a contract in accordance with A.A.C., R9-22-606, and the terms of the contract and applicable federal or state regulations. Written notice is provided to the MCO specifying the sanction to be imposed, the grounds for the sanction, and either the length of suspension or the amount of capitation to be withheld. The MCO may appeal the decision to impose a sanction in accordance with 9 A.A.C. 34. Intermediate sanctions may be imposed for, but are not limited to, the following actions:

- Substantial failure to provide medically necessary services that the MCO is required to provide to its enrolled members under the terms of its AHCCCS Contract,
- Imposition of premiums or charges in excess of the amount allowed under the 1115 Waiver,
- Discrimination among members based on their health status or need for health care services,
- Misrepresentation or falsification of information furnished to CMS or AHCCCS,
- Misrepresentation or falsification of information furnished to an enrollee, potential enrollee, or provider,
- Failure to comply with the requirement for physician incentive plan as delineated in contract,
- Distribution directly, or indirectly, through any agent or independent contractor, of marketing materials that have not been approved by AHCCCS or that contain false or materially misleading information,
- Failure to meet quality of care and quality management requirements,
- Failure to meet AHCCCS encounter standards,
- Violation of other applicable state or federal laws or regulations,
- Failure to fund the accumulated deficit in a timely manner,
- Failure to increase the Performance Bond in a timely manner, and
- Failure to comply with any other contract provisions.

AHCCCS may impose the following types of intermediate sanctions:

- Civil monetary penalties,
- Appointment of temporary management of an MCO,
- Allow members the right to terminate enrollment without cause and notify affected members of their right to disenroll,
- Suspension of all new enrollment, including auto assignments,
- Suspension of payment for recipients enrolled after the effective date of the sanction until CMS or AHCCCS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur, and
- Additional sanctions to allow under statute or regulation that address areas of noncompliance.

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### 5. MCO Performance Monitoring

AHCCCS provides regulatory oversight and conducts performance monitoring of its MCOs through a variety of methods.

#### 5.1 Performance Measurement

AHCCCS establishes performance standards, goals, and benchmarks based on national standards, such as the NCQA National Medicaid Means, whenever possible. AHCCCS and MCOs regularly evaluate metrics and other performance monitoring tools in order to ensure that there are effective and meaningful performance measurement techniques in place for populations served.

#### 5.2 Performance Measures

AHCCCS utilizes performance measures to monitor MCO compliance in meeting contractual requirements related to the delivery of care and services to members. In developing the performance measure set, AHCCCS considers the goals of the “Triple Aim for Populations”. As referenced in Section 3 of this document, the AHCCCS Quality Strategy is based firmly in the Triple Aim concepts for quality and effective health care delivery.

AHCCCS performance measures are based on the CMS Core Measure Sets, NCQA Healthcare Effectiveness Data and Information Set (HEDIS)<sup>®</sup> measures, SAMHSA quality measures, and other resources. AHCCCS performance measures are integral to each MCO’s QM/PI Program and may focus on clinical and non-clinical areas. MCOs are required to report on performance measures as identified in the contract. MCOs that provide LTSS shall also include LTSS-specific performance measures that examine, at a minimum, members’ quality of life and the MCOs’ rebalancing and community integration outcomes. Performance measures specific to members selecting a self-directed option may also be developed. The measures will consider underlying performance, performance gaps, reliability and validity, feasibility, and alignment. Performance measures are also evaluated based on a number of demographics in order to reduce, to the extent practical, health disparities based on age, race, ethnicity, sex, primary language, and disability status. The measures will support and align with the MCOs’ QM/PI Programs [42 CFR 438.330(c)(1)(ii)].

The AHCCCS performance measures are used to evaluate whether MCOs are fulfilling key contractual obligations. Such performance measures, established or adopted by AHCCCS, are also an important element of the agency’s approach to transparency in health services and VBP. MCO performance is publicly reported on the AHCCCS website (e.g., report cards and rating systems), as well as other means, such as the sharing of data with state agencies and other community organizations and stakeholders. MCO performance is compared to AHCCCS requirements, with the national NCQA Medicaid Mean (for NCQA HEDIS<sup>®</sup> measures) and the CMS Medicaid Median (for CMS Core Set Only measures) for the associated measurement period serving as the performance target for each contractually required performance measure.

MCOs are expected to achieve the established performance standards for performance measures. Performance measure reports may compare the MCOs’ results with each other and with Medicaid national averages. The rationale for establishing these measures is for MCOs to develop methods to continuously increase the well-being of their respective populations through the removal of barriers to care and ongoing process improvement. AHCCCS participates in national efforts focused on developing Medicaid and CHIP Core Measures to allow comparability across state programs.

#### 5.3 Performance Improvement Projects (PIPs)

Each MCO is expected to conduct PIPs in clinical and/or non-clinical areas that are expected to have a favorable impact on health outcomes and member satisfaction. AHCCCS mandates that MCOs participate

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in PIPs selected by the agency. MCOs must also select and design additional PIPs specific to needs and data identified through internal surveillance of trends. PIPs are developed according to 42 CFR 438.330, Quality Assessment, and Performance Improvement Program. PIPs are designed to correct significant system problems and/or achieve significant improvement in health outcomes as well as enrollee satisfaction, that is sustained over time, through the:

- Measurement of performance using objective quality indicators,
- Implementation of interventions to achieve improvement in access to and quality of care,
- Evaluation of the effectiveness of the interventions based on the performance measures, and
- Planning and initiation of activities for increasing or sustaining improvement [42 CFR 438.330(d)(2)].

AHCCCS-mandated PIP topics are selected through the analysis of internal and external data/trends and may include MCO input. Topics take into account comprehensive aspects of member needs, care, and services for a broad spectrum of members or a focused subset of the population, including those members with special health care needs or receiving LTSS (42 CFR 438.330). AHCCCS may also mandate that a PIP be conducted by one MCO, or group of MCOs, according to standardized methodology developed by AHCCCS. In addition, MCOs are required to identify and implement additional PIPs based on self-identified opportunities for improvement, as supported by root cause analysis, external/internal data, surveillance of trends, or other information available to the MCO.

For each AHCCCS-mandated PIP, AHCCCS develops a methodology to measure performance, collect data, and conduct analysis in a standardized way across MCOs. Utilizing financial, population, disease-specific data, and input from the MCOs, AHCCCS selects an indicator or indicators of performance improvement to be measured across MCOs. AHCCCS-mandated PIPs (historical and current) are posted on the [AHCCCS Quality & Performance Improvement](#) web page with applicable populations for each PIP defined within the PIP Methodology. MCO specific PIP interventions and results are outlined within the Annual EQR Technical Reports located on the [AHCCCS Health Plan Report Card](#) web page.

In consultation with states and other stakeholders, CMS may specify standardized performance measures and topics for PIPs to include alongside state-specified performance measures and PIP topics within state contracts [42 CFR 438.330(a)(2)]. MCOs are required to conduct PIPs, including PIPs required by the CMS, that focus on both clinical and nonclinical areas.

### 5.4 Regular Monitoring and Evaluation of MCO Performance

AHCCCS monitors and evaluates MCO compliance through ORs, the review and analysis of periodic reports as required in contract, program specific performance measures, and PIPs. Objectives of MCO monitoring and evaluation include:

- Determine if the MCO satisfactorily meets AHCCCS requirements as specified in contract, AHCCCS policies, A.R.S., A.A.C., and 42 CFR 438 Managed Care,
- Increase knowledge of the MCOs' operational encounter processing procedures,
- Provide technical assistance and identify areas where improvements can be made and to identify areas of noteworthy performance and accomplishments,
- Review progress in implementing recommendations made during prior reviews,
- Determine if the MCO is in compliance with its own policies and to evaluate the effectiveness of those policies and procedures,



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- Perform MCO oversight required by CMS in accordance with the AHCCCS 1115 waiver, and
- Provide information to an EQRO for its use as described in 42 CFR 438.364.

### *a. On-Site Operational Reviews (ORs)*

AHCCCS conducts administrative ORs of each contracted MCO at least once every three years, utilizing the process to meet the requirements of the Medicaid managed care regulations (42 CFR 438.358), to determine the extent to which each health plan meets AHCCCS Contract requirements, AHCCCS policies, and additional federal and state requirements. AHCCCS establishes standards for operational, programmatic, and clinical standards. To evaluate the MCO's compliance with each standard, AHCCCS reviews the MCO's records, reports, and information systems, and interviews key health plan staff. Additionally, AHCCCS staff reviews the progress of implementing the recommendations made during prior ORs, determines each MCO's compliance with its own policies and procedures, and evaluates its effectiveness. Agency staff from the DHCM, the Office of Administrative and Legal Services (OALS), the Division of Business and Finance (DBF), the OIG, and the OIFA review the operations of the MCO, conduct file reviews, and interview key health plan staff.

To maintain compliance with regulatory requirements and AHCCCS contract standards, AHCCCS reviews the following areas (as applicable) at least every three years:

- Case Management,
- Corporate Compliance,
- Claims and Information Systems,
- Delivery Systems,
- General Administration,
- Grievance System,
- Adult, EPSDT, and Maternal Child Health,
- Medical Management,
- Member Information,
- Quality Management,
- Reinsurance, and
- Third Party Liability.

Upon completion of an OR, MCOs are required to submit CAPs in any areas receiving a score of less than 95 percent. AHCCCS expects the vast majority of these CAPs to be implemented and closed within six months of AHCCCS' acceptance of the CAP. MCOs are required to submit a CAP update along with documentation demonstrating compliance to close each CAP.

AHCCCS may choose to review specific areas more frequently depending on identified needs. For example, in 2015, AHCCCS conducted a mid-cycle review in areas identified as a heightened concern. AHCCCS also uses the OR to increase its knowledge of each MCO's operational procedures, provide technical assistance, identify areas for improvement, and identify areas of noteworthy performance and accomplishment.

As a condition of the 1115 Waiver, AHCCCS performs extensive data validation. Known as encounter data, records of services provided are submitted to AHCCCS for all covered services including

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institutional, professional, dental, and medication/pharmacy services, with each having its own format. AHCCCS also performs annual validation studies on MCO data to ensure that the data has been reported in a timely manner and is accurate and complete, since sanctions may be imposed on the MCO based on the results of the data validation studies. AHCCCS provides technical assistance and training to the MCOs to support the MCO's ability to meet AHCCCS requirements. OR and data validation results are reported to CMS in accordance with the 1115 Waiver's terms and conditions.

### *b. Grievance and Appeals*

One of many critical objectives of the agency's grievance and appeals system is to advance and improve the quality, accessibility, and timeliness of health care services for AHCCCS members. AHCCCS has developed robust contractual requirements, which have been refined over time. Contracts dictate member-focused standards designed to support the timely provision by MCOs of medically necessary health care services, focusing on improvements in members' health and well-being. In addition to detailed contractual requirements that promote these objectives, AHCCCS also promulgated specific administrative regulations and clarified policies to which MCOs must adhere.

The OALS is responsible for oversight of the Title XIX/TXXI Grievance and Appeals system and the Grievance and Appeals system for members with an SMI designation. The OALS continually engages in the review of hearing cases resulting from appeals of adverse benefit determinations from managed care beneficiaries. Not only does AHCCCS monitor the number of beneficiary hearing requests filed against each MCO on a monthly basis, AHCCCS also reviews the categories of adverse benefit determinations to identify trends, outliers, and whether additional scrutiny of the MCOs service authorization process may be warranted. As mandated by 42 CFR 438.402, MCOs are permitted only one level of appeal.

Routinely, the agency's medical management department receives a listing of beneficiary requests for hearing from the OALS to review the adequacy of service authorization notices sent to beneficiaries pursuant to 42 CFR 438.404. Equally as important, each substantive hearing case resulting from the appeal of an adverse benefit determination is individually reviewed to evaluate MCO compliance from both a procedural standpoint and a clinical perspective. This scrutiny includes consideration of the MCOs' handling of grievances and appeals pursuant to 42 CFR 438.406 to ensure beneficiary access, meaningful participation, and effective MCO review. When deficiencies or concerns are identified, including those that pertain to quality of service, accessibility of service, and timeliness of service, or the adequacy or timeliness of the MCO notifications pursuant to 42 CFR 438.404 and 42 CFR 438.408, they are identified in the hearing decision or presented for follow-up through other mechanisms to achieve compliance.

Deficiencies and areas of concern are communicated to the appropriate divisions within the agency to be addressed. As a result, compliance actions may be instituted against MCOs, and corresponding policies and guidance may be developed or clarified. All hearing matters that present quality of care concerns regarding service delivery, accessibility, or timeliness are referred to the agency's quality management department for thorough investigation. In addition, findings from the OALS' reviews of MCO hearing cases and member concerns directed to the OALS are communicated within quarterly meetings to executive and management staff across the agency. These quarterly meetings are convened to evaluate MCO performance in a variety of operational areas. As part of the agency's continuing scrutiny of MCO quality, timeliness, and accessibility of health care delivery to members, staff from the OALS participate in ongoing ORs of each MCO's grievance and appeals system which evaluates, in part, MCO compliance with member Grievance and Appeals requirements.

A meaningful recordkeeping system is vital and fundamental to an effective grievance and appeals system. Thus, consistent with 42 CFR 438.416, each MCO must comply with detailed recordkeeping

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requirements for all grievances and appeals in order to inform its ongoing monitoring processes and the continual refinement of its quality strategies. Through its ORs and oversight activities, AHCCCS assesses each MCO's recordkeeping system to determine its efficacy.

### *c. Ongoing Review and Analysis of Deliverables*

To monitor compliance with rules, regulations, contracts, and policies on an ongoing basis, MCOs are required to submit a number of contract deliverables. Contract deliverables are due weekly, monthly, quarterly, annually, and on an ad hoc basis depending on the individual deliverable requirement. A chart of contract deliverables is included in the MCO contract; these deliverables may vary depending on the line of business.

### *d. Program Plans*

AHCCCS requires MCOs to submit annual Program Plan reports, which delineate implementation of the comprehensive approach utilized for ensuring high-quality and cost-effective services are provided for all Medicaid members within Arizona, including those with special health care and behavioral health needs. A distinct set of annual Program Plan reports summarize general QM/PI, maternity and family planning, and medical management strategies, as well as population specific requirements for EPSDT services (including dental services) mandated under CMS.

Each MCO is required to submit separate program plan reports for EPSDT, dental, maternity and family planning, medical management, and QM/PI. Each program plan must include a narrative, a prospective work plan, and a work plan evaluation. The narrative must identify operational and structural elements that shall ensure achievement of contractually required clinical, quality, and performance elements for all members under the care of an MCO. Prospective work plans focus on goals and methods for achieving performance and quality standards for the upcoming calendar year. Work plan evaluations offer an analysis of the previous year's activities related to quality and performance goals and strategies.

### *e. Quarterly Reports*

MCOs are required to submit Performance Measure Monitoring Reports to the AHCCCS Quality Improvement Team. These quarterly deliverables provide self-reported MCO data for contractually required performance measures. Each MCO utilizes its prospective Work Plan to identify performance goals/objectives and related interventions. Within the Performance Measure Monitoring reports, the MCOs include: an analysis of the results, an indication whether performance goals were met or not met, identified barriers, and identified opportunities for improvement.

In an effort to align MCO reporting across lines of business, the Performance Measure Monitoring Report template, attachment, and associated instructions provide essential guidance to effectively compare performance. In addition, a consolidated reporting format was created to efficiently facilitate AHCCCS Quality Improvement team review of Performance Measure Monitoring report submissions; format changes also expedited feedback provided to the MCOs.

### *f. Meetings and Staffings*

AHCCCS routinely conducts quality driven meetings that facilitate staff education and/or the wide-spread dissemination of quality-related information specific to MCO performance. These meetings include, but are not limited to, the following:

- **Clinical Oversight Committee:** quarterly meetings facilitated and managed by the clinical unit, which include the AHCCCS Director, executive management, and representatives across divisions, conducted to review MCO clinical and quality performance and discuss and review clinical initiatives.

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- **Operations Oversight Committee:** quarterly meetings facilitated and managed by the operations unit, which include the AHCCCS Director, executive management, and representatives across divisions, conducted to review MCO operational and financial performance.
- **Quarterly Quality Management MCO Meeting:** quarterly meetings facilitated by the clinical unit, which include representatives from MCO quality, MCH/EPSTD, behavioral health teams, and agency staff, to review quality objectives, policies and procedures, and provide resources and guest speakers who support overall quality efforts.
- **Quarterly Operations MCO Meetings:** quarterly meetings facilitated by the operations unit, for which over the course of a year, two of the annual meetings include only the DHCM representation and the other two meetings include attendance by the AHCCCS Director, executive management, and cross divisional representation. The MCOs provide overall updates on their operations, including clinical updates and updates on strategic initiatives.

### 5.5 Improvement/Interventions

To promote improvement at the MCO level, AHCCCS requires MCOs to participate in technical assistance or training sessions when opportunities for improvement are identified. MCOs are also encouraged to request technical assistance when questions arise. Additionally, AHCCCS conducts quality improvement and quality management related trainings at the quarterly Quality Management/Maternal Child Health meetings. AHCCCS has also established the following MCO requirements:

#### *a. Review and Analysis of Program Specific Performance Measures and Performance Improvement Projects*

AHCCCS reviews MCO performance measure results on a regular basis. Results are compared with established performance standards specified in contract and trends are identified. Results of measurements for PIPs are also reviewed and analyzed by MCO. Appropriate action is conducted depending on findings, such as requiring MCOs to implement CAPs and/or AHCCCS providing technical assistance to MCOs. Results are also analyzed by line of business and at the AHCCCS aggregate level, when possible, to identify systemic opportunities for improvement.

#### *b. Accreditation*

MCOs are required to inform AHCCCS as to whether they have been accredited by a private, independent accrediting entity and provide a copy of their most recent accreditation review, in accordance with managed care regulation requirements. Should the MCO renew or lose its accreditation, the MCO shall provide AHCCCS written notification (in the case of losing its accreditation) or a copy of the renewal certificate, as applicable, within 15 calendar days of notification or receipt from the accrediting entity. This information is available on the [AHCCCS Health Plan Report Card](#) web page.

AHCCCS added a contractual requirement that MCOs achieve NCQA First Accreditation, inclusive of the NCQA Medicaid Module, specific to their Medicaid line of business by October 1, 2023. MCOs with an ALTCS (EPD or DD) line of business shall also obtain the NCQA LTSS distinction prior to the date specified. While it is anticipated that accreditation activities should be initiated during CYE 2021 in accordance with AHCCCS direction, AHCCCS may delay the implementation of pre-accreditation activities and the NCQA accreditation requirement based on funding availability.

#### *c. Quality Rating System*

In accordance with the November 2020 updates to 42 CFR 438.334, AHCCCS intends to implement a Quality Rating System. Currently, AHCCCS utilizes its [AHCCCS Health Plan Report Card](#) to provide a comparison of MCOs by line of business related to the quality of care members enrolled in each MCO

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receive, how satisfied members are with their MCO, and how well the member's MCO met their expectations.

The AHCCCS Health Plan Report Card was enhanced during CYE 2018 based on internal and external stakeholder feedback. The AHCCCS Health Plan Report Card provides easy access to specific MCO related quality documents. AHCCCS looks forward to engaging with CMS in its development of mandatory measures and methodology to be included within the Medicaid Quality Rating Systems (QRS) as it looks to elect whether to utilize the CMS or a state alternative QRS framework.

### 6. Network Adequacy

In order to ensure MCO network adequacy, AHCCCS has developed a number of network adequacy and availability of services standards to address the requirements of 42 CFR 438.68 and 42 CFR 438.206, as outlined below:

#### 6.1 Provider Network Development and Management Plan (Network Plan)

The Network Plan outlines the MCO's process to develop, maintain, and monitor an adequate provider network which is supported by written agreements and is sufficient to provide access to all services under its contract. The Network Plan is submitted annually. Its purpose is to ensure sufficient provision of services to members by outlining network activity and performance in the preceding year, as well as proposing a comprehensive plan for the provision of services in the coming year.

The elements of the Network Plan are dictated by a checklist of mandatory elements outlined as part of ACOM Policy 415. The checklist is derived from federal and state law and regulations, policy, and AHCCCS initiatives, and is updated on a regular basis. Checklist elements that MCOs must include in the Network Plan include, but are not limited to, the following:

- A formal attestation of the MCO's network adequacy,
- An evaluation of the previous contract year's network plan,
- How services are provided promptly and reasonably accessible in terms of location and hours of operation,
- How the MCO ties network implications from its Cultural Competency Plans to ensure cultural and linguistic needs are met,
- A summary and review of the MCO's VBP initiatives and COE programs, and
- The MCO's process for identifying and publicizing providers that offer reasonable accommodations for members such as physical access, accessible equipment, and culturally competent communications.

#### 6.2 Minimum Network Requirements Verification

Each quarter, the MCOs submit a completed Minimum Network Requirement Verification Report (Verification Report). The requirements for this report are outlined in ACOM Policy 436. In the Verification Report, MCOs describe their compliance with minimum network requirements, including time and distance requirements. These requirements identify 13 provider types for which AHCCCS has developed minimum time and distance standards to ensure geographic access to services. The Verification Report includes standards specific to all MCOs, as well as some standards specific to RBHA and ALTCS EPD MCOs. Moreover, some standards are measured against specific member populations

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and the standards vary by county. These standards, as well as other minimum network requirements that define network access, are identified in [ACOM Policy 436](#).

AHCCCS validates the Verification Report submissions by conducting an independent time and distance analysis of the MCOs' compliance. This analysis is completed through a contract with AHCCCS' EQRO. Each quarter, AHCCCS provides its EQRO with each MCO's Verification Report submission, the MCO's Provider Affiliation Transmission (PAT) file, the MCO's enrolled membership, and a file of all AHCCCS-registered providers. For each MCO, AHCCCS' EQRO produces a report comparing the Verification Report submissions with its validation.

### 6.3 Appointment Availability Monitoring and Reporting

In order to evaluate the practical ability of members to find a timely appointment, AHCCCS has established minimum appointment availability requirements, outlined in ACOM Policy 417. Under this policy, AHCCCS establishes specific timeframes that members should expect to receive an appointment within a MCO's provider network. These timeframes are categorized by provider type and include varying degrees of need for appointments. Appointment availability standards monitor appointments with the following providers: PCPs, specialists, dentists, maternity care providers, behavioral health providers, and providers prescribing psychotropic medications. A separate section in the policy outlines appointment availability requirements specific to behavioral health appointments for members in legal custody of DCS.

### 6.4 Material Changes to the Provider Network

AHCCCS has established reporting requirements for when a significant change is made to an MCO's provider network in order to evaluate the impact of the change. As outlined in ACOM Policy 439, AHCCCS requires MCOs to evaluate changes made to their provider networks for materiality. A material change to provider network is defined as any change in the composition of, or payments to, the MCO's provider network that would cause or is likely to cause more than five percent of its members in a GSA to change where they receive services, or any change impacting fewer than five percent of members but involves a provider or provider group who is the sole source of a service, or operates in an area with limited alternate sources.

When the MCO identifies a material change to the provider network, the MCO submits an assessment of the impact of the change, how it will transition members, a communication plan regarding the change, and how the MCO will monitor the impact of the change after transition. After approval of a material change in provider network, AHCCCS commonly requires periodic reports on the status of transitioning members.

### 6.5 Provider Changes Due to Rates Reporting

The MCOs must identify when a provider leaves or reduces services due to rates, regardless of whether the change has a material impact on the provider network. Specifically, ACOM Policy 415 includes an attachment where plans report the name, type, whether the provider is a PCP, the region served, and number of members assigned to any provider leaving the network or reducing or diminishing their scope of services due to sufficiency of rates. The MCO must also conduct an analysis to determine if the loss is a material change and requires more in-depth reporting under ACOM Policy 439.

## 7. Value-Based Purchasing

AHCCCS is pursuing the implementation of long-term strategies that bend the cost curve while improving member health outcomes. A critical tool in achieving this strategic priority is VBP. The overall mission is

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to leverage the AHCCCS managed care model toward value-based health care systems where members' experience and population health are improved through:

- Aligned incentives with MCOs and provider partners, and
- A commitment to continuous quality improvement and learning.

VBP encompasses a variety of initiatives for payment reform, including APMs, Differential Adjusted Payments (DAP), E-Prescribing, and Directed Payments. The graphic display below outlines the long-term strategy AHCCCS employs to move along the continuum of APMs.

## Learning Action Network - Alternative Payment Model Framework Strategies

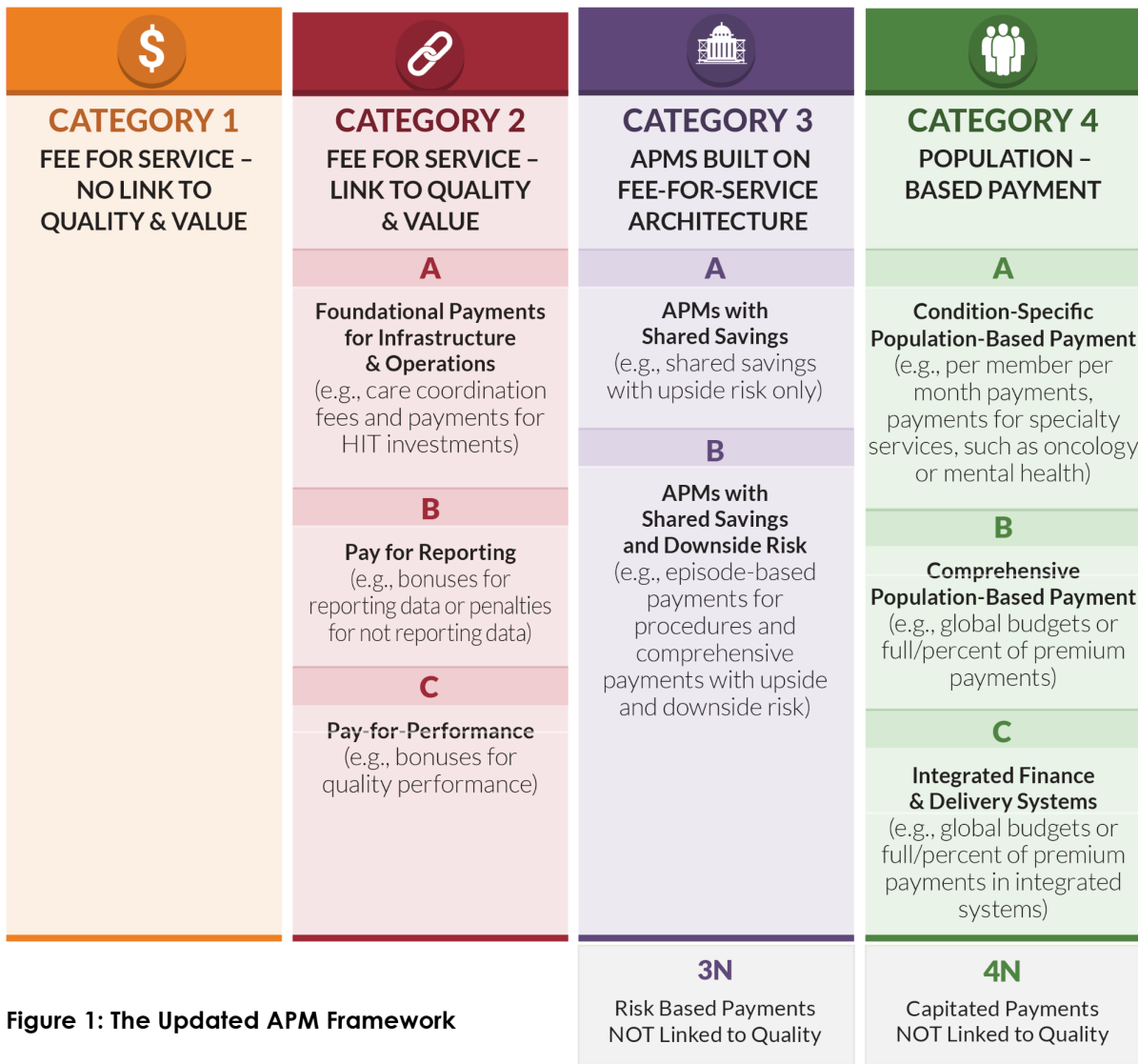


Figure 1: The Updated APM Framework

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Through VBP, AHCCCS is committing resources to leverage the State's successful managed care model to address inadequacies of the current health care delivery system such as fragmentation and paying for volume instead of quality.

AHCCCS has identified the following guiding principles for its VBP strategy:

- Engagement with stakeholders,
- Movement along the LAN-APM continuum,
- Balance prescriptive requirement while preserving MCO flexibility, and
- Data-driven decision making.

Through VBP, AHCCCS hopes to work toward achieving the following goals:

- Pay for value,
- Align payer and provider incentives,
- Innovate through competition,
- Improve quality, and
- Demonstrate results.

### 7.1 Alternative Payment Models

#### *a. LAN-APM Target Requirements*

AHCCCS is a committed partner in the [Health Care Payment \(HCP\) Learning and Action Network \(LAN\)](#) which strives to accelerate the health care system's adoption of effective APMs. Using LAN-APM Target Requirements, AHCCCS encourages contracted MCO activity in the area of quality improvement, specifically the development of initiatives conducive to improved health outcomes and cost savings.

AHCCCS has established contractually required targets for health plans to contract with providers at a selected percentage of overall medical spend under VBP/APM arrangements. Furthermore, AHCCCS has specified the sub-requirement for the proportion of those VBP/APM arrangements that must be under HCP LAN-APM Framework Categories 3 and 4. There is a LAN-APM Target Requirement and sub-requirement specific to each AHCCCS line of business. For example, the acceptable APM for MCOs includes pay for performance, shared savings, bundled payment, and capitation.

#### *b. Performance Based Payments*

AHCCCS employs its APM-Performance Based Payments (PBP) Initiative to encourage MCOs to develop initiatives designed to improve health outcomes and achieve cost savings by incentivizing providers to participate in APMs. PBPs are payments to providers for meeting certain performance measures targets that support LAN-APM initiatives. PBPs work to align incentives between MCOs and providers to increase the quality and efficiency of care by rewarding providers for improving performance across various quality measures to achieve cost savings and improve outcomes. MCOs are also able to pay out PBP based on Medical Loss Ratio (MLR) targets if linked to quality.

#### *c. Withhold and Quality Measure Performance Incentive*

The APM-Withhold and Quality Measure Performance (QMP) Incentive strives to encourage MCO activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the MCO and providers through APM strategies. AHCCCS implements this initiative under 42 CFR 438.6(b)(2) and 42 CFR 438.6(b)(3).



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AHCCCS withholds one percent of each MCO's prospective gross capitation. MCOs are then evaluated on AHCCCS-selected NCQA-HEDIS® performance measures where the MCOs are able to earn back their withhold amounts, as well as an additional incentive payment.

MCOs are evaluated on the following two items:

- Relative performance on NCQA HEDIS® performance measures to other MCOs, and
- Performance on NCQA HEDIS® performance measures compared to the NCQA Medicaid mean.

AHCCCS may consider in future years including a health equity component to the Withhold and QMP Incentive.

### 7.2 Differential Adjusted Payments (DAP)

Through DAP, AHCCCS is able to provide a uniform percentage increase to registered providers who provide a particular service under the contract and who meet specific criteria established by AHCCCS. The uniform percentage adjustment represents a positive increase to the AHCCCS FFS rates and MCOs' contracted rates. DAP aims to distinguish providers that have committed to supporting designated actions that improve members' care experience, improve members' health, and reduce cost of care growth.

AHCCCS began DAP in CYE 2017 and over the last four years has grown the program to support a variety of providers across the Arizona health care delivery system, including:

- Hospitals subject to All Patients Refined Diagnosis Related Groups (APR-DRG) reimbursement, excluding critical access hospitals,
- Critical access hospitals,
- Other hospitals and inpatient facilities,
- IHS/638 tribally owned and/or operated facilities,
- Nursing facilities,
- Integrated clinics,
- Behavioral health outpatient clinics,
- Physicians,
- Physician Assistants,
- Registered Nurse Practitioners,
- Dental providers, and
- HCBS providers.

Each DAP is time-limited for one year only, although a similar DAP may be implemented in the subsequent year. Providers must re-qualify for a DAP each year even when the DAP criteria remain the same. Examples of DAP criteria include: increasing the percent of electronic prescriptions prescribed to AHCCCS members, increasing the number of 6-week postpartum visits for obstetricians or gynecologists, and meeting or falling below the statewide average for the urinary tract infection (UTI) performance measure for nursing facilities. AHCCCS MCOs are required to pass DAP increases through to their contracted providers, maintaining rates to match the corresponding AHCCCS FFS rate increase percentages.

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### 7.3 E-Prescribing

E-Prescribing is a recognized and proven effective tool to improve members' health outcomes and reduce costs. Benefits afforded by the electronic transmission of prescription-related information include, but are not limited to, reduced medication errors, reductions of drug and allergy interactions, and therapeutic duplication, patient adherence, and increased prescription accuracy. AHCCCS MCOs are required to increase their E-Prescribing rate of original prescriptions. The goal percentage is specific to each AHCCCS line of business.

### 7.4 Directed Payment CMS Quality Criteria and Framework

42 CFR 438.6(c)(1)(iii)(B) provides AHCCCS with the flexibility to implement delivery system and provider payment initiatives under its MCO contracts. AHCCCS uses this federal authority to implement several directed payment initiatives for AHCCCS managed care programs.

Directed payments occur when AHCCCS directs its MCOs to pay specific amounts to providers under their managed care contracts. The directed payments work to advance delivery system reforms and/or performance improvement initiatives.

AHCCCS' directed payments focus on advancing the goals and objectives of AHCCCS' Quality Strategy to improve performance and provide high-quality services to AHCCCS members. AHCCCS is required to identify quality criteria and framework for each payment arrangement. AHCCCS uses goals and objectives outlined in AHCCCS' Quality Strategy to determine how each directed payment will be evaluated. When selecting performance measures for AHCCCS' directed payments, AHCCCS maintains its efforts to support the agency's Quality Strategy. AHCCCS works across divisions, as well as with external stakeholders through workgroups, when selecting performance measures to ensure that facilities required to report the data are able to do so.

Annually, AHCCCS is responsible for preparing CMS preprints for each of its directed payments for the following payment arrangements:

- Differential Adjusted Payments (DAP),
- Targeted Investments (TI),<sup>11</sup>
- Access to Professional Services Initiative (APSI),
- Pediatric Services Initiative (PSI),
- Hospitals Enhanced Access Leading to Health Improvements Initiative (HEALTHII), and
- Nursing Facilities Supplemental Payments (NF).

### 7.5 Targeted Investments Program

Integrating physical and behavioral health services is essential to reducing delivery system fragmentation. The TI Program provides financial incentives to eligible AHCCCS providers to develop systems for integrated care. In accordance with 42 CFR 438.6(c) and the 1115 Waiver, MCOs are required to provide financial incentives to eligible Medicaid providers who meet certain benchmarks for integrating and coordinating physical and behavioral health care for Medicaid beneficiaries. The TI Program aims to:

- Reduce fragmentation that occurs between acute care and behavioral health care,
- Increase efficiencies in service delivery for members with behavioral health needs, and

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<sup>11</sup> The TI preprint was approved as a multi-year preprint for the duration of the TI program.

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- Improve health outcomes for the affected populations.

The provider types that are eligible to participate in the TI Program include:

- Outpatient behavioral health clinics,
- Integrated clinics,
- Primary care practices, including: pediatricians, internal medicine practices, family practices, and nurse practitioners, and
- Hospitals.

Financial incentives are paid on an annual basis to participating provider practices, organizations, and hospitals based on requirements that vary over the five-year span of the TI Program.

At the end of Year One of the TI Program (October 1, 2016 through September 30, 2017), participating TI providers were eligible to receive payment following acceptance into the program. For Years Two and Three, directed incentive payments were tied to completing core components and related milestones. For Years Four and Five, payments are based on meeting or exceeding performance improvement targets for specified quality measures. The core components include the systems and process requirements that are intended to help further integration of primary care and behavioral health, requirements that TI participants must complete to receive incentive payments. TI participants are organized into adult primary care practice, adult behavioral health, pediatric primary care practice, pediatric behavioral health, justice, and hospital areas of concentration.

The core components and milestones focus on identifying high-risk AHCCCS members, including those with behavioral health needs, and connecting them to appropriate resources and services through enhanced care management and data sharing with both primary care and behavioral health providers. For example, core components common to several areas of concentration include establishing and using a high-risk registry, using care managers for individuals listed on the high-risk registry, using integrated care plans, and using protocols for two-way transmission of Admissions, Discharges and Transfer (ADT) information through the statewide Health Information Exchange (HIE). Additional core components focus on behavioral health and social determinants of health (SDOH) screening and follow up. It is believed these actions are improving care coordination and care outcomes. In the fourth and fifth program years, TI participants' performance is based on their performance on clinical outcome measures that are aligned with AHCCCS' Quality Strategy.

The measures of the systems of care established in the earlier years of the project were designed to improve care coordination and integration. The measures that were selected are intended to reflect Program participants' progress toward providing more coordinated and integrated care. The measures were selected from sources such as NCQA HEDIS® and the CMS Core Set measures and align with the AHCCCS quality measures.

### **8. Enabling Infrastructure: Data and Technology Systems**

AHCCCS performs extensive data validation of managed care data. Records of services provided (encounter data) are submitted to the agency for all covered services, including institutional, professional, dental, and medication/pharmacy services. These encounter data are submitted in standard Health Insurance Portability and Accountability Act of 1996 (HIPAA) and National Council for Prescription Drug Programs (NCPDP) formats and are subject to extensive data standards as well as extensive data quality editing. AHCCCS also performs annual validation studies on MCO encounter data to ensure that the data has been reported in a timely manner, is accurate, and is complete.

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### 8.1 Pre-paid Medical Management Information System

AHCCCS operates the Pre-paid Medical Management Information System (PMMIS), a mainframe database processing system made up of multiple subsystems, each with distinct functions supporting managed care as well as FFS processes. In 2020, AHCCCS began a modernization effort for its aging mainframe system by adding a vendor-hosted provider management system to integrate with the mainframe. This new “modular” approach, first proposed by CMS in 2016 as a way of improving systems, is the future of the AHCCCS PMMIS, where individual subsystems will be replaced by external modules until eventually the mainframe can be fully retired.

AHCCCS collects encounter data from all MCOs. An encounter is a record of a covered Medicaid service rendered by a registered AHCCCS provider to an AHCCCS member who is enrolled with a MCO on the date of service. MCOs are required to submit encounters for services provided to AHCCCS members for paid services, services eligible for processing with no financial liability (e.g., Medicare and third-party payer), prior period coverage (PPC), and administrative denials. Complete, accurate, and timely reporting of encounter data is critical for the program’s success. AHCCCS encounter formats follow national industry standards and code sets for encounter submissions and editing (837P/I/D and NCPDP PAH). All submitted encounters are subject to AHCCCS-specific requirements, as well as approximately 500 edits/audits, including federal coding standards (e.g., correct coding and medically unlikely edits). Data validation occurs in both a structured/formal process and on an ad hoc basis, as well as includes review by certified coders to ensure that encounter data is complete, accurate, and timely. Actuaries perform ad hoc analysis at least as often as each rate-setting period. In addition, Operational/Actuarial reports measure MCO encounter throughput by date of service and date of submission.

AHCCCS processes FFS claims submitted by providers; the claims are edited and priced within the claims system.

Data that is securely transferred to the CMS Transformed Medicaid Statistical Information System (T-MSIS) on a monthly basis. AHCCCS continues to work with CMS to ensure accuracy and validity of the state-reported data.

### 8.2 Data Warehouse

The AHCCCS Data Warehouse provides a timely and flexible way to monitor and analyze performance measure data. Utilization data may be reviewed by multiple characteristics, such as diagnosis, service, age, gender, or another characteristic type. The Data Warehouse is maintained on a regular basis by an in-house team of programmers and configuration specialists. The Information Services Division (ISD) fields requests for system changes, additions, and maintenance, and completes additions or changes according to policy, legislative, CMS, or other requirements.

### 8.3 Health Information Exchange (HIE)

Since 2006, AHCCCS providers and MCOs have supported a single statewide HIE called Health Current. Health Current has become an integral part of AHCCCS’ Quality Strategy and has grown to include 900 participating organizations representing laboratories, physical health and behavioral health providers, state agencies, and other payers, such as Accountable Care Organizations and for-profit health plans. These organizations represent thousands of healthcare practitioners and delivery sites across Arizona. For a complete list of participants, visit Health Current’s website at [www.healthcurrent.org](http://www.healthcurrent.org).

MCOs are using the clinical data that is available at Health Current to support their health care coordination and care management operations. MCOs have sent panels of their members to the HIE to receive a variety of alerts (including COVID-19 test results, hospital ADT, other inpatient, or discharge

## AHCCCS Quality Strategy

clinical event alerts), as determined by the MCOs. Health Current operates a Patient Centered Data Home (PCDH) alert when a member has been:

- Admitted to or discharged from an inpatient facility, or
- Registered at or discharged from an emergency department outside of Arizona.

A PCDH alert uses zip code mapping to send the alert from an out-of-state HIE to the MCO through Health Current. Having real time clinical information through these services is helping MCO with care continuity and management.

Health Current is working to improve provider workflow by offering more seamless ways for participants to integrate with the HIE via a direct EHR integration and a portal to improve access to registries, such as the Prescription Drug Monitoring Program (PDMP), the Arizona Immunization Registry, and the AZ-PIERS Registry for Emergency Medical Services (EMS) organizations. Strategic planning is underway with public health to expand the number of registries that are connected to the HIE to ease the reporting burden and to increase data sharing across the health care community. Health Current was awarded an Office of National Coordinator for Health Information Technology (ONC) grant in 2020 to enhance public health surveillance capability and plans to work with the ADHS to apply for other stimulus grants in 2021 and beyond.

Health Current supports multiple AHCCCS programs, including the DAP program, the Promoting Interoperability Program (formerly the EHRs' Incentive Program), the TI Program, and the agency's new WPCI. Working strategically with AHCCCS, the HIE sets exchange standards and data sets for its participants that can be used to improve the quality of the data that is available at Health Current for AHCCCS providers and MCOs.

Health Current announced a plan in September 2020 to merge with Colorado's HIE, CORHIO, to form a new regional organization which has the potential to create the largest health data utility in the western United States. AHCCCS anticipates being able to leverage the expertise in the newly formed organization to focus on electronic Clinical Quality Measures and greater support for electronic Performance Measure Management.

### 8.4 Telehealth

Telehealth is the use of digital technology, such as computers, telephones, smartphones, and tablets, to access health care services remotely. AHCCCS members who cannot travel to an office can use these devices from their homes to attend health care appointments with their providers. Telehealth can make access to health care more convenient, saving time and transportation costs. It allows people in rural communities, people with limited mobility, people in high-risk populations, and people with limited time or transportation to have options to access their PCPs and medical specialists, thereby eliminating barriers to care. It also helps to improve communication and coordination of care among members of the health care team and their patients.

AHCCCS covers all major forms of telehealth services, including telemedicine (real-time), asynchronous (store and forward), remote patient monitoring, and teledentistry. Telemedicine involves interactive audio and video in a real-time, synchronous conversation. It allows health care delivery, diagnosis, consultation, treatment, and transfer of medical data through interactive audio and video communications that occur in the physical presence of the patient. Asynchronous occurs when services are not delivered in real-time, but are uploaded by providers and retrieved, often through a secure online portal. Telephonic services (audio-only) use a traditional telephone to conduct health care appointments. AHCCCS also covers telehealth for remote patient monitoring and teledentistry.

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AHCCCS telehealth coverage and provider coding requirements, as well as additional telehealth resources, can be found on the AHCCCS [Telehealth Services](#) web page.

### 9. Conclusion

Improving and/or maintaining every member's health status, as well as increasing the potential for the resilience and functional health status of members with chronic conditions, is at the core of the Quality Strategy. AHCCCS uses a variety of modalities to drive quality through the system to achieve improvements and successes. AHCCCS' culture of quality is sustained by the combination of oversight and collaboration. Although AHCCCS has experienced significant quality improvements and successes, the agency and its MCOs continuously strive for:

- Improved performance by MCOs as a result of incentives, such as comparative reporting and financial incentives,
- Members who are better informed and who understand the value of preventive care,
- The ability for members with chronic diseases to maintain or improve their health,
- A physician community that is increasingly vested in the prevention of disease,
- Systematic research and sharing of best practices and lessons learned both locally and nationally,
- A significant reduction in the costs associated with treating disease and adverse health outcomes,
- Broader participation in collaborative community efforts to improve the health status of Arizonans,
- Identification of COE, and
- Provision of technical assistance programs with SMEs.

Built on a system of competition and choice, AHCCCS is a leader among the nation's Medicaid programs, operating a high-quality, cost-effective program with an average per enrollee, per year expense of only \$7,008 compared with the national average of \$8,057 in CYE 2019. Keeping a member-centered focus, AHCCCS will continue to work with partners and collaborate to advance innovative ideas that drive continuous improvement.

# AHCCCS Quality Strategy

## 10. Appendix

### 10.1 Links to Related Documents

#### *AHCCCS Contracts and Manuals*

[AHCCCS Contractor Operations Manual \(ACOM\)](#)

[AHCCCS Contracts](#)

[AHCCCS Medical Policy Manual \(AMPM\)](#)

#### *AHCCCS Reports*

[AHCCCS 1115 Waiver 2016-2021](#)

[AHCCCS Five Year Strategic Plan: 2018-2023](#)

[AHCCCS Quality & Performance Improvement – Performance Measures and Performance Improvement Projects](#)

[Annual Reports to CMS](#)

[External Quality Review Organization Reports](#)

[Quarterly Reports to CMS](#)

## AHCCCS Quality Strategy

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# Environmental Factors and Plan

## 12. Trauma - Requested

### Narrative Question

**Trauma**<sup>57</sup> is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma<sup>58</sup> paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

58 *Ibid*

### Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues?  Yes  No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?  Yes  No
3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?  Yes  No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?  Yes  No
5. Does the state have any activities related to this section that you would like to highlight.

AHCCCS has developed and modified policies as necessary to guide how we address individuals with trauma-related issues. There are multiple policies that address the use of trauma informed care and appropriate trauma focused treatment. In particular, AHCCCS' policy to address processes for assessment and service planning requires that these activities be conducted utilizing trauma informed principles. Further, there are policies that focus on early intervention strategies and psychiatric best practices for infants and toddlers. While the policies covering treatment guidelines for infants and toddlers may not specifically stipulate their use for parents or caregivers with substance use disorders, these policies can be utilized alongside parents in substance use programs, or to ameliorate the negative effects on children that may have developed while parents or caregivers were utilizing

substances. Not only do they offer clinical best practice guidelines for improving parent/caregiver knowledge and skills, but they also provide a table of nationally recognized tools for assessment of trauma and other potential developmental risk factors.

Managed Care Organizations (MCOs) are contractually required to ensure their behavioral health providers follow evidence-based practices, which include use of SUD treatment, Medication Assisted Treatment (MAT), and Trauma Informed Care. Further, they are obligated to ensure their provider networks include certified trauma informed behavioral health professionals and utilize routine trauma screenings. The MCOs are also required to ensure that their network of primary care physicians (PCPs) utilized standardized tools for identification of the need for trauma-informed care and treatment of substance use disorders within their scope of practice.

Current contracts require that MCOs implement standardized SUD assessments as identified within AHCCCS policy. Additionally, there is an existing requirement for a phased-in approach to implement the American Society of Addiction Medicine (ASAM) criteria (Third Edition, 2013) in substance use disorder assessments, service planning, and level of care placement. However, as of October 1 2022, MCOs will be required to utilize the complete ASAM Continuum for SUD assessment for members 18 and older, who also have co-occurring SUD and mental health needs. The ASAM Continuum provides counselors, clinicians, and other treatment team members with a computer-guided, structured interview for assessing and caring for patients with addictive, substance-related, and co-occurring conditions. The decision engine is based on the ASAM Criteria® and uses research-quality questions (including tools such as the ASI, CIWA, and CINA instruments) to generate a comprehensive patient report that details DSM SUD diagnoses, severity, and imminent risks as well as a recommended level of care determination.

Operational reviews (ORs) are a required component of regularly scheduled AHCCCS monitoring activities to ensure appropriate implementation of contract and policy requirements. Under the OR structure, MCOs are monitored for compliance with implementation of both trauma informed care and substance use treatment and services. Specifically, there are two standards under Medical Management that evaluate compliance with implementation of trauma informed care principles demonstrable evidence of trauma informed care practices, screenings, treatment, and network sufficiency. An additional standard exists for substance use disorder screening and treatment practices, which focuses on identification of youth needing SUD services.

AHCCCS gives MCOs the option of choosing from evidence-based standardized assessment tools, based on their community needs and population served. AHCCCS also prescribes tools for specific uses (e.g., ACES, ASAM, etc.). More specifically, under the Targeted Investment (TI) Primary Care Behavioral Health component, milestones were created that incentivized pediatric, primary care practitioners to utilize ACES or other evidence-based screening tools to identify potential evidence of trauma in children. As part of the milestone guidelines, pediatric practices developed collaborative protocols, which outline their screening and referral processes, as needed for trauma informed care under the behavioral health system. These collaborative protocols also enabled pediatric practitioners to identify children at high risk for chronic physical, developmental, behavioral, or emotional conditions and track them through a high risk registry. The registry tracks patients of highest risk that can be positively affected with appropriate interventions. These targeted milestone activities work in tandem with contractual and policy requirements to help identify children at risk for and in need of substance use services. Under these milestones, pediatric practitioners and care managers also received education and training related to trauma informed care principles.

AHCCCS plans the implementation of a standardized assessment tool on October 1, 2021, known as the CALOCUS, or Child and Adolescent Level of Care Utilization System. This tool is designed to identify appropriate levels of need and intensity of both services and resources to meet the behavioral and/or physical health needs of children aged six to 18. The CALOCUS assessment tool is designed to assess children and adolescents for four essential activities: (1) identification of immediate needs, especially if there is potential for risk of harm, (2) treatment planning processes, (3) establishment of medical necessity criteria for level of care and treatment, and (4) techniques and services for moving through the course of recovery. At a systemic level, the CALOCUS offers opportunities for identifying resource needs for complex populations (that can include children with SUD) and there are also offers a detailed tool that can facilitate cross system communication.

AHCCCS is considering utilization of the LOCUS (Level of Care Utilization System) for adults, as well as the Early Childhood Service Intensity Instrument (ECSII). Both tools evaluate level of need, resources, and protective factors for individuals needing services. The utilization of all three tools would allow AHCCCS to have a standardized continuum of assessments each of which is based on similar guidelines and evaluation criteria.

AHCCCS and the Managed Care Organizations (MCO) created a Person-Centered Service Plan and guidelines to support the Arizona Long Term Care System (ALTCS), which is now in the implementation phase. This person-centered approach is intended to improve engagement with members and their families. As part of the implementation, the Division of Developmental Disabilities within the Arizona Department of Economic Security provided the Support Coordinators with 13 hours of instruction to become certified as Trauma Support Specialists. Trauma informed care is a required class.

Additionally, workforce development activities for MCOs are guided by policy and contract. Each MCO is given the opportunity to identify their workforce development needs for trauma informed care and substance use diagnosis and treatment. There are contractual requirements as part of new employee orientation that focus on ensuring staff is aware of the principles of trauma informed care. Further, MCOs are required to ensure their networks have the capacity of appropriately licensed and trained professionals to deliver SUD assessment and treatment, as well as trauma-informed care, screening, and treatment to AHCCCS members.

Furthermore, AHCCCS not only encourages employment of peers, but MCOs are required to have locally established, Arizona-based, independent peer-run and family-run organizations within their network.

Additional information related to AHCCCS' accomplishments to date and current initiatives related to trauma informed care are summarized in the Summary Report for the Governor's Abuse and Neglect Prevention Task Force, May 2021. The Division of Developmental Disabilities (DDD) participated with AHCCCS in development of the Governor's Abuse and Neglect Prevention Task Force.

Please indicate areas of technical assistance needed related to this section.

None.

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**Footnotes:**

## Environmental Factors and Plan

### 13. Criminal and Juvenile Justice - Requested

#### Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.<sup>59</sup>

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.<sup>60</sup>

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

<sup>59</sup> Journal of Research in Crime and Delinquency: : *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Ren?e L. Binder. [OJJDP Model Programs Guide](#)

<sup>60</sup> <http://csgjusticecenter.org/mental-health/>

#### Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?  Yes  No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?  Yes  No
3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?  Yes  No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?  Yes  No
5. Does the state have any activities related to this section that you would like to highlight?

The Arizona Health Care Cost Containment System (AHCCCS) continues to lead joint activities between behavioral health, acute care, long-term care, and Arizona's criminal and juvenile justice systems. Annually updated Collaborative Protocols and System of Care Plans provide structure for the health plans to work together. Regularly occurring meetings take place at the state and local levels to focus on policy development, implementation, improving communication, identifying system barriers, and problem-solving. Collaborative development activities such as Drug Courts, Mental Health Courts, and Juvenile Detention Alternatives Initiative (JDAI) are examples of some of the work occurring in Arizona.

While Arizona does not have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions, screening and treatment are provided prior to adjudication and/or sentencing for individuals with mental health and substance use disorder (SUD) screening as a part of their intake protocols.

AHCCCS Complete Care (ACC) Managed Care Organizations (MCOs) maintain active and annually updated collaborative protocols with the justice agencies in their respective Geographic Service Areas (GSAs) to ensure enrolled members or eligible persons who

come in contact with the justice system, to the extent possible, have their mental health, SUD treatment needs, and physical health needs assessed and addressed, and that relevant issues are communicated and coordinated with the judiciary and justice partners. MCOs maintain co-located staff at both Juvenile and Adult Courts and Detention Centers to provide coordination of care between the acute, behavioral health system and the justice systems in meeting the enrolled members' needs. Staff are available to assist in enrolling members if they have not previously been identified as having physical/mental health, SUD treatment needs.

AHCCCS has collaborated with state and county governments and agencies to improve coordination within the justice system and create a more effective and efficient way to transition individuals from incarceration into the community. Currently, all MCOs are contractually required to provide "reach-in" services and care coordination to identify members with complex health needs prior to their release from incarceration. Through the reach-in service, the MCOs connect case managers to members pre-release to provide information and schedule appointments with primary care physicians and behavioral health providers as appropriate.

Criminal and Juvenile Justice liaisons and other co-located behavioral health staff are trained to work specifically with members involved in the criminal and juvenile justice systems as well as with those in their associated living environments. By assisting members with navigating the justice system, advocating for their individualized needs, assisting the justice system staff and judiciary, and accessing physical/behavioral health and SUD treatment for members, staff can better identify the appropriate services/supports within the community and connect members to appropriate levels of care.

In the state of Arizona, Correctional Health Services (CHS) has adopted practices to identify members with Serious Mental Illness (SMI) or SUD and to divert the members to appropriate treatment services. This is an initiative implemented by the State to reduce the number of adults with mental health disorders and co-occurring SUD in correctional facilities. The initiative engages a diverse group of organizations with expertise on these issues, including sheriff's departments, jail administrators, judges, community corrections professionals, treatment providers, mental health and substance use program directors, and other system stakeholders. Enrollment and care coordination activities specifically designed for this population are established in Collaborative Protocols jointly developed by the ACCs and the local courts, parole offices, and probation departments. These protocols define activities and timeframes for care coordination, screening, enrollment, preparation for services post release, communication, and participation on individual Child and Family Teams (CFTs) and Adult Recovery Teams (ARTs) for service planning activities. Behavioral Health Case Managers facilitate CFTs and ARTs and maintain active and ongoing communication with Probation and Parole Officers. Behavioral Health Individual Service Plans (ISPs) are designed to incorporate goals included in probation and parole plans and are reviewed and updated at CFTs and ARTs attended by probation and parole officers.

To address difficulties in receiving services after incarceration due to disenrollment, most counties in Arizona and the Department of Corrections have established Intergovernmental Agreements (IGA) to allow coverage for an individual on the day of their release from the detention center. To increase capacity of personnel working with members with behavioral health issues involved in the system, ACCs regularly cross-train local court personnel on the behavioral health system, including the CFT process, medical necessity determination for out-of-home placement, and other health topics as requested by the courts.

Peer and family support are also a priority. Currently there are peer/family support teams embedded within SUD treatment facilities, integrated health homes, and in dedicated peer-run organizations to ensure a comprehensive peer support network throughout the state. In addition, many peer/family support agencies have developed cross-agency collaboration initiatives and collaborate with jails to assist individuals prior to release with enrolling in, and coordinating, treatment services so they are able to smoothly transition back into the community and begin treatment as soon as possible. AHCCCS supports a recovery-oriented system of care (ROSC) and understands the important role that peer/family support plays in recovery. As a result, providers within the ACC network have incorporated peer/family support throughout the continuum of care, making it available at all levels and intensity of service.

In partnership with the Regional Behavioral Health Authorities and contracted providers, AHCCCS is utilizing SABG funds to facilitate justice and law enforcement partnership with:

- + Peer Support Specialists to offer pre-release care coordination, assessments, post-release systems navigation, facilitation of referrals for SUD, and health care services as individuals re-enter the community from county jail and state prison.
- + In-reach to the court system and inmates and outreach services to the business community to facilitate job placement and residential services.
- + Peer and Family Support Specialists to accompany law enforcement on ride-alongs to engage eligible individuals in the Drug Market Intervention Program.
- + Co-location of peer staff with pre-trial officers for assessment and connection to SUD providers.
- + Dedicated staff within law enforcement agencies to implement alternatives to incarceration for individuals with SUD and increase engagement in MAT.
- + Justice navigator teams at 24/7 MAT clinics.
- + Pre-trial diversion, drug court, and adult probation programs on harm reduction, overdose prevention, to include 1:1 case management.
- + Intervention and treatment services, including improved discharge planning and care coordination, for juveniles in the Office of Juvenile Justice and Delinquency Prevention detention centers (after plans are approved by SAMHSA GPO).

In August of 2021, AHCCCS provided RBHAs and TRBHAs with a clarification memo to provide guidance regarding the use of the

Mental Health Block Grant (MHBG) to purchase mental health treatment services for members while incarcerated. The Substance Abuse and Mental Health Services Administration (SAMHSA) issued a letter to Mental Health Commissioners on February 11, 2020, stating that treatment for individuals during incarceration is an allowable use of the MHBG, provided that the treatment services and the provider of such services meets the statutory requirements of the MHBG. This applies to individuals with a serious mental illness (SMI) designation as well as individuals diagnosed with serious emotional disturbance (SED). For MHBG purposes, the definition of incarceration will be used; incarceration is defined as holding a person in a detention center, jail, or prison (State or Federal) because of suspected or actual involvement in criminal activity. Provision of comprehensive services shall occur through appropriate mental health facilities and providers. Allowable services shall follow current MHBG policies and contracts and may include evaluation and treatment of a psychiatric disorder (including those related to competency restoration). Although most physical and behavioral health services may be covered by the Arizona Department of Corrections, Rehabilitation and Reentry (ADCRR), Arizona Department of Juvenile Corrections (ADJC), or Tribal Nations during a period of incarceration, there may be times when the use of MHBG funds is appropriate for services not covered by the ADCRR or ADJC (e.g., assessments and treatment planning for members transitioning into the facility to serve their sentence or transitioning out of the facility once a release date is set). MHBG shall continue to be the payor of last resort.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

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**Footnotes:**

## Environmental Factors and Plan

### 14. Medication Assisted Treatment - Requested (SABG only)

#### Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], 49 [4], and 63[5].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

**TIP 40** - <https://www.ncbi.nlm.nih.gov/books/NBK64245/> [ncbi.nlm.nih.gov]

**TIP 43** - <https://www.ncbi.nlm.nih.gov/books/NBK64164/> [ncbi.nlm.nih.gov]

**TIP 45** - <https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf> [store.samhsa.gov]

**TIP 49** - <https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf> [store.samhsa.gov]

**TIP 63** - [https://store.samhsa.gov/sites/default/files/SAMHSA\\_Digital\\_Download/PEP20-02-01-006\\_508.pdf](https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf) [store.samhsa.gov]

#### Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?  Yes  No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women?  Yes  No
3. Does the state purchase any of the following medication with block grant funds?  Yes  No
  - a)  Methadone
  - b)  Buprenorphine, Buprenorphine/naloxone
  - c)  Disulfiram
  - d)  Acamprosate
  - e)  Naltrexone (oral, IM)
  - f)  Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately\*?  Yes  No
5. Does the state have any activities related to this section that you would like to highlight?

In addition to the Substance Abuse Block Grant (SABG), AHCCCS is allocated other state and federally funding to treat Opioid Use Disorder (OUD). Some of the funding sources include various SAMHSA grants: State Opioid Response (SOR), State Opioid Response II (SORII), the Emergency COVID-19 and Supplemental Grant, and the State Pilot Grant Program for Treatment for Pregnant and Postpartum Women (PPW-PLT). AHCCCS also receives state funding such as the Governor's Substance Use Disorder funding.

Various OUD treatment options are available through these funding sources; most involve a team of professionals including

social workers, doctors, nurse practitioners, psychologists, and other behavioral health clinicians. Treatment begins with a clinical assessment to determine which treatment method is best for the individual. AHCCCS has worked collaboratively with state and federal partners including the community to identify the needs and gaps to overcome the opioid epidemic. The treatment system for opioid use disorder and other substance use disorders is comprised of multiple service components, including:

Individual and group counseling,  
Medication Assisted Treatment Programs (MAT),  
Residential Treatment,  
Intensive Outpatient Treatment,  
Partial Hospital Programs,  
Case or Care Management,  
Recovery Support Services,  
12-Step Fellowship, and  
Peer support Services.

In response to the continued opioid epidemic, the Governor's Office, along with AHCCCS and the Arizona Department of Health Services (ADHS) have collaborated in an effort to reduce overdose deaths in the state of Arizona. Naloxone is an opioid overdose reversal medication that is lifesaving for a person experiencing potentially fatal effects of opioids. Through this collaboration four major priorities have been identified to address this epidemic:

1. improving access to naloxone in our communities to reverse overdoses,
2. expanding access to treatment, especially MAT, and ensuring a pathway to treatment,
3. preventing prescription opioid drug abuse through appropriate prescribing practices, and
4. educating Arizonans on the dangers of opioid misuse and abuse.

Some of AHCCCS' initiatives to address the identified priority areas are as follows:

#### Improving access to Naloxone

In efforts to improve access to naloxone in Arizona's communities and reverse opioid overdoses, the SABG funds a statewide Overdose Education and Naloxone Distribution (OEND) program serving all SABG priority populations, community-based organizations, and multiple cross-sector partners including law enforcement, faith-based communities, and corporate partners to educate, train, distribute naloxone, and reduce stigma associated with substance use. In 2020, the OEND contractor distributed 148,371 doses of naloxone, reported 4,282 reversals, connected 1,106 individuals to treatment related to substance use and/or necessary medical care, and conducted 351 overdose education trainings throughout Arizona.

#### Expanding Access to Treatment

##### Certified SAMHSA Opioid Treatment Programs

AHCCCS recognizes the important role medication-assisted treatment (MAT) plays in the treatment of OUD and access to treatment. Arizona has a total of 66 certified SAMHSA Opioid Treatment Programs (OTPs) and two medication units. Of the 66 OTPs, one is located on tribal land, Pascua Yaqui Tribe's Health Department, and six are located within the Maricopa Correctional Health Facilities.

##### 24/7 Access Points

AHCCCS recognizes the important role MAT plays in the treatment of SUD and access to treatment. Arizona has four 24/7 access points to serve individuals who need immediate access to treatment services and connections to ongoing services. These 24/7 access points are located throughout Arizona (one in Tucson, one in Mesa, and two in Phoenix).

##### Mid Level Exemptions

AHCCCS recognizes the need for Mid-Level Practitioners and developed a process to allow those practitioners to dispense opioids within a MAT setting for individuals with opioid use disorder, as outlined in the AHCCCS Medical Policy Manual (AMPM) 660: Opioid Treatment Program. This exemption process follows the requirements specified in 42 CFR Part 8.11 for Opioid Treatment Programs (OTPs).

Collaboratively, AHCCCS and SAMHSA have approved 24 OTPs for the requested exemption to utilize 33 Mid-Level Practitioners since January 2021.

##### Opioid Treatment Services Locator

AHCCCS is funding Carahsoft, through the State Opioid Response II grant, to develop the Opioid Services Locator, a "one stop" portal that houses a daily census and capacity for available OUD treatment options and naloxone availability. The intent of this project is to eliminate "wrong doors" for individuals seeking OUD treatment, recovery, and ancillary services. The contractor will be responsible for building an electronic system for treatment providers to update their available capacity in real-time (e.g., number of available slots in local OTPs or Office Based Opioid Treatment (OBOT) facilities, number of available residential beds, and naloxone availability). The locator will be available to the general public and the Opioid Assistance and Referral Line will use the repository to create a "no wrong door" approach to navigating individuals with OUD to timely treatment options.

##### Educating Arizonans

AHCCCS and other community stakeholders educate and raise awareness within the community regarding what MATs are, the



services provided within the MAT setting, facility locations, and their availability throughout the state. As the SSA, AHCCCS continues to cite research about the importance of utilizing evidence-based MAT treatment in the community and have contract terms that require the Managed Care Organizations (MCOs) to maintain a network of MAT providers for their geographic service areas (GSAs).

*\*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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**Footnotes:**

## **660 - OPIOID TREATMENT PROGRAM**

EFFECTIVE DATES: 10/01/18, 01/08/20, 08/14/20, 04/01/21

APPROVAL DATES: 06/07/18, 10/03/19, 08/11/20, 03/03/21

### **I. PURPOSE**

This Policy applies to Opioid Treatment Programs (OTPs) requirements related to established legislation and coordination with the State Opioid Treatment Authority (SOTA).

### **II. DEFINITIONS**

**CENTER FOR SUBSTANCE ABUSE TREATMENT (CSAT)** Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) center to promote community-based substance abuse treatment and recovery services for individuals and families in every community. CSAT provides national leadership to improve access, reduce barriers, and promote high quality, effective treatment, and recovery services.

**DISPENSE** To deliver a controlled substance to an ultimate user by, or pursuant to, the lawful order of, a practitioner, including the prescribing and administering of a controlled substance, as specified in 42 CFR 8.2.

**MEDICATION ASSISTED TREATMENT (MAT)** The use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.

**MID-LEVEL EXEMPTION REQUEST** An exemption process as specified in 42 CFR Part 8.11 for Opioid Treatment Programs (OTPs) to request the Single State Authority (SSA) and the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Substance Abuse Treatment (CSAT) to provide approval to allow Mid-Level Practitioners to treat opioid-related withdrawal symptoms.

**MID-LEVEL PRACTITIONER**

An individual practitioner, other than a physician, dentist, veterinarian, or podiatrist, who is licensed, registered, or otherwise permitted by the United States or the jurisdiction in which he/she practices, to dispense a controlled substance in the course of professional practice. Examples of mid-level practitioners include, but are not limited to, health care providers such as nurse practitioners, nurse midwives, nurse anesthetists, clinical nurse specialists, and physician assistants who are authorized to dispense controlled substances by the State in which they practice, pursuant to 21 CFR 1300.01.

**OPIOID TREATMENT PROGRAMS (OTPs)**

Licensed and accredited Programs also referred to as Medication Assisted Treatment (MAT) Programs, authorized to dispense medications for the treatment of opioid use disorder through highly structured protocols defined by Federal and State regulations.

**STATE OPIOID TREATMENT AUTHORITY (SOTA)**

The individual responsible for administrative and clinical oversight of certified Opioid Treatment Programs (OTPs), including, but not limited to planning, developing, educating, and implementing policies and procedures to ensure that opioid dependency treatment is provided at an optimal level.

**SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)**

A public agency within the U.S. Department of Health and Human Services (HHS established by Congress in 1992 to make substance use and mental disorder information, services, and research more accessible).

**III. POLICY****A. OPIOID TREATMENT PROGRAM MID-LEVEL EXEMPTION PROCESS**

OTPs that employ Mid-Level Practitioners are required to complete the Mid-Level Exemption Request Process, as specified below, in order to allow those practitioners to Dispense opioids within a MAT setting for individuals with opioid use disorder. It is the responsibility of the practitioner to continuously monitor and abide by the Federal Guidelines for OTPs. Federal Guidelines for OTPs can be found on the SAMHSA website at [www.samhsa.gov](http://www.samhsa.gov). OTPs are responsible to maintain appropriate policies and procedures guiding the practice and supervision of Mid-Level Practitioners.

**1. Mid-Level Exemption Request Process**

- a. OTPs shall complete and submit all required information through the SAMHSA/CSAT OTP Extranet at <https://otp-extranet.samhsa.gov/login.aspx>,

- b. The Arizona SOTA shall coordinate a team of Subject Matter Experts (SMEs) to review the submitted request and supporting documentation,
- c. The Arizona SOTA shall approve, deny, and/or return requests for further clarification based on the information provided. Requests are reviewed to ensure the exemption does not:
  - i. Violate an existing federal or state law,
  - ii. Violate an existing tribal law,
  - iii. Jeopardize the safety, health, treatment of patients, and/or
  - iv. Impede fair competition of another service provider.
- d. Approved requests are submitted by the Arizona SOTA to CSAT for final approval. Mid-Level Exemption Requests that receive final approval from CSAT require renewal as indicated by CSAT,
- e. Additional Mid-Level Exemption Requests are also required when an OTP intends to hire additional Mid-Level Practitioners prior to renewal of the existing approved Exemption,
- f. Documentation of Mid-Level Practitioner qualifications and training is necessary when an OTP intends to hire replacement Mid-Level Practitioners prior to renewal of the existing approved Exemption, and
- g. The Renewal process shall be submitted 60 days prior to the expiration date for an approval process to begin.

**B. OPIOID TREATMENT PROGRAM REPORTING REQUIREMENTS**

Pursuant to A.R.S. §36-2907.14, in addition to all State or Federal licensing and registration requirements, any OTP (including New and Existing OTP sites) receiving reimbursement from AHCCCS or its Contractors must develop and submit Plans as specified in statute, and any relevant documentation, for review and approval by AHCCCS. Existing OTP sites are also required to submit an annual report no later than November 15 of each year. The submitted Plans will be posted to the AHCCCS website for public comment for 30 days. AHCCCS will make a determination on the sufficiency of the submitted documentation within 30 days of the close of the public comment period. If AHCCCS determines that there is a deficiency in any of the submitted documentation, the OTP will be provided 30 days, from day of notification, to correct the deficiency or AHCCCS will suspend reimbursement for OTP providers until deficiency is remediated. The Contractor is required to suspend payment to OTPs who do not receive AHCCCS approval.

1. Plans required for submission from the OTPs include:
  - a. Detailed security plan,
  - b. Neighborhood engagement plan,
  - c. Comprehensive plan to demonstrate how the OTP ensures that appropriate medication-assisted standards of care are met,
  - d. Community relations and education plan, and
  - e. Current diversion control plan.

Refer to the AHCCCS website for detailed information regarding expectations and submission requirements. Hospitals, jails, and OTPs on Tribal lands are exempt from the above reporting requirements.

**C. OPIOID TREATMENT PROGRAM NOTIFICATIONS TO THE STATE OPIOID TREATMENT AUTHORITY**

OTPs shall notify the SOTA of their intent to open new locations within the State, in addition to their notification to SAMHSA. OTPs shall send formal communication via email to AHCCCS/Division of Grants Administration (AHCCCS/DGA), [grantsmanagement@azahcccs.gov](mailto:grantsmanagement@azahcccs.gov).

1. The Communication shall include the following information:
  - a. Address of the new location,
  - b. Status of submission for licensure,
  - c. Information on whether the location will receive Medicaid funding, and
  - d. Confirmation of coordination with designated AHCCCS contracted Health Plans.
2. Any new OTP location receiving Medicaid funding shall complete and submit the required reporting as specified in this Policy.

# Environmental Factors and Plan

## 15. Crisis Services - Required for MHBG

### Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.<sup>61</sup> SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427)<sup>62</sup>,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

<sup>61</sup><http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

<sup>62</sup>Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

### Please check those that are used in your state:

#### 1. Crisis Prevention and Early Intervention

- a)  Wellness Recovery Action Plan (WRAP) Crisis Planning
- b)  Psychiatric Advance Directives
- c)  Family Engagement
- d)  Safety Planning
- e)  Peer-Operated Warm Lines
- f)  Peer-Run Crisis Respite Programs
- g)  Suicide Prevention

#### 2. Crisis Intervention/Stabilization

- a)  Assessment/Triage (Living Room Model)
- b)  Open Dialogue
- c)  Crisis Residential/Respite
- d)  Crisis Intervention Team/Law Enforcement
- e)  Mobile Crisis Outreach
- f)  Collaboration with Hospital Emergency Departments and Urgent Care Systems

#### 3. Post Crisis Intervention/Support

- a)  Peer Support/Peer Bridgers
- b)  Follow-up Outreach and Support
- c)  Family-to-Family Engagement
- d)  Connection to care coordination and follow-up clinical care for individuals in crisis
- e)  Follow-up crisis engagement with families and involved community members

- f)  Recovery community coaches/peer recovery coaches
- g)  Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

AHCCCS supports a coordinated system of entry into crisis services that are community based, recovery-oriented, person focused, and work to stabilize the individual as quickly as possible to assist them in returning to their baseline of functioning. Collaboration, the improvement of data collection standards, and communication are integral in enhancing quality of care leading to better health care outcomes, while containing cost. Expanding provider networks capable of providing a full array of crisis services geared towards the individual is expected to maintain a person's health and enhance quality of life. The collection, analysis, and use of crisis service data for crisis service delivery and coordination of care is critical to the effectiveness of the overall crisis delivery system.

AHCCCS utilizes the Regional Behavioral Health Authorities (RBHAs) as the Managed Care Organizations (MCOs) responsible for the full array of crisis services in their designated Geographical Service Area (GSA). The RBHAs are required to:

1. Maintain responsibility for the provision of a full continuum of crisis services to all individuals, within their GSA(s), including individuals in the Federal Emergency Services Program (FESP). Crisis services include but are not limited to; crisis telephone response, mobile crisis teams, and facility-based stabilization (including observation and detox), and all other associated covered services delivered within the first 24 hours (for Title XIX/XXI members) of a crisis episode.
2. Stabilize individuals as quickly as possible and assist them in returning to their pre-crisis level of functioning.
3. Provide solution-focused and recovery-oriented interventions designed to avoid unnecessary hospitalization, incarceration, or placement in a more segregated setting, utilizing a trauma-informed and responsive care approach.
4. Utilize the engagement of peer and family support services in providing crisis services.
5. Immediately assess the individual's needs, identify the supports and services that are necessary to meet those needs, and connect the individual to those services.
6. Not require prior authorization for emergency behavioral health services, including crisis services (A.A.C. R9-22-210.01),
7. Require subcontracted providers that are not part of Contractor's crisis network to deliver crisis services or be involved in crisis response activities during regular business operating hours.
8. Coordinate with all clinics and case management agencies to resolve crisis situations for assigned members.
9. Develop local county-based stabilization services to prevent unnecessary transport outside of the community where the crisis is occurring.
10. Ensure individuals are connected through warm handoffs throughout the crisis care continuum, to support the coordination of crisis services and connection to ongoing care.
11. Provide crisis services on tribal lands as dictated by each tribe within the Contractor's assigned GSAs:
  - a. Annually, the Contractor shall contact each tribe within the Contractor's GSAs to offer a full range of crisis services to establish agreements for the provision of crisis services on tribal lands, per the discretion and needs of the tribe,
  - b. Report annually the status of tribal agreements for the provision of crisis services on tribal lands in the Tribal Coordinator Report, and
  - c. Develop a process where tribal liaisons and appropriate clinical staff coordinate crisis services on tribal lands with crisis providers.
12. Provide non-emergency transportation for continuing care and/or for connection to community resources for immediate crisis stabilization.
13. Implement core and essential system requirements detailed in SAMHSA's National Guidelines for Behavioral Health Crisis Care.
14. Coordinate benefits and required payments of Liable Third Parties as specified in Arizona Contractor Operations Manual (ACOM) Policy 434.
15. Participate in a data and information sharing system, connecting crisis providers and member physicians through a health information exchange.

16. AHCCCS will provide the Contractor necessary access to member data, which shall be used to support crisis services care coordination for members receiving general mental health and substance use services through an AHCCCS Complete Care Contractor or AIHP.

17. Analyze, track, and trend crisis service utilization data to improve crisis services. Maintain data and be able to report information that contains, but is not limited to:

- a. Telephone call volume and metrics, calls resolved by phone, calls made in follow up to a crisis to ensure stabilization, and call dispositions including triage to Nurse-On Call services, referral, and dispatch of service providers, community and collaborative partners, and health plan notification for dual eligible members,
- b. Mobile team dispositions to include response timeframes, transports to crisis stabilization units and other facilities, initiation of court ordered evaluation/court order treatment COE/COT process, and coordination with collaborative partners, and
- c. Submit a Crisis Call Report of the total volume and disposition of crisis calls, and disposition of mobile team dispatch and outcomes received by local and toll-free Crisis Line numbers.

18. Provide the community information about crisis services and develop and maintain collaborative relationships with community partners including: fire, police, emergency medical services, hospital emergency departments, other AHCCCS MCOs, and other providers of public health and safety services, and:

- a. Have active involvement with local police, fire departments, and first responders, and other community and statewide partners in the development and maintenance of strategies for crisis service care coordination and strategies to assess and improve crisis response services,
- b. Provide, at a minimum, annual training to support and develop law enforcement agencies' understanding of behavioral health emergencies and crises, and
- c. Utilize and train tribal police to be able to assist in behavioral health crisis response on tribal land.

19. Develop a collaborative process to ensure information sharing for timely access to Court Ordered Evaluation (COE) services, and

20. Notify the MCO of enrollment within 24 hours of a member engaging in crisis services (telephone response, mobile crisis teams and/or stabilization services) and provide clinical recommendations for the individual's continuing care, so subsequent services can be initiated by the Contractor of enrollment.

RBHAs must also establish and maintain crisis stabilization settings that offer 24 hour substance use disorder/psychiatric crisis stabilization services including 23 hour crisis stabilization/observation capacity, for Individuals with Substance Use Disorders (SUDs), offer crisis stabilization services that provide access to all FDA approved Medication Assisted treatment (MAT) options covered under the AHCCCS Drug List, and provide short-term crisis stabilization services in an effort to successfully resolve the crisis and return the individual to the community instead of transitioning to a higher level of care. Crisis Stabilization settings must accept all crisis referrals, adhere to a "no wrong door" approach for referrals, and ensure streamlined practices for swift and easy transfer of individuals from law enforcement and public safety personnel. Crisis assessment and stabilization services may be provided in settings consistent with requirements to have an adequate and sufficient provider network that includes any combination of the following:

Licensed Level I acute (Behavioral Health Inpatient Facility) and sub-acute facilities (Behavioral Health Observation/Stabilization Service),  
Behavioral Health Residential facilities,  
Outpatient clinics (Outpatient Treatment Centers) offering 24 hours per day, seven days per week access, and Opioid Treatment Program (OTP).

RBHAs also have the discretion to include home-like settings such as apartments and single-family homes where individuals experiencing a psychiatric crisis can stay to receive support and crisis respite services in the community before returning home.

Further, RBHAs are also required to establish and maintain mobile crisis teams with the following capabilities:

1. Ability to travel to the place where the individual is experiencing the crisis.
2. Ability to assess and provide immediate crisis intervention.
3. Provide mobile teams that have the capacity to serve specialty populations including youth and children, hospital rapid response, and those who live with a developmental disability.



4. Provide services for the assessment and immediate stabilization of acute symptoms of mental illness, alcohol and other drug abuse, and emotional distress.
5. Employ reasonable efforts to stabilize acute psychiatric or behavioral symptoms, evaluate treatment needs, and develop individualized plans to meet the person's needs.
6. When clinically indicated, transport the individual to a more appropriate facility for further care.
7. Require mobile crisis teams to respond on site within the average of 60 minutes of receipt of the crisis call as calculated by utilizing the monthly average of all crises call response times.
8. Prioritize and incentivize expeditious response of mobile crisis teams that occur below established performance thresholds.
9. Prioritize law enforcement requests for mobile team dispatch with a target response time of 30 minutes or less.
10. Work collaboratively with law enforcement/public safety personnel and develop strategies to ensure mobile team response is effective and tailored to specific needs, and
11. Utilize credentialed peers or family support specialists for mobile crisis team response.

Finally, RBHAs must establish and maintain a 24 hours per day, seven days per week crisis response system. This requirement includes that each RBHA:

1. Establish and maintain a single toll-free crisis telephone number.
2. Publicize its single toll-free crisis telephone number throughout its assigned GSA(s) and include it prominently on the Contractor's website, the Member Handbook, member newsletters, and as a listing in the resource directory of local telephone books.
3. Have a sufficient number of staff to manage the telephone crisis response line.
4. Answer calls to the crisis response line within three telephone rings, with a call abandonment rate of less than 3 percent.
5. Include triage, referral, and dispatch of service providers and patch capabilities to and from 911 and other crisis providers or crisis systems, as applicable.
6. Provide telephone support to callers to the crisis response line including a follow-up call within 72 hours to make sure the caller is stabilized.
7. Offer interpretation or language translation services to persons who do not speak or understand English and for the deaf and hard of hearing.
8. Provide Nurse On-Call services 24 hours per day, seven days per week to answer general healthcare questions.

RBHAs are required to maintain collaborative relationships with community partners and have active involvement with local police, fire departments, first responders, and other community and statewide partners in the development and maintenance of strategies for crisis service care coordination and strategies to assess and improve crisis response services.

Law enforcement (LE) callers to the crisis lines are prioritized, receive direct access to crisis call supervisors, priority dispatch of crisis mobile teams. In addition, LE are able to drop off individuals at any crisis facility with a "no refusal" policy, with a target drop-off time at 23-hour observation units of 10 minutes or less.

RBHAs provide regular Crisis Intervention Team (CIT) training and Mental Health First Aid to LE and other community partners, including federal and tribal entities. RBHAs encourage two-way connections with LE and behavioral health providers in their communities; to enhance relationships and better support individuals experiencing behavioral health crises who engage with law enforcement. Additionally, RBHAs deliver police culture training to crisis providers to enhance system collaboration.

In Pima County, Arizona Complete Health has partnered with 911 dispatch to co-locate crisis staff at the local communications center. Crisis staff are available to divert inbound calls from 911 dispatchers for individuals experiencing a behavioral health crisis.

Additionally, crisis staff initiate outbound calls to individuals who have been identified by LE as needing following up for behaviors that mirror behavioral health symptomatology. This partnership allows for crisis staff to initiate and prioritize crisis mobile team response, when indicated, mitigating law enforcement involvement, reducing calls to 911 dispatch, while connecting the community with behavioral health care.

Since September 2018, AHCCCS has held regular behavioral health roundtable collaborations with statewide crisis providers, RBHA,s and other AHCCCS health plans to address system issues and develop strategies to enhance the delivery of crisis services throughout Arizona.

In continuing with system integration principles and streamlining the delivery system, AHCCCS will be integrating standalone RBHA services into its existing managed care organization structure in October 2022. In early 2019, AHCCCS released a request for information to solicit feedback regarding suggestions for integrating crisis services into the AHCCCS delivery system, in addition to requesting stakeholder feedback regarding crisis system enhancements and delivery of crisis services on tribal lands.

AHCCCS is in the process of developing a new standalone crisis policy expected to be released in August 2022.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

**Footnotes:**

## Environmental Factors and Plan

### 16. Recovery - Required

#### Narrative Question

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The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

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#### **Please respond to the following:**

1. Does the state support recovery through any of the following:

- a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?  Yes  No
- b) Required peer accreditation or certification?  Yes  No
- c) Block grant funding of recovery support services.  Yes  No
- d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?  Yes  No

2. Does the state measure the impact of your consumer and recovery community outreach activity?  Yes  No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

In Arizona, we have Peer-Run Organizations, Family-Run Organizations, and Specialty Providers that provide services to these populations based on the principles of recovery and resiliency. AHCCCS Policy AMPM 100 establishes the 9 Guiding Principles of Adult System of Care and Arizona Vision and 12 Principles for Children's System of Care. These principles came directly from members and family members to guide us as the State Medicaid Authority in the fundamental values of recovery in the adult system and resiliency in the children's system.

Recovery support services are for all AHCCCS members including adults with a serious mental illness designation. These services are provided to many specialty populations including members involved in the justice system, dual diagnosis, in tribal communities, and faith-based organizations. All individuals providing this service are credentialed as Peer Recovery Support Specialists (PRSS) through an AHCCCS approved training program.

Credentialed family support training is established in AHCCCS policy including elements for children with SED. Credentialed family support (CFSS) is provided by family members of children with SED who have completed training and credentialing with state approved curricula. This applies the peer principle to family support which traditionally can be provided by individuals without "lived experience." CFSS ensures that those providing the service can relate to those they are serving as peers with shared lived experience of raising children with SED.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

As stated above, recovery support services are available to all AHCCCS members, including those with substance use disorders, with specialty training and support specifically to members with opioid use disorders. PRSS serving members with SUD, have substantial representation within Arizona's recovery support workforce. PRSS servicing members with SUD are employed in many settings including medication assisted services (MAT programs).

5. Does the state have any activities that it would like to highlight?

The policies overseeing these services are informed and guided directly by stakeholders, including those receiving these services. In response to the public health emergency, the State began a program offering personal support to PRSS and CFSS to prevent burnout and compassion fatigue at no cost. Those providing this direct personal support are persons currently employed as a PRSS and CFSS, and are volunteering their time to support their colleagues. This program is operated by the Arizona Peer and Family Career Academy under contract with the State of Arizona.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

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**Footnotes:**

# Environmental Factors and Plan

## 17. Community Living and the Implementation of Olmstead - Requested

### Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights ([OCR](#)) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

### Please respond to the following items

- Does the state's Olmstead plan include :
  - Housing services provided.  Yes  No
  - Home and community based services.  Yes  No
  - Peer support services.  Yes  No
  - Employment services.  Yes  No
- Does the state have a plan to transition individuals from hospital to community settings?  Yes  No

Please indicate areas of technical assistance needed related to this section.

Technical Assistance is not being requested at this time.

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### Footnotes:

# **ARIZONA'S OLMSTEAD PLAN**

**Arizona Health Care Cost Containment System  
Arizona Department of Economic Security  
Arizona Department of Health Services**

**August 2001  
Revised Workplans: March 2003**

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**STATE OF ARIZONA**

**Jane Dee Hull  
Governor**

August 27, 2001

Dear Interested Parties:


We are pleased to provide you with a copy of *Arizona's Olmstead Plan*. This plan represents a collaborative effort by consumers, providers and advocacy groups to improve opportunities for the elderly and persons with disabilities to access community based services.

Input from individual consumers and advocacy groups has clearly shaped the vision and spirit of this document and served as an impetus for us to look critically at the strengths and limitations in our existing service system. *Arizona's Olmstead Plan* will serve as a blueprint for AHCCCS, ADHS and ADES to enable the elderly and persons with disabilities to live in integrated, community settings appropriate to their needs.

In summary, we acknowledge the dedication and commitment of all the participants who contributed to *Arizona's Olmstead Plan*. The development of this plan ensures that Arizona has a continuous quality improvement process in place for providing services to consumers.

Sincerely,

  
Phyllis Biedess  
Director

  
Catherine R. Eden  
Director

  
John L. Clayton  
Director





## PREFACE

Providing treatment in the most integrated setting is an underlying principle of the Arizona Health Care Cost Containment System/Arizona Long Term Care System (AHCCCS/ALTCS), Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) and Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) systems. As such, many aspects of the State's compliance with the Olmstead Decision are already incorporated in the rules, policies, and practices of these agencies. This document is not a comprehensive statement of every implementation of the community integration requirement of the Americans with Disabilities Act.

This document was drafted in the spirit of continuous quality improvement. We recognize that there are always opportunities to provide services to the citizens of the State in ways that better serve their needs and are consistent with self-determination even when the State complies with the mandates of federal law. The interest of the U. S. Department of Health and Human Services/ Centers for Medicare and Medicaid Services (DHHS/CMS)<sup>1</sup> in the Olmstead Decision came about because the CMS funds many of the services that are impacted by the Olmstead Decision both in Arizona and nationwide. Arizona believes it is in substantial compliance with the mandates of the Olmstead Decision, and statements contained in this document are not admissions by any of the Arizona agencies that they are not in compliance with the requirements of the Americans with Disabilities Act. The direction from the CMS simply provided Arizona with another vehicle for critical self-examination.

Readers should also note that improving community integration is a "living process." This document is a snapshot of the current state of the agencies and the challenges they face. It expresses potential solutions based on information and resources currently available. It attempts to plan for improvement in community integration and to assist agencies in establishing their priorities in the context of other critical issues that each of the State agencies face. As resources and competing priorities change, so will this plan. Changes may not always be reflected in a revised version of this plan even though the involved agencies intend to review and update this document (with community input) as time and resources permit.

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<sup>1</sup> As of July 2, 2001 the Health Care Financing Administration (HCFA) changed its name to the Centers for Medicare and Medicaid Services (CMS)

## EXECUTIVE SUMMARY

### ***Background***

#### **Why Did Arizona Prepare a Plan?**

As a result of the Olmstead Decision (Olmstead v L.C., 119 S.Ct.2176(1999), the Arizona Health Care Cost Containment System Administration (AHCCCS), the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) and the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) determined that it would be appropriate, and in the consumers' best interest, to convene a public planning process that would review the accomplishments of the state to date and identify areas for future endeavors to improve opportunities for consumers to live in the most appropriate integrated setting possible. The state agencies recognize that this is part of a continuous improvement process in which each agency was already involved prior to the Olmstead Decision and will continue to engage in. The preparation of the plan is also consistent with the Executive Order issued by President George W. Bush on June 18, 2001 in support of the Olmstead Decision.

#### **The Process of the Plan Development**

AHCCCS, ADES/DDD and ADHS/DBHS convened an initial meeting in June 2000 to discuss the Supreme Court decision and subsequent information from the Centers for Medicare and Medicaid Services. In August 2000, the state agencies identified the process to encourage consumer involvement in the plan development process. This has included the convening of four regional stakeholder meetings, including one that was conducted via videoconference, one subcommittee for document review and several additional agency specific planning meetings. In September 2000, the state invited representatives from each of the statewide councils to meet and provide recommendations on how to best secure additional consumer participation. The statewide councils recommended that the agencies first develop draft plans that could be presented to consumers for input. In November and December 2000, the state held statewide meetings to present these preliminary plans and receive input. The consumers recommended that the agencies develop a single, consolidated plan because of the issues common to all of the consumers and the three agencies. Based on this input, the state developed the draft consolidated plan and requested review by a group of volunteers from the stakeholder community. This review occurred in March 2001. During April and May 2001, the state revised the consolidated plan, again based on the consumer responses, and posted a copy of the revised plan on the AHCCCS website in early June. Additional stakeholder meetings occurred in late June to receive comments on this plan. The final plan was published and posted on the AHCCCS website in August 2001.

The agencies will periodically review and update the final plan and continue to seek consumer input as to the status of the recommendations.

## **Results and Conclusions**

AHCCCS, ADES/DDD and ADHS/DBHS have identified, with assistance and input from consumers, the priority issues for future development. These are:

### AHCCCS and ADES/DDD

- Consumer Directed Service: Develop and implement a plan to allow consumers to take a stronger role regarding the hiring and directing of their personal care attendants.
- Consumer Pay Increases for Home and Community Based Providers: Begin the process of increasing pay for home and community based workers; analyze current reimbursement rates to determine if an increase is appropriate, conduct a cost study, obtain necessary appropriations if necessary, and ensure the increase, if received, is passed through to direct care providers.

### ADHS/DBHS

- Re-evaluate the current service matrix that includes services and service reimbursement rates.
- Conduct ongoing analysis of the service network through the Regional Behavioral Health Authorities (RBHA).
- Continue with ongoing improvements through the collaborative effort of the RBHAs, Arizona State Hospital, ADHS/DBHS, AHCCCS, and ADES/DDD to meet the needs of special populations.

## ***About the Content***

This document is organized to allow consumers, advocates and providers easy access to specific areas of interest.

*Part I* provides general background on the Olmstead Decision and Arizona's philosophical base and consumers served.

*Part II, Common Elements*, provides a brief description of the system. This includes a discussion of the common components of the community based Medicaid programs in Arizona and the common themes on which the agencies are working. Labor force, education and consumer information, consumer-centered care management, and network development are the issues that are common to all of the agencies serving the populations in home and community based environments.

*Part III, Agency Specific Actions*, provides information about how each agency is addressing the six Olmstead Principles.

Services provided by the Arizona Health Care Cost Containment System/Arizona Long Term Care System for persons who are elderly and/or have a physical disability.

Services provided by the Arizona Department of Economic Security/Division of Developmental Disabilities to children and adults with a developmental disability.

Services provided by the Arizona Department of Health Services/Division of Behavioral Health Services to children and adults with behavioral health needs.

*Part IV, Appendices*, provides the reader with more detail regarding the Olmstead Decision principles, populations and programs, services and settings, definitions and acronyms, the work plans for each of the state agencies, and people and organizations that were involved in the development and/or review of this plan, including:

Appendix A: CMS Olmstead Principles

Appendix B: Program Descriptions and Populations Served

Appendix C: Services and Settings

Appendix D: Timeframe for Plan Development

Appendix E: Acronyms and Definitions

Appendices F, G, and H: The Work Plans for AHCCCS, ADES/DDD and ADHS/DBHS

Appendix I: Persons and Organizations Invited to Participate in the Planning Process

Appendix J: Links to Other Resources for Consumers

This Plan demonstrates the State of Arizona's historical and current emphasis on the same principles that are found in the Olmstead Decision. The State will look at system improvements so that it can continue to strive to ensure that persons with disabilities have appropriate access to and choice regarding community based services and placements.

## PART I: BACKGROUND AND INTRODUCTION

This document, Arizona's Olmstead Plan, provides a comprehensive approach to demonstrating the State of Arizona's historical and current emphasis on the principles that are found in the Olmstead Decision and its desire to continue to ensure that persons who are elderly and persons with disabilities have appropriate access and choice regarding community based services and placements.

### ***Olmstead Overview***

#### *Supreme Court Decision*

In June 1999, the United States Supreme Court rendered a decision, *Olmstead v L.C.*, 119 S.Ct. 2176 (1999), which provides an important legal framework for the efforts of the federal and state governments to integrate individuals with disabilities into the communities in which they live. The Court's decision issues a challenge to all of us, the public sector, private sector, advocates, consumers and families, to improve opportunities for individuals with disabilities to access systems of cost-effective community based services.

Under the Court's decision, States are required to provide community based services for persons with disabilities who would otherwise be entitled to institutional services when:

- (a) The State's treatment professionals reasonably determine that such placement is appropriate;
- (b) The affected person is in agreement with the decision; and
- (c) The placement can be reasonably recommended, taking into account the resources available to the State and the needs of others who are receiving State-supported disability services.<sup>2</sup>

A state may be able to meet its obligation under the Americans with Disabilities Act by demonstrating that it has a comprehensive, effectively working plan for placing qualified persons with disabilities in the most integrated setting appropriate, and a waiting list that moves at a reasonable pace not controlled by a State's objective of keeping its institutions fully populated.<sup>3</sup>

#### *Executive Order*

On June 18, 2001, President George W. Bush issued an Executive Order on Community Based Alternatives for Individuals with Disabilities. This Executive Order reconfirmed the Federal Government's support of the Olmstead Decision. It directed the United States Office of the Attorney General; the Secretaries of Health and Human Services, Education, Labor, and Housing and Urban Development; and the Commissioner of the Social Security Administration to "work cooperatively to ensure that the Olmstead Decision is implemented in a timely manner". These departments are directed to work with the States to "help them assess their compliance with the Olmstead Decision and the ADA in providing services to qualified individuals with disabilities

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<sup>2</sup> CMS Letter to State Medicaid Directors; January 14, 2000

<sup>3</sup> CMS Letter to State Medicaid Directors; January 14, 2000

in community based settings, as long as such services are appropriate to the needs of those individuals.”

### ***Arizona’s Philosophy***

Although the Court did not require states to develop a plan, Arizona believes that this is an opportunity for advocates, agencies, consumers and community stakeholders to collaborate on a plan that will guide the State toward improving access to home and community based settings and services. The state agencies that design, fund and provide services to persons with disabilities – the Arizona Health Care Cost Containment System (AHCCCS), the Arizona Department of Economic Security (ADES) and the Arizona Department of Health Services (ADHS), have a history of working under the premise that people should live in an appropriate integrated setting in the community.

### ***Olmstead Principles***

The *principles* of the Olmstead Decision, which this Plan addresses, are:

- Principle 1 -- Plan: Develop and implement a comprehensive, effectively working plan (or plans) for providing services to eligible individuals with disabilities in more integrated, community based settings.
- Principle 2 -- Involvement: Provide an opportunity for interested persons, including individuals with disabilities and their representatives, to be integral participants in plan development and follow-up.
- Principle 3 -- Assessment: Take steps to prevent or correct current and future unjustified institutionalization of individuals with disabilities.
- Principle 4 – Availability: Ensure the availability of community-integrated services.
- Principle 5 – Informed Choice: Afford individuals with disabilities and their families the opportunity to make informed choices regarding how their needs can best be met in community or institutional settings.
- Principle 6 – State and Community Infrastructure: Take steps to ensure that quality assurance, quality improvement and sound management support implementation of the plan.

A detailed description of the Olmstead Decision Principles is included in Appendix A.

### ***Arizona’s Purpose, Principles, Goals and Outcomes to Meet Olmstead***

#### **Purpose**

The *purpose* of this Plan is to provide an opportunity for the public agencies, provider agencies, consumers, families and advocates to collectively comment on the success that Arizona has demonstrated in meeting the principles of the Olmstead Decision and to identify and plan for improvements to the current community based system.

## **Guiding Principles**

The *guiding principles* of the state programs were in place prior to the Olmstead Decision and continue to guide the planning and delivery of services. Although the Arizona Health Care Cost Containment System (AHCCCS), the Arizona Department of Economic Security (ADES) and the Arizona Department of Health Services (ADHS) may state the specifics of these principles differently, they all essentially espouse:

- *Person-Centered Care Management* – Belief that the consumer is the primary focus and that the consumer, along with family and significant others, as appropriate, is an active participant in planning, delivery and evaluation of services. This also means that if a team approach is used that the team also should be “person-centered.”
- *Consistency of Services* -- Service systems are developed to ensure that consumers can rely on services being provided as agreed to by the consumer and the program representative. This means that the services are timely, consistent, dependable and appropriate.
- *Available and Accessible Services* -- Access to services is maximized when services are developed to meet the needs of the consumer. Service provider restrictions, limitations or assignment criteria are clearly identified to the consumer and family and significant others, as appropriate.
- *Most Integrated Setting* -- Consumers should be able to reside in the most integrated setting. To that end, consumers are afforded choice in remaining in their own home or choosing an alternative residential setting versus entering into an institution.
- *Collaboration with Stakeholders* -- The appropriate mix of services will continue to change. Resources should be aligned with identified consumer needs and preferences. Efforts are made to include consumers and families or other significant persons, service providers and related community resources, to assess and review the change of the service spectrum. Changes to the service system are planned, implemented and evaluated for continuous improvement.

## **Goals**

The *goals* of this Plan are to:

- Address the recommendations of the Centers for Medicare and Medicaid Services (CMS) and the Office of Civil Rights in meeting the principles embedded in the Olmstead Decision.
- Demonstrate the progress that Arizona has made in meeting these principles.
- Identify areas for improvements in the delivery of home and community based settings and services.
- Ensure that consumers, advocates and other stakeholders are included in the planning process.
- Identify the data that must be collected to achieve the goals.

- Evaluate the progress that the State of Arizona is making toward meeting the goals and revising them, as needed.

## **Outcomes**

The *outcomes* from this Plan are to provide a map to:

- Strengthen informed decision making and choice for consumers.
- Improve community service systems.
- Improve administrative processes to support community integration.
- Monitor the overall capacity of the service system to provide services and supports that improve access to community integration.

The planning process has provided an excellent opportunity for the public agencies, provider agencies, consumers, families and advocates to collaborate regarding improvement strategies that will assist Arizona in maintaining the principles of the Olmstead Decision.

## ***Populations and Programs***

The long term care and home and community based programs in Arizona are the responsibility of three state agencies and are differentiated by population and fund source. Because Medicaid is a significant funder of home and community based services and placements, it is the primary focus of this document. The populations and programs that are addressed in this plan are described in more detail in Appendix B, and include:

- **Elderly and persons with a physical disability**

Arizona Health Care Cost Containment System/Arizona Long Term Care System for persons who are Elderly and/or have a Physical Disability (AHCCCS/ALTCS/EPD)

- **Children and adults with developmental disabilities<sup>4</sup>**

Arizona Department of Economic Security/Division of Developmental Disabilities/ Arizona Long Term Care System for Persons with Developmental Disabilities (ADES/DDD/ALTCS/DD)

Arizona Department of Economic Security/Division of Developmental Disabilities/State Funded Program for Persons with Developmental Disabilities (ADES/DDD/DD)

- **Children and adults with behavioral health needs**

Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) through the Regional Behavioral Health Authorities (RBHAs).

Arizona recognizes that there are other programs and funds that provide additional supports to the same populations. These supports and services also enable people to live more independently in their own homes and communities, and, in some cases, prevent or delay the need for more intensive services through the Medicaid programs. These programs include:

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<sup>4</sup> In this document the ALTCS/DDD and the State-Funded DDD program will be discussed together as the DDD program.



Arizona Department of Economic Security/Aging and Adult Administration/Non-Medical Home and Community Based System (ADES/A&AA/NMHCBS)

Arizona Department of Economic Security/Rehabilitative Services Administration (ADES/RSA)

The three state agencies – AHCCCS, ADES, and ADHS -- have historically engaged in planning that involves local communities and constituencies. Arizona is the only state in which the Home and Community Based System has no limits on the number of consumers who can live in the community. The state has also underscored the importance of community based settings by expanding the living arrangements and options available to the consumer. Arizona's model for persons with disabilities and the elderly is founded on principles that stress choice, dignity, independence, individuality, privacy and self-determination.

### ***Arizona's Olmstead Plan and Its Implementation***

The state expects that the Plan will be a document that the state agencies will periodically monitor and update. Comments from the public are welcome at anytime. Once the Plan is completed, copies will be provided to members of the public and the Statewide Councils. The state agencies will transmit the Plan to the Governor and the Arizona State Legislature, and will post a copy on the AHCCCS website. The ADES and ADHS websites will contain a link to the AHCCCS website that will take the consumer directly to the document.

This Plan identifies both issues that are common to all of the state agencies and programs and issues that are specific to a particular population, agency or program. The work plans for monitoring and review are included in Appendices F (AHCCCS/ALTCS), G (ADES/DDD) and H (ADHS/DBHS) and with each agency being responsible for monitoring its own work plan. In addition, each agency will be responsible for addressing issues specific to them as well as collaborating on common issues as appropriate. Work plans will be updated by the agencies as needed.

Accomplishment of the strategies and goals will take the effective partnering of the agencies, consumers, providers, and, in some cases, permission of the federal government.

## PART II: COMMON ELEMENTS

### ***Common Components of Community Based Medicaid Programs in Arizona***

The Arizona Health Care Cost Containment System/Arizona Long Term Care System (AHCCCS/ALTCS) is the Medicaid program serving elderly, physically disabled (EPD) and developmentally disabled (DD) persons at risk of institutionalization in Arizona. In addition, the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) provides Medicaid and state-funded behavioral health services to children and adults with behavioral health needs. The Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) also has a State Only funded program. Other non-Medicaid programs, such as the Non-Medical Home and Community Based System (NMHCBS) and the Rehabilitation Services Administration (RSA), also offer other supportive services to the same populations – either prior to enrolling in a Medicaid program, in lieu of a Medicaid program if the person is not eligible, or as an additional support to a Medicaid program.

The Medicaid programs include the following common components for all of the identified populations (elderly, physically disabled, developmentally disabled and persons with behavioral health needs), with exceptions as noted. A complete listing of all services and placements is provided in Appendix C.

### **Home and Community Based Services (HCBS)**

Consumers may remain in their own homes or in alternative home settings. Support services are available to assist consumers to remain in the community.

There is no limit on the number of elderly, physically disabled and developmentally disabled consumers who can reside outside of institutions. Medicaid does limit expenditures to no more than the amount that would have been spent on individuals in institutions. Members' options and choices are based on need.

### **Alternative Residential Settings Under HCBS**

These settings provide a more community-integrated setting for persons who might otherwise need to reside in an institution. A variety of types of settings are available, based on the consumer's need. By having a variety of alternative settings with differing levels of care available consumers are able to delay institutionalization, or, in some cases, transfer from a nursing facility into an HCBS setting. More important than the savings experienced by using HCBS, this alternative to institutionalization provides consumers with a degree of independence and control that might not be available in an institutional setting.

The three State agencies realize that a person's own home is the most optimal setting. The State, however, tries to ensure that the Alternative Residential Settings, when they are needed, are the most home-like atmosphere possible.

### **Institutional Care**

Institutional care in either a Medicare and/or a Medicaid approved institution is available to consumers.

### **Behavioral Health Services**

These are services provided to eligible consumers either through the ALTCS/EPD and ALTCS/DD program or separately through the ADHS/DBHS for children and adults with behavioral health needs.

### **Acute Medical Care**

Acute medical care is available for all Medicaid eligible consumers.

### **Early Periodic Screening, Diagnosis and Treatment Program (EPSDT)**

This program is available for Medicaid eligible persons from birth to 21 years of age to provide early detection and treatment of medical and behavioral conditions.

### ***Common Themes for All State Agencies***

Just as there are common philosophies and common components across the home and community based programs and services, there are also common themes which all of the involved State agencies' programs address. Some of these common themes are more easily addressed and improved – such as education to consumers and development of advisory councils. Others, like the labor force issue, are more complicated and require creative solutions.

### **Labor Force**

Although the Olmstead Decision does not specifically mandate states to address labor force issues, Arizona is, nonetheless, concerned about the impact on its ability to support people in the most appropriate community-integrated setting. There are labor shortages throughout the nation. This includes many human service and health care/direct care industries, including workers that support the long term care industry and community-integrated services. Many experts have examined and reported on the reasons for the current and future shortages. Their analyses find similar causes: retirement of baby boomers; better opportunities in other fields in a robust economy; and a shortage of individuals entering the human service and health care/direct care fields. This is a complex issue that will take creativity from many different fronts at the federal, state and local levels.

The State believes that it will take a community coalition of education, employment development industries, commerce, providers and consumers to successfully address these labor force issues. The Arizona Health Care Cost Containment System (AHCCCS), the Arizona Department of Economic Security (ADES), and the Arizona Department of Health Services (ADHS) encourage advocates, providers and consumers to continue to support the recognition that care provided in a person's home is a valued profession to ensure that these types of jobs are considered by both potential and current employees and employers as work worthy of adequate pay and benefits – regardless of whether it is in the public or private arena. Solutions to labor force issues will

come about only by a combination of legislative support, fiscal support, changes in credentialing and scope of practice limitations and an adequate labor market. These solutions will take the combined efforts of all parties.

Labor force issues, however, are further complicated by the fact that state law and regulation govern “scope of practice” issues for many professions while prohibiting others who are not members of that particular profession from performing activities that are considered within a professional scope of practice. In addition, the diversity of Arizona’s population can result in the inappropriate matches of direct care workers with clients, particularly if the providers experience difficulties in recruiting and retaining persons with a similar language or cultural background as the clients for whom they work.

AHCCCS, ADES/DDD and ADHS/DBHS, all address labor force issues through analyzing network capacity and gaps, exploring issues related to licensure and scope of practice that may limit the ability to provide services to certain professionals, and identifying appropriate standards of care in the various programs. AHCCCS, ADES/DDD and ADHS/DBHS encourage providers to identify gaps and barriers to having an adequate and qualified workforce and to bring these issues forward. The State agencies will continue to monitor their contractors regarding the identification and filling of gaps.

In addition to encouraging community participation in addressing labor force issues, each of the state agencies continues to review and act upon specific labor force issues:

AHCCCS/ALTCS/EPD and ADES/DDD

AHCCCS along with ADES/DDD has identified the following areas where it can be of assistance:

- Personal Care Attendants -- AHCCCS will evaluate the possibility of using Medicaid ALTCS funds in the ALTCS program to pay spouses and parents. This will expand the network and make it easier for people to move back into their homes.
- Interim Pay for Personal Care Attendants -- AHCCCS will submit a State Plan Amendment requesting the Centers for Medicare and Medicaid Services approval to allow payment for a personal care attendant under the ALTCS program for a specified period of time when the consumer may be out of the home or in an alternative setting (e.g. hospitalization). This change will enable the consumer to keep the same personal care attendant.
- Pay Increases for Home and Community Based Providers -- AHCCCS recently completed a study on reimbursement rates for home and community based providers. The study resulted in an average increase, effective October 1, 2001, of 15.3% for the ALTCS/EPD program. Recently passed legislation requires each agency (AHCCCS, ADES/DDD and ADHS/BHS) to contract with an independent consulting firm for an annual study of the appropriateness of reimbursement rates to service providers. A complete study of reimbursement rates will be completed no less than once every five years. In addition, the State Agencies encourage providers and contractors to address the salaries of direct care workers with increases in budgets.
- Consumer Directed Services – AHCCCS along with ADES/DDD will develop and implement a plan to allow consumers to take responsibilities for recruiting, hiring,

training, scheduling, directing and firing their personal care attendant workers. This includes the possibility of allowing the consumer to delegate skilled tasks to Personal Care Attendants. AHCCCS and ADES/DDD remain committed, however, to ensuring that clients have sufficient information to make appropriate decisions and to understand that choosing consumer directed care is a voluntary act.

### ADHS/DBHS

ADHS/DBHS, to address labor issues, is re-evaluating its current service matrix that includes the types of services and the recommended service reimbursement rates. A consultant has been contracted to propose additional service types and facilitate the evaluation process. Services are being reviewed and revised based on the gap analysis data provided by the Regional Behavioral Health Authorities (RBHA). Recommendations are being made for an increase in service reimbursement rates where appropriate. ADHS/DBHS will need to implement proposed changes and provide training to providers on any enhancements to the service matrix. It is anticipated that these changes will increase reimbursements and expand the types of reimbursable services in the community.

### **Education and Information to Consumers**

One of the most difficult tasks for an agency is developing strategies in order to get the right information at the right time for consumers. For all of the programs, there are councils that include consumers and families. These organizations, working in collaboration with the state agencies, assist in the development, review and/or distribution of educational and informational materials to interested parties. In addition, for all programs, case managers and support coordinators work with consumers to assist them to understand the choices that they have for services and settings and the implications of those choices.

#### Informational Material

AHCCCS, in cooperation with ADES/DDD and ADHS/DBHS, will explore the possibility of developing and disseminating informational materials to help consumers make informed choices. One of the examples of current information that is provided is the ADHS/DBHS publication of the “Arizona Behavioral Health Systems - Guide to Services” handbook and “Your Rights and Self Advocacy” guidebook. These are distributed statewide to assist consumers with information about the service delivery system. The RBHAs are also required to provide a consumer’s handbook to all enrolled consumers. AHCCCS requires ALTCS Program Contractors and ADES/DDD to provide a member handbook to all ALTCS consumers.

#### Member/Provider Councils

Currently, several advocacy groups including member/provider councils, such as Advocates for the Seriously Mentally Ill, the Arizona Mental Health Association, the Arizona Alliance for the Mentally Ill, Mentally Ill Kids in Distress (MIKID), the ADHS/DBHS Consumer Advisory Board, the RBHA’s Human Rights Committee, the DDD Human Rights Committee, the Developmental Disabilities Advisory Council, the DDD Family Support Council, and the Arizona Center for Disability Law, provide exceptional supports to consumers and potential consumers through advocacy and information sharing. The Yavapai County Long Term Care System began operating its Member/Provider Council in July 2000. Beginning October 1, 2001, all ALTCS/EPD Program Contractors will convene member/provider councils that are

representative of the ALTCS/EPD consumers and the providers within a given geographic area. These councils are available to provide a forum for discussions and feedback on the Plan and any revisions. In addition, AHCCCS will require that member/provider councils include family members and other types of advocates.

### Consumer Advocacy

ADHS/DBHS has partnered with the University of Arizona to provide training on the philosophy of recovery to consumers and providers throughout Arizona and to staff from the Arizona State Hospital. This philosophy supports consumer choice that often includes obtaining employment. ADHS/DBHS will verify that trainings have occurred throughout the state and will also encourage the RBHAs to develop training programs for consumers interested in providing behavioral health services such as peer mentoring and peer advocacy. Currently, licensure standards related to experience and education have posed a barrier to consumers who are interested in providing direct care. Expanding training programs for peer mentors and revising current regulations will positively impact labor force issues.

### **Consumer Centered Care Management**

Consumer Centered Care Management is at the heart of the philosophical base of the programs offered in Arizona. Care management and support coordination is provided for consumers to ensure that their care is integrated and appropriate to their level of need and potential. The programs offer advocacy and case management to assist the consumer in directing his/her own care by providing information, education and support throughout the planning and service delivery process. State agencies realize that there is a need for ongoing training of this philosophy/approach for care managers.

The State also encourages consumers and their advocates or designated representatives to advocate for their own individual needs. This may include consumers identifying and developing, on a more informal basis, their own “circle of friends” as a way of being more active and integrated in their own communities. In addition, more training is needed because the more specialized people can be, the more effective they will be in working with others who have unique needs. The consumer must have the ability to initially identify and change the designation of their advocates and designated representatives, as needed.

Examples of the activities for self advocacy, in which consumers of behavioral health services are encouraged to participate, include completing Advance Directives (a well developed crisis plan) which identifies the service preferences if and when they are unable to make their own decisions due to their behavioral health symptoms. Another example is the Wellness Recovery Action Plan (WRAP) where personal goals related to recovery are identified. The plan has action steps determined by the consumer that they would need to complete in order to achieve the goals.

Case manager caseloads should also contain a mix of clients in both HCBS and institutional settings. However, when caseloads are exclusively made up of institutionalized consumers, ALTCS Program Contractors will be encouraged to have systems in place that will ensure institutionalized consumers are being appropriately assessed for community placement.

### **Provider Networks**

AHCCCS, ADES/DDD and ADHS/DBHS conduct ongoing analysis of the service networks in Arizona. AHCCCS and ADHS/DBHS require contractors to provide an Annual Provider Network Status Report and Quarterly Updates. ADES/DDD, as an AHCCCS contractor for ALTCS, provides this information for the members they serve.

Beginning October 1, 2001, all AHCCCS/ALTCS Program Contractors are required to have formal Network Development and Management Plans. The purpose of the plan is to identify the current status of the network at all levels and to project future needs based upon membership growth. The plans will, at a minimum, include: current status of the network; current network gaps; immediate short-term interventions when a gap occurs; interventions to fill network gaps, and barriers to those interventions; outcome measures/evaluations of interventions; ongoing activities for network development; specialty population; and membership growth/changes. AHCCCS reviews these plans and requires contractors to implement corrective actions when indicated.

ADHS/DBHS is in the process of implementing a new system for monitoring service networks. The policies were recently revised and now require additional elements that must be reported. In addition, ADHS/DBHS has set up a cross-functional team, including the Quality Management, Financial, and Clinical Bureaus, to conduct reviews of the Network Analysis Reports. The team is also in the process of identifying additional information that will be incorporated into the network analysis review process, such as problem resolution and consumer satisfaction data. This information will assist in evaluating the provider network including any material gaps. The Regional Behavioral Health Authorities may be required to develop corrective action plans to address any issues identified.

## PART III: AGENCY SPECIFIC ACTIONS

### **AHCCCS/ALTCS/EPD**

The Arizona Long Term Care System Elderly and Physically Disabled (ALTCS/EPD) program for persons that are elderly and persons with a physical disability has accomplished many milestones that support and maintain consumers in the most integrated settings. These requirements are codified in contracts with the Program Contractors and AHCCCS policy and procedures that are available on the Arizona Health Care Cost Containment System (AHCCCS) website ([www.ahcccs.state.az.us](http://www.ahcccs.state.az.us)). A work plan can be found in Appendix F.

### **Comprehensive Effective Working Plan (Principle 1)**

This is a core principle since it suggests that states should develop a comprehensive, effective plan to provide services to individuals with disabilities in more integrated, community based settings. Through the Olmstead Plan (Plan), Arizona has an opportunity to build upon a model that incorporates many of the elements embodied in the first principle. For example, the ALTCS program has a wide spectrum of home and community based services (HCBS) and a solid range of alternative residential settings in the community (See Appendix C). The emphasis on HCBS is reflected in the high percentage of consumers living in the community. For example, nearly 50 percent of the elderly or persons with physical disabilities reside in the community and receive HCBS. Building upon this foundation, AHCCCS is working with the community to develop a comprehensive working plan.

AHCCCS will continue to support the principles of the Olmstead Decision in making reasonable efforts to ensure that potential and current consumers are assessed, provided information, and offered an array of services and settings that can enhance the consumer's opportunity to live in the most community-integrated setting possible. As part of that effort, AHCCCS will periodically monitor and update the Work Plan found in Appendix F of this document.

### **Plan Development and Implementation Process (Principle 2)**

The Centers for Medicare and Medicaid Services (CMS) has suggested that states should provide an opportunity for interested persons to be involved in the plan development. AHCCCS has involved key stakeholders and will continue to involve consumers, program contractors, advocates, community stakeholders and all other interested parties in formulating its portion of Arizona's Olmstead Plan. A listing of persons and organizations that were invited to participate in the development, review and comment on the Plan is included in Appendix I.

AHCCCS will post the completed Plan on its website and will invite all interested members of the community to provide written comments to AHCCCS at any time throughout the year. AHCCCS will periodically review, with interested parties, the status of the work plan, and continue to refine the document. AHCCCS will continue to include the consumers, program contractors, advocates, community stakeholders and all other interested parties in these ongoing review and update activities.



### **Assessment on Behalf of Potentially Eligible Populations (Principle 3)**

This principle is designed to prevent or correct current and future unjustified institutionalization of individuals with disabilities. Many states must begin their planning process by correcting unwarranted nursing facility placements. Arizona is fortunate that we are not starting from that point and can build on a philosophy that stresses independence in the most integrated setting. Planning for community integration begins before the consumer enters the nursing facility and a more collaborative approach is required between case managers and the HCBS system. Because Arizona does not provide prior period coverage for HCBS, there is no funding available to engage in early planning that would allow for an easier transition from the institution to home. To correct this, AHCCCS is reviewing the possibility of providing prior period coverage for HCBS.

AHCCCS monitors the system to ensure that this principle is met by:

- Reviewing the outcome of assessments made by the program contractors to ensure that consumers are placed in the most integrated and most appropriate placement.
- Redesigning the ALTCS computer system to improve data collection capabilities.
- Reviewing the current level of care assessment tools utilized by program contractors to evaluate if changes should be made to the tool. In addition, AHCCCS will require a standard assessment be used by the Elderly and Physically Disabled (EPD) Program Contractors throughout the state to ensure uniformity in each geographic region.
- Providing incentives to ALTCS/EPD Program Contractors for appropriate placement in home and community settings allowing consumers to reside in the most integrated environment.

Advocacy agencies can also assist in ensuring appropriate and early assessment and discharge planning occur. The State encourages advocacy groups to meet with nursing facility resident councils and program contractors to negotiate and ensure the availability of timely and accurate information for consumers.

### **Availability of Community-Integrated Services (Principle 4)**

AHCCCS provides a wide range of services and settings to assist people with integration into their communities, and because this is an entitlement program, there is no waiting list for the ALTCS/EPD program. The enrollment increases in the ALTCS HCBS program, as well as increases in the utilization of services, are reflective in the increases of expenditures for the program.

<b>CHANGE IN ALTCS EXPENDITURES BY SERVICE CATEGORY</b>	
<b>FEDERAL FISCAL YEAR 1996 - 1999</b>	
<b>ALTCS SERVICE (EXCLUDING CASE MANAGEMENT)</b>	<b>ALTCS % OF EXPENDITURE GROWTH FFY 1996 – FFY 1999</b>
<b>Home Health Services (RN and HHA)</b>	<b>+89%</b>
<b>Attendant Care</b>	<b>+47%</b>
<b>Home-Delivered Meals</b>	<b>+83%</b>
<b>Housekeeping</b>	<b>+13%</b>
<b>Personal Care</b>	<b>-18%</b>
	<b>(Attributable to increase in Attendant Care)</b>
<b>Other (Adult Day Health, Environmental Modification, Alternative Residential Settings)</b>	<b>+680%</b>
	<b>(Attributable to Alternative Residential Settings)</b>
<b>Respite Care</b>	<b>+138%</b>

Please refer to Appendix C for a complete listing of the ALTCS/EPD services and settings that are available.

Principle 4 stresses the importance of making HCBS accessible. Since the AHCCCS program was founded on this principle, the focus is on how to improve accessibility. Complete accessibility to HCBS is not always possible in rural areas or when there is a lack of providers. The goal, however, is still appropriate and AHCCCS and its Program Contractors must identify the gaps and quantify the problems to begin finding solutions. Some of the strategies that AHCCCS uses to measure accessibility are:

- Annual operational and financial reviews of the Program Contractors conducted by AHCCCS to determine areas of best practices and areas that need improvement.
- The Community Based Services and Settings Report. It will be updated every two years and will help identify and quantify gaps in service.
- An ALTCS Member Survey to solicit consumer ideas about what works, where attention should be focused for the future and what needs to be improved, has recently been completed. AHCCCS/ALTCS will share the results with the community and analyze the findings to determine possible steps to implement for program improvement.
- Periodic assessment of the accessibility and availability of services with the primary care providers, through communication with consumers and Program Contractors; and by measuring general member satisfaction with the ALTCS program.
- Review of annual general or focused member surveys performed by Program Contractors. The results of these surveys are communicated to AHCCCS/ALTCS and the Member/Provider Councils and provide a measurement of satisfaction as well as case

manager performance, appointment waiting time, transportation wait times and culturally competent treatment.

Recently, the CMS removed the limit on the number of consumers who can reside in HCBS. Although the ALTCS/EPD program had never met the HCBS limitation in the past several years, it was critical for AHCCCS to have this perceived barrier removed.

The two critical coordination activities for the AHCCCS/ALTCS program are case management and ongoing coordination and planning at the state and local levels. Case management provides assistance to individuals at all stages of the eligibility and service delivery process and local providers and planning bodies meet regularly to improve linkages among services.

As an entitlement program, AHCCCS/ALTCS must continue to grow to meet the increasing population needs of Arizona's eligible populations. In 2000, there were 110,000 non-institutionalized Arizonans age 65 or older in need of some type of assistance with mobility or self-care. By 2014, the number of persons 85 and older will double to approximately 149,000. Not all of the elderly will require assistance; however, the rapid population growth of elderly persons is one indicator of the type of expansion that the community based services and settings may require.

AHCCCS/ALTCS has in place or will research concepts that can improve the availability of community-integrated services.

#### Financial Incentives

AHCCCS will continue to offer financial incentives to program contractors who exceed the targets set for HCBS.

#### Reimbursement for Home and Community Based Placements and Services

AHCCCS is exploring the financial impact of paying for HCBS and placements from the time that an applicant applies for ALTCS rather than from the day the individual is found eligible for ALTCS. This arrangement should support community placements and may reduce costs if individuals do not need to go to a nursing facility in order to have their bills paid from the day they apply and are found eligible for ALTCS.

#### Transition Funds

In response to comments from the public hearings, AHCCCS will review the potential to provide funding to assist people in transitioning into their own homes, including providing deposit funds for rental apartments and houses, utilities and telephones, and providing start-up funding for household items and furniture.

#### Assistive Technology

In addition, the state is encouraging the Arizona Technology Access Program, which is federally funded, to develop recommendations and training modules to provide additional training to clients, case managers and direct care providers for the improved use of assistive technology. This should include the development of a comprehensive strategy for assistive technology to ensure a successful placement, including adequately trained personnel to assist a person with his/her assistive technology needs.

### **Informed Choice (Principle 5)**

The principle of Informed Choice underscores the purpose of a home and community based program that gives individuals with disabilities and their families an opportunity to make informed choices about how their needs can be met in the community. A basic tenet of the ALTCS/EPD program is to involve consumers in decision making about what services they want and where they want to live. For consumers to be able to make informed choices, they must have information about the available range of living arrangements, types of services, methods of service delivery, and the likely benefits, disadvantages and risks of each option. For example, people who are participating in the ALTCS/EPD program in Maricopa County should receive information about the three program contractors for acute and long term care services so that they can make an informed choice. The participants also need to receive a thorough explanation of the array of services and settings available so that they have informed choice and decision-making abilities relative to their care plan. To achieve that goal, each consumer is assessed to determine the most integrated placement for that consumer when considering the individual's medical and support needs. The case manager is responsible for facilitating placement/services based primarily on the consumer's choice. In addition:

1. Program Contractors prepare informational materials (i.e., consumer handbooks, newsletters, and brochures) and submit them to AHCCCS/ALTCS for prior approval.
2. Applicants are given information about available ALTCS services and settings during the eligibility process and advised of their rights and responsibilities.
3. AHCCCS/ALTCS is conducting focus groups with "baby boomers" to determine what long term care information would be beneficial and how best to distribute the information.

For individuals who cannot communicate their needs and choices, the Planning Team must develop a plan that is in the individual's best interest. The Team may include the individual, the family, the guardian, the case manager, the service provider, the residential provider, friends and any others chosen by the individual.

AHCCCS will work collaboratively with consumers, advocates and the Program Contractors to identify effective approaches to ensure that current and potential consumers are provided the necessary information to make informed choices.

### **State and Community Infrastructure (Principle 6)**

The CMS advised states to ensure that quality assurance, quality improvement and sound management principles support the plan. Some of the strategies that AHCCCS has in place are:

1. A requirement that all program contractors have an annual Quality and Utilization Management Plan that evaluates the quality of care. The program contractors must document the results and explain how the goals were met or unmet, document and trend quality management activities that have occurred and suggest what needs to be changed for the next year. AHCCCS reviews each program contractor's plan.
2. AHCCCS continually re-evaluates what is needed for a good management structure and incorporates those tenets in the contracts.

3. The Program Contractors' network and infrastructure are monitored in an annual operational review.
4. AHCCCS staff address all complaints or concerns referred to the agency. All complaints/concerns/quality of care issues are logged in, tracked and maintained in a centralized database. The allegations are identified and research is performed by obtaining and reviewing documentation from the numerous sources (e.g. Arizona Department of Health Services, Adult/Child Protective Services, Arizona State Board of Nursing, providers, program contractors and other regulatory agencies). Referrals are made to AHCCCS' Office of Program Integrity and shared with the Attorney General's Office, as appropriate. Findings are reviewed and discussed for actions taken on the case which may include policy and procedure changes, educational or in-services training, plans of correction, prosecution, bed holds and/or suspension or termination of the contracts.
5. Annual Operational and Financial reviews are performed by AHCCCS to ensure program compliance (Case Management, Network, Behavioral Health, Quality Utilization Management, Grievance and Requests for Hearing, Financial and Administrative). The reviews will identify areas where improvements can be made and recommendations are made to the program contractors. AHCCCS monitors the program contractor's progress on implementing the changes and provides the program contractor with technical assistance if necessary.

The AHCCCS/ALTCS program will continually look at ways to improve the ALTCS program. The addition of Network Management and Development Plans and Member/Provider Councils (see Principle 5) are two additional approaches to ensure the ALTCS program continues to improve and meet the needs of the consumers that it serves. The Member/Provider Councils also include consumer advocacy groups.

## **ADES/DDD**

### **Comprehensive, Effective Working Plan (Principle 1)**

The Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) State and Federal Funded Program for Persons with a Developmental Disability (DD) supports this core principle since it suggests that states should develop a comprehensive, effective plan to provide services to individuals with disabilities in more integrated, community based settings. ADES/DDD has historically worked to ensure that consumers are provided with assessments, information and services that will support them in the most integrated community setting that is appropriate. Through the Olmstead Plan (Plan), ADES/DDD has the opportunity to continue to build upon this model. ADES/DDD offers an array of community-integrated settings and services to support those settings. ADES/DDD also encourages consumers and their families to be active participants in service decisions. The emphasis on home and community based services (HCBS) is reflected in the high percentage of consumers living in the community. For example, over 99 percent of persons with developmental disabilities live in the community.

ADES/DDD will continue to support the principles of the Olmstead Decision in making reasonable efforts to ensure that potential consumers and consumers are assessed, provided information, and offered an array of services and settings that can enhance the individual's opportunity to live in the most community-integrated setting possible. As part of that effort, ADES/DDD will periodically monitor and update the Work Plan found in Appendix G of this document.

### **Plan Development and Implementation Process (Principle 2)**

The Centers for Medicare and Medicaid Services (CMS) has suggested that states should provide an opportunity for interested persons to be involved in the Plan development. ADES/DDD has involved key stakeholders and will continue to involve consumers and their families, providers, advocates, other community stakeholders and all other interested parties in formulating its portion of the Plan. A listing of persons and organizations that were invited to participate in the development, review and comment on this Plan is included in Appendix I.

ADES/DDD will provide a link to the completed Plan on its website and will invite all interested members of the community to provide written comments to ADES/DDD at any time throughout the year. ADES/DDD will periodically review, with interested parties, the status of the work plan, and continue to refine the document. ADES/DDD will continue to include consumers and their families, providers, advocates, other community stakeholders and all other interested parties in these ongoing review and update activities.

### **Assessment on Behalf of Potentially Eligible Populations (Principle 3)**

ADES/DDD has determined that existing assessment and planning procedures are adequate to identify individuals currently in institutionalized settings, to identify institutionalized individuals who could benefit from more integrated community settings and to identify individuals in the community who are at risk of placement in an unnecessarily restrictive setting.

Individual planning processes include the Individual and Family Service Plan (IFSP) for children under age three, the Individual Service Plan (ISP) for individuals over age three, and the Person-Centered Planning process which is being pilot tested at this time. All plans are reviewed annually as part of the current planning process. An annual Arizona Health Care Cost Containment System/Arizona Long Term Care System (AHCCCS/ALTCS) review of Medicaid eligible individuals is also conducted. Assessments from therapists and psychologists as well as functional assessments and employment assessments are also reviewed as part of this process.

Decisions to move an individual to the most integrated setting must include an assessment of their ability to live in the setting. There must be agreement to the move by the individual and the team of system representatives, professionals, and family members or other persons who are significant to the individual. Service plans and the planning process should be long term and anticipate future needs as well as current needs. On an individual basis, the planning process and overall philosophy support placement in the most appropriate integrated setting chosen by the individual.

Family members and others are currently being trained as part of the Person-Centered Planning Process to facilitate plan development focusing on the individual's goals including the long term needs to reach those goals. Addressing the service system changes needed to prepare for these trends will provide more options and choices for the individuals.

For special populations, such as persons with developmental disabilities who also are receiving services at the Arizona State Hospital, there is a special joint discharge planning process that occurs prior to enrollment of the individual with a Program Contractor or Regional Behavioral Health Authority (RBHA).

The ADES/DDD is planning a number of improvements to assessment and planning, including:

- Taking steps to ensure quality implementation of the IFSP and the ISP. The process and tools have been developed and work well.
- Taking actions to enhance the system's responsiveness to service changes/changes in need.
- Improving the identification of persons at risk of moving to more restrictive settings.
- Expanding the Person-Centered Planning process to other locations in the state after the pilot is completed.

### **Availability of Community-Integrated Services (Principle 4)**

ADES/DDD has a wide range of community-integrated settings and support services available for consumers who have a developmental disability. Among the current initiatives that ADES/DDD is pursuing to further improve community integration are Home of Your Own and Family Support. The Home of Your Own program assists individuals with disabilities in determining if they are interested in becoming homeowners and in assessing the financial viability of home ownership, and may provide up to \$10,000 per person to be used for a down payment or closing costs on the purchase of a home. Family support groups, and educational support for them, continue to grow throughout the state including an increasing number of self-advocates.

Integrated services can be provided in every residential setting to varying degrees. ADES/DDD is planning a number of improvements to promote integrated services in each setting, including increasing the opportunities for and knowledge about community services in settings, increasing opportunities for individuals to engage in community activities, improving learning skills, establishing an information contact, expanding transportation opportunities, and addressing best practices.

For individuals who cannot fully participate and individuals without family or other informal caregivers, ADES/DDD will ensure that the individual's team knows the person and has a commitment to their well being, uses volunteers and mentors, and has access to legal advocacy and individual opportunities.

In order to address gaps in services, ADES/DDD plans to address the issues of the following support services: transportation, skill levels of residential providers, creating meaningful day activities, and increasing availability of therapies, home nursing, respite, habilitation, and transition services. The degree to which there is a shortage of the service varies in different parts of the state.

ADES/DDD will also address employment services, networks and assistive technology.

### **Informed Choice (Principle 5)**

ADES/DDD affords individuals with developmental disabilities and their families with the opportunity to make informed choices regarding how their needs can best be met in the community or institutional settings. In addition to providing consumers and their families with written and verbal information and with information on how to access other family advocacy and support groups, ADES/DDD has a number of initiatives in progress, including:

*Case Management Options* – a pilot project in Districts VI, II and part of District I that allows individuals and families to make choices on case managers, including contracted agencies or individuals, parents, family members, consumers or Division staff.

*Person-Centered Planning* – which supports ADES/DDD's direction of self-determination by ensuring more family/consumer control of the services they need. It allows for families/consumers to control their own budget and select services and providers when and as they need them. The pilot will be evaluated and will become available statewide depending upon the results of the evaluation.

*Core Indicators Project* – a project that pilots a set of quality indicators. Consumers are surveyed to determine the extent of community integration, choice and self determination, independence, quality of relationships, quality of life, satisfaction with service coordination, access to supports and services, safety, health, respect and rights and satisfaction with providers. Results will allow Arizona, and the other states that are participating, to develop practical strategies to improve quality of supports and services.

*Voucher Program* – the opportunity for over 1,000 people to use vouchers to purchase services. This empowers families and individuals to choose providers and streamlines the service delivery system.



*Partners in Policymaking* – a Pilot Parents of Southern Arizona initiative, supported by ADES/DDD, which promotes opportunities for individuals with developmental disabilities to become more involved in planning and decision making. The initiative is an innovative leadership-training program that teaches people to be community leaders and to affect systems and policy change at the local, state and national levels.

In order to support and ensure that individuals and their families have the information needed and the ability to make decisions based on accurate information, the following overall concepts need to be incorporated into all levels of service planning and delivery.

- Information that supports individuals and families making informed choices needs to be readily and comprehensively available.
- Individuals and families need to know that they do have choices and they need to know how to exercise those choices and decision-making rights. Individuals need to be provided opportunities to learn decision-making skills, and to understand that they have the right to change their minds.
- For individuals who cannot communicate their desires/choices, the Planning Team must develop a plan that is in the individual’s best interest. The Team may include the individual, the family, the guardian, the support coordinator, the service provider, the residential provider, friends and any others who know the individual.

In addition, ADES/DDD will develop written materials and explore options for various forms of delivery. This will include a 1-800 number, a website, connections with current clients or families of clients for peer support and strengthening peer support networks. ADES/DDD will also explore additional opportunities to inform individuals about choice and consequences.

The Rehabilitation Council, Independent Living Centers and the Governor’s Council on Developmental Disabilities are reviewing the decision-making process for employment. Their recommendations, which will support individual choice and informed decision making, should be implemented.

### **State and Community Infrastructure (Principle 6)**

ADES/DDD engage in continuous improvement processes that include quality assurance reviews and enhancement of sound management practices. There are two mechanisms currently in place that will provide information for monitoring the overall system responsiveness to integrated services.

The Core Indicators Project: Arizona, along with over 20 other states is piloting a set of quality measures - Core Indicators. Consumers are surveyed to determine the extent of community integration, choice and self determination, independence, quality of relationships, quality of life, satisfaction with service coordination, access to supports and services, safety, health, respect and rights and satisfaction with providers. Results allow states to develop practical strategies to improve quality of supports and services. Specific areas included in the indicators related to community integration are:

- People are receiving supports to find and maintain employment in integrated settings and earn increased wages.

- People use integrated community services and participate in everyday community activities.
- People make life choices and participate actively in planning their services and supports.
- People are satisfied with the services and supports they receive – The proportion of people who report satisfaction with where they live.

Waiting List Tracking -- Program Managers in each ADES/DDD District of the State track the number of persons waiting for a less-restrictive setting or service – residential and/or employment. Based on information available as of August 15, 2000, there are nine (9) individuals who are working in sheltered employment settings that are prepared to move to employment in a more integrated setting. There are fifty-four (54) individuals prepared to move to a more integrated residential setting. Twenty two of the clients reside at the Arizona Training Program at Coolidge (ATPC) in the larger cottages and are willing to move to smaller settings if they can remain on the ATPC campus. The 54 individuals represent only 2 percent of those who are living out of home. In each case, the availability of appropriate options is delaying the changes.

The combination of information from the core indicators, AHCCCS/ALTCS audits and Program Manager tracking provides a very specific means of monitoring improvement in providing integrated service settings and services.

To ensure that the contracting and resource development functions support placement in integrated settings, the ADES/DDD will review the contracting process, identify additional methods to support consumers in the community, and promote creativity among providers in serving clients.

## ***ADHS/DBHS Children and Adults with Behavioral Health Needs***

### **Comprehensive, Effective Working Plan (Principle 1)**

The strategic plan for the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) strives to promote healthy development and provide effective prevention, evaluation, treatment, and rehabilitation for those individuals in need of behavioral health services. A successful system allows for personal empowerment and can assist the individual in leading a responsible, productive and meaningful life. Therefore, Arizona's Olmstead Plan (Plan) includes principles that are consistent with the guiding Olmstead Decision principles.

Foremost is preventing the unnecessary institutionalization of children and adults whose behavioral health needs can be met in more appropriate integrated settings. Arizona has successfully met this objective as evidenced by the decline in the average daily census and the average length of stay at the Arizona State Hospital since 1997. The Regional Behavior Health Authorities (RBHAs) expenditure reports indicate that inpatient hospitalization costs have been decreasing and expenditures for community supports have been increasing significantly during this same time period. This success has been greatly due to the RBHAs' increased utilization of community based mental health services. Currently, 99 percent of children and adults with behavioral health needs are residing in the community utilizing community based services. Services such as case management, in-home supports and respite care have expanded and continued expansion in these areas is anticipated, as ADHS/DBHS continues to assure that the behavioral health needs of the consumers are met in integrated settings when appropriate.

ADHS/DBHS, in conjunction with the RBHAs, have historically believed that consumer(s) and those significant to the consumer(s) should have a voice and actively participate in their care and/or the care of those close to them. The goal is to continue striving to include individuals in their service provision. This is best done by providing information to consumers regarding all aspects of the behavioral health service delivery system, including but not limited to, assessment, available services, treatment and after-care. Provision of complete and accurate information allows for responsive, comprehensive, and when appropriate community based services tailored to the individual, family, community, and culture.

To ensure that the principles set forth in this document are adhered to, ADHS/DBHS will periodically monitor and update the Work Plan found in Appendix H. The Plan will be reviewed bi-annually by the ADHS/DBHS management team and annually with the other agencies participating in this Plan.

### **Plan Development and Implementation Process (Principle 2)**

ADHS/DBHS has involved key stakeholders and will continue to involve consumers and their families, the RBHAs, providers, advocates, other community stakeholders and all other interested parties in formulating its portion of Arizona's Olmstead Plan. A listing of persons and organization that were invited to participate in the development, review and comment on this Plan is included in Appendix I.

**PART III: AGENCY SPECIFIC ACTIONS**  
**ADHS/DBHS – CHILDREN AND ADULTS WITH BEHAVIORAL HEALTH NEEDS**

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ADHS/DBHS will provide a link on its website to the completed Plan and will invite all interested members of the community to provide written comments to ADHS/DBHS at any time throughout the year. ADHS/DBHS will periodically review, with interested parties, the status of the Work Plan, and continue to refine the document.

**Assessment on Behalf of Potentially Eligible Populations (Principle 3)**

A critical ADHS/DBHS responsibility is to provide oversight and regulation to the RBHAs. This is demonstrated in a variety of forms. ADHS/DBHS develops policies and procedures regarding the assessment of service delivery, including the utilization of community based services and systemic needs and provides the RBHAs with a Quality Management/Utilization Management Plan (QM/UM). The RBHAs, as indicated in ADHS/DBHS policy, are responsible for conducting service delivery assessments according to the QM/UM Plan and determining service needs in their region. The RBHAs develop area-specific policies and procedures consistent with the guidelines set forth by ADHS/DBHS and ensure adherence by the area providers. Annual reviews of the RBHA's adherence to the QM/UM Plan, policies and procedures, and practices, as well as their monitoring activities of area providers are conducted by ADHS/DBHS and feedback is provided to enhance service delivery. A cross-functional monitoring team consisting of representatives from the Quality Management and Financial Departments and the Clinical Bureaus conduct these reviews (Operational and Financial Reviews) so that it is comprehensive in nature. These annual Operational and Financial Reviews include reviewing service delivery assessment methods (data systems), case files, and adherence to mandates.

On a practical level, the behavioral health system in Arizona requires prior authorization for inpatient hospitalization or residential treatment to ensure that such restrictive placements are necessary to address individual needs and could not be addressed in less restrictive settings. Long term inpatient placements are periodically reviewed to determine if the individual has achieved maximum benefit and to ensure the placement should continue. RBHAs are required to report quarterly (to ADHS/DBHS) on data (i.e., average length of stay, admission information, and discharge data) verifying that institutional placements and acute care is monitored and not over-utilized.

An additional safeguard to prevent against the over-utilization of long term restrictive placements has been developed to ensure that individuals being hospitalized at the Arizona State Hospital have been appropriately assessed. All pending Arizona State Hospital admissions must be reviewed by the RBHA of jurisdiction and Arizona State Hospital representatives prior to hospitalization. Both authorities review severity of referring illness, expected outcome, and the identification of discharge goals. If admission is determined necessary, a discharge plan is initiated upon admission outlining goals for transitioning back into the community as quickly as appropriate. Additionally, incentives for the RBHAs have been developed by ADHS/DBHS to maintain the Arizona State Hospital census at predicable levels, to promptly place patients who are ready for discharge and to prevent readmission by providing appropriate monitored community services.

ADHS/DBHS will continue to coordinate and assure that meetings take place to allow for collaboration with other agencies regarding service delivery. The current monthly meetings held

with representatives from ADHS/DBHS, ADES/DDD, the RBHAs, and the Arizona State Hospital to coordinate discharge for persons with multiple service needs, will continue. Any barriers identified in these meetings will be addressed through the development of workgroups, and if necessary, ADHS/DBHS will revise or write policies to address the issue. ADHS/DBHS will also be developing on-going collaborative meetings with stakeholders, representatives from ADHS/DBHS, ADES/Division of Children, Youth and Families, ADES/DDD, Arizona Department of Juvenile Corrections, RBHAs and the Arizona Administrative Office of the Courts to decrease barriers to services for children and families served by the state agencies. ADHS is in the process of developing strategies to improve the assessment of and provision of services to children who are served by multiple agencies.

#### **Availability of Community-Integrated Services (Principle 4)**

ADHS/DBHS mission is to provide a comprehensive array of services to meet a person's behavioral health needs in community based settings. The RBHAs are responsible for determining the service needs in their region and developing a plan to meet those identified needs. As indicated earlier, ADHS/DBHS monitors the RBHAs to ensure that the service needs identified are being addressed and that multiple services exist. Currently, RBHAs deliver a full range of behavioral health services including prevention programs for adults and children, a full continuum of services for adults with substance abuse and general behavioral health disorders, adults with serious mental illness (SMI), and children with serious emotional disturbances (SED). The RBHAs accomplish this either directly or by developing a network of providers to deliver the services. A list of available services is included in Appendix C.

Service delivery options are expected to increase in the near future in Arizona. ADHS/DBHS has Intergovernmental Agreements with other state agencies to expand the provision of integrated community services. There are two initiatives currently underway which will additionally increase the utilization of integrated services within the state. They are as follows:

1. House Bill 2003 – This provides additional funding for services such as housing and vocational rehabilitation services to improve integration at the community level.
2. Proposition 204 – The implementation of Proposition 204 allows for matching funds for identified consumers thereby requiring the development of additional community based services.

In addition to the above, a provision from the State's Tobacco Settlement of \$50 million for adults with SMI diagnoses and \$20 million for children has been appropriated to increase community services. Finally, the Centers for Medicare and Medicaid Services (CMS) waiver which raises Medicare eligibility, will be used to expand community behavioral health services.

ADHS/DBHS is currently participating in a rate review with AHCCCS to expand Medicaid funding to include vocational services and personal assistance. Also being evaluated is a prospective rate that will include providers' development/start-up costs. RBHAs are focusing on developing housing and residential support services that have been identified through gap analysis data.

**PART III: AGENCY SPECIFIC ACTIONS**  
**ADHS/DBHS – CHILDREN AND ADULTS WITH BEHAVIORAL HEALTH NEEDS**

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Other activities underway to enhance community based services include the development of Active Community Treatment (ACT) case management teams for adults. The ACT model of case management has, in other states, proven successful in supporting individuals upon their discharge from state institutions. The model provides a clinical team whose members have expertise in housing, vocational rehabilitation, substance abuse, medication management, and symptom management. These teams have been quite successful in other states assisting consumers with community integration. ADHS/DBHS has also sponsored an Integrated Treatment Consensus and Statewide Advisory Panel to establish best practice guidelines, training and improved methods for service delivery to persons with co-occurring mental health and substance abuse disorders. ADHS will continue to facilitate these discussions and support development of integrated community services for individuals with mental health and substance abuse issues.

Additionally, the ADHS/DBHS and the RBHAs, in collaboration with ADES, and Rehabilitative Services Administration (RSA) are developing peer mentor trainings and additional supported employment opportunities to increase available services. The RBHAs are also encouraged to expand consumer run programs including drop-in centers, clubhouses, and peer counseling.

The Bureau of Children’s Services, in partnership with other child-serving agencies, has been involved in the implementation of a number of projects to coordinate services to children served by the RBHAs. Single Purchase of Care (SPOC), is a joint process developed in collaboration with the Department of Economic Security, the Department of Juvenile Corrections, and the Administrative Office of the Courts to provide a streamlined purchasing system of behavioral health care for children. The Early Childhood Behavioral Health Task Force was developed to define a system that provides access to comprehensive infant mental health services from trained and qualified practitioners in community based settings. Interagency Case Management Projects (ICMP) are currently being implemented and designed to centralize, coordinate and manage the services for children and youth. In addition to the above collaboration efforts, the Bureau of Children’s Services also collaborates in other programs which include: Model Court, No Wrong Door, 300 Kids Project, and area Children’s Coordinating Councils. The ADHS/DBHS has also added respite care for family members as a service covered by AHCCCS for children and adults with behavioral health needs.

**Informed Choice (Principle 5)**

ADHS/DBHS have developed policy requirements to ensure that individuals (including children and their families) are informed about their treatment options, including medications. Consumers are required and encouraged to take part in the service planning process and service plan reviews and can also identify any additional persons they may wish to be a part of their clinical team. These individuals may be family members, designated representatives, friends, etc. who can assist them in making informed choices about their treatment. Additionally, persons with a serious mental illness who are assessed as being unable to participate in treatment decisions and therefore are in need of special assistance, are referred for advocacy services as required by ADHS/DBHS policy.

A variety of methods to increase client awareness to available treatment options include meetings held with consumers at drop-in centers to assist and support the development of

recovery plans such as the Wellness Recovery Action Plan (WRAP). These plans clearly state the consumer's choices regarding treatment. In addition, a Recovery Training program will be provided at the Arizona State Hospital by the University of Arizona to educate consumers who are currently hospitalized on their treatment options to allow for more informed choices. Representatives from the ADHS/DBHS Bureau for Adult Services and Bureau for Children's Services attend the Arizona Behavioral Health Planning Counsel and the Children's Planning Counsel meetings to increase knowledge and information sharing regarding available services. This exchange of information provides a greater opportunity for consumers to be educated about how to make informed treatment choices.

### **State and Community Infrastructure (Principle 6)**

ADHS/DBHS has the responsibility for direct oversight, both financially and programmatically for the activities of each of the RBHAs that sub-contract with provider networks including more than 1,300 service providers throughout the state. Monitoring for contract compliance, adherence to Medicaid regulations, fiscal accounting, program design, delivery, and effectiveness, as well as client satisfaction, occurs in a structured manner and on a periodic basis as indicated in previous sections. If necessary, additional monitoring may occur throughout the year based on outcome of the yearly monitoring reviews. Also included in the review process is data provided regarding the availability of and timeliness of appointments and if the consumer's presenting problems are being adequately addressed by the services designated in the service plan.

Consumer satisfaction surveys are completed biannually. Additional surveys to be implemented in the future include: the Mental Health Statistical Improvement Project (MHSIP) Youth Services Survey, MHSIP Youth Service Survey for Families, MHSIP (Adapted) Family Survey, and a Recovery Survey. This data will be analyzed as part of the quality improvement process for monitoring the service delivery system.

ADHS/DBHS initiatives focusing on expansion of community based services include:

1. Implementation of the recent changes to the behavioral health covered services array including the addition of new services (i.e. peer and family support) and provider types (i.e. Community Service Agencies and Rural Substance Abuse Transitional Center).
2. Integrated treatment for persons with co-occurring disorders.
3. A new process and policy for analyzing the sufficiency of the provider networks and identifying service gaps so they can be addressed in a timely manner.

## **PART IV: APPENDICES**

### **APPENDIX A: CENTERS FOR MEDICARE AND MEDICAID SERVICES OLMSTEAD PRINCIPLES**

Principle 1 -- Plan: Develop and implement a comprehensive, effectively working plan (or plans) for providing services to eligible individuals with disabilities in more integrated, community based settings. When effectively carrying out the principle:

- The State develops a plan or plans to ensure that people with disabilities are served in the most integrated setting appropriate. It considers the extent to which there are programs that can serve as a framework for the development of an effectively working plan. It also considers the level of awareness and agreement among stakeholders and decision makers regarding the elements needed to create an effective system, and how this foundation can be strengthened.
- The plan ensures the transition of qualified individuals into community based settings at a reasonable pace. The State identifies improvements that could be made.
- The plan ensures that individuals with disabilities benefit from assessments to determine how community living might be possible (without limiting consideration to what is currently available in the community). In this process, the individuals are provided the opportunity for informed choices.
- The plan evaluates the adequacy with which the State is conducting thorough objective and periodic reviews of individuals with disabilities in institutional settings (such as State institutions, ICFs/MR, nursing facilities, psychiatric hospitals and residential services facilities for children) to determine the extent to which they can and should receive services in a more integrated setting.

Principle 2 -- Involvement: Provide an opportunity for interested persons, including individuals with disabilities and their representatives, to be integral participants in plan development and follow-up. When effectively carrying out this principle:

- The State involves people with disabilities (and their representatives, where appropriate) in the plan development and implementation process. It considers what methods could be employed to ensure constructive, on-going involvement and dialogue.



**PART IV: APPENDICES**

**APPENDIX A: CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) OLMSTEAD PRINCIPLES**

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- The State assesses what partnerships are needed to ensure that any plan is comprehensive and works effectively.

Principle 3 -- Assessment: Take steps to prevent or correct current and future unjustified institutionalization of individuals with disabilities. When effectively carrying out this principle:

- The State has a reliable sense of how many individuals with disabilities are currently institutionalized and are eligible for services in community based settings. The plan considers what information and data collection systems exist to enable the State to make this determination. Where appropriate, the State considers improvements to data collection systems to enable it to plan adequately to meet needs.
- The State evaluates whether existing assessment procedures are adequate to identify institutionalized individuals with disabilities who could benefit from services in a more integrated setting.
- The State also evaluates whether existing assessment procedures are adequate to identify individuals in the community who are at risk of placement in an unnecessarily restrictive setting.
- The plan ensures that the State can act in a timely and effective manner in response to the findings of any assessment process.

Principle 4 -- Availability: Ensure the Availability of Community-Integrated Services. When effectively carrying out this principle:

- The plan identifies what community based services are available in the State. It assesses the extent to which these programs are able to serve people in the most integrated setting appropriate (as described in the ADA). The State identifies what improvements could be accomplished including the information systems, to make this an even better system, and how the system might be made comprehensive.
- The plan evaluates whether the identified supports and services meet the needs of persons who are likely to require assistance in order to live in the community. It identifies what changes could be made to improve the availability, quality and adequacy of the supports.
- The State evaluates whether its system adequately plans for making supports and services available to assist individuals who reside in their own homes with the presence of other family members. It also considers

whether its plan is adequate to address the needs of those without family members or other informal caregivers.

- The State examines how the identified supports and services integrate the individual into the community.
- The State reviews what funding sources are available (both Medicaid and other funding sources) to increase the availability of community based services. It also considers what efforts are under way to coordinate access to these services. Planners assess the extent to which these funding sources can be organized into a coherent system of long term care that affords people with reasonable, timely access to community based services.
- Planners also assess how well the current service system works for different groups (e.g. elderly people with disabilities, people with physical disabilities, developmental disabilities, mental illness, HIV-AIDS, etc.). The assessment includes a review of changes that might be desirable to make services a reality in the most integrated setting appropriate for all populations.
- The plan examines the operation of waiting lists, if any. It examines what might be done to ensure that people are able to come off waiting lists and receive needed community services at a reasonable pace.

Principle 5 – Informed Choice: Afford individuals with disabilities and their families the opportunity to make informed choices regarding how their needs can best be met in community or institutional settings.

- The plan ensures that individuals who may be eligible to receive services in more integrated community based settings (and their representatives, where appropriate) are given the opportunity to make informed choices whether and how their needs can best be met.
- Planners address what information, education, and referral systems would be useful to ensure that people with disabilities receive the information necessary to make informed choices.

Principle 6 – State and Community Infrastructure: Take steps to ensure that quality assurance, quality improvement and sound management support implementation of the plan. When effectively carrying out this principle:

**PART IV: APPENDICES**

**APPENDIX A: CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) OLMSTEAD  
PRINCIPLES**

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- Planners evaluate how quality assurance and quality improvement can be conducted effectively as more people with disabilities live in community settings.

The State also examines how it can best manage the overall systems of health and long term care, so that placement in the most integrated setting appropriate becomes the norm. It considers what planning, contracting and management infrastructure might be necessary to achieve this result at the State and community level.

## APPENDIX B: BRIEF PROGRAM DESCRIPTIONS

Programs that support the target populations in community settings are defined according to the population that they serve. Some programs, such as Rehabilitative Services, Non-Medical Home and Community Based Service System and other types of services are available to more than one population group.

### **AHCCCS/ALTCS/EPD**

*Arizona Health Care Cost Containment System/Arizona Long Term Care System for Persons who are Elderly and/or have a Physical Disability (AHCCCS/ALTCS/EPD)*

ALTCS/EPD services are provided either directly or indirectly, in the 15 Arizona counties, by Program Contractors under contract with AHCCCS, to persons who are elderly or who have a physical disability. Program Contractors coordinate, manage and provide acute care, institutional care, home and community based care, behavioral health and case management services to ALTCS/EPD consumers. The typical ALTCS/EPD consumer is a white female between 80 and 89 years of age, and 18 percent of the EPD consumers are over 90 years of age.

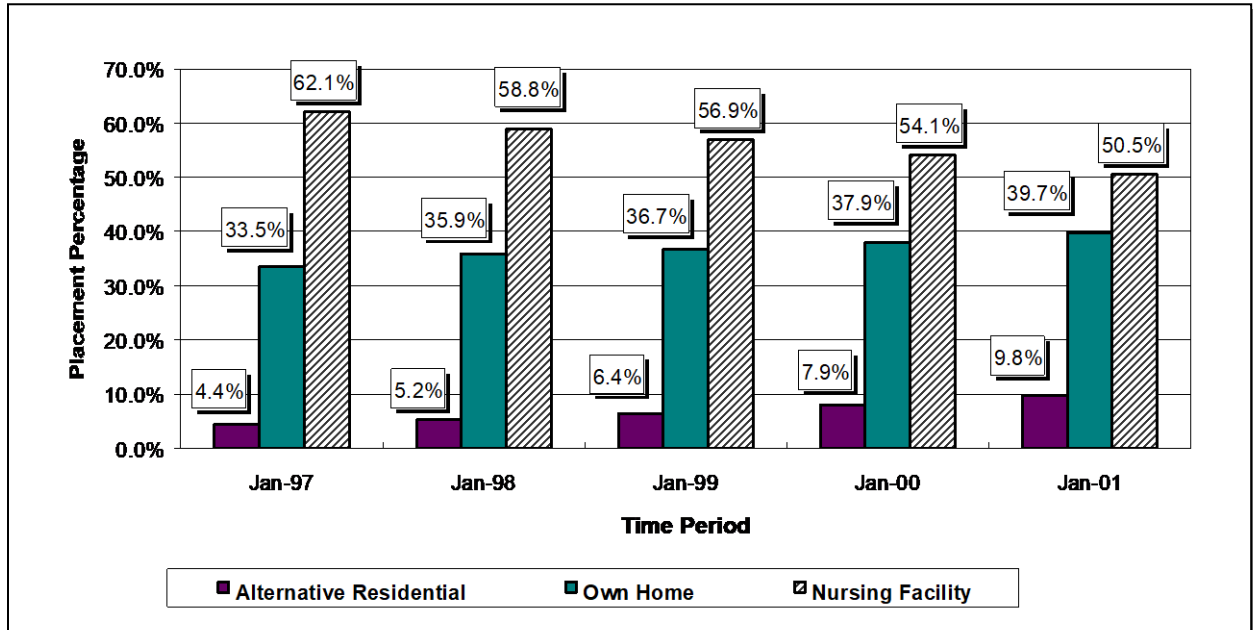
As of May 1, 2001, there were 19,515 elderly and physically disabled persons enrolled in the ALTCS/EPD program. The number of consumers currently residing in nursing facilities is 9,953. The home and community based population is divided into “own home” and “alternative residential settings.” As of May 1, 2001, 8,196 consumers lived in their own home and 1,366 lived in Alternative Residential settings.

Table 1 shows the change from January 1997, through January 2001, in the proportion of ALTCS/EPD members who reside in their own home, alternative residential settings and nursing facilities. Nearly 50 percent of the consumers in the ALTCS/EPD program reside in home and community based settings (own home and alternative residential settings). The proportion of nursing facility residents has declined from 62.1 percent in 1997 to 50.5 percent in 2001.

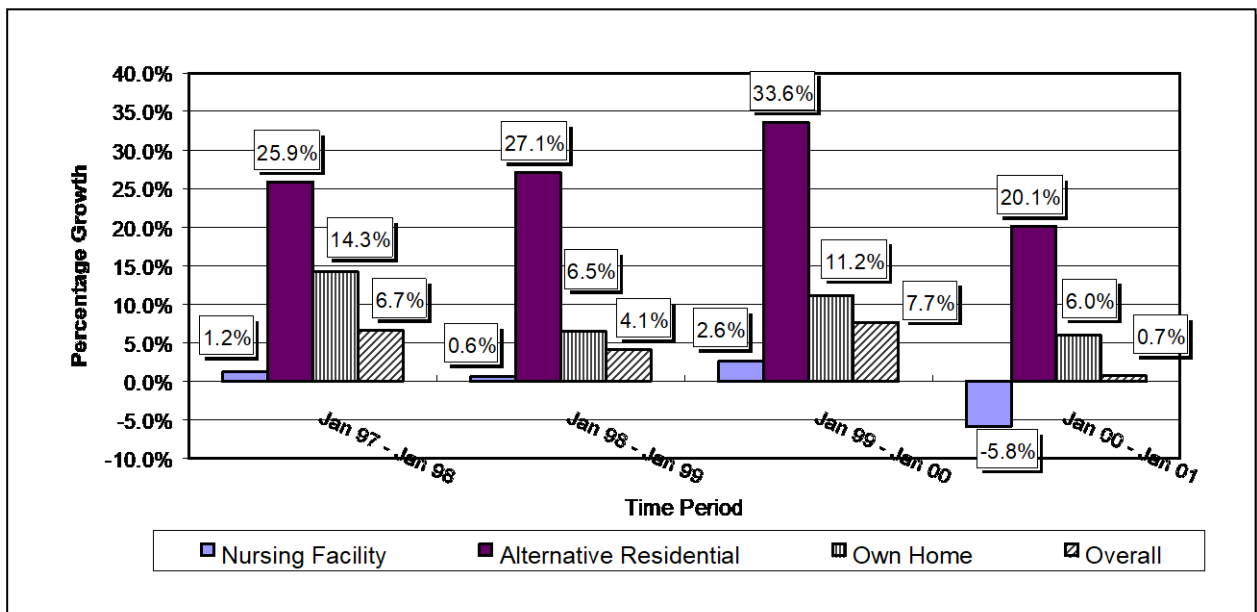
Table 2 takes this same data that made up Table 1 and shows the percentage of growth that has occurred in members who reside in their own homes, alternative residential settings and nursing facilities for the same time period. Nursing facility growth has essentially remained flat or decreased over this time period. The largest proportion of growth is with those members residing in alternative residential settings. Those members residing in their own homes or alternative residential settings continue to grow at a rate greater than the overall ALTCS/EPD growth.

For more information call 1-(800) 654-8713, extension 4614 or visit the AHCCCS web site at [www.ahcccs.state.az.us](http://www.ahcccs.state.az.us).

**Table 1: Increases in the Proportion of ALTCS/EPD Consumers Who Live in the HCBS**



**Table 2: Growth in Own Home and Alternative Residential Compared with Growth in Overall ALTCS/EPD Population**



**ADES/DDD**

*Arizona Department of Economic Security/Arizona Long term Care System for Persons with Developmental Disabilities (ADES/ALTCS/DD) and the Arizona Department of Economic Security/State-Funded Program for Persons with Developmental Disabilities (ADES/DDD/DD)* <sup>5</sup>

The Medicaid-funded ALTCS/DD program for consumers with a developmental disability provides acute health, behavioral health, in home, alternative residential and institutional services. The DD State-Funded program offers essentially the same services as does the ALTCS/DD program except for acute and behavioral health services. The state-funded program is limited in the amount of services that it can provide because it is limited to appropriated State funds. Some DD State-Funded consumers can qualify for the Acute Medicaid program and thus obtain their acute and behavioral services from this source.

Over the past five years, the trend toward placement in integrated community settings has remained constant for persons with developmental disabilities.

<b>LIVING LOCATIONS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES AS OF APRIL 30, 2001</b>		
<b>Settings</b>	<b>Title XIX</b>	<b>State Funded</b>
• ICF-MR (Coolidge, Windsor, Pinchot, Campbell, Earll and Hacienda)	166	28
• Skilled Nursing Facility (SNF & ICF)	58	3
• Group Homes	1,964	192
• Adult Developmental Homes	276	40
• Home with Community Based Services (Independent Settings and With Family)	9,717	6,944
Total	12,181	7,207

For more information call 1-866-229-5553 or visit the ADES website at [www.de.state.az.us](http://www.de.state.az.us).

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<sup>5</sup> In this document the ALTCS/DD and the State-Funded DD program will be discussed together as the ADES/DDD program.

## **ADHS/DBHS**

*Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) for children and adults with behavioral health needs.*

The ADHS/DBHS serves as the single state authority to provide coordination, planning, administration, regulation and monitoring of the state behavioral health system. Behavioral health services include alcohol, drug and mental health services. ADHS/DBHS contracts with intermediary organizations, known as the RBHAs, to administer behavioral health services in the state. RBHAs are responsible for the development of regional provider networks that deliver effective services, develop services in response to client needs, coordinate care within the provider network, and continually seek to improve client outcomes.

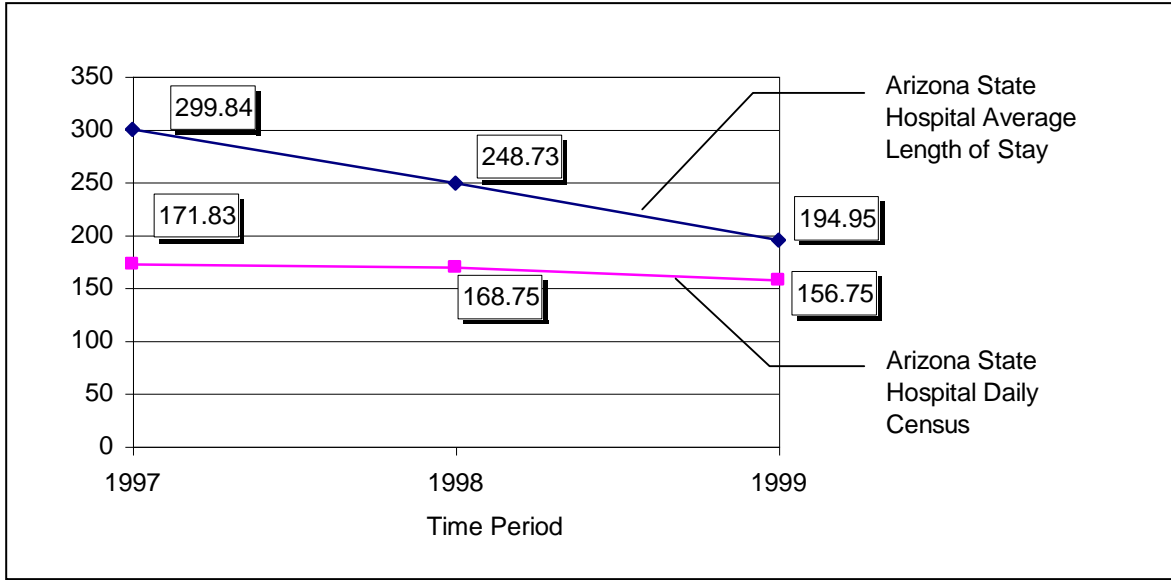
The ADHS/DBHS, through the RBHAs, served a total of 30,907 Title XIX and Title XXI children, adults with general mental health needs, adults with a serious mental illness and adults with substance abuse issues during calendar year 2000.

Approximately 99 percent of these individuals are receiving community based services. Children and adults who are at risk of institutionalization may require higher levels of care including acute hospitalization when community services are not available or are inadequate to meet their needs.

ADHS/DBHS has identified the need for community based services and was ranked first in the nation in a 1997 evaluation of state mental health spending priorities conducted by the International Association of Psychosocial Rehabilitation Services (IAPRS). Concerned over some states' reliance on expensive psychiatric hospitals in an era of scarce behavioral health resources, the IAPRS awarded Arizona top honors for overall progress in moving from an institutionally-based mental health system to a community based system of behavioral health care. Overall, the study found that Arizona expended 83 percent of its mental health budget on community programs, compared with 73 percent in California and 67 percent in Wisconsin, the second and third ranked states.

As indicated in the following chart, the average daily census and the average length of stay at the Arizona State Hospital has decreased steadily since 1997. Aggressive discharge planning which begins upon admission to the Arizona State Hospital has assisted in the successful transition to home and community based services upon discharge.

**Table 3: Arizona State Hospital Length of Stay and Admissions/Discharge Trends<sup>6</sup>**



For more information call 1-(800)-867-5808 or visit the Department of Health Services website at [www.hs.state.az.us](http://www.hs.state.az.us).

## **Supporting Community Agencies**

### **ADES/A&AA/Non-Medical HCBS**

*Arizona Department of Economic Security/Aging and Adult Administration/Non-Medical Home and Community Based System (ADES/A&AA/NMHCBS)*

The Non-Medical Home and Community Based Service System (NMHCBS) offers an array of services designed to assist individuals to live as independently as possible in their homes or communities. Services are provided through a comprehensive case managed system. This single point of entry is provided by the Area Agencies on Aging and their provider network.

This program is a support to the Arizona Long Term Care System (ALTCS) program as it assists those who do not meet ALTCS eligibility criteria (financial and medical). This program does not provide institutional services, and it is not an entitlement program. “Anecdotally, the NMHCBS program may keep consumers from entering into the

<sup>6</sup> Statewide Average Length of Stay (LOS) and Statewide Average Daily Census is broken down by year for all civilly committed adults (SMI and Non-SMI). LOS was determined on the month of admission regardless of the date of discharge and the date of discharge had to have been by 12/31/00. Statewide Average Daily Census is determined by taking the census on the last day of each month of the year and then averaging for that year.



ALTCS program by quickly providing services that help them maximize their independence at an earlier stage in the need for assistance.”<sup>7</sup> The services provided through the NMHCBS program to maintain people in their own homes includes: Adult Day Health Care, Case Management, Home-Delivered Meals, Housekeeping; Home Health Aid, Personal Care, Respite Care, Home Nursing, Congregate Meals in Senior Centers, Outreach, Transportation, Home Repair, Recreation/Socialization, Legal Assistance, Advocacy, Ombudsman, and Information and Referral.

There are three major focuses of the NMHCBS System. First, the system provides an array of services to prevent inappropriate or premature institutionalization. Second, the system allows an individual to live independently in his/her home or community setting as long as possible. Third, the system strengthens the informal supports created by families and caregivers of older Arizonans and Arizonans with disabilities.

For more information call 1-602-542-4446, the Elder Line at 1-800-686-1431, Adult Protective Services at 1-877-767-2385 or the State Health Insurance Assistance Program at 1-800-432-4040.

### **ADES/RSA**

#### ***Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA)***

Several programs are provided through ADES/RSA in support of persons with disabilities becoming or remaining independent in their homes and communities. As with the Non-Medical Home and Community Based Services program, the people who participate in these programs may not necessarily be at risk of institutionalization; however, participation in these programs further enhances their independence and are, therefore, important components of a community integration approach.

These programs include Vocational Rehabilitation (VR), Independent Living Rehabilitation Services (ILRS), Employment Support Services (ESS), Arizona Industries for the Blind (AIB) and Vocational Services for the Seriously Mentally Ill.

Vocational Rehabilitation (VR): Helps people with disabilities become or remain economically independent through work by decreasing or eliminating their need for ongoing government supports through integrated, meaningful, and sustained work.

Independent Living Rehabilitation Services (ILRS): Facilitates the integration and full inclusion of individuals with significant disabilities into the mainstream of American society. Core services include: information and referral; independent living skills training; peer counseling, and self-advocacy. In addition, funds are used in part to support the Statewide Independent Living Council (SILC).

Employment Support Services (ESS): Assists individuals with the most significant disabilities to maintain successful employment. Extended employment support

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<sup>7</sup> Arizona's Community-Based Services and Settings Report; October 2000; AHCCCS & ADES; page 1.

**PART IV: APPENDICES**  
**APPENDIX B: BRIEF PROGRAM DESCRIPTIONS**

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services are provided by Community Rehabilitation Program (CRP) providers under contract with RSA.

Arizona Industries for the Blind (AIB): Provides employment and training opportunities for Arizonans who are legally blind.

Interagency Service Agreement (ADHS/DBHS and ADES/RSA) for Vocational Services for the Seriously Mentally Ill. The overall goal of the agreement is to ensure that each program performs its job and coordinates to improve services to persons who have a serious mental illness.

For more information call 1-(800) 563-1221 or visit the Department of Economic Security website at [www.de.state.az.us](http://www.de.state.az.us).

## APPENDIX C: SERVICES AND SETTINGS

For more detailed information, please contact the specific state agency or visit their websites.

### Elderly, Physically Disabled and Developmentally Disabled

The services an ALTCS consumer receives may include:

- Home and Community Based Services (HCBS)
- Institutional Care Services
- Acute Care Services
- Early Periodic Screening, Diagnosis and Treatment (birth to 21 years of age)
- Behavioral Health Care

Home and Community Based Services (HCBS) are services that prevent institutionalization and are provided in the consumer's home or in a residential setting such as a foster care home or group home for the people with a developmental disability.

#### In-Home Services:

- Adult Day Care
- Habilitation
- Homemaker Services
- Personal Care
- Transportation
- Attendant Care
- Home-Delivered Meals
- Hospice
- Respite
- Environmental Modifications
- DD Day Care
- Home Health Aid
- Nursing Services
- Therapies

#### Alternative Residential Services:

- Adult Foster Care
- Developmental Group Home
- Behavioral Health Level III
- Assisted Living Home
- Behavioral Health Level I
- Assisted Living Center – Unit Only
- Behavioral Health Level II

Institutional Care Services

- Nursing Facilities - Care for consumers who require round-the-clock skilled nursing care and related services but do not require hospitalization. The care is needed to ensure the individual receives treatments, medications, a therapeutic diet and rehabilitative nursing under the direction of a physician.
- Intermediate Care Facilities for the Mentally Retarded - Specialized care centers designed to meet the specific needs of the mentally retarded or persons with related conditions.
- Other Institutional Settings - Include residential treatment facilities for individuals under age 21, institutions for mental disease for individuals under age 21 or 65 and older, or hospice.

Acute Care Services

- |   |   |                                  |
|---|---|----------------------------------|
| • Well-baby care (free check-ups and immunizations) | • Doctors' office visits  | • Complete physical examinations |
| • Emergency dental care                             | • Immunizations   | • Hospital                       |
| • Nutritional information                           | • Speech testing  | • Lab and X-rays                 |
| • Prescriptions and medical supplies                | • Substance and drug services   | • 24-hour emergency medical care |
| • Durable medical equipment                         | • Transportation, if no public, private or free transportation is available |                                  |

Behavioral Health Services

- |                            |                                |                               |
|----------------------------|--------------------------------|-------------------------------|
| • Screening and Evaluation | • Counseling & Other Therapies | • Doctor Services             |
| • Medicine                 | • Emergency/Crisis Services    | • Inpatient Hospital Services |
| • Transportation           |                                |                               |

**Early Periodic Screening, Diagnosis and Treatment Program**

(EPSDT). The services listed below are covered for eligible persons from birth to 21 years of age:

- Health screening services
- Eye testing and glasses
- Behavioral health services
- Complete physical exams
- Dental exams and treatment
- Other necessary health care, diagnostic services, treatment and measures required by section 1905(r) (5) of the Social Security Act
- Immunizations
- Hearing tests and hearing aids

**Children and Adults with a Behavioral Health Needs**

These services may include:

- Behavioral Health Care
  - Screening and Evaluation
  - Medicine
  - Transportation
  - Counseling & Other Therapies
  - Emergency/Crisis Services
  - Doctor Services
  - Inpatient Hospital Services
- Alternative Residential Behavioral Health Levels I, II and III
- Institutions for Mental Disease (i.e., Arizona State Hospital)

If the client is also Medicaid eligible, he/she will receive Acute Care and EPSDT services as identified in the previous section.

## APPENDIX D: ARIZONA'S OLMSTEAD PLAN TIMEFRAME FOR DEVELOPMENT

The key milestones in the development of the Arizona's Olmstead Plan were:

June 28, 2000 - Representatives from the three agencies met to discuss the Supreme Court decision, the Centers for Medicare and Medicaid Services (CMS) letter regarding Olmstead and how the state might proceed in the development of Olmstead Plans.

August 23, 2000 - Representatives from Arizona Department of Economic Security (ADES), Arizona Health Care Cost Containment System (AHCCCS) and Arizona Department of Health Services/Department of Behavioral Health Service (ADHS/DBHS) discussed concepts for a plan, identified a process to encourage consumer involvement and acknowledged the value to this process of Statewide Councils and public forums throughout the state.

September 20, 2000 - The state invited two representatives from each of the statewide councils to meet with the state agencies. A summary of the Olmstead Decision and its implications were presented and an update was given to the representatives. The group discussed how to best proceed with consumer participation. The preference of the group was to have some level of draft material so there would be a basis to begin the dialogue. As a result of this input, AHCCCS, ADES/Division of Developmental Disabilities (DDD) and ADHS/DBHS each developed a preliminary plan.

November 29 and December 5, 2000 - Public Meetings The state agencies hosted a Video Conference in Phoenix and a public meeting in Tucson to seek further input from the public on the preliminary plans. The public had access to the draft plans for approximately one month prior to the meetings via mailed hard copy and the AHCCCS website.

February 8, 2001 - AHCCCS transmits Arizona's Olmstead Plan Draft to stakeholders.

March 1, 2001 - The state agencies and selected volunteer stakeholders meet to discuss revisions to the Draft Plan.

June 21 and June 22, 2001 - Second set of meetings for public comment on Arizona's Olmstead Plan Draft.

August 2001 - The final Arizona's Olmstead Plan is published.

## **APPENDIX E: ACRONYMS AND KEY DEFINITIONS**

- ADES – Arizona Department of Economic Security: The state agency responsible for human service programs and services, including programs and services to persons with a developmental disability.
- ADHS – Arizona Department of Health Services: The state agency responsible for the delivery of public health and mental health services is the Arizona Department of Health Services (ADHS). The Department is comprised of five service areas with the Division of Behavioral Health Services (DBHS) being the largest service area, comprising about 75 percent of the agency’s personnel and budget.
- AHCCCS – Arizona Health Care Cost Containment System: Arizona’s state agency responsible for Medicaid and Health Care programs for people who meet the eligibility requirements.
- ALTCS – Arizona Long Term Care System – the AHCCCS program for persons who are elderly and persons with disabilities and at risk of an institutional level of care.
- DBHS - Division of Behavioral Health Services -- The ADHS division responsible for planning, administering and monitoring a comprehensive system of services for children, individuals with drug and alcohol problems, individuals with general mental health issues and adults with a serious mental illness (SMI). ADHS/DBHS also provides prevention services and inpatient services at the Arizona State Hospital.
- DDD – The Division of Developmental Disabilities in the ADES that serves as a Program Contractor to AHCCCS for home and community based and long term care services for persons with a developmental disability.
- EPD – Persons who are elderly and/or persons with a physical disability.
- GMH – General Mental Health.
- Prior Period Coverage – The period of time from the 1<sup>st</sup> day of the month of application or the 1<sup>st</sup> eligible month whichever is later to the day a member is enrolled with the contractor.
- Program Contractor -- The managed care organizations that contract with AHCCCS to deliver long term care services, behavioral health services, and case management and home and community based services to ALTCS consumers.
- RBHAs – Regional Behavioral Health Authorities – The contractors under the ADHS/DBHS that plan and administer all behavioral health services in Arizona, including TRBHAs (Tribal Regional Behavioral Health Authorities).

## APPENDIX F: WORK PLAN – AHCCCS/ALTCS

ACTIONS	END DATE	AGENCY COMMENT
<p>1. Arizona’s Olmstead Plan: AHCCCS will post the completed Plan on its website and will invite all interested members of the community to provide written comments to AHCCCS at any time throughout the year. AHCCCS will periodically review, with interested parties, the status of the work plan, and continue to refine the document.</p> <p>Hard copy will also be distributed to Advocacy Councils and others upon request.</p> <p><i>Principles 1 &amp; 2</i></p>	Ongoing	<p>Initial plan distributed August 2001.</p> <p>02/2003: Workplan reviewed and updated.</p>
<p>2. Member/Provider Councils: Beginning October 1, 2001, all AHCCCS ALTCS program contractors will convene member/provider councils that are representative of the ALTCS consumers, family, advocates and the providers within a given geographic area. Purpose of the councils is to promote a collaborative effort to enhance the service delivery system in local communities. These councils will also be able to provide a forum for discussions and feedback on the Plan and any revisions.</p> <p><i>Principles 2, 5 &amp; 6</i></p>	October 2001	02/2003: Incorporated into all Elderly and Physically Disabled (EPD) program contractor contracts as of October 2001.
<p>3. Informed Choices by Consumers: AHCCCS, in cooperation with ADES/DDD and ADHS/DBHS, will explore the possibility of developing and disseminating informational materials to help consumers make informed choices.</p> <p><i>Principles 3 &amp; 5</i></p>		2/2003: No action taken. The interagency workgroup is no longer active. AHCCCS will consider other approaches to address this item.



**PART IV: APPENDICES**  
**APPENDIX F: WORK PLAN – AHCCCS/ALTCS**

ACTIONS	END DATE	AGENCY COMMENT
<p>4. Continue to offer financial incentives to the AHCCCS/ALTCS/EPD program contractors who exceed the targets set for the number of people receiving home and community based services.</p> <p><i>Principles 3 &amp; 6</i></p>	Not applicable	<p>Ongoing.</p> <p>02/2003: Program Contractors continue to develop the services and settings so that the percentage of people placed in HCBS programs continues to increase. AHCCCS has made no changes to the financial incentives.</p>
<p>5. “Prior Period Coverage” for Home and Community Based Services: Explore possibility of paying for home and community based (in-home and alternative residential settings) from the time that an applicant applies for ALTCS rather than from the day the individual is found eligible for ALTCS (Prior Period Coverage).</p> <ul style="list-style-type: none"> <li>• Determine financial impact; Centers for Medicare and Medicaid Services (CMS) approval; implement.</li> </ul> <p><i>Principle 4</i></p>		<p>02/2003: No plans to implement at this time because it may require a budget increase.</p>
<p>6. Spouses and Parents as Paid Caregivers: Explore possibility of a waiver from the CMS to pay spouses and parents.</p> <ul style="list-style-type: none"> <li>• Determine financial impact; waiver request to CMS; implement.</li> </ul> <p><i>Principle 4</i></p>		<p>02/2003: AHCCCS requested CMS approval but the request was not approved.</p>

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**APPENDIX F: WORK PLAN – AHCCCS/ALTCS**

<p>7. Payment to Assist Transition From Institutional to Home and Community Based Settings: Review the potential to provide funding to assist people to transition into their own homes, including providing deposit funds for rental and utilities and providing start up funding for household items and furniture.</p> <ul style="list-style-type: none"> <li>Determine financial impact; CMS approval; implement.</li> </ul> <p><i>Principle 4</i></p>		<p>02/2003: The CMS recently informed AHCCCS that approval of this service would require our ALTCS Medicaid waiver to be renegotiated for cost neutrality. If AHCCCS amends the ALTCS waiver at a later time, this recommendation will be considered.</p>
<p>8. Interim Pay for Personal Care Attendants: Develop and implement plan to pay for a personal care attendant for a specified period of time when the consumer may be out of the home or alternative setting (e.g. hospitalization).</p> <ul style="list-style-type: none"> <li>Determine financial impact; CMS approval; implement.</li> </ul> <p><i>Principle 4</i></p>		<p>02/2003: AHCCCS requested CMS approval but the request was not approved.</p>
<p>9. Pay Increases for Home and Community Based Providers: Implement the approximately 15.3% pay increase for ALTCS/EPD home and community based providers that will be effective October 1, 2001.</p> <p><i>Principle 4</i></p>	<p>October 2001</p>	<p>Implemented the October 2001 rate increases.</p> <p>02/2003: Rates are reviewed annually for adjustments. An inflationary adjustment was made effective October 1, 2002.</p>

<p>10. Consumer Directed Services: Develop and implement plan to allow consumers to take responsibilities for recruiting, hiring, training, scheduling, directing and firing their personal care attendant workers. This includes the possibility of allowing the consumer to delegate skilled tasks to Personal Care Attendants.</p> <ul style="list-style-type: none"> <li>Assess liability issues for State agencies and managed care organizations, determine scope of consumer direction (skilled vs. non-skilled); receive CMS approval; implement.</li> </ul> <p><i>Principles 4 &amp; 5</i></p>		<p>02/2003: No formal activity to date. However, under the existing policies and practice ALTCS members are able to accept or refuse caregivers sent to their home. Also, if they are able to identify a potential caregiver they can refer this person to the provider agency to be hired. The potential caregiver must meet the training and other requirements of the hiring agency.</p>
<p>11. Network Development and Management Plans: Beginning October 1, 2001, all AHCCCS/ALTCS program contractors are required to have formal Network Development and Management Plans. AHCCCS will review and monitor the plans annually and as needed.</p> <p><i>Principles 4 &amp; 6</i></p>	<p>October 2001</p>	<p>02/2003: This requirement was incorporated into all program contractor contracts as of October 2001. Plans are reviewed and acted on as needed.</p>
<p>12. Request the Arizona Technology Access Program (AzTAP) to develop recommendations and a training module to provide additional training to consumers, case managers and direct care providers for the improved use of assistive technology.</p> <p><i>Principle 5</i></p>	<p>February 2003</p>	<p>02/2003: AHCCCS has requested AzTAP to address.</p>

**PART IV: APPENDICES**  
**APPENDIX F: WORK PLAN – AHCCCS/ALTCS**

<p>13. Assess during the annual Operational and Financial Reviews – Are Program Contractor provider networks being affected by labor issues. Does the Program Contractor have plans to address any identified labor issue. How are program contractors involving their Member/Provider Councils in dealing with any identified labor issues?</p> <p><i>Principles 4 &amp; 6</i></p>	<p>Ongoing beginning October 2001</p>	<p>02/2003: Labor issues have become less of an issue because of increases to provider reimbursement rates over the current and past two contract years and because of a downturn in the economy. Program contractors have discussed labor issues with their Councils as needed. In general Program contractors state that their providers are able to find the needed caregivers. Continue to monitor.</p>
<p>14. Update the Community Based Report every two years.</p> <p><i>Principle 6</i></p>	<p>2004</p>	<p>02/2003: An updated report was published 05/2002. It is available at:  <a href="http://www.ahcccs.state.az.us/publications/commrpt/2002/hcbsannual2002a.pdf">http://www.ahcccs.state.az.us/publications/commrpt/2002/hcbsannual2002a.pdf</a></p>

## APPENDIX G: WORK PLAN – ADES/DDD

UPDATED 1/15/03

ACTIONS	END DATE	AGENCY COMMENT
<p>1. Arizona’s Olmstead Plan: Link the DDD website to the AHCCCS website which will contain the completed Plan. Invite all interested members of the community to provide written comments to DDD at any time throughout the year. DDD will periodically review, with interested parties, the status of the work plan, and continue to refine the document.</p> <p><i>Principles 1 &amp; 2</i></p>	10/2001	The DDD web page is linked to the AHCCCS Website containing the Olmstead plan.
<p>2. Include in the Best Practice Program, a category that would highlight program innovations in community integration for each type of setting.</p> <p><i>Principle 4</i></p>		The Division conducts an annual workshop showcasing the best practices across the state and will be including community integration in the 2002 workshop.
<p>3. Encourage the Arizona Technology Access Program, which is federally funded, to develop recommendations and a training module to provide additional training to clients, case managers and direct care providers for the improved use of assistive technology. This should include the development of a comprehensive strategy for assistive technology to ensure a successful placement, including adequately trained personnel to assist a person with his/her assistive technology needs.</p> <p><i>Principle 4</i></p>	1/22/2002	Letter sent to Jill Oberstein regarding implementation of the objective January 22, 2002. Meeting was held between the Division and Jill Oberstein on 9/3/2002. The Arizona Technology Access Program trained Division training team on November 1, 2002.

<p>4. Integration: Improve access to services and opportunities in the community, including employment and training</p> <p><i>Principle 4</i></p>		<p>Various activities are being implemented to improve access including the use of a Fiscal Intermediary, Member Directed Supports, Person Centered Planning and the Case Management pilot. The DES is also reviewing the provision of employment services. Retroactive to 10/1/2001, employment services have been added to the Arizona Medicaid Long Term Care program.</p>
<p>5. Labor Force: Develop a statewide initiative to address the shortage of therapists, nurses, home and community based providers and other direct care staff.</p> <p><i>Principles 4 &amp; 5</i></p>		<p>The Division has looked at new and innovative approaches to increase the network of providers. The Division held a “roundtable” discussion on provider network issues in January 2002. Four priority strategies were developed out of this process and management staff were identified as leads on each of the strategy areas. The Arizona Legislature approved an allocation to increase rates of providers receiving below average negotiated rates, beginning July 2002. In late 2002, a new rule was promulgated to institute a Qualified Vendor system for procuring providers. This new process will begin on July 1, 2003.</p>
<p>6. Access to services and community: Find residential providers with skills and interest in serving people with serious problems – such as behavior problems.</p> <p><i>Principles 4 &amp; 5</i></p>		<p>The Division has implemented an initiative named the Community Protection Project to increase the focus of placing individuals with significant behavior challenges into the community. Beginning August 2002 the Division has initiated new behavioral health services designed to support individuals in</p>

		the community and reduce/prevent inpatient placements. The Division held a special forum on autism and has developed a work plan for improvements based on the recommendations.
<p>7. Information: AHCCCS, in cooperation with ADES/DDD and ADHS/DBHS, will explore the possibility of developing and disseminating informational materials to help consumers make informed choices.</p> <p><i>Principle 5</i></p>		The Division is exploring the option of using a self-advocate as a consultant and the Arizona People First organization to address this objective.[Due to a lack of funds this has been put on hold] The Division has initiated a Self-Determination Council with the State People First organization. The Council will assist the Division to communicate with self-advocates.
<p>8. Person Centered Planning: Complete pilot and evaluation and develop detail plans for expansion, including options to promote community integration and improve services.</p> <p><i>Principle 5</i></p>		The Division implemented a pilot. Evaluation of the pilot was completed and recommendations for statewide implementation have been articulated.
<p>9. Person-Centered Planning: Complete improvements to the Individual Family Service Plan (IFSP) and Individual Service Plan (ISP) processes to include ensuring individuals facilitating and participating have information and training, establish process to ensure clear expectations for facilitators, include mechanism to include all relevant persons.</p> <p><i>Principle 5</i></p>		This is an on-going effort to improve the planning processes and training to further integrate person centered planning into the various planning processes.
<p>10. Choice: Continue implementation of the Options for Case Management Services that will provide individuals and families with choices in case management personnel, and develop plans for nursing home residents, and use of mentors.</p> <p><i>Principle 5</i></p>		The Division piloted Private Case Management, providing families and members with choices. The pilot was evaluated and a recommendation made to deploy the options statewide on July 1, 2003.

<p>11. Access to Services and Community: Increase services and supports to prevent unnecessary institutionalization and to improve the integration of people who do reside in institutions.</p> <p><i>Principle 5</i></p>		<p>As noted above in item 4, the Division continues to look at ways to improve access to services. In addition the Division is working to improve and increase opportunities for integration for those individuals who continue to reside in institutional settings. (Memo from Assistant Director to ATPC regarding semi-annual reports of integrative activities-January 15, 2002)</p>
<p>12. Skills: Ensure support coordinators have the information and can and do review it with individuals and families, and other staff have appropriate interview, assessment and service planning skills, and provide educational opportunities for direct care staff.</p> <p><i>Principle 5</i></p>		<p>The Division is increasing the communication options to better inform support coordinators and families about services and supports. The Division has been actively involved in working with the Glendale Community College on a curriculum for direct care staff.</p>
<p>13. Access to Services: Prepare a Network Plan that will identify gaps in services and action steps to fill those gaps. Include responsiveness to changes and needs. Develop the Network Plan with local stakeholders - families, individuals, providers, and advocacy groups. Coordinate the Network Plans with other funders and programs; Rehabilitative Services Administration, Behavioral Health, School Systems, Arizona Department Of Transportation for transportation and providers of services. Ensure staff orientation and training always includes philosophy of individual choice and decision making. Promote individual choice of providers as a means for supporting providers being innovative in creating options for individuals.</p> <p><i>Principles 4, 5 &amp; 6</i></p>		<p>The Division created a Network Plan for each District and a combined plan for the entire state beginning in 2001. The second iteration was completed in 2002 and includes a quarterly reporting mechanism with review by the senior management group for actions to be identified and addressed. In addition, a behavioral health network plan was developed in 2002. The plans include a regular review process by each District and a quarterly review by the Statewide Management Team.</p>



<p>14. Develop information and options for methods of delivery to describe the system, inform individuals about the right to make decisions and have choices, identify the choices and options, provide qualitative information about services and providers and demonstrate the interrelationship of choices.</p> <p><i>Principle 5</i></p>		<p>As noted above, the Division is exploring the option of using a self-advocate as a consultant and the Arizona People First organization to address this objective. [Due to a lack of funds this has been put on hold] The Division has initiated a Self-Determination Council with the State People First organization.</p>
<p>15. Complete implementation of the following:</p> <ul style="list-style-type: none"> <li>- A 1-800 phone number.</li> <li>- Website with information about the system, services, providers and individual rights.</li> <li>- Connections for new families and individuals to people with expertise in system.</li> <li>- Supporting peer networking opportunities through projects such as the independent living centers, Arizona Bridge to Independent Living (ABIL) and DIRECT Center for Independence, Inc.</li> </ul> <p><i>Principle 5</i></p>		<ul style="list-style-type: none"> <li>• 1-800 numbers have been implemented for each District and for Central Office.</li> <li>• The Division has implemented a website with information. This will continually be refined and improved. The address is: <a href="http://www.de.state.az.us/ddd/">http://www.de.state.az.us/ddd/</a></li> <li>• The Division piloted a chat room but believes this was not the most effective means for communicating directly with families. Other options such as “list servers” are being explored.</li> <li>• The Division continues to fund and contract for a “mentor” program.</li> <li>• The Division has completed a guide for families called “Navigating the System”</li> </ul>

<p>16. Encourage Rehabilitation Services Administration to review and implement the recommendations from the Rehabilitation Council, Independent Living Centers and Governor’s Council on Developmental Disabilities on decision-making process for employment.</p> <p><i>Principle 6</i></p>		<p>As noted above, the Department is looking at the future of employment services for persons with developmental disabilities. AHCCCS has agreed to include employment services under the ALTCS program retroactive to October 2001. The Department is considering a possible transfer of these services from the Rehabilitation Services Administration to the Division of Developmental Disabilities.</p>
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## APPENDIX H: WORK PLAN – ADHS/DBHS

ACTION	END DATE	COMMENT
<p>1. AHCCCS, in cooperation with ADES/DDD and ADHS/DBHS, will explore the possibility of developing and disseminating informational materials to help consumers make informed choices.</p> <p><i>Principle 1</i></p>	Ongoing	
<p>2. Arizona’s Olmstead Plan: Link the DHS website to the AHCCCS website which will contain the completed Plan. Invite all interested members of the community to provide written comments to DHS at any time throughout the year. DHS will periodically review, with interested parties, the status of the work plan, and continue to refine the document.</p> <p><i>Principles 1 &amp; 2</i></p>	Oct. '01	Link is operational. No comments have been received as of 12/02.
<p>3. Establish Service Planning Guidelines and post on website.</p> <p><i>Principle 3</i></p>	Ongoing	DBHS currently reviewing Service Planning Guidelines posted on the Web Site and proposing revisions if needed. Additional guidelines may be added in the future.
<p>4. Revise DBHS Discharge Policy.</p> <p><i>Principle 3</i></p>	2/1/03	Policy committee has determined that this policy will be deleted and replaced with an Assessment and Treatment Planning Policy that is currently in draft form.
<p>5. Establish monthly meeting of representatives from ADHS/DBHS, ADES/DDD, RBHAs, and Arizona State Hospital to coordinate discharge planning.</p> <p><i>Principle 3</i></p>	Ongoing	Meetings are scheduled every 6wks. Next meeting 1/03. Meeting also includes representatives from AHCCCS Health Plans.

**PART IV: APPENDICES**  
**APPENDIX H: WORK PLAN – ADHS/DBHS**

ACTION	END DATE	COMMENT
<p>6. Ad Hoc workgroup including RBHAs, Arizona State Hospital, ADHS/DBHS, ASMI, AHCCCS, ADES/DDD meets to review results of pilot assessment tools, how to implement, and description of placements that would meet the needs of special populations.</p> <p>*This workgroup is now focusing on similar issues for people diagnosed with Borderline Personality Disorder.</p> <p><i>Principle 3</i></p>	<p>July 2002</p> <p>Ongoing</p>	<p>The group has divided into three sub-committees that include technical assistance, education, and advocacy.</p> <p>This group also has access to the Olmstead consultant, Clarence Sundram.</p>
<p>7. Implement the components of the Children’s Intergovernmental Agreement, as new issues are addressed and developed.</p> <p><i>Principles 3 &amp; 4</i></p>	<p>10/31/03</p>	<p>J-K lawsuit settled. Children's Behavioral Health Annual Action Plan 11/1/01-10/31/02 implemented. Plan is revised and updated yearly. Family and Child Teams developed/statewide training provided.</p>
<p>8. Implementation of Proposition 204 including an aggressive outreach plan is being implemented to assist consumers and family members in completing applications for these benefits from AHCCCS. The RBHAs anticipate hiring staff to assist in this process. Ongoing assessment will be needed to determine what community based services will be needed to serve this population.</p> <p>Ongoing assessment will be needed to determine what community based services will be needed to serve this population.</p> <p><i>Principle 4</i></p>	<p>9/02</p> <p>Ongoing</p>	<p>T/RBHA AHCCCS Eligibility Representative Workgroup meets on an as needed basis. Manual was revised and statewide “retraining” completed 9/02.</p> <p>ASSESSMENT DBHS has assigned a Network Development Clinical Team to each RBHA to assist RBHAs in assessing service gaps and providing TA for network development.</p>
<p>9. Require review of all pending RBHA or Arizona State Hospital admissions to Arizona State Hospital.</p>	<p>July '01</p>	

**PART IV: APPENDICES**  
**APPENDIX H: WORK PLAN – ADHS/DBHS**

ACTION	END DATE	COMMENT
<i>Principle 4</i>		
10. Complete the annual revision of the agreement regarding the Arizona State Hospital Community Placement Fund. <i>Principle 4</i>	July '03	Arizona State Hospital staff revise agreement every fiscal year and provide it to RBHA CEOs.
11. Implement Active Community Treatment (ACT) case management teams. <i>Principle 4</i>	6/03	ACT teams have been est. in all 5 RBHAs. Network development plans include the addition of more teams in all RBHAs in 2003.
12. Oversight of House Bill 2003 implementation that provides additional funding for services such as housing and vocational rehabilitation services. <i>Principle 4</i>	6/03	Initial Data Validation completed; 6 mo. reviews scheduled Fidelity measures being scored on a regular basis and programs being reviewed as part of the monitoring process.
13. Expand consumer run programs (RBHAs). <i>Principle 4</i>	Ongoing	Covered Services Policy implemented 10/3/01 provides additional options for Consumer Run Programs. NARBHA, CPSA, ValueOptions, and PGBHA currently have programs. DBHS has assigned a Network Development Clinical Team to each RBHA to provide to assist RBHAs in assessing service gaps and providing TA for network development.
14. Complete and implement the best practice guidelines, training and improved methods for service delivery to persons with co-occurring mental health and substance abuse disorders developed by the Integrated Treatment Consensus Panel.	Ongoing	Best Practice Guidelines on Web Site, U of A conducted Training of the Trainers, Local and State panels meet on a regular basis. ValueOptions has Monthly trainings with

**PART IV: APPENDICES**  
**APPENDIX H: WORK PLAN – ADHS/DBHS**

ACTION	END DATE	COMMENT
<i>Principles 4 &amp; 6</i>		National Expert. Other RBHAS have training dates scheduled with National Experts during 2002.
<p>15. ADHS/DBHS will verify that trainings have occurred throughout the state and will also encourage the RBHAS to develop training programs for consumers interested in providing behavioral health services such as peer mentoring and peer advocacy.</p> <p><i>Principle 5</i></p>	July 2002	Training coordinators workgroup met monthly to develop training modules to be implemented statewide.
<p>16. Re-evaluate the current service matrix that includes types of services and service reimbursement rates.</p> <p><i>Principle 6</i></p>	10/03/01	Re-evaluation completed and statewide trainings conducted for Covered Services Policy. Policy implemented 10/03/01. *Additional training will be provided to Frontline Service Providers in January 2003.
<p>17. Conduct ongoing analysis of the service network through the RBHAS; and provide an Annual Provider Network Status Report and Quarterly Updates on their provider network status including any material gaps in the network and how they plan to address any issues identified.</p> <p><i>Principle 6</i></p>	Ongoing	DBHS has assigned a Network Development Clinical Team to each RBHA to provide to assist RBHAS in assessing service gaps and providing TA for network development. Quarterly reports are reviewed by T/RBHA teams.

## **APPENDIX I: PERSONS AND ORGANIZATIONS INVITED TO PARTICIPATE IN ARIZONA'S OLMSTEAD PLANNING PROCESS**

### **AGENCIES/ORGANIZATIONS/ASSOCIATIONS**

- Alzheimer's Association
- Area Agency on Aging, - Region I
- Area Agency on Aging, Region II, Pima Council on Aging
- Arizona Alliance for the Mentally Ill (AAMI) -- NAMI Arizona
- Arizona Assisted Living Federation of America
- Arizona Association for Home Care
- Arizona Association for Homes and Housing for the Aging
- Arizona Behavioral Health Planning Council
- Arizona Bridge to Independent Living
- Arizona Center for Disability Law
- Arizona Civil Rights Advisory Board
- Arizona Commission for the Deaf and Hard of Hearing
- Arizona Council for the Hearing Impaired
- Arizona Department of Economic Security
- Arizona Department of Health Services
- Arizona Early Intervention Program (AZEIP)
- Arizona Health Care Association
- Arizona Health Care Cost Containment System
- Arizona Office for Americans with Disabilities
- Arizona State Hospital Advisory Board
- Arizona Technology Access Program
- Behavioral Health Consumers in Action
- Carondelet Home Health
- Central Arizona Council on Developmental Disabilities
- City of Holbrook, City Council
- Cochise Health Systems

## **AGENCIES/ORGANIZATIONS/ASSOCIATIONS**

- Community Partnership of Southern Arizona (CPSA)
- Developmental Disabilities Advisory Council
- DIRECT Center for Independence, Inc.
- Division of Developmental Disabilities District Councils
- Eden Center
- Foundation For Senior Living
- Four County Conference on Developmental Disabilities
- Freedom Manor
- Gila River Indian Community
- Good Shepherd
- Governor’s Advisory Council on Aging
- Governor’s Committee on Employment of People with Disabilities
- Governor’s Council on Blindness & Visual Impairment
- Governor’s Council on Developmental Disabilities
- Governor’s Council on Spinal & Head Injuries
- Heritage Home Healthcare
- Interagency Council of Infants and Toddlers
- Intertribal Council of Arizona (ITCA)
- John C. Lincoln Hospital
- Lifemark Health Plans (now Evercare)
- Maricopa Advisory Council
- Maricopa Home Health
- Maricopa Managed Care Systems
- Mental Health Association of Arizona
- Mercy Care Plan
- Moore Advocacy Consulting
- Native American Community Health
- Navajo Nation
- Northern Arizona Regional Behavioral Health Association
- Office of the Attorney General
- Office of the Governor



**AGENCIES/ORGANIZATIONS/ASSOCIATIONS**

- Parent and Friends of Arizona Training Program at Coolidge
- Pascua Yaqui Tribe
- People First
- Pima Council on Developmental Disabilities
- Pima Health Systems
- Pinal/Gila County Long Term Care
- Pinal Gila Behavioral Health Association
- Sage Employment and Community Services – Division of the Blake Foundation
- San Carlos Apache Tribe
- St. Luke’s Health Initiatives
- State Rehabilitation Council
- Statewide Independent Living Council
- Statewide Medicaid Advisory Council
- The ARC of Arizona, Inc.
- The ARC of Tucson
- The EXCEL Group (BHS Yuma)
- Tohono O’odham
- ValueOptions
- White Mountain Apache Tribe
- Yavapai County Long Term Care

## **PARTICIPANTS**

- Pam Allan
- Karen Barno
- Lynn Bejnar
- Skip Bingham
- Edna Bonham
- Keith Bonham
- Nancy Boyle
- Kathy Byrne
- Marcella Cardone
- Sue Clift
- Leslie Coney
- Marge Cook-Dixon
- Jozef de Groot
- Martha J. Dennler
- Matt Devlin
- Cam Dibiase
- Max Dine
- Patricia Dominguez
- Dana Evans
- Stew Grabel
- Jeannie Harmon
- Robert Harmon
- Paul Harrington
- Scott Gardner
- Li-Su Javedan
- Helena Kalmis
- Diane King
- Diane Krenn
- Vicki A. Kronabetter
- Lynn Larson
- Brian Lensch
- Donna Lerma
- Dina Lesperance
- Dave Maass
- Liana Martin
- Kelly McLearn
- Robert McMorran
- Teresa McMorran
- Ann Meyer
- Susan Michael
- Teresa Moore
- Sandra Pahl
- Edie Petersen
- Arathi Premkamur
- Jill Preston
- Debbie Quinn
- Laura Teike
- John Rosa
- Patsy Rosa
- Virginia Roundtree
- Alan Schafer
- Tim Sikkema
- Claire Sinay
- Karen Smith
- Vicky Staples
- Sondra Stauffacher
- Dan Steffy
- Heather Steiner
- Mary Tatom
- Len Trainor
- Gene van den Bosch
- Michael Ward
- Kay Wingate

## APPENDIX J: RESOURCES FOR CONSUMERS

### THE ELDERLY

- Arizona Health Care Cost Containment System/Arizona Long- Term Care System Administration (AHCCCS/ALTCS); 1-800-654-8713, ex. 4690; [www.ahcccs.state.az.us](http://www.ahcccs.state.az.us)
- Arizona Department of Economic Security/Aging and Adult Administration; 1-602-542-4446; Elder Line 1-800-686-1431; Adult Protective Services 1-877-767-2385
- State Health Insurance Assistance Program 1-800-432-4040
- Area Agency on Aging - Region I – Maricopa  
Mary Lynn Kasunic – Phone: 1-602-264-2255; Fax: 1-602-264-2299; E-mail: [Kasunic@aaaphx.org](mailto:Kasunic@aaaphx.org)
- Area Agency on Aging - Region II - Pima Council on Aging  
Marian Lupu – Phone: 1-520-790-7262; Fax: 1-520-790-7577; E-mail: [Mlupu@pcoa.org](mailto:Mlupu@pcoa.org)
- Area Agency on Aging - Region III – Northern Arizona Council of Governments  
Louise Wolverton – Phone: 1-520-774-1895; Fax: 1-520-214-7235; E-mail: [lwolverton@nacog.org](mailto:lwolverton@nacog.org)
- Area Agency on Aging – Region IV – Western Arizona Council of Governments  
Jill Harrison – Phone: 1-520-782-1886; Fax: 1-520-329-4248; E-mail: [jillh@wacog.com](mailto:jillh@wacog.com)
- Area Agency on Aging – Region V – Pinal/Gila Council for Senior Citizens  
Olivia Guerrero – Phone: 1-520-836-2758; Fax: 1-520-421-2033; E-mail: [pgcse@casagrande.com](mailto:pgcse@casagrande.com)
- Area Agency on Aging – Region VI – Southeastern Arizona Government Organization  
Kathleen Heard – Phone: 1-520-432-5301; Fax: 1-520-432-5858; E-mail: [kheard@seago.org](mailto:kheard@seago.org)

<b>THE ELDERLY (CONTINUED)</b>
<ul style="list-style-type: none"> <li>• Area Agency on Aging – Region VII – Navajo Area Agency on Aging LaVerne Wyaco – Phone: 1-520-871-6797; Fax: 1-520-871-6255; E-mail: <a href="mailto:laverne.wyaco@ndoh.org">laverne.wyaco@ndoh.org</a></li> <li>• Area Agency on Aging – Region VIII – Intertribal Council of Arizona Lee Begay – Phone: 1-602-258-4822; Fax: 1-602-258-4825; E-mail: <a href="mailto:lbegay@itcaonline.com">lbegay@itcaonline.com</a></li> </ul>
<b>PERSONS WITH A DEVELOPMENTAL DISABILITY</b>
<ul style="list-style-type: none"> <li>• Arizona Department of Economic Security/Division of Developmental Disabilities; 1-866-229-5553; <a href="http://www.de.state.az.us">www.de.state.az.us</a></li> <li>• Arizona Department of Economic Security/Rehabilitation Services Administration, 1-800-563-1221; <a href="http://www.de.state.az.us">www.de.state.az.us</a></li> </ul>
<b>PERSONS WITH A PHYSICAL DISABILITY</b>
<ul style="list-style-type: none"> <li>• Arizona Health Care Cost Containment System/Arizona Long Term Care System Administration (AHCCCS/ALTCS); 1-800-654-8713, ex. 4690; <a href="http://www.ahcccs.state.az.us">www.ahcccs.state.az.us</a></li> <li>• Arizona Department of Economic Security/Rehabilitation Services Administration, 1-800-563-1221; <a href="http://www.de.state.az.us">www.de.state.az.us</a></li> </ul>
<b>PERSONS WITH BEHAVIORAL HEALTH NEEDS</b>
<ul style="list-style-type: none"> <li>• Arizona Department of Health Services/Division of Behavioral Health Services; 1-800-867-5808; <a href="http://www.hs.state.az.us">www.hs.state.az.us</a></li> <li>• Arizona Department of Economic Security/Rehabilitation Services Administration, 1-800-563-1221; <a href="http://www.de.state.az.us">www.de.state.az.us</a></li> <li>• Advocates for the Seriously Mentally Ill; 1-800-421-2124</li> <li>• Mental Health Association; 1-800-MHA-9277; <a href="http://www.mhaaz.com">www.mhaaz.com</a></li> <li>• MIKID Mentally Ill Kids in Distress; 1-800-35-MIKID; <a href="http://www.accessarizona.com/community/groups/mikid">www.accessarizona.com/community/groups/mikid</a></li> </ul>

## Environmental Factors and Plan

### 18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

#### Narrative Question

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MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.<sup>63</sup> Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.<sup>64</sup> For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.<sup>65</sup>

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.<sup>66</sup> Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.<sup>67</sup>

According to data from the 2015 Report to Congress<sup>68</sup> on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

<sup>63</sup>Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

<sup>64</sup>Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

<sup>65</sup>Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from [www.cdc.gov/injury/wisqars/index.html](http://www.cdc.gov/injury/wisqars/index.html).

<sup>66</sup>The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

<sup>67</sup>Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM>

<sup>68</sup>[http://www.samhsa.gov/sites/default/files/programs\\_campaigns/nitt-ta/2015-report-to-congress.pdf](http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf)

**Please respond to the following items:**

- Does the state utilize a system of care approach to support:
  - The recovery and resilience of children and youth with SED?  Yes  No
  - The recovery and resilience of children and youth with SUD?  Yes  No
- Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
  - Child welfare?  Yes  No
  - Juvenile justice?  Yes  No
  - Education?  Yes  No
- Does the state monitor its progress and effectiveness, around:
  - Service utilization?  Yes  No
  - Costs?  Yes  No
  - Outcomes for children and youth services?  Yes  No
- Does the state provide training in evidence-based:
  - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?  Yes  No
  - Mental health treatment and recovery services for children/adolescents and their families?  Yes  No
- Does the state have plans for transitioning children and youth receiving services:
  - to the adult M/SUD system?  Yes  No
  - for youth in foster care?  Yes  No
- Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)  
 Regardless of the type, amount, duration, scope, service delivery method, and population served, the Arizona Health Care Cost Containment System (AHCCCS) requires all health plans to ensure that their service delivery system:
  - Coordinate and provide access to high-quality health care services informed by evidence-based practice guidelines in a cost-effective manner,?
  - Coordinate and provide access to high-quality health care services that are culturally and linguistically appropriate, maximize personal and family voice and choice, and incorporate a trauma-informed care approach,
  - Coordinate and provide access to preventive and health promotion services, including wellness services,
  - Coordinate and provide access to comprehensive care coordination and transitional care across settings; follow-up from inpatient to other settings; participation in discharge planning; and facilitating transfer from the children's system to the adult system of health care,
  - Coordinate and provide access to chronic disease management support, including self-management support,
  - Conduct behavioral health assessment and service planning following a Health Home Model,
  - Coordinate and provide access to peer and family delivered support services, based on member's needs, voice, and choice,
  - Provide covered services to members in accordance with all applicable federal and State laws, regulations, and policies,
  - Coordinate and integrate clinical and non-clinical health-care related needs and services across all systems,
  - Implement health information technology to link services, facilitate communication among treating professionals and between

the health team and individual and family caregivers, and

11. Deliver services by providers that are appropriately licensed or certified, operating within their scope of practice, and registered as an AHCCCS provider.

AHCCCS further requires that at all MCOS work in partnership to meet, agree upon, and reduce to writing joint collaborative protocols with each county, district, or regional office of:

1. Administrative Office of the Courts,
2. Juvenile Probation and Adult Probation,
3. Arizona Department of Corrections and Arizona Department for Juvenile Corrections,
4. Arizona Department of Child Safety (DCS),
5. Tribal Nations and Providers (Refer to this section above),
6. Veterans Affairs, and
7. The county jails.

MCOs must ensure that each collaborative protocol addresses, at a minimum, the procedures for each entity to coordinate the delivery of covered services to members served by both entities.

#### MHBG-Specific Examples

For the youth population identified as experiencing First Episode Psychosis (FEP), or experiencing Serious Emotional Disturbances (SED), AHCCCS ensures providers are coordinating with an array of community services, including but not limited to: treatment services, medical services, Federally Qualified Health Centers (FQHCs), school-based service programs, case management, suicide prevention and ideation services, skills training and development, and family preservation services.

AHCCCS providers also focus on services and programs that address school violence related to mental health through Youth Engagement Specialists that are trained to outreach and assess the needs of these youth populations and ensure refer to services are occurring as needed. The Youth Engagement Specialists are trained in assessment and suicide prevention and have been and will continue working with students referred by schools for behavioral health services. These supportive services have continued to be offered to students through telehealth and in-person appointments. Even with the virtual schooling that has taken place over the last year due to the pandemic, these referrals and appointments continue to be well attended. AHCCCS providers continue to build relationships with school districts within each Geographic Service Area (GSA), with many partnerships within local schools already in place to ensure coordination of services between youth identified as at risk.

AHCCCS is currently utilizing supplemental MHBG funding to expand services within these vulnerable populations through the building and identification of additional services and providers for children and adolescents. AHCCCS will ensure providers are building partnerships with key stakeholders for these populations to ensure youth services are inclusive of all areas of need. These additional projects include the following items:

#### Children/Adolescents with SED

Implementation of a statewide standardized process for early identification and referral for SED assessment,  
Implementation of co-located models of care and strengthening of evidence-based practice delivery for justice involved youth,  
Implementation of a Child Psychiatry Access Program (CPAP) to expand access to child and adolescent psychiatrists for Primary Care Providers (PCPs), and  
Expansion of the availability of parent and family support services, Child and Family Team (CFT) coaches, and professional development opportunities to support the behavioral health workforce.

#### Children/Adolescents experiencing FEP

Support for additional FEP positions to provide outreach and treatment services,  
Support the training and staff time to participate in evidence-based practices, and  
Funding of supplies and outreach materials.

#### SABG-specific examples

1. To better serve youth who are most at risk for substance use disorder, AHCCCS is utilizing SABG funding to launch several new projects within the continuum of care that target adolescents.
2. Service providers are developing opportunities to cultivate youth with lived experience to serve as peer support as adults. AHCCCS is referring to this as pre-peer support. Programming includes mentorship programs, youth-led community projects, and youth development programs collaboratively implemented with American Indian tribes, justice system partners, and youth diversion.
3. Detention Centers employ Behavioral Health Technicians and Clinicians to administer assessments for youth without an existing community-based treatment relationship. This improves continuity of care for youth in detention settings.
4. AHCCCS is submitting plans to SAMHSA to potentially expand the number of Juvenile Justice Engagement Team (JJET) Liaisons to include services for juveniles in qualified detention facilities. JJETs primary purpose is to resolve service barriers and other concerns for Probation, families, or other treatment stakeholders while juveniles temporarily reside in detention facilities.
5. AHCCCS' plan also includes non-billable outreach and coordination staff for qualified detention centers and billable Covered Services to include substance use disorder treatment and support services. Individual therapy, case management, and Teen AA classes are most offered to juveniles in a detention setting.

6. Building upon the work of the PPW-PLT learning collaborative, AHCCCS is using SABG funding to support programs that integrate SUD treatment with health and family service agencies with a focus on pregnant and postpartum women and their babies and children.

7. Service providers are offering maternal mental health programs that support the complex OB and substance use disorder needs of pregnant and postpartum women in recovery. Services include the provision of MAT (Medication Assisted Treatment) modalities through data-waivered, office-based opioid treatment counselors, expanding both perinatal and postpartum depression programs and family support services.

8. Detoxification programs for substance-exposed newborns and supportive services to their mothers are being offered together, serving the mother/baby dyad. Parenting courses are a key component of programming.

9. Supported independent living programs utilize outpatient services for women in substance use disorder who are living with their children while in recovery. In these programs, treatment is designed to replicate a full-time job. Women are engaged in services 40 hours per week and childcare is provided. Case management, group processing, individual counseling, life skills (budgeting, scheduling, meal planning, etc.), vocational services, and 12 step meetings are offered.

7. Does the state have any activities related to this section that you would like to highlight?

None additional.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

**Footnotes:**



## Environmental Factors and Plan

### 19. Suicide Prevention - Required for MHBG

#### Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

#### Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years?  Yes  No

2. Describe activities intended to reduce incidents of suicide in your state.

The goals of our state plan to address suicide in Arizona include:

1. Improve the mental health of individuals and communities,
2. Perform surveillance to monitor suicide in Arizona and identified targeted demographic groups, and
3. Ensure treatment and support services are available to clinicians, communities, families, and survivors.

Activities to meet these goals include:

1. Develop and disseminate information on suicide prevention resources and training,
2. Increase the resilience and well-being of Arizona youth,
3. Increase awareness of available financial opportunities to improve the stability of families and reduce financial stressors,
4. Improve social connectedness and help seeking behavior,
5. Increase access to mental health care for Arizonans by adopting the Zero Suicide model statewide,
6. Provide recommendations regarding mental health treatment parity,
7. Perform a gap analysis on suicide related data and implement a surveillance system for suicide related events in Arizona,
8. Conduct surveillance on Protective Factors in Arizona,
9. Conduct a 50-state review to inform Arizona suicide prevention efforts,
10. Increase access to the crisis system,
11. Increase access to resources and services for individuals and communities that have experienced suicide and increase access to prevention materials,
12. Increase access and awareness to support of suicide survivors, and
13. Increase access and awareness to targeted resources in the community for high-risk populations.

3. Have you incorporated any strategies supportive of Zero Suicide?  Yes  No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?  Yes  No

5. Have you begun any targeted or statewide initiatives since the FFY 2020-FFY 2021 plan was submitted?  Yes  No

If so, please describe the population targeted.

AHCCCS manages the COVID-19 Emergency Response Suicide Prevention (ERSP) Grant, which provides suicide screening and follow-up services in Pima County to those uninsured and underinsured with suicidal ideation and who are 25 years of age and older. This occurs primarily through emergency departments, psychiatric facilities, and crisis line referrals. Through Arizona Complete Health (AzCH) and a contract with CODAC. CODAC Behavioral Health Technicians (BHTs) will screen individuals in emergency departments and inpatient psychiatric facilities for suicidal ideation and identify/screen those persons who may have been or are at risk of domestic violence.

AHCCCS works closely with the Arizona Coalition for Military Families and their Secure Your Weapon campaign. The statewide Secure Your Weapon campaign was launched in 2021 to encourage gun owners (primarily veterans and first responders) to have a gun safety plan in place, recognize the signs of behavioral health crises, and know how to receive behavioral health services. The AHCCCS suicide prevention team serves as the subject matter experts for the campaign.

Also, AHCCCS is in the process of becoming a Zero Suicide organization with an emphasis on training opportunities available to all staff. Further, suicide prevention messaging is regularly included in agencywide updates. The suicide prevention team hosts a quarterly Zero Suicide taskforce meeting of statewide stakeholders, including other state agencies who are also adopting the

model.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not being requested at this time.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

**Footnotes:**

## Environmental Factors and Plan

### 20. Support of State Partners - Required for MHBG

#### Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

#### Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?  Yes  No
2. Has your state identified the need to develop new partnerships that you did not have in place?  Yes  No

If yes, with whom?

AHCCCS' commitment to collaborative efforts begins at its administrative level, where mental health, substance use services, and acute care are administered out of one agency. Both the Single State Authority (SSA) and State Mental Health Authority (SMHA) designation is held by a representative of the AHCCCS Executive Team. AHCCCS partners with numerous Arizona state agencies, including the Department of Economic Security (DES), Arizona Department of Juvenile Corrective (ADJC) and Arizona Department of Corrections (AZDOC), Department of Education (ADE), the Administrative Office of the Courts (AOC), the Department of Housing, the Governor's Office of Youth, Faith and Family, and the Department of Child Safety (DCS), to provide a comprehensive array of publicly funded services to children and adults through memorandums of understanding (MOUs), contractual agreements, and/or informal relationships. Formal partnerships include:

A partnership with the Arizona Department of Economic Security/Rehabilitation Services Administration (DES/RSA) through an Interagency Service Agreement (ISA), AHCCCS and RSA work together to provide specialty employment services and supports for enrolled members who have a Serious Mental Illness (SMI) designation.

AHCCCS requires, through contract and policy, that all Managed Care Organizations (MCOs) providing behavioral health services develop Collaborative Protocols or MOUs with system stakeholders including; the Department of Child Safety, Administrative Office of the Courts (juvenile and adult probation), Department of Corrections (adult and juvenile), and the Veterans' Administration.

Related to SABG Primary Prevention efforts, AHCCCS requires through contract that all contracted coalitions develop a Memorandum of Understanding (MOU) with the AHCCCS Complete Care (ACC) Health Plan, the American Indian Health Program

(AIHP), Regional Behavioral Health Authority (RBHA), and/or Tribal Regional Behavioral Health Authority (TRBHA), in their respective Local Jurisdiction(s) providers and/or agencies necessary to facilitate information sharing, resources sharing, and to provide services for any referrals for individuals within primary prevention programming. This is done to ensure service availability and referrals as needed for primary prevention activity participants, as well as to ensure that primary prevention coalitions are not operating in silos within the behavioral health system.

An Interagency Service Agreement (ISA) between AHCCCS and ADE outlines the collaborative and training expectations between behavioral health and the school system in order to enhance outcomes for children involved in both systems. In addition to this ISA, in August 2018 the Arizona Legislature allocated \$7 million to be utilized by behavioral health agencies to provide behavioral health services to school-aged children specifically in a school setting. An associated allocation of \$3 millions was given directly to the schools for them to provide Mental Health First Aid Training to school personnel. These collaborative efforts, including the ISA, support local schools' provision of services under the Individuals with Disabilities Education Act (IDEA).

In an Intergovernmental Agreement (IGA) between AHCCCS and Pima County Board of Supervisors, AHCCCS is tasked with providing a comprehensive, community-based system of mental health care for persons with an SMI designation who are residing in Pima County.

AHCCCS and the DOH developed an Interagency Service Agreement (ISA) which ADOH provided specialized real estate technical assistance for AHCCCS housing development projects, including project underwriting, risk assessment analysis, and providing recommendations to AHCCCS on the feasibility of funding particular housing projects for members with an SMI designation. AHCCCS also entered into agreements with ADOH to leverage its SMI Housing Trust Funds into ADOH administered Low Income Tax Credit Projects in exchange for a set-aside of units for SMI members in two new affordable housing projects, resulting in additional SMI housing capacity.

An IGA also exists between AHCCCS and the Maricopa County Board of Supervisors. This agreement ensures service provision for remanded juveniles as well as for members with an SMI designation, Non-SMI members, and those needing Local Alcohol Reception Services. While Maricopa County is obligated to provide certain services, this agreement ensures individuals are entered into the larger public behavioral health system at the earliest point.

AHCCCS is a member of the Arizona Substance Abuse Partnership (ASAP) which serves as the single statewide council on substance abuse issues. ASAP brings together stakeholders at the federal, state, tribal, and local levels to improve coordination across agencies; address identified gaps in prevention, treatment, and enforcement efforts, and; improve fund allocation. ASAP utilizes data and practical expertise to develop effective methods for integrating and expanding services across Arizona, maximizing available resources. ASAP also studies current policies and recommends relevant legislation for the Arizona Legislature's consideration. AHCCCS' Chief Medical Officer (CMO) Dr. Sara Salek is currently the Vice-Chair of the ASAP.

AHCCCS regularly attend and are members of the Substance Abuse Coalition Leaders of Arizona (SACALAz), a community organization that educates and raises awareness about substance use issues, and advocates for policy change. SACLAz was developed to strengthen and support the collective impact of substance abuse coalitions in Arizona.

Tribal and Regional Behavioral Health Authorities (T/RBHAs), contracted providers, and AHCCCS are all active participants in the Arizona Suicide Prevention Coalition. This group conducts research, gathers data, creates publicity, and works to make policy changes; areas of focus include the media, Native Americans, older adults, and youth.

AHCCCS System of Care staff participates as a member of the Arizona Community of Practice on Transition. This is a collaborative group of state agencies and stakeholder organizations including the Department of Economic Security/Division of Developmental Disabilities, Department of Child Safety (child welfare), Rehabilitation Service Administration (RSA), Arizona Office of the Courts (AOC), Arizona Department of Education (DOE), Arizona Department of Health Services (ADHS)/Office of Children with Special Health Care Needs, Raising Special Kids, and the Arizona Statewide Independent Living Council. The group meets monthly to collaborate, develop, and coordinate transition services, professional development, and resources related to improving the transition experience for youth who have disabilities. The Arizona Community of Practice on Transition is dedicated to the practice of shared leadership and using Leading by Convening as a framework to guide its work.

AHCCCS has focused on developing collaborations that both drive system initiatives and leverage funding. By working with the community partners as well as internal and external stakeholders, AHCCCS is able to implement policies and programs that extend beyond the behavioral health system. With cross system collaboration, AHCCCS has had the opportunity to positively impact areas such as the foster care system, the prescription drug epidemic, mental health first aid, and homeless outreach.

*Please indicate areas of technical assistance needed related to this section.*

Technical assistance is not being requested at this time.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

**Footnotes:**

## Environmental Factors and Plan

### 21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

#### Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf).<sup>69</sup>

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

<sup>69</sup><https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf>

#### Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

Arizona Behavioral Health Council response:

Substance Misuse Prevention Services are largely managed through the Governor's Office of Children Youth and Families. The services are provided through contracts with individual local organizations.

Health Plans in Arizona seeking to provide Substance Use Treatment and Recovery Services submit proposals in response to a Request for Proposal from AHCCCS. Through this process, AHCCCS selects organizations with winning bids. These services are monitored within the context of the submitted proposals and terms of the Request for Proposals.

Draft of The Request for Proposals are subject to public comment and within that context, the Planning Council may comment on these documents and the plan for services.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?  Yes  No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?  Yes  No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Arizona Behavioral Health Council response:

During the past several years, the Council has been meeting at the AHCCCS offices in Phoenix. Historically the Council also periodically traveled around the state to seek direct involvement from providers and recipients of services, but that arrangement has been suspended due to pressures to accommodate the travel limitations of AHCCCS staff and the needs of Council members. Since early 2020 due to COVID 19, the Council has been meeting via Video conference (ZOOM and GOOGLE). Using that method, we have still been able to hear from persons and Council members around the state. However, there are often limitations with this system. Some Council members do not have computer and Wi-Fi that makes it easy for them to participate, and this leads to some persons needing to attend meetings only by phone. This circumstance is less than ideal, but the COVID restrictions are more important at this time.

Council meetings are planned in partnership with AHCCCS. AHCCCS might propose topics that may be of interest to the Council.

Further, the Council may have an issue of interest where AHCCCS can provide a speaker or administrator who can assist in further

exploration of the concern.

In recent years, the Council has been able to obtain more data on issues of its interest. The Office of Data Analysis within AHCCCS has provided some reports that were generated specifically in response to Council interest and concern. Further, the Council has received periodic presentations on data topics of interest to the Council. This information is a key resource for the Council as it pursues its role.

The concerns that have been raised by the Council tend to be systemic in nature. When a problem is identified, the Council will arrange a meeting with the appropriate AHCCCS or provider administrator. Depending on the scope of the issue, the Council may ask for a follow up report.

*Please indicate areas of technical assistance needed related to this section.*

Technical assistance is not being requested at this time.

*Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.<sup>70</sup>*

<sup>70</sup>There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

**Footnotes:**

**DATE:** August 11, 2020

**TO:** Substance Abuse and Mental Health Services (SAMHSA)

**FROM:** Ali De La Trinidad, Project Manager, Arizona Behavioral Health Planning Council

**SUBJECT:** Arizona Behavioral Health Planning Council Minutes

In July 2019, the Arizona Behavioral Health Planning Council (BHPC) agreed to record each of their meetings in lieu of written minutes. The BHPC follows the Arizona Open Meeting Law and minutes are uploaded to AHCCCS' website within 3 working days after the meeting.

These recordings are available on AHCCCS' website at <https://www.azahcccs.gov/Resources/Grants/CMHS/>.

If you have any questions or concerns regarding these recordings, please contact me at 602-417-4706 or [ali.delatrinidad@azahcccs.gov](mailto:ali.delatrinidad@azahcccs.gov).

Thank you.

**ARIZONA BEHAVIORAL HEALTH PLANNING COUNCIL**  
**701 E. Jefferson St. MD 6500**  
**Phoenix, AZ 85034**

August 24, 2021

Substance Abuse and Mental Health Services Administration (SAMHSA)  
Center for Mental Health Services (CMHS)  
Division of State and Community Systems Development (DSCSD)  
5600 Fishers Lane  
Station 14E26C  
Rockville, MD 20857

Dear Sir or Madam,

The Arizona Behavioral Health Planning Council is required by Public Law 103-321 to review Arizona's Block Grant Application for Children and Adults for 2022-23. This must occur before it is submitted to the U.S. Department of Health and Human Services (DHHS) so that Arizona may receive the Federal Mental Health Block Grant and the Federal SABG for 2022. On August 19, 2021, the Council received the draft application from Arizona Health Care Cost Containment System (AHCCCS) and on August 20, 2021, the Council met to review the application. Through this meeting, the Council was able to comment on and recommend changes. A summary of our comments was submitted to AHCCCS on August 23, 2021. The Planning Council is submitting this letter to the Center for Mental Health Services to provide information regarding our role and activities.

The Planning Council has included integrated representation between mental health and substance abuse since 1999, with the participation of behavioral health and substance misuse providers. In addition, the Council has strong representation by persons experienced in behavioral health and substance abuse treatment, persons with personal experience and persons who have a family member with behavioral health and substance misuse challenges.

The Council's membership reflects the diverse cultures in Arizona. Currently, the Council has one American Indian individual, who is the family member of an adult with a Seriously Mentally Ill (SMI) diagnosis and an Hispanic individual who represents a service provider. Also, there are older adults, and individuals with SMI designation in the behavioral health system, family members of young children with SED and family members of adults with SMI. There are individuals who are in recovery from substance misuse. One Council member also represents a provider that specifically provides services to children with SED. Additionally, the Council recruits and retains individuals throughout the state, including individuals from Tucson, Southern Arizona (San Manuel), and Northern Arizona (Prescott and Show Low). The Council has made contacts to seek a representative from a tribal behavioral health organization, but we have postponed pursuit of this objective until the COVID situation stabilizes. Arizona tribal entities currently are primarily focused

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(Public Laws 99-660, 100-639, and 102-321)**



on COVID 19 as it should be, and our pursuit of representation on the Council should wait until there are fewer urgent matters facing the tribes. At this time, the Council has members from all the required state agencies. A chart that details the Council representation is included in the application.

During the past several years, the Council has been meeting at the AHCCCS offices in Phoenix. Historically the Council also periodically traveled around the state to seek direct involvement from providers and recipients of services, but that arrangement has been suspended due to pressures to accommodate the travel limitations of AHCCCS staff and the needs of Council members. Since early 2020 due to COVID 19, the Council has been meeting via Video conference (ZOOM and GOOGLE). Using that method, we have still been able to hear from persons and Council members around the state. However, there are often limitations with this system. Some Council members do not have computer and Wi-Fi that makes it easy for them to participate, and this leads to some persons needing to attend meetings only by phone. This circumstance is less than ideal, but the COVID restrictions are more important at this time.

Council meetings are planned in partnership with AHCCCS. AHCCCS might propose topics that may be of interest to the Council. Further, the Council may have an issue of interest where AHCCCS can provide a speaker or administrator who can assist in further exploration of the concern.

The Planning Council is charged with the mission of:

- Reviewing plans and submitting to the State any recommendations for modification;
- Serving as an advocate for adults with a serious mental illness and children who are seriously emotionally disturbed, including individuals with mental illnesses or emotional problems;
- Monitoring, reviewing, and evaluating, not less than once per year, the allocation and adequacy of mental health services in the State; and Participating in improving mental health services within the State.

The Arizona Behavioral Health Planning Council meets monthly.

The **Planning and Evaluation Committee** of the Council works with the Office of Data Analysis in AHCCCS to obtain reports on the block grants and Arizona public behavioral health services in general. The entire August 20, 2021 meeting of the Council was devoted to work of the **Planning & Evaluation Committee** for the purpose of reviewing the Block Grant application. The Council submitted suggested language changes on the plan to AHCCCS. In the overall, the Council appreciated the thorough job that was done in preparation of the application. All questions were addressed which is a significant improvement from applications prepared in the past. During the process of the plan review the Council identified a number of system concerns and questions that are summarized below according to sections in the plan:

### **Strengths/Needs Assessment**

--Although the Council agrees that the Adult 9 principles and the Children's System 12 principles are valuable, more work needs to be done to strengthen the impact of these principles on Arizona service delivery. In addition, the Council believes that the Offices of Individual and Family Affairs within

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AHCCCS, the RBHAs and the health plans are strengths of the system that should be highlighted in this section. .

**Unmet needs:** Areas of concern in this section include:

-- The Council expressed its concerns that Peers and Family Members do not have access to peer and family support services of their choice in Northern Arizona.

-- Another area of need is for individualized substance use disorder treatment in Northern Arizona.

**Priority Areas**

--The Council would like to see employment training and placement added to the priority list,

**The Health Care System, Parity and Integration**

--The Council recommends that the OIFA offices should be described in more detail in this section.

--The Council would like to see more discussion of Parity in this section.

**Person Centered Planning**

-- The Council recommends that CLAS standards need to be referenced in this section. The AHCCCS policy on Person Centered Planning should also be referenced in this section.

**Substance Use Disorder Treatment**

--As stated above, the Council expressed its concern that Substance Use Disorder Treatment in Northern Arizona does not accommodate the individual needs of persons needing treatment.

**Trauma**

--The Council pointed out that there are initiative regarding Trauma as demonstrated by training of Division of Developmentally Disabled employees and the creation of a Governor's Task Force on Trauma.

**Criminal Justice:**

--The Planning Council believes that Arizona has a robust system of services in this area with the exception that there is a need for services to be provided to inmates prior to release. Development of this service is hindered by requirements/restrictions of funding sources.

**Crisis Services**

--The Council recommends that the section under this heading be reordered. Changes have been suggested.

**Recovery**

--The Council would like to see the Arizona system address differences in definition of "recovery" between Substance Abuse and Mental Health.

**Community Living and the Implementation of Olmstead**

--The existing plan is out of date. The Council is seeking to participate in the development of a new Arizona Olmstead Plan. It is especially important that Peers and Family members participate in the development of this Plan.

**Children and Adolescents M/SUD Services**

--The Council pointed out that neither Peers nor Family members on Northern Arizona are able to choose who would be the provider of their Peer or Family delivered support services.

**Suicide Prevention**

--The Council believes that treatment is Suicide Prevention and should be recognized as such.

**Support of State Partners**

--The Council had a small addition it suggested.

**State Planning/Advisory Council and Inpiti on the Mental Health/Substance Abuse Block Grant Application**

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(Public Laws 99-660, 100-639, and 102-321)**

--Although the Council had provided content for this section, it was not included in the material made available to the Council on August 19. No doubt this was due to the tight time frames imposed for completion of this application.

Through its **Advocacy and Legislative Committee**, the Council is active in reviewing and tracking state and federal legislation pertaining to mental health services. This year through the Advocacy and Legislative Committee, the Council has been provided comment to AHCCCS on the following:

- Recommendations for use of additional Crisis dollars
- Recommendations for use of additional SABG dollars
- 988 plan development,
- proposed policy changes for Peer Support Services in the Behavioral Health System.

The Council meetings at AHCCCS include staff who are directly involved in the statistical and financial data collection, and subsequent Block Grant development. The participation of these persons in Council meetings results in better coordination and communication between the Council and AHCCCS.

In recent years, the Council has been able to obtain more data on issues of its interest. The Office of Data Analysis within AHCCCS has provided reports that were generated specifically in response to Council interest and concern. This responsiveness to our data needs and questions is greatly appreciated. Further, the Council has received periodic presentations on data topics of interest to the Council. This information is a key resource for the Council as it pursues its role.

The Council has received presentations on topics of interest:

- In 2020, the Council received a presentation and later it received more information from the Governor's Office of Children Faith and Families about the Substance Abuse Prevention Programs managed through that office. Access to information about this portion of the SABG funded activities has been sought by the Council for several years. AHCCCS was able to assist the Council in establishing a productive reporting relationship with the Governor's Office.
- In the past year, the Council hosted guests that represent two agencies that provide services to young adults experiencing first on-set psychosis. These presentations were very informative. The Council hopes to learn about other block grant funded programs in the future.
- Another guest gave a report about traditional healing services – a service category sometimes funded with MHBG dollars. Dollars spent for this service category are very small. However, the Council has had an interest in this activity because it has a special importance to our American Indian members.
- More recently, the Council has been pursuing the topic of emergency preparedness. Wild fires and other such calamities in the state are a threat to all Arizona citizens, but they are of particular concern for persons who are more vulnerable such as those who have behavioral health challenges.

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Thank you for the opportunity to provide comment on the 2022-23 Arizona Mental Health and SABG Application. The Council regards this work to be of significant importance, and we are please to take part in this process.

Sincerely,

A handwritten signature in black ink, appearing to read "Vicki Johnson". The signature is fluid and cursive, with the first name "Vicki" and last name "Johnson" clearly distinguishable.

Vicki Johnson  
Chair, Arizona Behavioral Health Planning Council

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(Public Laws 99-660, 100-639, and 102-321)**



**BEHAVIORAL HEALTH PLANNING COUNCIL MEETING**

**Friday, January 15, 2021**

**10:00am – 12:00pm**

**AGENDA**

MEETING LOCATION	CALL IN AVAILABILITY
<p align="center">AHCCCS (Virtual with call in availability)</p>	<p align="center">888 475 4499 US Toll-free Meeting ID: 896 3659 5529</p>
<p>1. Welcome</p> <ul style="list-style-type: none"> <li>1) Roll Call</li> <li>2) Ensure a Quorum</li> <li>3) Call Meeting to Order</li> <li>4) New Member Application</li> </ul>	<p align="center">Vicki Johnson, Council Chair Vicki Johnson, Council Chair Vicki Johnson, Council Chair Vicki Johnson, Council Chair</p>
<p>2. BHPC By Laws Update</p>	<p align="center">Ali De La Trinidad, AHCCCS</p>
<p>3. Data Request Update</p> <ul style="list-style-type: none"> <li>• AZ Families First (AFF) Collaborative</li> <li>• RBHA SABG Report/Alternative Utilization Funding Report</li> <li>• Traditional Healing Claims</li> </ul>	<p align="center">Jill Rowland, Chief Clinical Officer, AHCCCS Lori Petre, AHCCCS</p> <p align="center">Lori Petre, AHCCCS</p>
<p>4. Homeless Shelter at ASH</p>	<p align="center">Ryan Vernick, ADOH, Council Member</p>
<p>5. State Agency Updates</p>	<p align="center">Council Members</p>
<p>6. Committee Updates</p> <ul style="list-style-type: none"> <li>• Planning &amp; Evaluation</li> <li>• Community Advisory</li> <li>• Advocacy &amp; Legislation</li> </ul>	<p align="center">R. Brubaker Council Member Vicki Johnson, Council Member David Delawder, Council Member</p>
<p>7. Call to the Public</p>	<p align="center">Council Chair Vicki Johnson</p>
<p>8. Adjourn at _____</p>	<p align="center">Next Council Meeting February 19, 2021 10am-12pm Virtual Meeting</p>

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**BEHAVIORAL HEALTH PLANNING COUNCIL MEETING**

**Friday, February 19, 2021**

**10:00am – 12:00pm**

**AGENDA**

MEETING LOCATION	CALL IN AVAILABILITY
<p align="center">AHCCCS (Virtual with call in availability)</p>	<p align="center">888 475 4499 US Toll-free Meeting ID: 896 3659 5529</p>
<p>1. Welcome</p> <ul style="list-style-type: none"> <li>1) Roll Call</li> <li>2) Ensure a Quorum</li> <li>3) Call Meeting to Order</li> <li>4) New Member Application</li> </ul>	<p align="center">Vicki Johnson, Council Chair Vicki Johnson, Council Chair Vicki Johnson, Council Chair Vicki Johnson, Council Chair</p>
<p>2. By Laws Update</p> <ul style="list-style-type: none"> <li>• Membership</li> <li>• April/October Review</li> </ul>	<p align="center">Vicki Johnson, Chair</p>
<p>3. Data Request Update</p> <ul style="list-style-type: none"> <li>• AZ Families First (AFF) Collaborative</li> <li>• RBHA Funding Report</li> <li>• Traditional Healing Claims</li> </ul>	<p align="center">Ali Hesketh, Council Member Lori Petre (or Designee), AHCCCS Lori Petre (or Designee), AHCCCS</p>
<p>4. Homeless Shelter at ASH</p>	<p align="center">Suzanne Legander, CEO, STAR</p>
<p>5. Warming Center</p>	<p align="center">Skylar Bryce</p>
<p>6. Advocates for Human Potential Inc., (AHP) Letter</p>	<p align="center">Vicki Johnson, Chair</p>
<p>7. COVID Updates</p>	<p align="center">Council Members</p>
<p>8. State Agency Updates</p>	<p align="center">Council Members Non-Members</p>
<p>9. Committee Updates</p> <ul style="list-style-type: none"> <li>• Planning &amp; Evaluation</li> <li>• Community Advisory</li> <li>• Advocacy &amp; Legislation</li> </ul>	<p align="center">R. Brubaker Council Member Vicki Johnson, Council Member David Delawder, Council Member</p>
<p>10. Call to the Public</p>	<p align="center">Council Chair Vicki Johnson</p>
<p>11. Adjourn at _____</p>	<p align="center">Next Council Meeting March 19, 2021 10am-12pm Virtual Meeting</p>

**"...to advise, review, monitor, and evaluate all aspects of the development of the State Plan"  
(Public Laws 99-660, 100-639, and 102-321)**

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**"...to advise, review, monitor, and evaluate all aspects of the development of the State Plan"  
(Public Laws 99-660, 100-639, and 102-321)**



**BEHAVIORAL HEALTH PLANNING COUNCIL MEETING**  
**Friday, December 18, 2020**  
**10:00am – 12:00pm**

**AGENDA**

MEETING LOCATION	CALL IN AVAILABILITY
<p align="center">AHCCCS (Virtual with call in availability)</p>	<p align="center">888 475 4499 US Toll-free Meeting ID: 693 407 663</p>
<p>1. Welcome</p> <ul style="list-style-type: none"> <li>1) Roll Call</li> <li>2) Ensure a Quorum</li> <li>3) Call Meeting to Order</li> <li>4) New Member Application</li> </ul>	<p align="center">Vicki Johnson, Council Chair  Vicki Johnson, Council Chair  Vicki Johnson, Council Chair  Vicki Johnson, Council Chair</p>
<p>2. Review/Revise BHPC By Laws</p>	<p align="center">Council Members</p>
<p>3. Data Request Update</p> <ul style="list-style-type: none"> <li>• AZ Families First (AFF) Collaborative</li> <li>• RBHA SABG Report/Alternative Utilization Funding Report</li> </ul>	<p align="center">Jill Rowland, Chief Clinical Officer, AHCCCS  Lori Petre, AHCCCS</p>
<p>4. MHBG/SABG TA Funds</p> <ul style="list-style-type: none"> <li>• Mortality Reports Available</li> </ul>	<p align="center">Michelle Skurka, AHCCCS</p>
<p>5. Independent Case Review (ICR) Report</p>	<p align="center">Michelle Skurka, AHCCCS</p>
<p>6. Mini Needs Assessment</p>	<p align="center">Michelle Skurka, AHCCCS</p>
<p>7. State Agency Updates</p>	<p align="center">Council Members</p>
<p>8. Committee Updates</p> <ul style="list-style-type: none"> <li>• Planning &amp; Evaluation</li> <li>• Community Advisory</li> <li>• Advocacy &amp; Legislation</li> </ul>	<p align="center">R. Brubaker Council Member  Vicki Johnson, Council Member  David Delawder, Council Member</p>
<p>9. Call to the Public</p>	<p align="center">Council Chair Vicki Johnson</p>
<p>10. Adjourn at _____</p>	<p align="center">Next Council Meeting  January 15, 2021 10am-12pm  Virtual Meeting</p>

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**BEHAVIORAL HEALTH PLANNING COUNCIL MEETING**

**Friday, August 21, 2020**

**9:00AM – 12:30PM**

**AGENDA**

MEETING LOCATION	CALL IN AVAILABILITY
<p align="center">AHCCCS (Virtual with call in availability)</p>	<p align="center">888 475 4499 US Toll-free Meeting ID: 693 407 663</p>
<p>1. Welcome</p> <p>1) Introductions 2) Ensure a Quorum 3) Call Meeting to Order</p>	<p align="center">Vicki Johnson, Council Chair Vicki Johnson, Council Chair Vicki Johnson, Council Chair</p>
<p>2. SABG/MHBG Mini Block Grant Application Review</p> <p>1) Council Letter</p>	<p align="center">Richard Brubaker</p>
<p>3. Data Request Update</p> <p>1) RBHA SABG Reports/Alternative Utilization Funding Report 2) Mohave County Report</p>	<p align="center">Lori Petre, Administrator, AHCCCS Jill Rowland, Chief Clinical Officer, AHCCCS</p>
<p>4. Call to the Public</p>	<p align="center">Council Chair Vicki Johnson</p>
<p>5. Adjourn at _____</p>	<p align="center">Next Council Meeting September 18, 2020 10am-12pm Virtual Meeting</p>

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## BEHAVIORAL HEALTH PLANNING COUNCIL MEETING

Friday, May 21, 2021

10:00am – 12:00pm

### AGENDA

MEETING LOCATION	CALL IN AVAILABILITY
AHCCCS (Virtual with call in availability)	888 475 4499 US Toll-free Meeting ID: 896 3659 5529
1. Welcome <ul style="list-style-type: none"> <li>1) Roll Call</li> <li>2) Ensure a Quorum</li> <li>3) Call Meeting to Order</li> <li>4) New Member Application</li> </ul>	Vicki Johnson, Council Chair Vicki Johnson, Council Chair Vicki Johnson, Council Chair Vicki Johnson, Council Chair
2. Data Request Update <ul style="list-style-type: none"> <li>• RBHA Funding Report</li> <li>• Traditional Healing Claims</li> </ul>	Lori Petre (or Designee), AHCCCS
3. First Episode Program	Shasa Jackson, Clinical Coordinator Valleywise Health
4. Rehabilitation and Reentry Update: Modified Therapeutic Community and DUI Programming	Lori Adams, Council Member Arizona Department of Corrections
5. Needs Assessment Recommendations	Gabrielle Richard, AHCCCS
6. COVID Updates	Council Members
7. State Agency Updates	Council Members Non-Members
8. Committee Updates <ul style="list-style-type: none"> <li>• Planning &amp; Evaluation</li> <li>• Community Advisory</li> <li>• Advocacy &amp; Legislation</li> </ul>	R. Brubaker Council Member Vicki Johnson, Council Member David Delawder, Council Member
9. Call to the Public	Council Chair Vicki Johnson
10. Adjourn at _____	Next Council Meeting June 18, 2021 10am-12pm Virtual Meeting Contact <a href="mailto:Ali.Delatrinidad@azahcccs.gov">Ali.Delatrinidad@azahcccs.gov</a> for meeting access.

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**BEHAVIORAL HEALTH PLANNING COUNCIL MEETING**

Friday, March 19, 2021

10:00am – 12:00pm

**AGENDA**

MEETING LOCATION	CALL IN AVAILABILITY
<p align="center">AHCCCS (Virtual with call in availability)</p>	<p align="center">888 475 4499 US Toll-free Meeting ID: 896 3659 5529</p>
<p>1. Welcome</p> <ul style="list-style-type: none"> <li>1) Roll Call</li> <li>2) Ensure a Quorum</li> <li>3) Call Meeting to Order</li> <li>4) New Member Application (TP)</li> </ul>	<p align="center">Vicki Johnson, Council Chair Vicki Johnson, Council Chair Vicki Johnson, Council Chair Vicki Johnson, Council Chair</p>
<p>2. Data Request Update</p> <ul style="list-style-type: none"> <li>• AZ Families First (AFF) Collaborative</li> <li>• RBHA Funding Report</li> <li>• Traditional Healing Claims</li> </ul>	<p align="center">Ali Hesketh, Council Member Lori Petre (or Designee), AHCCCS Lori Petre (or Designee), AHCCCS</p>
<p>3. Mini Needs Assessment</p>	<p align="center">Richard Brubaker, Council Member</p>
<p>4. COVID Updates</p>	<p align="center">Council Members</p>
<p>5. State Agency Updates</p>	<p align="center">Council Members Non-Members</p>
<p>6. Committee Updates</p> <ul style="list-style-type: none"> <li>• Planning &amp; Evaluation</li> <li>• Community Advisory</li> <li>• Advocacy &amp; Legislation</li> </ul>	<p align="center">R. Brubaker Council Member Vicki Johnson, Council Member David Delawder, Council Member</p>
<p>7. Call to the Public</p>	<p align="center">Council Chair Vicki Johnson</p>
<p>8. Adjourn at _____</p>	<p align="center">Next Council Meeting April 16, 2021 10am-12pm Virtual Meeting Contact <a href="mailto:Ali.Delatrinidad@azahcccs.gov">Ali.Delatrinidad@azahcccs.gov</a> for meeting access.</p>

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**BEHAVIORAL HEALTH PLANNING COUNCIL MEETING**  
**Friday, June 18, 2021**  
**10:00am – 12:00pm**

**AGENDA**

MEETING LOCATION	CALL IN AVAILABILITY
<p align="center">AHCCCS (Virtual with call in availability)</p>	<p align="center">888 475 4499 US Toll-free Meeting ID: 896 3659 5529</p>
<p>1. Welcome</p> <ul style="list-style-type: none"> <li>1) Roll Call</li> <li>2) Ensure a Quorum</li> <li>3) Call Meeting to Order</li> </ul>	<p align="center">Vicki Johnson, Council Chair</p>
<p>2. SAMHSA MHBG/SABG Full Application Review</p>	<p align="center">Vicki Johnson, Council Chair</p>
<p>3. Data Request Update</p> <ul style="list-style-type: none"> <li>• RBHA Funding Report</li> <li>• Traditional Healing Claims</li> </ul>	<p align="center">David Rudnick AHCCCS</p>
<p>4. Utilization of SED Funding</p>	<p align="center">Alisa Randall, Assistant Director AHCCCS</p>
<p>5. DCAIR Updates</p> <ul style="list-style-type: none"> <li>• 9 8 8 Crisis Project</li> <li>• 1115 Waiver Updates</li> <li>• ARPA Community Meetings</li> </ul>	<p align="center">Dana Flannery, AHCCCS</p>
<p>6. AHCCCS Peer Support Policies</p>	<p align="center">Susan Kennard and Dave Delawder Council Members</p>
<p>7. COVID Updates</p> <ul style="list-style-type: none"> <li>• Communities Changing Landscape</li> </ul>	<p align="center">Council Members</p>
<p>8. State Agency Updates</p>	<p align="center">Council Members Non-Members</p>
<p>9. Committee Updates</p> <ul style="list-style-type: none"> <li>• Planning &amp; Evaluation</li> <li>• Community Advisory</li> <li>• Advocacy &amp; Legislation</li> </ul>	<p align="center">R. Brubaker Council Member Vicki Johnson, Council Member David Delawder, Council Member</p>
<p>10. Call to the Public</p>	<p align="center">Council Chair Vicki Johnson</p>
<p>11. Adjourn at _____</p>	<p align="center">Next Council Meeting July 16, 2021 10am-12pm Virtual Meeting Contact <a href="mailto:Ali.Delatrinidad@azahcccs.gov">Ali.Delatrinidad@azahcccs.gov</a> for meeting access.</p>

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**BEHAVIORAL HEALTH PLANNING COUNCIL MEETING**  
**Friday, July 16, 2021**  
**10:00am – 12:00pm**

**AGENDA**

MEETING LOCATION	CALL IN AVAILABILITY
<p align="center">AHCCCS (Virtual with call in availability)</p>	<p align="center">888 475 4499 US Toll-free Meeting ID: 896 3659 5529</p>
<p>1. Welcome</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Roll Call</li> <li><input type="checkbox"/> Ensure a Quorum</li> <li><input type="checkbox"/> Call Meeting to Order</li> </ul>	<p align="center">Vicki Johnson, Council Chair Ali De La Trinidad, AHCCCS Vicki Johnson, Council Chair</p>
<p>2. SAMHSA MHBG/SABG Full Application Review August 20<sup>th</sup> 9am-3pm</p>	<p align="center">Vicki Johnson, Council Chair</p>
<p>3. Alternative Funding Report</p>	<p align="center">David Rudnick, AHCCCS Office of Data Analytics</p>
<p>4. Traditional Healing Claims</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Health Choice AZ</li> <li><input type="checkbox"/> AZ Complete Health Response</li> <li><input type="checkbox"/> Possible Changes through Waiver</li> </ul>	<p align="center">Shawn Nau, CEO Health Choice AZ Written Response Amanda Bahe/Dana Flannery, AHCCCS DCAIR</p>
<p>5. Challenges/Opportunities</p>	<p align="center">Council Members</p>
<p>6. H2O</p>	<p align="center">David Bridge, AHCCCS DHCM Housing Programs</p>
<p>7. Emergency Preparedness Plan</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> State Agencies</li> <li><input type="checkbox"/> Proposal - Draft</li> </ul>	<p align="center">Council Members Representing State Agency Non-Members</p>
<p>8. COVID Updates</p> <ul style="list-style-type: none"> <li>• Communities Changing Landscape</li> </ul>	<p align="center">Council Members</p>
<p>9. State Agency Updates</p>	<p align="center">Council Members Non-Members</p>
<p>10. Committee Updates</p> <ul style="list-style-type: none"> <li>• Planning &amp; Evaluation</li> <li>• Community Advisory</li> <li>• Advocacy &amp; Legislation</li> </ul>	<p align="center">R. Brubaker Council Member Vicki Johnson, Council Member David Delawder, Council Member</p>
<p>11. Call to the Public</p>	<p align="center">Council Chair Vicki Johnson</p>

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**(Public Laws 99-660, 100-639, and 102-321)**

August 20, 2020 9am-3pm  
Virtual Meeting  
Contact [Ali.delatrinidad@azahcccs.gov](mailto:Ali.delatrinidad@azahcccs.gov) for meeting access.

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**"...to advise, review, monitor, and evaluate all aspects of the development of the State Plan"  
(Public Laws 99-660, 100-639, and 102-321)**



**BEHAVIORAL HEALTH PLANNING COUNCIL MEETING**  
**Friday, September 18, 2020**  
**10:00am – 12:00apm**

**AGENDA**

MEETING LOCATION	CALL IN AVAILABILITY
<p align="center">AHCCCS (Virtual with call in availability)</p>	<p align="center">888 475 4499 US Toll-free Meeting ID: 693 407 663</p>
<p>1. Welcome</p> <ul style="list-style-type: none"> <li>1) Introductions</li> <li>2) Ensure a Quorum</li> <li>3) Call Meeting to Order</li> </ul>	<p align="center">Vicki Johnson, Council Chair Vicki Johnson, Council Chair Vicki Johnson, Council Chair</p>
<p>2. Review Minutes - August 14, 2020</p>	<p align="center">Council Member</p>
<p>3. State Agency Updates</p> <ul style="list-style-type: none"> <li>• State Medicaid/BH</li> <li>• State Housing</li> <li>• State RSA/VR</li> </ul>	<p align="center">Council Members</p>
<p>4. Data Request Update</p> <ul style="list-style-type: none"> <li>• Mohave County Report</li> <li>• RBHA SABG Reports/Alternative Utilization Funding Report</li> </ul>	<p align="center">Jill Rowland, Chief Clinical Officer, AHCCCS Vicki Johnson, Council Chair</p>
<p>5. Committee Updates</p> <ul style="list-style-type: none"> <li>• Planning &amp; Evaluation</li> <li>• Community Advisory</li> <li>• Advocacy &amp; Legislation</li> </ul>	<p align="center">R. Brubaker &amp; V. Johnson, Council Members Dan Haley, Council Member David Delawder, Council Member</p>
<p>6. Call to the Public</p>	<p align="center">Council Chair Vicki Johnson</p>
<p>7. Adjourn at _____</p>	<p align="center">Next Council Meeting October 16, 2020 10am-12pm Virtual Meeting</p>

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**BEHAVIORAL HEALTH PLANNING COUNCIL MEETING**  
**Friday, October 16, 2020**  
**10:00am – 12:00pm**

**AGENDA**

MEETING LOCATION	CALL IN AVAILABILITY
<p align="center">AHCCCS (Virtual with call in availability)</p>	<p align="center">888 475 4499 US Toll-free Meeting ID: 693 407 663</p>
<p>1. Welcome</p> <ul style="list-style-type: none"> <li>1) Roll Call</li> <li>2) Ensure a Quorum</li> <li>3) Call Meeting to Order</li> </ul>	<p align="center">Vicki Johnson, Council Chair Vicki Johnson, Council Chair Vicki Johnson, Council Chair</p>
<p>2. Department of Developmental Disabilities Presentation</p>	<p align="center">Susanne Arnold, DES</p>
<p>3. Technical Assistance Funding (SABG/MHBG)</p>	<p align="center">Michelle Skurka, Grants Administrator</p>
<p>4. Data Request Update</p> <ul style="list-style-type: none"> <li>• Mohave County Report</li> <li>• RBHA SABG Reports/Alternative Utilization Funding Report</li> </ul>	<p align="center">Jill Rowland, Chief Clinical Officer, AHCCCS Vicki Johnson, Council Chair</p>
<p>5. State Updates</p>	<p align="center">Susan Junck, Council Member Ryan Vernick, Council Member Alicia Ruiz, Council Member</p>
<p>6. Committee Updates</p> <ul style="list-style-type: none"> <li>• Planning &amp; Evaluation</li> <li>• Community Advisory</li> <li>• Advocacy &amp; Legislation</li> </ul>	<p align="center">R. Brubaker Council Member Dan Haley, Council Member David Delawder, Council Member</p>
<p>7. Call to the Public</p>	<p align="center">Council Chair Vicki Johnson</p>
<p>8. Adjourn at _____</p>	<p align="center">Next Council Meeting November 20, 2020 10am-12pm Virtual Meeting</p>

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**BEHAVIORAL HEALTH PLANNING COUNCIL MEETING**  
**Friday, November 20, 2020**  
**10:00am – 12:00pm**

**AGENDA**

MEETING LOCATION	CALL IN AVAILABILITY
<p align="center">AHCCCS (Virtual with call in availability)</p>	<p align="center">888 475 4499 US Toll-free Meeting ID: 693 407 663</p>
<p>1. Welcome</p> <ul style="list-style-type: none"> <li>1) Roll Call</li> <li>2) Ensure a Quorum</li> <li>3) Call Meeting to Order</li> <li>4) New Application</li> </ul>	<p align="center">Vicki Johnson, Council Chair  Vicki Johnson, Council Chair  Vicki Johnson, Council Chair  Vicki Johnson, Council Chair</p>
<p>2. GOYFF Updates</p>	<p align="center">Susan Alameda, Governor’s Office of Youth Faith and Family</p>
<p>3. Data Request Update</p> <ul style="list-style-type: none"> <li>• Mohave County Report</li> <li>• RBHA SABG Reports/Alternative Utilization Funding Report</li> </ul>	<p align="center">Jill Rowland, Chief Clinical Officer, AHCCCS Lori Petre, AHCCCS</p>
<p>4. MHBG/SABG TA Funds</p>	<p align="center">Michelle Skurka, AHCCCS</p>
<p>5. State Opioid Response (SOR)</p>	<p align="center">Alisa Randall, AD, AHCCCS</p>
<p>6. State Agency Updates</p>	<p align="center">Council Members</p>
<p>7. Committee Updates</p> <ul style="list-style-type: none"> <li>• Planning &amp; Evaluation</li> <li>• Community Advisory</li> <li>• Advocacy &amp; Legislation</li> </ul>	<p align="center">R. Brubaker Council Member  Vicki Johnson, Council Member  David Delawder, Council Member</p>
<p>8. Call to the Public</p>	<p align="center">Council Chair Vicki Johnson</p>
<p>9. Adjourn at _____</p>	<p align="center">Next Council Meeting  December 18, 2020 10am-12pm  Virtual Meeting</p>

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# Environmental Factors and Plan

## Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

- State Education Agency
- State Vocational Rehabilitation Agency
- State Criminal Justice Agency
- State Housing Agency
- State Social Services Agency
- State Health (MH) Agency.

Start Year: 2022      End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
David Delawder	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Jane Kallal	Youth/adolescent representative (or member from an organization serving young people)			
John Baird	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Kathy Bashor	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Greg Billi	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Kathryn Blair	Providers	Yavapai County Public Fiduciary		
Richard Brubaker	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Kim Foy	State Employees	Arizona Department of Economic Security		
Bill French	Persons in recovery from or providing treatment for or advocating for SUD services			
Olivia Gutzman	State Employees	Arizona Department of Housing		
Daniel Haley	Persons in recovery from or providing treatment for or advocating for SUD services			
Vicki Helland	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Allie Hesketh	State Employees	State Social Services Agency		
Vicki Johnson	Parents of children with SED/SUD			

Susan Kennard	State Employees	State Mental Health Agency		
Scott Lindbloom	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Alida Montiel	Representatives from Federally Recognized Tribes			
Stacy Paul	State Employees	Arizona Department of Corrections		
Teresa Pena	Providers	Valle Del Sol		
Aayna Rispoli	State Employees	Arizona Department of Education		
Alicia Ruiz	State Employees	State Vocational Rehabilitation Agency		

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

**Footnotes:**

# Environmental Factors and Plan

## Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
<b>Total Membership</b>	<b>20</b>	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	6	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	1	
Parents of children with SED/SUD*	1	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	0	
Persons in recovery from or providing treatment for or advocating for SUD services	2	
Representatives from Federally Recognized Tribes	1	
<b>Total Individuals in Recovery, Family Members &amp; Others</b>	<b>11</b>	<b>55.00%</b>
State Employees	7	
Providers	2	
Vacancies	0	
<b>Total State Employees &amp; Providers</b>	<b>9</b>	<b>45.00%</b>
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	1	
<b>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</b>	<b>1</b>	
Youth/adolescent representative (or member from an organization serving young people)	1	

\* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Refer to Arizona Behavioral Health Planning Council letter dated August 24, 2021.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

**Footnotes:**

# Environmental Factors and Plan

## 22. Public Comment on the State Plan - Required

Narrative Question

[Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. § 300x-51\)](#) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

### Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
- a) Public meetings or hearings?  Yes  No
- b) Posting of the plan on the web for public comment?  Yes  No
- If yes, provide URL:  
<https://www.azahcccs.gov/AHCCCS/PublicNotice>
- UPDATED 11/2/2021  
Public Notices and Opportunities for Public Comment  
Behavioral Health  
Arizona 2022 Combined Block Grant Application DRAFT
- <https://www.azahcccs.gov/AHCCCS/PublicNotices/#behavioralhealth>
- c) Other (e.g. public service announcements, print media)  Yes  No

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**Footnotes:**

## Environmental Factors and Plan

### 23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction<sup>1,2</sup> on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the [Consolidated Appropriations Act](#), 2018 (P.L. 115-141) signed by President Trump on March 23, 2018<sup>3</sup>.

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user (IVDU)* is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs (PWID)*.

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers<sup>4</sup>. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs<sup>5</sup>: These documents can be found on the Hiv.gov website: <https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs>,

1. [Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016](https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf) from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy <https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf>,
2. [Centers for Disease Control and Prevention \(CDC\) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016](http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf) The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention <http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf>,
3. [The Substance Abuse and Mental Health Services Administration \(SAMHSA\)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs](http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf) <http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf>,

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

<sup>1</sup> Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds **only** and is consistent with guidance issued by SAMHSA.

<sup>2</sup> Section 1931(a)(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C. § 300x-31(a)(1)(F)) and 45 CFR § 96.135(a) (6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the [Federal Register](#) (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

<sup>3</sup> Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

<sup>4</sup> Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set-aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

<sup>5</sup> ***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a [description of the elements of an SSP](#) that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio-hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;



- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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**Footnotes:**



**Revision Request:  
Web Block Grant Application System (WebBGAS)  
FY 2022-2023 Combined Behavioral Health  
Assessment and Plan Submitted (SABG Plan)  
Section IV. Environmental Factors and Plan  
Item 23. Syringe Services (SSP)**

**March 7, 2022**

**FY 2022-2023 Combined Behavioral Health Assessment and Plan Submitted (SABG Plan),  
Section IV. Environmental Factors and Plan, Item 23. Syringe Services (SSP)**

March 7, 2022

Theresa Mitchell Hampton, DrPH, M.Ed.  
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**RE: FY 2022-2023 Combined Behavioral Health Assessment and Plan Submitted (SABG Plan), Section IV.  
Environmental Factors and Plan, Item 23. Syringe Services (SSP)**

Dear Dr. Theresa Mitchell Hampton:

Thank you for the opportunity to submit a Revision Request through the WebBGAS portal to support our efforts to utilize the Substance Abuse Block Grant (SABG) to fund elements for a statewide Syringe Service Program (SSP) throughout Arizona. The Arizona Health Care Cost Containment System (AHCCCS), which serves as the Single State Authority, has worked to develop, bid, and subsequently award a statewide contractor, herein known as “contracted provider,” “statewide provider,” or “Sonoran Prevention Works (SPW).” We aim to implement the program through the following strategies to reduce the rates of overdose, drug-related deaths and injuries, and the transmission of infectious diseases; improve the health and wellness of people who use drugs (PWUD); and reduce costs and burden associated with substance use/misuse on public systems:

- 1) Naloxone distribution, education, and training;
- 2) Statewide Syringe Service Program;
- 3) Trainings for professionals and the broader community;
- 4) Peer support program to facilitate linkages to treatment and wrap-around supports;
- 5) Fentanyl testing strip distribution, education, and training;
- 6) Tailored programming and services for women, especially pregnant and parenting women (SABG Priority Population);
- 7) Culturally appropriate services and resources; and
- 8) Stakeholder relationship and capacity building to ensure long-term program sustainability.

As part of this request we included a detailed AHCCCS work plan, timeline for implementation, copies of existing SSP protocols (Arizona Senate Bill 1250), budget and budget justification – *SSP budget portions highlighted in yellow* – including plans for disposal of injection equipment, description of current training needs, location of SSP related activities to be supported with federal funds, SSP metric information, and a few attachments to support the overall request.

The overall aim of this Revision Request is to receive SAMHSA approval to implement our comprehensive, evidence-based, statewide SSP for Arizona to meet the needs of those most vulnerable to overdose and other drug-related consequences.

With your approval, AHCCCS can increase and improve access to care for Arizonans in need of critical support services. I welcome any further questions or requests for additional information.

Sincerely,



Kristen Challacombe, Deputy Director for Business Operations

March 2022

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**FY 2022-2023 Combined Behavioral Health Assessment and Plan Submitted (SABG Plan),  
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**1. BACKGROUND**

***Description of proposed model(s) and plans, including MOUs with SSP providers who can supply needles; the grantee will need to maintain documentation showing that any needle/syringe purchases were made with non-federal funds;***

*Note: The work plan and accompanying attachments submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA) were developed and adapted from the Arizona Health Care Cost Containment System's (AHCCCS) Substance Abuse Block Grant (SABG) proposal submitted for bid by and subsequently awarded to Sonoran Prevention Works (SPW). Portions of the proposal by SPW are included in this work plan, as the proposal is the workplan to be implemented.*

On May 24, 2021, Governor Doug Ducey signed into law Arizona Senate Bill 1250, [Short Title: overdose; disease prevention; programs](#), allowing a city, town, county or non-governmental organization, including a local health department or an organization that promotes scientifically proven ways of mitigating health risks associated with drug use and other high-risk behaviors, to establish a Syringe Service Program (SSP) and supports. In addition, on October 26, 2021 – through a Determination of Need (DON) request to the Centers for Disease Control and Prevention (CDC) from the Arizona Department of Health Services (ADHS) – the CDC determined that the State of Arizona is at risk for a significant increase in viral hepatitis infection or HIV outbreak due to injection drug use.

Sharing unsterile injection equipment contributes to the transmission of Hepatitis C (HCV), HIV, and Hepatitis B (HBV) among people who inject/use drugs (PWID/PWUD).<sup>1</sup> SSPs are proven and effective community-based programs supporting a range of services including access to and disposal of sterile syringes and injection equipment, naloxone and fentanyl test strip (FTS) education and distribution, testing for HCV, HBV, and HIV, and linkages to substance use, mental health, and infectious disease care and treatment. SSPs provide services to the most marginalized individuals within our communities, many of whom are often served through SABG funds (i.e., uninsured/ underinsured individuals), and often rely on SSPs as their only source for health care.<sup>2 3</sup> Decades of research has shown that SSPs provide low-barrier support to PWUD, are safe and cost-effective, reduce healthcare related costs to hospitals/health care systems (e.g., AHCCCS), and increase the likelihood of an individual entering substance use treatment.

Substance Use Disorder (SUD) in the United States is at epidemic levels and has had a disproportionate and long-lasting impact in the State of Arizona. Between June 15, 2017 to November 26, 2021, Arizona experienced 11,235 suspected opioid related deaths and 81,100

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<sup>1</sup> Journal of Infectious Diseases: <https://doi.org/10.1080/23744235.2020.1727002>

<sup>2</sup> Journal of Acquired Immunodeficiency Syndrome: 10.1097/QAI.0000000000001792

<sup>3</sup> Centers for Disease Control and Prevention: <https://www.cdc.gov/ssp/syringe-services-programs-summary.html>

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suspected overdoses.<sup>4</sup> In addition, data from the Arizona Department of Health Services (ADHS) showed that “HIV infections with injection drug use reported as a risk factor have remained relatively stable, yet high, since 2014. In 2020, 15.8 percent of all prevalent cases, and 11 percent of incident cases report IDU as a risk factor. Additionally, opioid-related morbidity and mortality continue to increase with a 198 percent increase in suspected opioid deaths between 2012 and 2019.”<sup>5</sup>

Although there is ample literature demonstrating evidence behind treatment for SUD, drug use prevention and treatment efforts are often unable to meet the full spectrum of needs (i.e., wraparound supports) to help reduce the prevalence of chaotic drug use. For many SABG recipients, traditional drug treatment is not always viable or successful due to access barriers, limited availability, rigorous requirements, and personal preferences. According to a report analyzing utilization among Medicaid enrollees with a SUD diagnosis to understand service utilization patterns revealed that only 20 percent of females and 25 percent of males with SUD are receiving community-based services specific to treating their SUD or behavioral health condition.<sup>6</sup> These alarmingly low rates indicate that many individuals with SUD are not receiving the needed treatment and support through the current models of care in our communities. Though the data is specific to Medicaid enrollees, AHCCCS can generalize the data to recipients of SABG funds (N-TXIX/XXI) as services have been historically underutilized across the state. As such, a comprehensive approach that goes beyond naloxone education, training, and distribution is needed to adequately address the needs of substance users across Arizona.

Through this, AHCCCS seeks to expand the current Overdose Education and Naloxone Distribution (OEND) statewide contract to include elements of SSPs to its provision of services to engage the hardest-to-reach Arizonans who use drugs – those who are most medically complicated, and the highest cost to public systems. This new initiative includes the following strategies to reduce the rates of overdose, drug-related deaths and injuries, and the transmission of infectious diseases; improve the health and wellness of PWUD; and reduce costs and burden associated with substance use/misuse on public systems:

- 1) Naloxone distribution, education, and training;
- 2) Statewide Syringe Service Program\*\*;
- 3) Overdose education and trainings;
- 4) Peer support and wraparound services;
- 5) Fentanyl testing strip distribution, education, and training;
- 6) Tailored programming and services for women (SABG Priority Population) \*\*;
- 7) Culturally appropriate services and resources; and

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<sup>4</sup> Arizona Department of Health Services: <https://www.azdhs.gov/prevention/womens-childrens-health/injury-prevention/opioid-prevention/index.php>

<sup>5</sup> Arizona Department of Health Services: Determination of Need Request, dated October 26, 2021.

<sup>6</sup> Burns & Associates, A Division of Health Management Associates: Delivery of Services to AHCCCS Members with Substance Use Disorder in Calendar Years 2018, 2019 and 2020.

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8) Expanded network of key community stakeholders\*\*.

\*\*Indicates new service not previously funded through SABG.

**2. WORKPLAN**

*Adapted from SPW’s bid proposal effective January 1, 2022:*

AHCCCS, through the statewide contractor, SPW, aims to develop and implement comprehensive, evidence-based treatment strategies for the State of Arizona to meet the needs of the most vulnerable to overdose and other drug-related harms. *Figure 1* below displays the conceptual model developed for this project, illustrating the relationship between the interventions, immediate outcomes, and long-term outcomes.

Figure 1. Conceptual Model

Intervention	Immediate Outcomes	Long-term Outcomes
1) Naloxone distribution, education, and training 2) Syringe Service Program 3) Education and training 4) Peer support and wraparound services 5) Fentanyl testing strip distribution, education, and training 6) Tailored programming and services for women 7) Culturally appropriate services and resources 8) Expanded network of key community stakeholders	<ul style="list-style-type: none"> <li>• Increased initiation, continuation, and coordination of evidence-based treatment for individuals who use drugs</li> <li>• Increased harm reduction behaviors such as reduced or safer use, supply testing, and overdose prevention kits</li> <li>• Increased proper disposal of used syringes</li> <li>• Increased public awareness and community engagement</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced rates of overdose, drug-related deaths and injuries, and transmission of infectious diseases</li> <li>• Improved health and wellness of people who use drugs</li> <li>• Reduced costs and burden associated with substance use/misuse on public systems</li> </ul>

To achieve the listed outcomes, our strategy consists of eight (8) overarching strategies/interventions:

- 1) Naloxone distribution, education, and training:** Expand a comprehensive, statewide naloxone distribution, education, and training initiative for PWUD, prescribers, pharmacists, AHCCCS members and the public. Through the subcontracted provider, we aim to achieve the following objectives:
  - a. Distribute Narcan doses via kits to communities across Arizona through targeted street and community outreach.
  - b. Conduct in-person and web-based training sessions for prescribers, pharmacists, AHCCCS members, and the public, emphasizing evidence-based responses to opioid overdose and post-overdose support.
  - c. Provide naloxone training and technical assistance to the correctional system to at least 50 percent of Arizona jails and 75 percent of state prisons distributing naloxone upon release.

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- d. Train 10 percent of Arizona group homes for transition-age youth on overdose prevention, recognition, and response.
- 2) A statewide SSP:** Through SPW, AHCCCS aims to implement the following elements for a statewide SSP:
- a. Develop and expand needle and hypodermic syringe disposal education and options for the State of Arizona to reach at least 25 percent (5,640) of individuals who have injected drugs in the past year. In order to maximize our reach among our target population, we have developed four strategies to deliver supplies to PWUD: 1) fixed sites, 2) mobile units, 3) mail order programs, and 4) kiosks. Supplies include syringes, safe disposal containers, hygiene and wound care kits, internal and external condoms, rapid home HIV tests, and other associated supplies.
  - b. Implement a statewide SSP with sites in Yavapai, Maricopa, Pinal, Pima, Yuma, Mohave, Cochise, Navajo, Santa Cruz, and Graham counties (in partnership with Southwest Recovery Alliance, Southern AZ AIDS Foundation, and Community Medical Services). The statewide provider will also create new and expanded mobile and delivery based SSP services to reach PWUD across Arizona. In this project period, we aim to reach at least 25 percent of Arizonans who have injected drugs in the past year (an estimated 5,640 people in 2020).
  - c. Coordination navigation services and treatment referrals for mental illness, substance use disorder, and other co-occurring disorders for SSP participants, as appropriate. SSPs provide an excellent opportunity to engage PWUD in a community setting with peer support from people with lived experience with substance use. Individuals seeking needles or other supplies may also be offered referrals to navigation services, treatment referrals, or additional services as appropriate. Individuals receiving services from the SSP will be referred into the peer support program as appropriate.
  - d. Develop and disseminate educational materials to at least 5,640 individuals through the SSP. Educational material may include the following topics: Overdose prevention, peer support services, infectious disease and transmission prevention, education, referrals, and treatment referrals for mental illness, SUD, and co-occurring disorders.
  - e. Develop and distribute evidence-based standards for distributing and disposing of needles and hypodermic syringes. Currently, the statewide provider, in collaboration with AHCCCS, in the planning phases of developing a statewide SSP standards board in collaboration with people who inject drugs and individuals who work and volunteer at SSPs.
- 3) Training for professionals and the broader community;** Through SPW, AHCCCS aims to implement the following stigma reduction trainings for professionals and the broader community:
- a. Develop and distribute educational material to at least 30,000 people through print and electronic distribution. With AHCCCS guidance, SPW will review and adapt existing educational material targeted at PWUD, the general public,



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providers, pharmacists, AHCCCS members, and other specific populations as appropriate.

- b.** Provide at least 20 free, training sessions for community members and the broader public. SPW's training sessions are typically geared toward community members, resource organizations, and medical/behavioral health professionals, with specialized curricula for numerous populations and professions. In coordination with AHCCCS and the program officer, SPW will review and update all training curricula and materials for free general training sessions geared toward community members. Current training topics include overdose prevention and naloxone use, opioid use disorder, stimulant use disorder, stigma, injection-related complications, and other relevant issues. These general trainings are offered in-person or virtually, including virtual video workshops or self-paced online courses.
  - c.** Provide at least 15 training sessions to medical, behavioral health, and social service providers. SPW will develop or enhance trainings on overdose prevention, fentanyl test strip use, stimulants, and other emerging topics and deliver to drug treatment providers, substance use prevention coalitions, health care providers, AHCCCS members, SABG priority populations, organizations who serve women who use drugs, and other groups who engage with PWUD.
  - d.** Conduct at least three trainings each year in each Geographic Service Area (GSA) in Arizona to the Department of Child Safety regional offices on overdose prevention and harm reduction. SPW will adapt existing curriculum to specifically address the unique needs of transition-age youth struggling with substance use/misuse.
  - e.** Provide training to at least 50 percent of Community Corrections offices on overdose prevention. Due to the disproportionate impact of opioid overdoses on criminal-justice involved individuals, we will make a concerted effort to train those that work in the criminal justice system with specialized content for this population.
- 4) Peer support program to facilitate linkages to treatment and wrap-around supports;** Through SPW, AHCCCS aims to implement the following peer support program through the following strategies:
- a.** Develop and implement a network of at least 75 provider organizations to facilitate linkages to evidence-based care navigation services for individuals requiring a higher level of care. Peer support staff, or Harm Reduction Outreach Workers (HROWs) at SPW work at SSPs and conduct street outreach in order to identify new clients and facilitate referrals to CMS and other organizations.
  - b.** Provide at least 1,500 referrals to treatment through peer support staff for individuals requiring a higher level of care. Referrals may include treatment for: SUD, mental illness, mental health and harm reduction-based counseling, screening and treatment for HIV, viral hepatitis, and STIs, medical treatment and basic wound care. HROWs are peer-certified and specially trained to provide intensive case management services to include support around drug treatment,

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medical care, mental health, housing, criminal justice involvement, identification replacement, and other services.

- c. Disseminate risk reduction material through peer support staff to 5,000 individuals. Supply kits may include condoms, hygiene products, naloxone kits, fentanyl test strips, and other necessities.
- d. Promote awareness through in-depth training for 2,700 individuals about the relationship between injection drug use and communicable diseases, recommended steps for disease transmission prevention, and options for treatment. Through syringe services and rapid HIV/HCV screening, peer support specialists will provide education on prevention, risk mitigation, and treatment for HIV, HCV, and other communicable diseases including hepatitis A and B, COVID-19, and STIs.

**5) Fentanyl testing strip distribution, education, and training;** Through SPW, AHCCCS aims to implement the following strategies:

- a. Distribute 120,000 rapid fentanyl testing strips (FTS) to communities across the State of Arizona in Year 1. Distribution will be prioritized to people who use drugs (all drugs, including heroin, stimulants, and pills), their friends and family, and organizations who can effectively distribute test strips to people at risk for overdose. SPW maintains the lowest available cost-effective pricing agreement with pharmaceutical companies for FTS in Arizona and will continue to do so for this project. Our budget for this proposal includes resources to purchase 120,000 FTS for statewide distribution.
- b. Develop and distribute FTS training materials and modules. FTS educational material will include content such as the use of FTS; alleviating fears and stigma; education on harm reduction and how it relates to using the testing strips to test for the presence of fentanyl; and information regarding use and/or disposal of substances that test positive for fentanyl. This content will be made available to PWUD, families, AHCCCS members, community-based organizations, and the general public.

**6) Tailored programming and services for women, especially pregnant and parenting women (SABG Priority Population);** Through SPW, AHCCCS aims to implement the following strategies for this SABG Priority Population:

- a. Provide outreach and care coordination services to at least 200 women who use drugs, prioritizing pregnant and parenting women. Tailored programming and services for women who use drugs may include pediatric medical treatment and care, child welfare, Arizona Department of Child Safety (DCS) coordination, legal assistance, early childhood education, and family counseling, in addition to other services needed by all PWUD. We aim to serve a minimum of 30 women in each region.
- b. Staff the statewide SSP with at least one staff member who specializes in supporting women who use drugs, particularly pregnant and parenting women. The staff member will travel throughout the state to provide services, as well as training and education for project staff and partners.

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- c. Prioritize the delivery of services and training to SABG priority populations. In compliance with SAMHSA and AHCCCS regulations for the use of SABG funds, all services provided through the resources requested for this project will prioritize the following SABG populations: 1) pregnant women/teenagers who use drugs by injection, 2) pregnant women/teenagers with a SUD, 3) other persons who use drugs by injection, 4) women/teenagers with a SUD, with dependent children and their families, including women who are attempting to regain custody of their children, and 5) all other individuals with a SUD, regardless of gender or route of use. With respect to naloxone distribution, education and training, we aim to increase the utilization of SPW services among SABG priority populations by at least 10 percent during the three-year project period.
  - d. Participate in statewide groups to conduct provider education on decreasing stigma and utilization of evidence-based practices for pregnant and parenting women who use drugs. Along with Objective 3C, we will make concerted efforts to train providers who treat women who use drugs, as well as incorporate gender-informed principles in our general training.
- 7) Culturally appropriate services and resources;** Through SPW, AHCCCS aims to implement the following:
- a. Provide Spanish translations and culturally sensitive versions of services and resources. SPW has provided Spanish translations of educational and outreach materials, as well as offered peer support services in Spanish since 2019. SPW currently has Spanish-speaking outreach staff in five Arizona counties. All printed educational materials will be available in English and Spanish, and additional materials will be revised for cultural sensitivity when working with tribal nations. In the event that our outreach staff do not speak the same language as the participants that they encounter, we will offer a telephone translation service to ensure that all participants are able to effectively communicate with SPW staff.
  - b. Host at least 20 training sessions in Spanish and distribute materials to at least 1,000 Spanish-speaking clients.
- 8) Stakeholder relationship and capacity building to ensure long-term program sustainability.** Through SPW, AHCCCS aims to implement the following:
- a. Convene an Advisory Board consisting of leadership representatives from across the health and social service systems. Potential Advisory Board members include PWUD people with lived experience, SSPs, state and local government agencies, Substance Use Disorder and behavioral health treatment providers, health departments, health clinics and systems, correctional health, first responders, community-based organizations, mutual aid groups, local businesses, schools, colleges and universities, and neighborhoods. The Advisory Board will provide overall project guidance, promote the program and services, build collective capacity, and reduce stigma amongst the public. Utilizing a

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collective impact model<sup>7</sup> for this project, SPW will act as this initiative's backbone, bringing CMS, ASU CHS, and many of our other partners together with the shared goal of preventing overdose and increasing harm reduction infrastructure in Arizona.

- b. Evaluate and continuously improve the services provided through our program through regular data monitoring, performance reports, and quality improvement methods. With the support of ASU CHS, a system of evaluation that measures the project's impact across all partners will be created. Peer support will be used not only to provide low-barrier harm reduction services to participants, but to gauge community need and response to ensure that we are including community voices and adapting interventions to evolving community needs. A critical part of this project is collecting reliable data to assess performance, evaluate progress, and continuously improve services and internal control systems. Additionally, we will maintain and expand SPW's inventory tracking system to monitor the supply and distribution of naloxone, FTS, and related outreach supplies purchased with SABG funds.
- c. Identify and disseminate best practices and recommendations for sustaining and expanding the program. All project processes, protocols, tools, evaluations, publications, and reports will be documented for dissemination to sustain and expand our collective efforts.

**Acquiring Syringes and Needles through Non-Federal Funds:** The SPW, submits an annual letter attestation to AHCCCS affirming they will not utilize federal funds to purchase syringes/needles. AHCCCS will continue this practice to ensure compliance with state and federal regulations. SPW is dedicated to ensuring that participants have access to all the supplies they need to stay as safe and healthy as possible, including syringes and needles. In support of this project, SPW will continue to fund the purchase of syringes and needles through a combination of grassroots fundraising methods as well as grant funding from a diverse range of private and public funders. SPW has a long history of utilizing grassroots fundraising methods, including one-time and monthly sustaining donations and program service revenue to support the work and help to fund the purchase of program supplies. SPW is committed to seeking out a diverse range of funders who share our values, and can support the purchasing of lifesaving supplies, such as syringes and needles, for participants. For years, SPW has worked to build and maintain relationships with funders dedicated to supporting health and harm reduction services to people impacted by substance use, including Broadway Cares, the Gilead Foundation, AIDS United, and more. SPW has also received funding from county health departments, hospital systems, and foundations across Arizona. Additionally, SPW proactively seeks out and applies to new funding opportunities that can further support the purchase of syringes and needles.

**Applicable MOUs with SSP Providers who can supply needles:** SPW is the acquirer of the syringes and needles needed for their program, we do not have a signed MOU in place. In lieu of

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<sup>7</sup> Sagrestano LM, Finerman JCR. COLLECTIVE IMPACT MODEL IMPLEMENTATION. J Health Hum Serv Adm. 2018;41(1):87-123. <https://www.jstor.org/stable/26974591>.

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an MOU, we have an executed contract that we can submit as part of this request outlining how SPW will acquire syringes and needles through non-federal funds.

**3. TIMELINE FOR IMPLEMENTATION**

Please refer to **Attachment A** at the end of this document for the timeline for implementation.

**4. COPY OF EXISTING SSP PROTOCOLS OR GUIDELINES**

AHCCCS, in consultation with SPW, will utilize the following protocols/guidelines, and applicable state law such as:

- a. Arizona Revised Statutes (ARS) Title 36, Chapter 6, Article 15: [Title 36, chapter 6, Arizona Revised Statutes. ARTICLE 15. OVERDOSE AND DISEASE PREVENTION. 36-798.51. Overdose and disease prevention programs; requirements; standards](#)
- b. Centers for Disease Control and Prevention: [Syringe Service Programs, A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation \(published 2020\)](#)
- c. NASTAD: [Syringe Services Program \(SSP\) Development and Implementation Guidelines for State and Local Health Departments \(published 2012\)](#)
- d. National Harm Reduction Coalition: [Guide to Developing and Managing a Syringe Service Program \(published 2010, updated 2020\)](#)

**5. BUDGET, BUDGET JUSTIFICATION, AND PROPOSED ACTIVITIES, INCLUDING A PLAN FOR DISPOSAL OF INJECTION EQUIPMENT**

**Budget/Budget Justification:** Please refer to **Attachment B** for the budget justification at the end of this document.

**Proposed Activities:**

- 1) Naloxone distribution, education, and training;
- 2) A statewide SSP;
- 3) Trainings for professionals and the broader community;
- 4) Peer support program to facilitate linkages to treatment and wrap-around supports;
- 5) Fentanyl testing strip distribution, education, and training;
- 6) Tailored programming and services for women, especially pregnant and parenting women (SABG Priority Population);
- 7) Culturally appropriate services and resources; and
- 8) Stakeholder relationship and capacity building to ensure long-term program sustainability.

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**Plan for disposal of injection equipment:** Because Arizona recently legalized SSPs, there is a gap in the development and distribution of evidence-based standards for distributing and disposing of needles and hypodermic syringes. AHCCCS, in collaboration with the contracted provider, Sonoran Prevention Works, is in the planning phase of developing a statewide SSP standards board in collaboration with PWID and individuals who work and volunteer at SSPs. SPW aims to follow applicable Arizona law regarding the disposal of injection equipment ([SB 1250: Article 15: 36-798.51. Overdose and disease prevention programs; requirements; standards](#)):

*“A program established pursuant to this section shall develop standards for distributing and disposing of needles and hypodermic syringes based on scientific evidence and best practices. the number of needles and hypodermic syringes disposed of through a program shall be at least equivalent to the number of needles and hypodermic syringes distributed through the program.”*

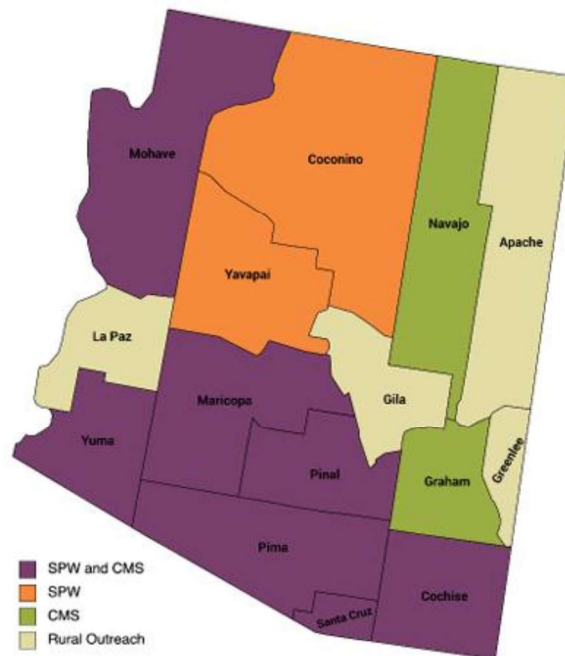
**6. DESCRIPTION OF CURRENT TRAINING AND TECHNICAL ASSISTANCE NEEDS**

Training/Technical Assistance Item	Description	Resource
Data & Evaluation	Arizona needs a comprehensive method to track and evaluate key performance indicators (KPIs), basic demographics, etc. KPIs include Naloxone (intranasal, intramuscular) Education & Distribution, Fentanyl distribution/testing, syringes received/distributed, etc.	SAMHSA Technical Assistance: <a href="https://harmreductionhelp.cdc.gov/s/">https://harmreductionhelp.cdc.gov/s/</a>

**7. LOCATION OF SSP RELATED ACTIVITIES TO BE SUPPORTED WITH FEDERAL FUNDS**

AHCCCS will implement a statewide SSP to adequately address the needs of PWUD across the Arizona community. *Figure 2* (below) shows the statewide reach of our program, with SPW and Community Medical Services (CMS) presence both in 9 separate counties (covering a combined 11 counties). Our strategy also includes extensive plans to adequately address the needs of the four counties without physical SPW or CMS presence through rural outreach, mobile clinics, virtual services, and main-in programs. (covering a combined 11 counties) throughout Arizona: Mohave, Yuma, Maricopa (most populous), Pinal, Pima, Santa Cruz, Cochise, Coconino, Yavapai, Navajo, and Graham counties.

Figure 2



**8. SIGNED STATEMENT (I.E., ANNUAL CERTIFICATION)**

Signed and included as part of this request (**Attachment C**).

**9. SSP METRIC INFORMATION**

***SABG sub-recipients, )i.e., community-based organizations), implementing new or expanding existing SSPs will need to collect basic SSP metrics information (e.g., number of syringes***

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***distributed, estimated number of syringes returned for safe disposal, number of persons tested for HIV or viral hepatitis, and referrals to HIV, viral hepatitis and substance use disorder treatment).***

AHCCCS developed an evaluation design into the method of approach to measure project performance, identify best practices, and facilitate continuous program improvement. Using the RE-AIM framework, the contracted provider, SPW, will gather data from program staff and participants at SPW and CMS through monthly programmatic reports and electronic health records. The data will track all measurable objectives, required reports, and reports for use by the advisory committee and executive team. All data collection methods will take into consideration the language, norms and values of the focus populations. All data collection, data storage, and data analysis procedures will be approved by the Institutional Review Board (IRB) at Arizona State University. Data sharing and transfer agreements will be developed with all partners and sub-awardees pursuant to IRB approved processes. All data will be protected and stored according to IRB approved protocols.

In compliance with [SAMHSA guidance](#) for State Block Grants, AHCCCS will collect the following information related to SSPs:

- Number of syringes distributed,
- Estimated number of syringes returned for safe disposal,
- Number of persons tested for HIV or viral hepatitis,
- Referrals to HIV/Viral Hepatitis testing and treatment, and
- Referrals to substance use disorder treatment.



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**10. ATTACHMENTS A – E:**

***Attachment A: Timeline for Implementation***

Milestones	Lead	Year 0 (Administrative)				Year 1 (2022)				Year 2 (2023)				Year 3 (2024)				Year 4
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Develop SABG RFP	AHCCCS																	
RFP out for Bid	AHCCCS																	
RFP Proposal Evaluation & Contractor Selection	AHCCCS																	
Receive Determination of Need for SSP in AZ (obtained Oct-21)	AHCCCS																	
Contract Executed (December 1)	AHCCCS																	
Develop SABG-SSP Metrics for Contractor	AHCCCS																	
Receive Approval for SABG Funds for SSP Activities	AHCCCS																	
Naloxone Distribution, Education, and Testing (ongoing)	Contractor																	
Syringe Service Program (pending SAMHSA approval)	Contractor																	
Fentanyl Testing Strip Distribution, Education, and Testing	Contractor																	
Programming for Pregnant and Parenting Women (SABG)	Contractor																	
Contract Close-Out for Statewide Vendor	Contractor																	
Final Deliverable for Statewide Vendor	Contractor																	

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**Attachment B: Budget Justification**

**AHCCCS/Sonoran Prevention Works (SPW)  
Syringe Service Program (SSP)  
Budget and Justification  
01/01/2022-12/31/2022**

**A. Personnel:**

<b>Position (1)</b>	<b>Key Staff (3)</b>	<b>Annual Salary/ Rate (4)</b>	<b>Level of Effort (5)</b>	<b>Total Salary Charged to Award (6)</b>
Syringe Services Program Manager	x	\$60,000	100%	\$60,000
Syringe Services Team Lead		\$21/hr	100%	\$43,680
SSP Trainer		\$20/hr	100%	\$41,600
Women's Health Peer Support Specialist		\$21/hr	100%	\$43,680
Syringe Service Program Specialists (5)		\$19/hr	100%	\$197,600
Operations Associate		\$22/hr	25%	\$11,440
Naloxone and Fentanyl Test Strip Distribution Coordinator		\$19/hr	100%	\$39,520
<b>FEDERAL REQUEST</b>				<b>\$437,520</b>

**JUSTIFICATION:**

- Syringe Services Program Manager will oversee the in-person syringe services to include Yavapai, all of Mohave, Maricopa, Pinal, Cochise, and Pima counties, and ensure that supply delivery occurs for individuals unable to reach those physical programs. The position requires a background in outreach, managing remote teams, operationalizing new programs, and ensuring cross-program collaboration to leverage SPW's existing staff and programming to support the statewide syringe service program. They will oversee the five Syringe Service Program Specialists.
- Syringe Services Team Lead will provide support to the SSP Manager in day-to-day staffing of the five SSPs. They will be the first line of defense in cases of conflict, sharps exposure, and scheduling, and will serve as a backup for any staff who will be on extended leave.
- Trainer will deliver online and in-person training for AHCCCS patients, community members, pharmacists, drug treatment organizations, medical providers, and others to increase knowledge of overdose prevention, naloxone, fentanyl test strips, and other harm reduction topics.
- Women's Health Peer Support Specialist will conduct outreach to women who use drugs (particularly pregnant and parenting women) and organizations who serve them. They will be the resident expert on supporting women who use drugs and train the rest of the staff on interventions and resources to support women who use drugs in all three GSAs.

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- Syringe Service Program Specialists are peer-support certified individuals who will run SSPs in Mohave, Yavapai, Pinal, Cochise, and Yuma counties. In partnership with other SPW staff, volunteers, and community partners, they will conduct fixed site distribution, home delivery, and mobile syringe services in line with AZ statute and the expectations of this SSP.
- Operations Associate will run SPW’s Harm Reduction by Mail program to ensure that individuals unable to access services through our 5 SSPs can still receive supplies, referrals, and peer support by mail.
- Naloxone & Fentanyl Test Strip Distribution Coordinator will manage organizational requests for naloxone and fentanyl test strips, distribute them equitably and timely, and oversee inventory management.
- **Fringe Benefits:**

Position (1)	Name (2)	Rate (3)	Total Salary Charged to Award (4)	Total Fringe Charged to Award (5)
All	FICA, worker’s comp, health insurance, state unemployment insurance	see table below	\$437,520	\$96,886
<b>FEDERAL REQUEST</b>				<b>\$96,886</b>

**JUSTIFICATION:**

Fringe Category	Rate
Retirement	n/a
FICA	7.65%
Insurance (worker’s comp)	1.26%
Health insurance	\$7500 per FTE
State unemployment insurance tax	6.18% on first \$7000
Total	26.53%

**B. Travel:**

Please note: All travel expenditures will require itemized receipts and will not exceed the State allowable rates which can be found in the State of Arizona Accounting Manual (SAAM) <https://gao.az.gov/publications/saam>.

Purpose (1)	Destination (2)	Item (3)	Calculation (4)	Travel Cost Charged to the Award (5)
Statewide travel	In state	Mileage	10,000 miles x .445	\$4,445
	In State	Lodging	State of AZ allowable reimbursement rate	\$3,000
	In state	Meals	State of AZ allowable reimbursement rate	\$1,500
<b>FEDERAL REQUEST</b>				<b>\$8,945</b>

**JUSTIFICATION:**

Local travel needed to conduct outreach, support staff, attend training events, and conduct other SSP project activities. Local travel rates not to exceed allowable rates in SAAM.

**C. Equipment (Over \$5,000 per item):**

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Item(s) (1)	Quantity (2)	Amount (3)	% Charged to the Award (4)	Total Cost Charged to the Award (5)
				n/a

**JUSTIFICATION:**

**D. Supplies (Items costing less than \$5,000 per unit):**

Item(s)	Rate	Cost
Fentanyl test strips	\$0.70 x 50,000	\$35,000
Intramuscular naloxone	\$35,000	\$35,000
SSP Supplies (excluding syringes) see justification	\$15,000 x 12 months	\$180,000
Leased Vehicle (Dedicated 100% for SSP_	\$4,800 per year	\$4,800
Laptops	\$500 x 6.25 FTE	\$3,125
Cell phones	\$350 x 6.25 FTE	\$2,187
Office supplies	\$100 x 12 months	\$1,200
Office Furniture	\$500 per employee x 6.25 FTE	\$3,125
Printing	Varied	\$3,125
SSP advertisement	Varied see justification	\$5,000
<b>FEDERAL REQUEST</b>		<b>\$272,562</b>

**JUSTIFICATION:**

1. Fentanyl test strips - SPW will purchase and distribute 120,000 strips to decrease overdose and increase awareness of safer drug use among people who use drugs. These will be primarily offered to SABG priority populations and organizations who reach those populations.
2. Intramuscular naloxone - SPW will purchase and distribute naloxone to decrease overdose and build relationships with people who use drugs. These will be offered to SABG priority populations, organizations who reach those populations, AHCCCS members, and the general public.
3. SSP Supplies include tourniquets, hygiene products, wound care supplies, food kits (less than \$3/person), cottons, sharps containers, bags, alcohol wipes, and more to be distributed at the SSPs in accordance with Arizona statute, federal law, and the expectations of this proposal. Grant funds will not be used to purchase hypodermic syringes or needles.
4. Leased vehicle to be utilized in Cochise and Pinal counties by the Syringe Service Program Specialists for countywide coverage and deliveries. Vehicle will not be used for purposes outside the scope of this award.
5. Laptops and cell phones to be purchased for the 6.25 FTE to collect data, provide referrals, coordinate with team members, and support participants.
6. Office supplies & furniture to be purchased for the 6.25 FTE. Items include pens, paper, notebooks, mice, chairs, desks, and other related items.
7. Printing to distribute educational materials to participants and community members, print posters, brochures, data collection forms, and other related materials.

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8. SSP Advertisement of program to include digital advertising, billboards, bus shelter ads, and other related efforts to increase awareness and utilization of the program.

**Contractual:**

**COSTS FOR CONTRACTS MUST BE BROKEN DOWN IN DETAIL AND A NARRATIVE JUSTIFICATION PROVIDED. A SEPARATE ITEMIZED BUDGET IS REQUIRED FOR EACH CONTRACTOR. IF APPLICABLE, NUMBERS OF CLIENTS SHOULD BE INCLUDED IN THE COSTS.**

Name (1)	Service (2)	Rate (3)	Other	Cost (4)
Southern Arizona AIDS Foundation	Pima County Syringe Services	\$93,200	700 unique individuals to be reached annually	\$93,200
Southwest Recovery Alliance	Maricopa County Syringe Services	\$480 x 104 outreach events	1,500 unique individuals to be reached annually	\$49,920
ASU College of Health Solutions	Evaluation	\$106,426	n/a	\$106,426
Community Medical Services	24/7 supply provision and Statewide systems change coordination	\$175,002	1,370 unique individuals to be reached annually	\$175,002
Tory Howell	Graphic & web design	\$80/hr x 10 hrs	n/a	\$800
Kurt Clark	IT	\$80/hr x 10 hrs	n/a	\$800
TBD	Medical waste disposal services	\$600/mo x 12 months	n/a	\$7,200
<b>FEDERAL REQUEST</b>				<b>\$433,348</b>

***JUSTIFICATION:***

1. **Southern AZ AIDS Foundation** will administer a syringe service program three days/week in Tucson to benefit this project with an approximate X projected individuals to be reached. The program will meet the requirements set out in Arizona statute and in this RFP's scope of work.

Item	Rate	Total cost
Bilingual Health Education & Testing Specialist	\$38,854/yr @ 0.75 FTE	\$29,141
Health Education & Testing Specialist	\$36,774/yr @ 0.75 FTE	\$27,581
ERE	\$56,722 * 27.0%	\$15,315
State travel	Allowable state rates	\$534
Direct program costs	\$2,700 x 1.5 FTE	\$4,050
Allocable program support	\$1,397 x 1.5 FTE	\$2,095

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Occupancy costs	1.10% x \$84,600	\$931
Indirect costs	17.00% * \$79,647	\$13,553
<b>Total</b>		<b>\$93,200</b>

2. **Southwest Recovery Alliance** will administer a syringe service program two days/week in Phoenix to benefit this project with an approximate 1500 individuals to be reached. The program will meet the requirements set out in Arizona statute and in this RFP's scope of work.

<b>Item</b>	<b>Rate</b>	<b>Total cost</b>
Outreach events	\$480 x 104	\$49,920
<b>Total</b>		<b>\$49,920</b>

**3. ASU College of Health Solutions (ASU CHS)**

<b>Item</b>	<b>Rate</b>	<b>Total cost</b>
Personnel	See below	\$56,580
ERE	See below	\$17,122
Indirect Costs	See below	\$32,724
<b>Total</b>		<b>\$106,426</b>

**ASU CHS Personnel**

<b>Position (1)</b>	<b>Name (2)</b>	<b>Key Staff (3)</b>	<b>Annual Salary/Rate (4)</b>	<b>Level of Effort (5)</b>	<b>Total Salary Charge to Award (6)</b>
(1) Site PI	William Riley	Yes	\$199,300	15%	\$29,895
(2) Project Manager	Kailey Love	No	\$84,099	15%	\$12,615
(3) Data Analyst	Megan Phillips	No	\$67,000	21%	\$14,070
<b>Total</b>					<b>\$56580</b>

1. The Site PI will be responsible for providing regular oversight of all the ASU-related activities for the grant. This includes evaluation design, data design, data collection, performance assessment, development of performance measures, quality improvement, data management, tracking, analysis and reporting. The Site PI will also oversee and ensure the completion of evaluations to assess program performance and internal organizational controls and management.
2. The Project Manager will coordinate project service and activities, including implementing project activities, internal and external coordination, developing materials, and conducting meetings. The Project Manager will work closely with SPW leadership to develop an

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organizational project management plan to ensure the goals and objectives of the project are completed in a timely manner and within budget.

- The Data Analyst will be responsible for implementing all data collection policies and procedures, including working directly with SPW and CMS staff to audit current processes and develop recommendations to improve data accuracy. The Data Analyst will also work with the ASU team to develop monthly performance reports that will be disseminated to the project team for broader discussion. The Data Analyst will support SPW staff in preparing data and evaluation sections for grant reports to AHCCCS and SAMHSA.

ASU CHS ERE

Position (1)	Name (2)	Rate (3)	Total Salary Charged to Award (4)	Total Fringe Charged to Award (5)
(1) Site PI	William Riley	27.3%	\$29,895	\$8,161
(2) Project Manager	Kailey Love	33.58%	\$12,615	\$4,236
(3) Data Analyst	Megan Phillips	33.58%	\$14,070	\$4,725
<b>Total</b>				\$17,122

Arizona State University defines fringe benefits as direct costs, estimates benefits as a standard percent of salary applied uniformly to all types of sponsored activities, and charges benefits to sponsors in accordance with the Federally-negotiated rates in effect at the time salaries are incurred. An estimated cost escalation has been included and is consistent with ASU policy for both fringe rates and IBS. The current Rate Agreement was approved April 20, 2021. The estimated cost of ERE is \$17,122 for the personnel effort allocated in this project, which is based upon the following rates for FY 2023 and thereafter:

ASU CHS Indirect Cost Rate

ERE Rate Estimates	Faculty	Staff
FY 2023 Estimated Rates	27.3%	33.58%

Organization's Indirect Cost Rate for Other Sponsored is 44.4% of Modified Total Direct Costs MTDC (44.4% of \$73,702). Indirect costs are calculated using rates approved by US Department of Health and Human Services (DHHS). The University's Current Rate Agreement was approved on April 20, 2021.

MTDC includes salaries and wages, fringe benefits, materials and supplies, services, publications, rental/equipment/software fees, travel, and the first \$25,000 of each sub-award. Exclusions from MTDC include graduate student tuition remission, participant support, sub-awards over the first \$25,000, capital equipment, and scholarships/fellowships.

- Community Medical Services** will oversee state systems coordination – Arizona Department of Corrections, jails, Community Corrections, and Arizona Department of Child Safety. They will also provide low barrier public access to harm reduction supplies at each of their clinics, and provide peer support staff in each Geographical Service Area to offer treatment and linkage to care for those accessing supplies and support with conducting public trainings.

Item	Rate	Total cost
Program Supervisor - Tina Braham	\$93,600 x 0.05 FTE	\$4,680
Peer Support x 3	\$41,600 x 3 @ 0.50 FTE ea	\$62,400

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ERE	8.65% x \$67,080 \$480/mo x 1.5 FTE	\$14,442
Local travel	State rate	\$1,980
Contractual - supply kiosks + maintenance	\$3,500 x 25 \$4000 maintenance	\$91,500
<b>Total</b>		<b>\$175,002</b>

- Tory Howell will provide hourly rate graphic and web design service to support the promotional and educational goals of the project.
- Kurt Clark will provide hourly rate IT assistance to staff on the project as needed.
- Heinfeld Meech will conduct SPW's required single audit. This contract makes up 20% of SPW's federal contracts.
- Medical waste disposal services to pay for the safe and sterile disposal of syringes collected through the program.

**E. Construction: NOT ALLOWED**

**JUSTIFICATION:**

**F. Other: (Include Other Consultants):**

Item	Rate	Cost
Phoenix office	\$22,800/yr x 30%	\$6,840
Tucson office	\$14,400/yr x 43%	\$6,192
Phoenix & Tucson utilities	\$18,000 x 37% (average)	\$6,660
Storage	\$9,000 x 75%	\$6,750
Office maintenance & repairs	\$2,400 x 37% (average)	\$888
Cell service	\$503/yr x 6.25 FTE	\$3,144
<b>FEDERAL REQUEST</b>		<b>\$30,474</b>

**JUSTIFICATION:**

- Phoenix and Tucson offices will be allocated by staff FTE to grant. Offices are necessary for in-person work, supply receiving, and kit assembly.
- Utilities for Phoenix and Tucson offices allocated by staff FTE to grant.
- Storage units required for Phoenix, Tucson, Prescott, Kingman, Yuma, Bisbee, and Casa Grande to store SSP supplies, fentanyl test strips, and naloxone. Units will be allocated by staff FTE in the region to the grant.
- Office maintenance and repairs to include plumbing, electrical, sterilization, and other standard repairs.
- Cell service to ensure staff are able to communicate with each other, community partners, and participants.

**G. Total Direct Charges: \$1,279,735**

**H. Indirect Cost Rate or Administration (See Footnote below):**

Calculation (1)	Indirect Cost Charged to the Award (2)
16.3%	\$208,596



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<b>FEDERAL REQUEST</b>	\$208,596
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**JUSTIFICATION:** Admin overhead is the rate requested for all federal grants. The costs include payroll and accounting software, accounting fees, WiFi, CPA, and other administrative costs associated with the harm reduction program.

**K. Total Project Costs:** **\$1,488,331**

**L. BUDGET SUMMARY** (should include future years, as applicable to the grant, and projected total):

<b>Category</b>	<b>AHCCCS?SP W SSP 1/1/2022- 12/31/2022</b>
Personnel	\$437,520
Fringe	\$96,886
Travel	\$8,945
Equipment	\$0
Supplies	\$272,562
Contractual	\$433,348
Other	\$30,474
<b>Total Direct Charges</b>	<b>\$1,279,735</b>
Indirect Charges or Administration	\$208,596
<b>Total Project Costs</b>	<b>\$1,488,331</b>

**FY 2022-2023 Combined Behavioral Health Assessment and Plan Submitted (SABG Plan),  
Section IV. Environmental Factors and Plan, Item 23. Syringe Services (SSP)**

**Attachment C: Signed statement (i.e., Annual Certification)**

March 7, 2022

Theresa Mitchell Hampton, DrPH, M.Ed.  
Public Health Advisor/State Project Officer / COR II / FAC-P\PM  
HHS Region VIII (MT and UT), and IX (AZ; HI; and NV), and (CNMI, FSM, GU, and PU)  
U.S. Department of Health and Human Services (DHHS)  
Substance Abuse and Mental Health Services Administration (SAMHSA)  
Center for Substance Abuse Treatment (CSAT)  
Division of State and Community Assistance (DSCA)  
Performance Partnership Grant Branch (PPGB)  
5600 Fishers Lane, Station 13N16-E  
Rockville, MD 20857 (courier/overnight use 29000)  
O: (240) 276-1365  
E: [theresa.mitchell@samhsa.hhs.gov](mailto:theresa.mitchell@samhsa.hhs.gov)

Dear Dr. Theresa Mitchell Hampton:

In accordance with the Consolidated Appropriations Act, 2016, Division H, the Arizona Health Care Cost Containment System (AHCCCS) respectfully submits the following attestation.

*SEC. 520. Notwithstanding any other provision of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, That such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

For programmatic questions, please contact José Echeverría Vega at (602)417-4743 or [jose.echeverriavega@azahcccs.gov](mailto:jose.echeverriavega@azahcccs.gov).

Sincerely,



Kristen Challacombe, Deputy Director for Business Operations

CC:

Alisa Randall, AHCCCS  
Hazel Alvarenga, AHCCCS  
Nereyda Ramirez, AHCCCS  
Emma Hefton, AHCCCS  
Christopher Shoop, AHCCCS  
José Echeverría Vega, AHCCCS

March 2022  
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**FY 2022-2023 Combined Behavioral Health Assessment and Plan Submitted (SABG Plan),  
Section IV. Environmental Factors and Plan, Item 23. Syringe Services (SSP)**

***Attachment D: CDC Determination of Need for Arizona 10/26/2021***

***Attachment E: Arizona Revised Statute: Article 15: 36-798.51. Overdose and disease prevention programs***

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Due to formatting, Attachments D and E can be found in the next two pages.

March 2022  
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October 26, 2021

Kristen Herrick, MPH, CHES  
Chief, Office of Disease Integration & Services  
Arizona Department of Health Services  
150 North 18th Avenue, Suite 110, Phoenix, AZ 85007  
Email: [kristen.herrick@azdhs.gov](mailto:kristen.herrick@azdhs.gov)

Dear Ms. Herrick,

The Arizona Department of Health Services (ADHS) submitted a determination of need request to the Centers for Disease Control and Prevention (CDC) with data examining whether the state is experiencing or at risk for an increase in viral hepatitis or HIV infection due to injection drug use (IDU). Consulting with CDC to determine need is a requirement in the process of seeking approval to use federal funds to support syringe services programs (SSPs). All such requests are reviewed by a panel of CDC subject matter experts who evaluate submitted data in accordance with the *U.S. Department of Health and Human Services (HHS) Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*.

The Arizona Department of Health Services provides persuasive data that the state is at risk for a significant increase in viral hepatitis or HIV infections due to injection drug use. HIV infections with injection drug use reported as a risk factor have remained relatively stable, yet high, since 2014. In 2020, 15.8% of all prevalent cases, and 11% of incident cases report IDU as a risk factor. Additionally, opioid-related morbidity and mortality continue to increase, with a 198% increase in suspected opioid deaths between 2012 and 2019.

Arizona also provides supporting evidence that their state is at risk. CDC's Vulnerability Assessment (2106) identified Mohave County as being at risk for rapid dissemination of HIV or HCV infections among persons who inject drugs. Importantly, while syringe services programs were not officially sanctioned by the state until May 2021, several SSPs operating prior to the change in policy report large numbers of participant interactions, syringe provision, and naloxone distribution, with 435 reported overdose reversals.

Taken together, Arizona's request for a determination of need presents compelling data that the State is at risk for significant increase in viral hepatitis or HIV infections due to injection drug use.

This notice may be used by state, local, territorial, or tribal health departments or eligible HHS-funded recipients to apply to direct federal funds to support SSPs. As there is no expiration date for this notice, ADHS may elect to either (1) immediately request to direct current federal funding to support SSPs or (2) delay requests to direct funds to support SSPs until a subsequent fiscal year. The State is strongly encouraged to discuss plans to direct funds for SSPs with your federal funding agencies. Only CDC directly-funded, eligible awardees should submit a request to CDC to direct funding for SSP activities.

Thank you for your interest in the public health implications of injection drug use in Arizona. If you have any questions or require further technical assistance, please do not hesitate to send an email to [SSPCoordinator@cdc.gov](mailto:SSPCoordinator@cdc.gov).

Sincerely,  
CDC SSP Determination of Need Panel

**Senate Engrossed**

**REFERENCE TITLE: overdose; disease prevention; programs**

**State of Arizona  
Senate  
Fifty-fifth Legislature  
First Regular Session  
2021**

**CHAPTER 382**  
**SENATE BILL 1250**

**AN ACT**

**AMENDING TITLE 36, CHAPTER 6, ARIZONA REVISED STATUTES, BY ADDING ARTICLE 15; RELATING TO PUBLIC HEALTH.**

**(TEXT OF BILL BEGINS ON NEXT PAGE)**

Be it enacted by the Legislature of the State of Arizona:

Section 1. Title 36, chapter 6, Arizona Revised Statutes, is amended by adding article 15, to read:

**ARTICLE 15. OVERDOSE AND DISEASE PREVENTION**

**36-798.51. Overdose and disease prevention programs; requirements; standards**

A. A CITY, TOWN, COUNTY OR NONGOVERNMENTAL ORGANIZATION, INCLUDING A LOCAL HEALTH DEPARTMENT OR AN ORGANIZATION THAT PROMOTES SCIENTIFICALLY PROVEN WAYS OF MITIGATING HEALTH RISKS ASSOCIATED WITH DRUG USE AND OTHER HIGH-RISK BEHAVIORS, OR ANY COMBINATION OF THESE ENTITIES, MAY ESTABLISH AND OPERATE AN OVERDOSE AND DISEASE PREVENTION PROGRAM. A PROGRAM ESTABLISHED PURSUANT TO THIS SECTION SHALL HAVE ALL OF THE FOLLOWING OBJECTIVES:

1. TO REDUCE THE SPREAD OF VIRAL HEPATITIS, HIV AND OTHER BLOODBORNE DISEASES IN THIS STATE.
2. TO REDUCE NEEDLE-STICK INJURIES TO LAW ENFORCEMENT OFFICERS AND OTHER EMERGENCY PERSONNEL.
3. TO ENCOURAGE INDIVIDUALS WHO INJECT DRUGS TO ENROLL IN EVIDENCE-BASED TREATMENT.
4. TO INCREASE PROPER DISPOSAL OF USED SYRINGES.
5. TO REDUCE THE OCCURRENCE OF SKIN AND SOFT TISSUE WOUNDS AND INFECTIONS RELATED TO INJECTION DRUG USE.

B. A PROGRAM ESTABLISHED PURSUANT TO THIS SECTION SHALL OFFER ALL OF THE FOLLOWING:

1. DISPOSAL OF USED NEEDLES AND HYPODERMIC SYRINGES.
2. NEEDLES, HYPODERMIC SYRINGES AND OTHER INJECTION SUPPLY ITEMS AT NO COST AND IN QUANTITIES SUFFICIENT TO ENSURE THAT NEEDLES, HYPODERMIC SYRINGES AND OTHER INJECTION SUPPLY ITEMS ARE NOT SHARED OR REUSED.
3. EDUCATIONAL MATERIALS ON ALL OF THE FOLLOWING:
  - (a) OVERDOSE PREVENTION.
  - (b) PEER SUPPORT SERVICES.
  - (c) THE PREVENTION OF HIV, VIRAL HEPATITIS TRANSMISSION AND THE INCIDENCE OF SKIN AND SOFT TISSUE WOUNDS AND INFECTIONS.
  - (d) TREATMENT FOR MENTAL ILLNESS, INCLUDING TREATMENT REFERRALS.
  - (e) TREATMENT FOR SUBSTANCE USE DISORDER, INCLUDING REFERRALS FOR SUBSTANCE USE DISORDER TREATMENT.
4. ACCESS TO KITS THAT CONTAIN NALOXONE HYDROCHLORIDE OR ANY OTHER OPIOID ANTAGONIST THAT IS APPROVED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION TO TREAT A DRUG OVERDOSE, OR REFERRALS TO PROGRAMS THAT PROVIDE ACCESS TO NALOXONE HYDROCHLORIDE OR ANY OTHER OPIOID ANTAGONIST THAT IS APPROVED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION TO TREAT A DRUG OVERDOSE.
5. FOR EACH INDIVIDUAL WHO REQUESTS SERVICES, PERSONAL CONSULTATIONS FROM A PROGRAM EMPLOYEE OR VOLUNTEER CONCERNING MENTAL HEALTH OR SUBSTANCE USE DISORDER TREATMENT OR REFERRALS FOR EVIDENCE-BASED SUBSTANCE USE DISORDER TREATMENT, AS APPROPRIATE.

C. A PROGRAM ESTABLISHED PURSUANT TO THIS SECTION SHALL DEVELOP STANDARDS FOR DISTRIBUTING AND DISPOSING OF NEEDLES AND HYPODERMIC SYRINGES BASED ON SCIENTIFIC EVIDENCE AND BEST PRACTICES. THE NUMBER OF NEEDLES AND HYPODERMIC SYRINGES DISPOSED OF THROUGH A PROGRAM SHALL BE AT LEAST EQUIVALENT TO THE NUMBER OF NEEDLES AND HYPODERMIC SYRINGES DISTRIBUTED THROUGH THE PROGRAM.

**36-798.52. Immunity**

A. NOTWITHSTANDING TITLE 13, CHAPTER 34, AN EMPLOYEE, VOLUNTEER OR PARTICIPANT OF A PROGRAM ESTABLISHED PURSUANT TO SECTION 36-798.51 MAY NOT BE CHARGED WITH OR PROSECUTED FOR POSSESSION OF ANY OF THE FOLLOWING:

**1. A NEEDLE, HYPODERMIC SYRINGE OR OTHER INJECTION SUPPLY ITEM OBTAINED FROM OR RETURNED TO A PROGRAM ESTABLISHED PURSUANT TO SECTION 36-798.51.**

**2. A RESIDUAL AMOUNT OF A CONTROLLED SUBSTANCE CONTAINED IN A USED NEEDLE, USED HYPODERMIC SYRINGE OR USED INJECTION SUPPLY ITEM OBTAINED FROM OR RETURNED TO A PROGRAM ESTABLISHED PURSUANT TO SECTION 36-798.51.**

**B. SUBSECTION A OF THIS SECTION APPLIES ONLY IF THE PERSON CLAIMING IMMUNITY PROVIDES VERIFICATION THAT A NEEDLE, HYPODERMIC SYRINGE OR OTHER INJECTION SUPPLY ITEM WAS OBTAINED FROM AN OVERDOSE AND DISEASE PREVENTION PROGRAM ESTABLISHED PURSUANT TO SECTION 36-798.51.**



**APPROVED BY THE GOVERNOR MAY 24, 2021.**

**FILED IN THE OFFICE OF THE SECRETARY OF STATE MAY 24, 2021.**

## Environmental Factors and Plan

### Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
Sonoran Prevention Works (Contractor)	340 E. Dunlap Ave, Phoenix, AZ -85020	\$1,488,331.00	No	3	Yes

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

**Footnotes:**