

ARIZONA HEALTH AND DISABILITY PARTNERSHIP PROJECT ABSTRACT

Even with many decades of services provided to encourage and support people with disabilities to achieve employment goals, only 37.4% of Arizonans with disabilities aged 18-64 are working and only 23.2% are working full time. The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) established new provisions to support SSI/SSDI beneficiaries to leave disability rolls and become self-sufficient through employment. One provision of TWWIIA includes a state option to adopt a “Medicaid Buy-In” program to allow workers with disabilities to maintain eligibility for state public health care coverage (AHCCCS in Arizona) and pay a premium for the coverage. Arizona adopted a Buy-In program that allows consumers to earn up to \$50,028 and still be eligible for Medicaid. 1,004 AHCCCS-eligible individuals with work-related disabilities are currently enrolled in the program. However, there are still several specific barriers we will address with the funding from this grant:

1. Train and build awareness among mental and physical health care practitioners, especially those enrolled in the Medicaid and Medicare health systems on the techniques they can use to make effective employability decisions and partner with other providers to ensure consumers have every opportunity to maintain mental and physical health while still being able to work. A neuropsychologist and an occupational physician will be sub-contracted to provide this peer-to-peer training and consultation.
2. Educate consumers via mass media and public relations campaigns in conjunction with the TWWIIA Program Manager for Recruitment and Outreach (PMRO) and the contractor selected to serve as the Arizona Work Incentives Planning and Assistance (WIPA) program to ensure that consumers with disabilities adopt and maintain a “can-work” attitude.
3. Provide comprehensive, in-depth training to all of Arizona’s Employment Networks (ENs) contracted by the Social Security Administration to provide Ticket-to-Work program participants with the employment services needed to find and keep a job. As with many other states, the majority of enrollees in the Buy-In are not earning a high enough wage to eliminate dependency upon cash benefits. It is advantageous to the Medicaid program to have well-trained ENs providing comprehensive services designed to help beneficiaries work toward full time employment so eventually they will have health care provided by employer-provided insurance instead of relying exclusively on the public health care system.

**MEDICAID INFRASTRUCTURE GRANT APPLICATION
“ARIZONA HEALTH AND DISABILITY PARTNERSHIP”
PROJECT NARRATIVE**

Background Analysis:

The employment rate of working-age adults with disabilities in Arizona as of 2004 is 37.4%. Only 23.2% work full time. The employment rate during the same period for working-age adults without disabilities is 76.1%. Clearly we have a severe disparity between those adults with disabilities who work and those without disabilities. This data is from “Annual Disability Status Reports in the United States”, published by Cornell University’s Rehabilitation Research and Training Center on Disability Demographics and Statistics. According to the principle investigator, Andrew Houtenville, it is important to refer to the employment rate rather than the unemployment rate.

Unemployment reports measure only those people who are in the workforce; that is, those who are actively looking for a job. Since many people with disabilities are not actively looking for work for various reasons, they are not counted as being in the labor force and are also, therefore, not counted in unemployment statistics. The Cornell statistics give a more reliable picture as they take into account the entire working-age population and measure their work activity according to the percentage actually working. Much of the work being undertaken to increase employment of People with Disabilities (PWDs) relates to motivating people who do not consider themselves to be employable or for whatever reason are not actively looking for work. Rather than ignoring them because they do not show up in labor force statistics it is more appropriate to extrapolate the total number of PWDs who are potentially available to become employed by measuring all PWDs, not just those looking for work.

Given that methodology, then, let's look at the number of potential workers with disabilities in Arizona who could become employed if motivated and encouraged to do so. According to the Year 2000 census in Arizona there are 546,773 working-age adults with disabilities or 19.4% of the total working-age population of 2,813,449. If only 23.2% of those are fully employed,¹ that leaves 76.8% of working-age adults with disabilities or 419,922 Arizonans with disabilities who could potentially benefit from employment services and supports.

It should, however, be noted that these statistics represent people who self-identify as having a disability that affects their physical or mental ability in some manner including possibly their ability to work. There will always be some percentage whose disabilities are so severe that they simply cannot work either full or part time. There are also those who do not work in the community by choice, such as stay-at-home parents. So how do we effectively measure the potential number of PWDs who might enter the labor force and whose disabilities are significant enough that they might reasonably need services and supports to do so as opposed to doing it on their own?

Perhaps the most critical group to examine first is those PWDs currently receiving Social Security Disability Insurance payments (SSDI) and/or Supplemental Security Income (SSI). In 2004 there were 73,268 PWDs in Arizona receiving SSI. According to Social Security's "Ticket Tracker" as of July 7, 2006 that reports the number of Tickets to Work

¹ Since 14.2% are only working part-time we are including those in the group with potential to achieve full employment with intervention services. This is appropriate since the definition of part-time in the state data might only be one hour of work per week.

distributed, Arizona's citizens have been issued 176,016 tickets. Therefore, that represents a 60/40 split between SSDI and SSI recipients, respectively. Of the total tickets distributed only 1,440 of those tickets have been assigned to either the State VR agency or private Employment Networks. The SSI/SSDI rolls are a good indicator of those who might need services to return to work for several reasons:

1. Prior to the Ticket to Work and Work Incentives Improvement Act only 1 person in 500 who entered the disability rolls ever left it to go to work, a statistic shocking to most.
2. The criteria used by Social Security for benefits eligibility is generally considered fairly stringent and specifically related to ability to work at the time of disability onset. Consequently, those found eligible could generally be considered to have "significant" work disabilities.
3. Because these new programs including the Medicaid Buy-In and other recently adopted work incentives are fairly new, people who have not worked in a long time and who now might find work appealing and less risky are likely to need remedial training and other services to be marketable to employers.

It is fair to say that Arizona, like most other states, has struggled to fully realize the potential of the Ticket to Work Program. It is generally recognized nationally that the SSA payment provisions for Employment Networks (ENs) do not allow sufficient risk-sharing and up-front payments to encourage most experienced providers to accept Tickets let alone those who might want to start a new EN or those sole practitioners who do not have large amounts of capital to sustain a 3-5 year break-even point by participating as an

EN. However, in September, 2005 SSA issued a Notice of Proposed Rulemaking that significantly revised the payment structure of the Ticket Program and proposed new partnering opportunities between ENs and the State VR Agencies. These rules are projected to be finalized in October, 2006. SSA also announced the creation of the Program Manager for Recruitment and Outreach (PMRO) and awarded a contract to CESSI, Inc. earlier this year whose charge it is to market the program to beneficiaries with tickets, bring existing ENs back into participation and entice new ENs to join the program. To complement that effort SSA currently is evaluating competitive bids for a newly revamped Work Incentives Planning and Assistance (WIPA) program, formerly Benefits Planning, Assistance and Outreach (BPAO), to work closely with the PMRO. These changes, along with traditional employment programs promise to greatly improve the landscape for PWDs to have opportunities to achieve self-sufficiency through work.

In Arizona, the primary funding streams dedicated to employment of PWDs are administered through the Arizona Rehabilitation Services Administration (VR) and the Division of Development Disabilities (DDD). Consumers with DD are provided employment services through the DDD and VR provides services to non-DD consumers, including a separate program for those who are blind/visually impaired. Last year VR served approximately 20,000 consumers and placed 2,128 into jobs. Although Arizona is in Order of Selection due to insufficient funding to serve all who seek services, the good news is that the State Legislature just approved full-funding match for Arizona VR to draw down its full federal share of funds, which should greatly improve VR's ability to increase services. Arizona's VR agency also has a contract with the U.S. Department of

Labor to fund 19 Navigators in the One-Stop Career Centers statewide. That funding is \$1,618,202 over a four-year period.

During FY 2004 the DDD spent \$9M state-appropriated funds for 1,870 consumers with DD in supported employment. 874 of those were in sheltered workshops, 690 were in enclaves and 306 were in competitive employment with a job coach. The total number of DDD consumers receiving any services is 24,000 and of those 16,443 are enrolled in Arizona Long Term Care Services. 1/3 are 21-55 years old.

Arizona has a Medicaid Buy-In program in place and currently has 1,004 subscribers, which is a 43% increase over last year. The newly approved state budget includes \$4,765,900 for the Buy-In budget. The program allows individual earned income up to \$50,028 per year with a maximum premium of \$35 per month. Services under the Buy-In are provided as follows:

BACKGROUND

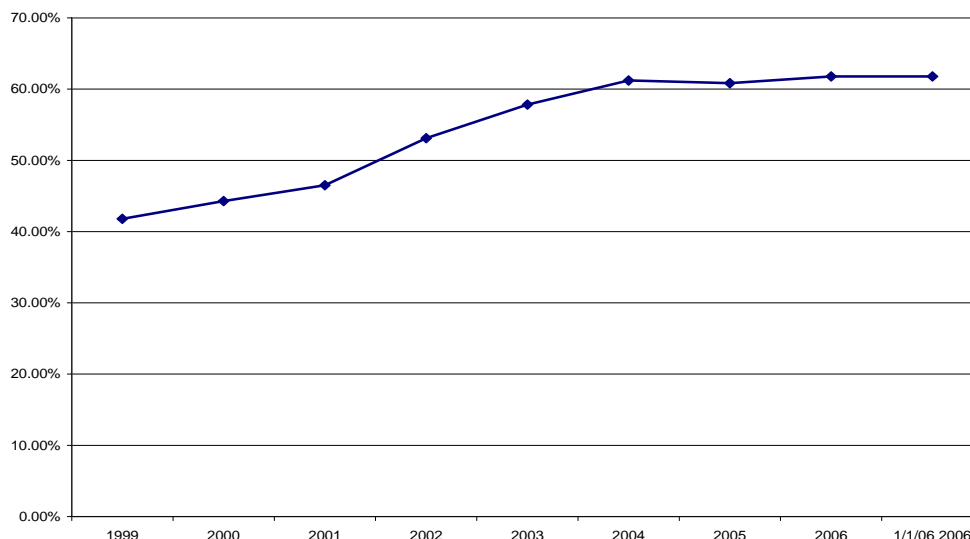
The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid program. AHCCCS is the Single State Medicaid agency, reporting directly to the Governor. The Arizona Long Term Care System (ALTCS) is AHCCCS' program for providing long term care to Medicaid eligible persons who are elderly or who have physical or developmental disabilities. There are currently over 41,000 individuals in the ALTCS program. AHCCCS contracts with long term care managed care entities, called Program Contractors, to provide the full continuum of acute, long-term and behavioral

health services to ALTCS members. It operates under a very flexible § 1115 waiver. Over 60% of members who are elderly or who have physical disabilities receive home and community based services (HCBS), and 95% of persons with developmental disabilities receive HCBS.

Consumers are able to move from a HCBS setting to an institutional setting without losing the opportunity to again receive HCBS without delay due to any type of waiting list. The design of the ALTCS program has placed only limited restrictions on the ability of consumers to live outside of institutional settings.

To appreciate the success of the ALTCS program in keeping the HCBS population out of institutions, the following chart illustrates the growth of the Elderly and Physically Disabled HCBS placement rate. The HCBS placement percentage rose from 41.8% to over 61.21%. The HCBS placement rate for individuals with developmental disabilities is approximately 98%.

Home and Community Based Services Placement



ELIGIBILITY

Individuals must be financially eligible for ALTCS. The Legislature established ALTCS financial eligibility at 300 percent of the Federal Benefit Rate (FBR), which is used by the Social Security Administration to determine eligibility for Supplemental Security Income (SSI). ALTCS members are required to contribute a share of the cost for their institutional care, which is calculated by taking an individual's income and subtracting certain allowable deductions. Once financial eligibility has been established, a Pre-Admission Screening (PAS) is conducted by a registered nurse or social worker to determine if the individual is at immediate risk of institutionalization in either a nursing facility or an ICF/MR. If deemed necessary, the registered nurse or social worker may refer the case to a physician for a final determination. AHCCCS has developed five standardized PAS instruments: one is used to screen persons who are elderly and/or physically disabled and the others are age-specific for DD. The PAS instruments use

weighted scores to provide information on the functional, medical, nursing, and social needs of an individual, which are the basis for determining medical eligibility for ALTCS services.

SERVICES

ALTCS members receive comprehensive acute care medical services, including physician visits, prescription drugs, laboratory and other diagnostic services, transportation, and hospitalization. In addition they receive mental health and substance abuse services. Covered long-term care services include nursing facility services, case management, speech, physical, occupational, respiratory and audiology therapies, hospice, adult day health, home delivered meals, home health agency services, homemaker, personal care, respite care, habilitation, attendant care, home modifications and emergency alert systems.

The Program Contractor assigns a case manager to each ALTCS member. The case manager coordinates care with the primary care provider and is responsible for identifying, planning, obtaining and monitoring appropriate services that meet the member's needs.

ALTCS approved HCBS settings for EPD members include the member's home, adult foster care, assisted living homes, assisted living centers, level II and level III behavioral health facilities, hospices, group homes for traumatic brain injured members, and rural substance abuse transitional agencies.

By providing a variety of alternative settings with differing levels of care, ALTCS members are able to delay institutionalization or, in some cases, transfer from nursing home care into an HCBS setting. More important than the savings experienced by using HCBS, this alternative to institutionalization provides members with a degree of independence and control not available in an institutional setting.

CAPITATION

Similar to the acute care program, AHCCCS pays Program Contractors prospectively on a capitated, per member, per month basis. ALTCS capitation rates are blended rates, which include nursing facility costs, HCBS, acute medical care services, behavioral health services, case management services and administrative costs.

Arizona has enjoyed a booming economy for more than two decades, relatively unscathed by the economic downturn that occurred after 9/11. We are second only to Nevada as having the highest economic growth rate in the nation. According to the Arizona Department of Commerce the projected growth rate for 2007 is expected to continue at 3.7%. Employers continue to report difficulty recruiting enough qualified workers to fill jobs. As of April, 2006 the industries with the highest job growth are construction, financial services, professional & business services, education & health services and leisure & hospitality, all industries that simply cannot be deployed overseas. It is time for Arizona's employers to have better access to this valuable group of talented, skilled workers.

Although our Governor, our legislature, employers, service providers and advocates clearly have established cohesive partnerships that demonstrate a commitment to increasing employment opportunities for PWDs and have for many years, challenges remain, especially in the areas we propose to address in this grant application. Health care professionals (both mental and physical) must be brought into this equation, consumers with disabilities must be informed about all of the new options available to them and service providers must be armed with the correct information to pass along to the consumers they serve and the employers with whom they interface.

Our Medicaid Infrastructure Grant in addition to our already existing partnerships and in concert with the WIPA and the PMRO show great promise to further reduce the barriers to economic self-sufficiency for thousands of Arizonans with disabilities.

Use of Grant Funds:

A. Removal of Barriers: One key barrier to employment is the role of health care practitioners in determining fitness for work. These barriers exist due to the following cultural and business practices:

1. Mental and physical health care practitioners² routinely are asked to make a decision about a specific individual's ability or fitness to work. They are asked to make these decisions based upon medical criteria alone without information about the type of job their patient might otherwise be qualified to do or interested in doing. Consequently, they have no choice

² "Practitioners" for purposes of this application include doctors of physical and psychiatric medicine but also includes therapists, psychologists, nurses, physician's assistants and any other health care practitioner charged with determining fitness for work.

but to advise patients not to work at all or to “ease” themselves into the work force as a part time employee without a full exploration of reasonable options for their patient or without a full understanding of how other professionals might be able to help in making those decisions.

2. For those employees who become ill or are injured while working employers will often not allow an employee to return to work without a doctor’s “release”. Doctors are reluctant to take any risk at all in advising their patient to return to work for fear that they will be held liable if further illness or injury occurs. Many of these employees then end up on Long-Term Disability and ultimately on SSDI.
3. In our culture, if a doctor says it, it must be so! Many people may feel fully capable of working and desire to do so, but accept the advice of their health care provider without challenge. As a culture we are trained at an early age to follow the advice of our doctor. We lose control of making our own choices about our lives and or careers by having the expectation that doctors know better than we do about such matters. However, without thorough evaluations and consultations with a team of professionals and without consideration for the type of job a consumer might do, they are channeled onto public benefits (and often poverty) as a result of this cultural norm.
4. In some programs such as Temporary Assistance for Needy Families (TANF), the consumer with a disability is automatically put into a “deferred” status without even being asked about their interest or

possibility of working. The health care practitioner (usually contracted by Medicaid) does little more than arbitrarily fill out a form attesting to inability to work. In some of those cases, this is done in lieu of actually delivering the health care services that might make the patient able to work again.

We propose to use MIG funds for two sub-contracts to educate practitioners about ways to work with their patients on returning to work.

1. We will sub-contract with Med Pro, Inc. to provide education services to mental health practitioners to help them understand what resources are available in the community and the techniques that can be used to help their patients return to work without jeopardizing their health. Dr. Philip Barry (vitae attached) with Med Pro is an accomplished neuropsychologist with many years of experience working with people who have mental health disabilities, head injuries and other psychosocial conditions. It will be necessary for Dr. Barry to find ways to be part of the everyday worklife of mental health practitioners. Dr. Barry will go to them since we know that it is almost impossible to get health care practitioners to come to events for the type of training and awareness-building we propose. We believe it is essential that such a message as this be delivered on their own “turf” by one of their peers. Initially, we will focus on public health contractors (Medicaid and Medicare). AHCCCS will initially facilitate and seek cooperation for the project from the Medical Directors of all our Health Plans that are contracted with us to help “nudge” their practitioners to participate. Dr. Barry will

deliver a 2-4 hour training in the offices of each of these providers about the impact they have on their patient's lives by arbitrarily making decisions about fitness for work when, in fact, they could help their patients much more by looking at other approaches. Dr. Barry will challenge each to choose at least two of their patients to target and will bring in other team members, such as an Employment Network, a Work Incentives Specialist or other partners and specifically show how these techniques can succeed.

2. A separate sub-contract will be awarded to a physical medicine doctor who specializes in occupational medicine. We have not yet identified the specific physician to do this work. However, we have identified a few possible practitioners to fill this need. This contractor will use the same methodologies as Dr. Barry above and in some cases, both doctors will present together, especially at large conferences. However, as we discussed above, we believe it is critical that practitioners who serve people with physical disabilities get this message from one of their peers.
3. Both of these sub-contractors will provide regular reports to the Project Director and be part of the Advisory Committee to be established for this project. The Director and the Advisory Committee will monitor the outcomes and look for trends in systemic changes that may be needed to achieve the goal of better return to work services for individuals with disabilities.

B. Health Systems Change: The data collected from the project component described in A. above will be used to determine any systems changes that may be needed in the Medicaid Program. Some examples might be:

1. Do Medicaid payment rates provide enough funds for health care practitioners to conduct adequate work capability evaluations? Is there another funding source (e.g. JOBS program, VR) that might allow funds to be “blended” to encourage and facilitate better evaluations and treatments for return-to-work activities?
2. Would health care practitioners be more inclined to attend return-to-work training programs if Continuing Education Units were allowed for attendance?
3. Is the addition of other team members (e.g. benefits planners, Employment Networks) helpful or a hindrance for practitioners in their normal course of treatment?
4. Is the Medicaid program adequately compensating or allowing payment for assistive devices, including hearing aids? If the system were to provide payment for devices, can it be cost-justified?

C. Communications/Access Plan:

1. CONSUMER AWARENESS CAMPAIGN: One of the greatest fears consumers have about returning to work is losing health care coverage. To allay this fear, the TWWIA included a Medicare extension of 8 ½ years of continued benefits post-employment. TWWIA also established

the state option to develop a Medicaid Buy-In program and this Infrastructure Grant to assist states in developing that program and promoting employment. Unfortunately, to date there has been only minimal marketing of the Buy-In program and the other provisions of TWWIA.

We propose a consumer awareness and education campaign that will collaborate and coordinate with the new WIPA and PMRO outreach activities. By combining resources with them we can achieve a greater overall outcome. The funding requested in this grant is to develop a campaign and collaterals in conjunction with the PMRO and WIPA designed to keep in front of consumers and allay those fears. Funds allocated in year 1 will be used for the design of the campaign. We plan to actually implement the campaign in Years 2-4.

Arizona was a Phase I state for implementation of the Ticket to Work Program. However, there has been almost no additional marketing to consumers since the tickets were first mailed beginning in February, 2002. We are aware of plans by the WIPA and PMRO to jointly sponsor bi-weekly Work Incentive Seminars (WISE). They plan to use mailings to targeted groups to encourage participation. We plan to dovetail with those activities by using media and public relations activities designed to further promote the TWWIA programs including the Buy-In to achieve two

things: 1) facilitate “can-work” attitudes among consumers and employers; and 2) encourage participation in the WISE. We plan to use successful people with disabilities who are working and are self-supporting in media activities such as paid TV and radio spots as well as public affairs programming and activities. We think it is important to reach people where they are: in front of the TV, driving in their car or riding the bus. This approach, of course, is not our only consumer outreach and education plan. We still plan to use stakeholder partnerships and collaboration in a big way. However, with 60% of our ticket holders being those who are on SSDI, the fact is they are not generally participating in traditional “disability” events or organizations. Many are people who were working and supporting a family until something happened that caused a permanent disability. Many of these individuals do not identify with the traditional “disability community”. They are reachable only through the same outlets as the general public.

By using general media to reach consumers, we not only change their attitudes but that of the general public as well, including families and employers. We believe that the message here needs to be delivered by their peers with a disability – the same approach as we believe is necessary in A. above to effectively change attitudes and practices of health care practitioners. The design of the campaign will be facilitated through a sub-contract with an advertising and/or public relations firm in

conjunction with the project Advisory Committee that will include consumers. We will evaluate how this will fit with the PMRO and WIPA campaigns and consider all of us using the same contractor(s) for continuity of design and coordination. It should be noted that the state VR agency, Employment Networks and the One-Stops will also be part of the Advisory Committee as well so we can include any campaign activities they might be planning.

2. EMPLOYMENT NETWORK COMPREHENSIVE TRAINING: The National Employment Network Association is actively developing comprehensive training for ENs nationally. According to program evaluation reports contracted by SSA and the Ticket to Work Advisory Panel, including an EN Summit held in Washington, D.C. three years ago, most private ENs are traditional VR providers who are accustomed to providing services and being paid for those services as opposed to outcome-based programming and payments. As a result, the Ticket to Work Program has suffered tremendously over the first five years of implementation.

New rules being promulgated by the SSA and expected to be final in October, 2006 are designed to share more of the up-front financial risk and help ENs achieve greater outcomes earlier. Further, they are designed to facilitate a much better partnership between ENs and the state VR

agencies. Arizona was among the first 13 states chosen to begin implementation of the program in 2002. We are proud of the collaboration and cooperative we have achieved among all stakeholders. We had the first consumer job placement under the Ticket to Work Program, received the first payment SSA made to an EN, had the first employee to achieve one year of employment and two years of employment. We developed the first statewide EN Association in the country. However, even with all that success early in the program we have only two ENs left in the state who are actively participating in the Ticket to Work program other than the VR agency.

ENs nationally have been clamoring for comprehensive training on how to successfully operate an EN day-to-day. We plan to sub-contract with NENA to deliver this training to the 27 ENs currently still contracted with SSA and any new ENs that will sign up as a result of PMRO recruiting. We believe it is critical that these ENs have a thorough understanding of all aspects of operating the Ticket Program and providing services to consumers. One challenge with the Medicaid Buy-In nationally is that many of the enrollees are working at minimal levels of employment. ENs are specifically designed to work with beneficiaries to get them off of the cash benefit rolls and into self-supporting employment. Unless we have well-trained, effective ENs who can handle the upcoming demand and help consumers achieve self-sufficiency, the Medicaid Buy-In rolls will

continue to grow and not achieve any savings because consumers will stay on the program instead of joining employer-provided health care programs that are usually available only to employees working full time. The Buy-In is intended to be a “buffer” while consumers achieve and advance in competitive, community-based full-time employment. By doing so we believe they will then not be dependent upon the Buy-In long-term except for those consumers who need Personal Assistance Services.

D. Partnerships: We already have a basic Advisory Committee established to plan and implement this project. Currently it includes AHCCCS, our state VR agency, ABIL Employment Services and Goodwill of Central Arizona (the two most active ENs in the state), Med Pro, Inc. and the Governor’s Council on Developmental Disabilities. We plan to add members to the Committee to include the occupational physician discussed in A. above, the Arizona Chamber of Commerce as a major conduit to employers, a representative from our One Stop delivery system, consumer advocates, a WIPA and PMRO representative, a NENA representative, a public relations/advertising representative and others identified as needed as we implement the project.

E. Monitoring Plan: We have included resources in our proposed budget for data collection and reporting. This will enable us to track data to ensure timely and accurate quarterly reports about our project to CMS in accordance with the provisions of this RFP. In addition, we will track outcome data from the project

components described in A., B., and C. above to ensure that we are meeting the project objectives and taking remedial action where objectives are not being met. Data will also be used to identify potential systems change activities and research needs that may be undertaken as a result of project implementation. We will also coordinate with other stakeholders to attempt to coordinate information on how our project impacts employment of people with disabilities. In particular we want to monitor the relationship between use of the Buy-In and the amount of earnings of enrollees to determine the effectiveness of using the Buy-In to leave the benefit rolls instead of facilitating dependency upon it.

F. Research/Program Development: As mentioned throughout this narrative our goal is to facilitate employment of people with disabilities, but to influence systems and establish partnerships designed to make consumers self-sufficient and self-supporting in every way. For this reason, it is important that we continue to monitor and refine our program to offer comprehensive services and a flexible system (including on-the-job personal assistance) but not continue to add people to the Buy-In Program who are not achieving self-sufficiency. One of our key objectives is to ensure that consumers have the same health care quality and insurance options as the general work force. This is particularly important for people with psychiatric disabilities. It will be critical to develop an effective means of soliciting feedback from consumers and employers on the benefits they derive from the Buy-In program and collect their suggestions on ways to improve

program outcomes. Insurance parity in the work place is a key area we need to monitor and explore.

Products and Timeline: During the first project year we do not anticipate a need for any legislative activity. What follows is a list of goals to be achieved during year 1 and the timeframe we expect to start and complete each:

<u>Goal/Activity</u>	<u>Start</u>	<u>Complete</u>	<u>Resp.</u>
1. Hire a Project Director and other staff	Jan	Jan	AHCCCS
2. Expand Advisory Committee	Jan	Mar	AHCCCS
3. Plan/Design Practitioner Training	Jan	Feb	MedPro
4. Deliver Practitioner Training	Mar	Dec	MedPro
5. Design Ad/PR Campaign	Apr	Dec	Adv Comm
6. Conduct EN Training	Mar	Dec	NENA
7. Identify Data Collection Systems	Mar	Apr	AHCCCS
8. Solicit Consumer/Employer Feedback	Apr	Dec	AHCCCS
9. Evaluate Data for Systems Improvements	Jul	Dec	AHCCCS

Organization and Staffing: Most of the substantive work will be conducted with the advice of the Advisory Committee and through sub-contracts with experts in specific areas of project implementation. AHCCCS’ staffing plan is designed to facilitate the outcomes, collect the data, administer the grant, handle logistics for the Advisory Committee and the sub-contractors and evaluate program effectiveness. These activities will be handled mainly by the Project Director. We will conduct a national search for the

Project Director. We intend to hire a person with a disability who has background in project management and human resources. The Project Director will report to Alan Schafer, ALTCS Manager.³ We have included a preliminary job description in the attachments for the Project Director. We have included a resume for Alan Schafer who will have ultimate responsibility for project outcomes. The Project Director will facilitate the Advisory Committee, direct the data collection and reporting and will manage and monitor the sub-contractors to ensure outcomes are achieved, services are effectively delivered and timelines are met. The current base Advisory Committee will recruit other Committee Members to meet the expansion goal of the Committee.

Subcontractors:

Dr. Phil Barry, Med Pro, Inc.

Dr. Barry will provide the Mental Health Care Practitioner Training. Dr. Barry's resume is included in the attachments.

Occupational Physician – to be determined.

We have not yet identified a physician who specializes in occupational medicine. We have two possible physicians identified. We will identify this subcontractor in January and February and hope to have a contract solidified and work to begin in March.

³ ALTCS is the Arizona Long Term Care System, which is part of AHCCCS. AHCCCS is the applicant, but the project will be managed by ALTCS.

National Employment Network Association (NENA)

NENA will be contracted to deliver comprehensive EN training throughout the grant period. They will provide three instructors to deliver an initial three-day training to the current 27 ENs in Arizona and subsequent 1-day subject-area training bi-monthly. Susan Webb will be the lead trainer and her resume is included in the attachments.

National Consortium for Health Systems Development (NCHSD)

We have included membership in NCHSD in our budget as part of our technical assistance plan. Since we are new to the MIG initiative, we will need the experience and resources embodied in NCHSD. They have already been extremely helpful to us in answering questions about whether our PAS Program meets the program criteria. We have found their website helpful in identifying other states that are doing similar activities to what we are planning so that we can look to them for assistance and collaborate with them going forward.

Advertising/Public Relations Agency – to be determined

We will sub-contract with an advertising and/or public relations organization to provide the technical design and implementation of a consumer education and awareness campaign. The Advisory Committee will be significantly involved in the design and content of the campaign. We intend to coordinate as much as possible with the outreach materials and activities of the PMRO and the WIPA. We might even use the same agency as they do for designing our campaign.

Technical Assistance Plan:

We have included funds in our application for membership in the National Consortium for Health Systems Development (NCHSD). We have already received very valuable information and assistance from NCHSD staff and have used their website to identify other states that are doing work similar to what we plan to do. One of our first orders of business will be to contact the states currently identified and discuss their projects and evaluate how we can be of mutual value to each other. Kansas, Louisiana, Maine, North Carolina, Utah, North Dakota and Vermont are states we have initially identified as potentially helping us design our consumer education campaign and health care practitioner training. By being a member of NCHSD we can keep up to date on what other issues we might want to address in subsequent years. Their website offers another place to post information about our project components that might be useful to other states.

We have evaluated the technical assistance menu on the NCHSD website for additional ideas that might dovetail with our year 1 proposal and what we might want to take on in subsequent years. In particular we anticipate needing help with assessment tools and strategies to collect data from consumers and employers. We do a good job of collecting information on health care utilization, but we are unsure about how to relate that to tracking employment outcomes. We are aware of the difficulties other stakeholders have in this regard, and we do not want to be intrusive on consumers' privacy. Consequently,

it will be helpful to us to have help from CMS and NCHSD on successful strategies other states have used in that regard.