930– IMPLEMENTATION AND FIDELITY MONITORING OF SAMHSA EVIDENCE-BASED PRACTICES

EFFECTIVE DATE: 10/01/24

APPROVAL DATE: 05/02/24

I. PURPOSE

The Policy applies to ACC, ACC-RBHA, ALTCS E/PD, DES DDD (DDD), and Non-Title XIX/XXI Contractors; Fee-For-Service (FFS) Programs including: the American Indian Health Program (AIHP), Tribal ALTCS, TRBHA; and all FFS populations, excluding Federal Emergency Services Program (FESP). (For FESP, refer to AMPM Chapter 1100).

The Policy establishes program requirements, eligibility criteria, and ongoing expectations for providers engaged in the provision of Evidence-Based Practices (EBPs) identified by the Substance Abuse and Mental Health Services Administration (SAMHSA) for individuals with an SMI designation. This policy outlines scoring thresholds to evaluate if services provided are consistent with fidelity standards outlined within each EBP Kit.

FFS providers shall adhere to the policy requirements established throughout this policy addressing provider responsibilities, including ensuring appropriate referrals are made to connect members to the services outlined in this policy.

II. DEFINITIONS

Refer to the AHCCCS Contract and Policy Dictionary for common terms found in this Policy including:

ASSERTIVE COMMUNITY TREATMENT (ACT)	**BEHAVIORAL HEALTH PARAPROFESSIONAL (BHPP)**	**BEHAVIORAL HEALTH PROFESSIONAL (BHP)**
BEHAVIORAL HEALH RESIDENTIAL FACILITY (BHRF)	**HEALTH CARE DECISION MAKER (HCDM)**	**MANAGED CARE ORGANIZATION (MCO)**
MEMBER	**PEER AND RECOVERY SUPPORT SPECIALIST (PRSS)**	**PERMANENT SUPPORTIVE HOUSING (PSH)**
QUALITY-OF-CARE CONCERNS (QOC)	**QUALITY MANAGEMENT (QM)**	**SERIOUS MENTAL ILLNESS (SMI)**

For purposes of this Policy, the following terms are defined as:

CONSUMER OPERATED SERVICES (COS)/PEER-RUN ORGANIZATION (PRO)	Owned, administratively controlled, and operated by peers, and emphasize self-help as an operational approach. 1. Independent: Owned, administratively controlled, and operated by peers that share the lived experiences of the members and populations they serve. 2. Autonomous: Decisions about governance related to fiscal and financial, personnel, policy, contracting, training, program, advocacy, cultural competence and services and operational management are made by the peer-run program. 3. Accountable: Responsibility for decisions rests with the peer-run program. 4. Peer Controlled: The governance board composition is at least 51 percent peers. 5. Peer Workers: Staff, management, and board of directors (governance) are individuals who share the lived experiences of the members and populations they serve.
COORDINATED ENTRY SYSTEM	As defined by Maricopa Association of Governments (MAG). Each Continuum of Care (CoC) receiving CoC Program funding from the Department of Housing and Urban Development (HUD) is required to develop and implement a centralized or coordinated assessment system (also known as "coordinated entry"). Coordinated entry is a process for assessing all people experiencing homelessness in the CoC to identify their vulnerability levels and prioritize persons who are most in need of assistance for available housing and services. The goals of coordinated entry are to increase the efficiency of a local crisis response system and improve fairness and ease of access to services, including housing and mainstream benefits.
DEDICATED PERMANENT SUPPORTIVE HOUSING TEAM	A team that is dedicated to providing permanent supportive housing services following SAMHSA Fidelity for Permanent Supportive Housing (PSH). The team is skilled and trained in the Evidenced-Based Practices (EBP) of PSH, receives ongoing technical assistance from the Contractor, and participates in fidelity monitoring.

HOUSING FIRST	As defined by the National Alliance to End Homelessness, Housing First is a homeless assistance approach that prioritizes providing permanent housing to people experiencing homelessness, thus ending their homelessness, and serving as a platform from which they can pursue personal goals and improve their quality of life. This approach is guided by the belief that people need basic necessities like food and a place to live before attending to anything less critical, such as getting a job, budgeting properly, or attending to substance use issues. Additionally, Housing First is based on the understanding that client choice is valuable in housing selection and supportive service participation, and that exercising that choice is likely to make a client more successful in remaining housed and improving their life.
SUPPORTED EMPLOYMENT (SE)	Supported employment services means services that shall assist individuals with a Serious Mental Illness (SMI) designation in preparing for, identifying, and maintaining integrated, paid, competitive employment. Services may include job coaching, transportation, assistive technology, specialized job training, person-centered service planning, job development, and individually tailored supports.

III. POLICY

The Evidence-Based Practices (EBPs) identified within this policy, include Permanent Supportive Housing (PSH), Assertive Community Treatment (ACT), Supported Employment (SE), and Consumer Operated Services (COS)/PROs, which are intended to support members living with a Serious Mental Illness (SMI) by utilizing these EBPs, and are shown through research to be effective in meeting the needs of members. SAMHSA EBP Kits shall be utilized by contracted and non-contracted providers when delivering these services to individuals with an SMI designation. Services shall be provided in accordance with AMPM Policy 310-B, and all other applicable requirements as outlined in Contract and Policy.

The Contractor and providers are responsible for adhering to the applicable SAMHSA EBP Kit and performing fidelity monitoring as specified in Contract and this Policy. The Contractor and providers are responsible for implementing training and monitoring toward achieving High Fidelity Implementation and scores. The Contractor and providers are responsible for remediation plans in the event a provider is found to score an “Insufficient Fidelity Implementation” as identified in each EBP.

A. PERMANENT SUPPORTIVE HOUSING

The Contractor and provider agencies who offer PSH services shall utilize the SAMHSA PSH Evidence EBP Kit as a framework for developing and implementing all aspects of PSH.
Key components of the PSH EBP Kit include, but are not limited to:

1. Staffing
   The availability and adequacy of the services. The Contractor shall establish criteria for the provider agency to become a dedicated PSH team. The criteria shall require the Dedicated PSH team and their staff to:
   a. Be trained in SAMHSA PSH EBP,
   b. Maintain low staff to member ratios (one dedicated PSH team member per 12-15 members) as described in SAMHSA PSH EBP, and
   c. Receive ongoing training and technical assistance from the Contractor.

2. Operations
   The Dedicated PSH team shall collaborate with the member's health home to supplement supportive services with a primary focus on services related to housing stability and income stability. The Dedicated PSH team shall utilize Housing First principles paired with motivational interviewing and assertive engagement techniques. Dedicated PSH teams shall communicate to the members that participation in PSH services is voluntary. PSH providers shall relay to the member that the member's housing and/or rental assistance support is not contingent upon the member receiving PSH services and that members may access or request PSH services at any time. It is the responsibility of the PSH team to use motivational interviewing techniques and engagement strategies to encourage the members to actively participate in receiving services as designed in their service plan.
   PSH services includes, but is not limited to:
   a. Outreach, engagement, and re-engagement,
   b. Transportation,
   c. Peer support and natural support engagement,
   d. Housing readiness assistance (e.g., assisting the member with obtaining necessary documents such as state identification, birth certificates, income verification),
   e. Coordination and completion of housing application(s),
   f. Coordination of care with housing providers, public housing authorities, coordinated entry systems, and participation in Adult Recovery Team (ART) meetings,
   g. Housing search assistance,
   h. Home visits and supportive services focused on housing stability, this includes assisting the member with understanding the terms of their lease and supporting members with access to decent, safe, and affordable housing,
   i. Assistance with maintaining or increasing income; this includes assisting the member with applying for Social Security benefits, utilizing the SSI/SSDI outreach, Access, and Recovery (SOAR) process, as applicable, attending appointments, and assistance with finding competitive integrated employment, and
   j. A Dedicated PSH team member assigned shall work in partnership with the member to identify the frequency in which face-to-face visits will occur and the location in which they will occur with the member, which will be reflected within the service plan.

3. Eligibility
   The Contractor shall establish criteria that identifies the population of individuals in need of PSH services, which may include members already housed. The criteria shall be approved by AHCCCS prior to implementation. All individuals with an SMI designation who are experiencing housing insecurity are eligible for PSH services. The Contractor shall work with the contracted providers to ensure members identified as having a PSH need are provided information on available services, benefits and upon member agreement, are referred for PSH services. Examples for establishing the criteria include:
   a. The member has an SMI designation,
   b. The member is experiencing housing instability in Arizona as defined in the AHCCCS Housing Program Guidebook,
   c. The member is experiencing chronic homelessness, has been homeless for at least 12 months or on at least four separate occasions in the last three years,
   d. The member has been diagnosed with a chronic health condition,
   e. The member is currently in an institutional setting and high risk for homelessness upon release from that setting,
   f. The member experiences frequent utilization of services such as crisis services, inpatient admissions, and or emergency department visits, and
   g. The member has been identified through the Statewide Housing Administrator or the Coordinated Entry System as a member on an existing housing prioritization waitlist who is likely to be referred for a subsidy within the next 60 days.

   The Contractor shall ensure providers use the ICD-10 Z code, Z59.811, on submitted claims to identify members who are experiencing housing instability and shall also use the Homeless Management Information System (HMIS) Report provided to the Contractor to identify members experiencing unsheltered homelessness.

4. Fidelity Monitoring
   The Contractor shall complete monitoring of fidelity to the EBP with the Dedicated PSH team. Refer to section on Fidelity Monitoring which further specifies expectations related to the ongoing monitoring of EBP implementation. Specific information is provided below as it relates to the implementation of the EBP of PSH.
   a. PSH teams shall participate in AHCCCS-funded, third-party, fidelity monitoring, utilizing the SAMHSA PSH "Evaluating Your Program" Kit. Below are scoring thresholds that will be utilized in the assessment of PSH implementation:
      i. High to Moderate Fidelity Implementation: 21 – 28,
      i. Moderate to Low Fidelity Implementation: 18.5 – 20, and
      ii. Insufficient Fidelity Implementation: 18 and below.

B. ASSERTIVE COMMUNITY TREATMENT

The Contractor and providers who offer ACT services shall utilize the SAMHSA ACT EBP Kit as a framework for developing and implementing all aspects of ACT.

Key components of ACT include, but are not limited to:

1. Staffing
   ACT shall be delivered by a transdisciplinary team of 10 – 12 professional health care workers responsible for coordinating a comprehensive array of services. The ACT team shall maintain 24-hour, daily coverage to support members after hours. The Contractor shall develop and implement an AHCCCS approved SAMHSA Evidence Based Practice (EBP) Fidelity Monitoring Manual (including but not limited to a methodology for selecting providers to review, a desktop manual for utilizing the SAMHSA Toolkits, and a desktop manual standardizing technical assistance for providers based on scoring outcomes of Fidelity Monitoring) to monitor the provision of the SAMHSA EBPs to ensure services provided are consistent with fidelity as specified within the respective SAMHSA Toolkits. At full membership capacity (10:1 member to professional health care worker ratio), a staffed ACT team shall include, at a minimum, the following disciplines with the described responsibilities:
   a. An ACT Leader (also known as a Team Lead) who:
      i. Provides clinical and administrative oversight to team,
      ii. Supervision to frontline ACT team members, and
      iii. Engages in direct support to members of the ACT team, at least 50% of the time.
   b. A psychiatrist or licensed psychiatric mental health nurse practitioner who:
      i. Is an AHCCCS registered provider,
      ii. Attends at least two team meetings per week,
      iii. Delivers clinical services,
      iv. Shares responsibility for monitoring members' clinical status,
      v. Provides clinical leadership, and
      vi. Shares responsibility with ACT Leader for ensuring quality services are provided.
   c. Two registered nurses licensed by the Arizona State Board of Nursing who:
      i. Are in good standing,
      ii. Function as full team members, and
      iii. Conduct home visits, treatment planning, medication administration, and health education.
   d. Two co-occurring disorder specialists (also known as Substance Abuse Specialists) who:
      i. Have at least one year of training or clinical experience in substance use treatment,
      ii. Participate in and receive at least eight hours of continuing education annually related to co-occurring disorders, EBP intervention, and treatment, and
      iii. Receive weekly supervision from a qualified Behavioral Health Professional (BHP).
   e. Two employment and education specialization and/or vocational specialists who:
      i. Have at least one year of experience and/or training providing supported employment, and
      ii. Receives ongoing employment training to maintain competency in providing services, and supervision from the ACT Leader.

f. Housing Specialist who:
   i. Has received training in the SAMHSA EBP of PSH and receives ongoing training to support members as needed,
   ii. Demonstrates a knowledge of community resources, housing options, and screening tools utilized to support members in obtaining and maintaining safe housing, and
   iii. Supports the member in resolving landlord/tenant concerns.
g. Credentialed Peer and Recovery Support Specialist (PRSS) with lived behavioral health experience,
h. Program Assistant who:
   i. Organizes, coordinates, and monitors clinical and operations of the team,
   ii. Manages daily team schedule, and
   iii. Triages and coordinates member and team communication.
i. Other team members such as Family Support Partners, or other disciplines identified as critical to the success of members.

Refer to the SAMHSA ACT EBP Kit for further staffing information.

ACT team staff shall receive the necessary training, support, and technical assistance from the Contractor and provider agency to consistently carry out the duties specified within the SAMHSA EBP Toolkit to ensure fidelity requirements are met. This may include ongoing training from the provider, Contractor, or third-party professional resources specific to their position on the ACT Team.

The ACT team members shall receive clinical supervision from a qualified BHP as required by their profession and/or independent licensing bodies and ADHS licensing requirements.

2. Operations
   a. The ACT team shall function as the member's primary provider of services for the purpose of recovery and resiliency and shall attempt to support members in meeting their needs to live in the community, attempts shall be documented in clinical record. ACT team services include, but are not limited to:
      i. Psychiatric and medication management,
      ii. Behavioral health treatment planning,
      iii. Behavioral health and substance use treatment (including individual and group counseling),
      iv. Hours of Operation
         1) 24-hour, daily coverage that aligns with practices outlined in the SAMHSA ACT EBP Kit.
         2) Crisis support and management with 24-hour that aligns with practices outlined in the SAMHSA ACT EBP Kit, daily coverage, and
         3) Hours of operation and crisis service coverage shall be made available to members on ACT teams.
      v. Coordination of emergency department visits, hospital admissions and discharges,
      vi. Peer support and natural support engagement,
      vii. Housing needs,
      viii. Employment/vocational activities, and
      ix. Case management.

b. The ACT team shall meet face to face with each other at a minimum of four times per week to review the status of each member. Meetings shall include documentation of a daily communication log, staff report(s), and review of services provided/needed for each member receiving ACT.
c. The ACT team members shall be available via in-person, text, e-mail, phone call, or other acceptable forms of Health Insurance Portability and Accountability Act (HIPAA) compliant communication to one another throughout the day to provide consultation and assistance,
d. Services are delivered in vivo within the places and contexts where they are needed (where members live, work, engage in meaningful activities). ACT teams provide individualized, flexible services within the community to support members more effectively,
e. The ACT Team members shall be cross trained in each specialty area to support members' needs as clinically appropriate, and
f. The ACT team shall maintain the frequency of member contact specified in the member's treatment plan, and triage any unexpected events, crisis, or potential crisis situations. ACT Teams shall maintain the average expectation of four in-person visits a week for a total average of 120 minutes face to face with members as outlined in the SAMHSA ACT EBP Kit.

3. Eligibility

Members receiving ACT services typically have needs that have not responded effectively to traditional, less intensive, behavioral health services. ACT is a voluntary service, based on a non-coercive relationship with mutual respect and the understanding that the member is the expert on what recovery and resiliency means in their life.

The member shall meet all the following criteria to be evaluated for ACT team level of care:

a. Diagnosis

Members have at least one of the following as a primary diagnosis:

i. Schizophrenia,
ii. Schizoaffective disorder,
iii. Other psychotic disorders (shall be SMI qualifying),
iv. Major depressive disorder, and/or
v. Bipolar disorder or other affective disorders.

b. Service Needs
Members have at least one of the following service needs:
   i. Discharge from an extended stay of three months or more in an inpatient behavioral health hospital or an extended stay of three months or more in a residential facility in the last 12 months,
   ii. Two or more psychiatric hospitalizations or four or more psychiatric emergency room visits in the last 12 months,
   iii. Two or more interactions with law enforcement related to symptoms of mental illness in the last 12 months,
   iv. Historic, current, or future risk of criminal justice involvement due to symptoms of mental illness,
   v. Recurrent or persistent symptoms of mental illness,
   vi. Current homelessness, concerns for ability to maintain housing, and/or residing in substandard housing, and/or
   vii. A history of traditional office-based interventions which have demonstrated little to no improvement for the member.

c. Members have significant functional impairment as specified in AMPM Policy 320-P associated with at least one of the following daily tasks needed to function independently within the community:
   i. Maintaining basic personal hygiene,
   ii. Meeting basic nutritional needs,
   iii. Meeting personal financial needs and/or obligations (budgeting, paying bills, etc.),
   iv. Engaging in and meeting medical, legal, and housing needs and services,
   v. Recognizing and avoiding common dangers or hazards to oneself or one's possessions,
   vi. Persistent or recurrent inability to perform activities of daily living independently, including but not limited to, adhering to medications as prescribed (behavioral health or physical health medications),
   vii. Consistent inability to become employed, maintain employment, and/or carry out household duties due to symptoms of their behavioral health, and/or
   viii. Inability to maintain a safe, healthy living situation because of their behavioral health condition(s).

d. Members may have one or more of the following:
   i. An inability to participate, remain engaged, and/or respond to traditional outpatient interventions, and/or
   ii. An inability to independently meet and maintain basic survival needs.

4. Intake and Evaluation Process
The ACT team shall develop and implement a standardized intake and evaluation process for members which includes at minimum:
   a. Documentation of a consultation between referring provider and receiving medical provider to assess for appropriate level of care,
   b. Orientation of member to the ACT model and the services available shall occur within seven days of the completed intake. This orientation shall include, but not limited to, in person review of resources available, introduction to all ACT team members, instruction on how to contact the team during regular and afterhours, and
   c. Refer to section on intake and evaluation process, which further outlines expectations.

5. Outreach, Engagement, and Re-Engagement
   a. Inclusion of Natural Supports: The ACT team shall attempt to engage member-identified natural supports in the assessment, treatment planning, and ongoing service delivery to further support ongoing education and support of the member in their wellness journey,
   b. The ACT team shall engage and encourage the member to contribute to each step of treatment and recovery planning,
   c. All discussions, evaluations, and staffing related to the medical necessity of ACT team services and transition to a lower or higher level of care shall be documented in the medical record as specified in AMPM Policy 940,
   d. Documentation of transition to less intensive services shall include a systematic plan to maintain continuity of treatment at appropriate levels of intensity to support the member's continued recovery and have easy access to return to the ACT team if needed, and
   e. Refer to section on Outreach, Engagement, Re-engagement, which further outlines expectations.
6. Level of Care Transition
   a. Transition to Lower Level of Care:
      i. The ACT team shall conduct, at minimum, a monthly review of the needs for ACT,
      ii. The ACT team shall use explicit criteria for the need to transfer to a less intensive service option. Should the ACT team identify the need to transfer the member to a less intensive option, the ACT team shall:
         1) Ensure that the transition is gradual and individualized, with continuity of care,
         2) Develop a transition plan incorporating graduated step down in intensity and overlapping team meetings as needed and/or requested by the member to facilitate the transition of the member to the lower level of care,
         3) Conduct at minimum two in person visits a week with the member during the transition to a lower level of care,
         4) Provide information to the member on how to return to the ACT team, as needed; this shall be documented in the member's medical record, and
         5) Monitor the member's status following transition to a lower level of care based on member need and as requested by, and in consultation with, the member.
   b. Transition to Higher Level of Care
      If the member requires a higher level of care, outside of what is considered an acute need (e.g., inpatient psychiatric care, detox), the ACT team shall work to effectively transition the member to the higher level of care as soon as clinically indicated. The ACT team shall:
      i. Perform a peer-to-peer consultation and coordination with the ordering physician,
      ii. Develop a transition plan,
      iii. Provide coordination of care,
      iv. Provide ongoing staffing to ensure an effective transition to a higher level of care, and
      v. If the member requires a higher level of care and is unable to consent to treatment, the contracted provider will abide by the statutory requirements of AAC Article 9 Chapter 21.

c. If a member resides in a setting in which a duplication of services occurs, a weekly staffing shall occur with supporting documentation to identify that each provider is providing services as specified in the member's treatment plan and/or service plan, and to evaluate the clinical appropriateness of continuing with ACT while engaged in a higher level of care. Documentation of clinical appropriateness shall be submitted by the provider for review and approval by the Contractor. Documentation shall be made available to AHCCCS upon request.

7. Fidelity Monitoring

The Contractor shall complete monitoring of fidelity to the EBP with the ACT provider. Refer to section on Fidelity Monitoring which further specifies expectations related to the ongoing monitoring of EBP implementation. Specific information is provided below as it relates to the implementation of the EBP of ACT. ACT Teams shall participate in AHCCCS-funded, third-party fidelity monitoring, utilizing the SAMHSA ACT Kit for evaluation. Below are scoring thresholds that will be utilized in the assessment of ACT implementation:

a. High Fidelity Implementation: 113 – 140,
b. Moderate Fidelity Implementation: 85 – 112, and
c. Insufficient Fidelity Implementation: 84 and below.

C. SUPPORTED EMPLOYMENT

The Contractor and providers who offer Supported Employment (SE) shall utilize the SAMHSA SE EBP Kit to develop and implement all aspects of SE services.

1. Staffing
   a. Employment specialists shall maintain a caseload of 25 or fewer members (25:1 ratio),
   b. Employment specialists shall provide vocational services as specified in AMPM Policy 310-B and ACOM Policy 447, and
   c. Employment specialists shall carry out all phases of vocational services that include engagement, intake, assessment, job development, job placement, job coaching, and ongoing support.

2. Organization

SE services are implemented with the following components:

a. Integration with treatment team. Employment Specialists shall be part of the member's treatment team, attend regular treatment team meetings, share in decision-making, and maintain frequent contact (e.g., monthly treatment team meetings, weekly case management staffing) with treatment team members,
b. Vocational unit
   i. Employment specialists function as a unit, rather than a group of practitioners, and
   ii. Employment specialists have group supervision, share information with each other, and help each other with cases.
c. Zero Exclusion
   i. Employment specialists shall encourage all members to participate in SE, and
   ii. Employment specialists, in addition to the referring agency, are prohibited from using job readiness, substance use (current or past), criminal justice involvement (current or past), or cognitive function as exclusionary criteria from participating in SE services.

3. Services
   a. Vocational assessment(s) to identify strengths, skills, and interests,
   b. Rapid search for competitive employment,
   c. Individualized job search,
   d. Diversity of jobs development, offer of a variety of employment options in different settings,
   e. Permanence of employment development, a competitive opportunity that is not temporary or time-limited,
   f. Employment transitions, including but not limited to helping members end employment when appropriate, find new employment, and self-advocate for wage increases, job benefits, and/or promotions,
   g. Ongoing support, which is individualized, time-unlimited, and can be used to support a variety of member needs (education, crisis intervention, job coaching, transportation),
   h. Community-based services,
   i. Assertive engagement and outreach (such as phone calls, frequently visited locations in the community, home visits, and as applicable, contacting natural supports), and
   j. Benefits counseling through the utilization of resources such as DB101, independent living centers, or other forms of support.

4. Intake and Evaluation Process
   a. The SE provider shall develop and implement a standardized intake and evaluation process for members which includes at minimum: A current service plan which meets the criteria specified in AMPM Policy 320-O,
   b. Documented assessment of the member's employment goals, strengths, and identified areas for support, and
   c. Refer to section E. Contractor and Provider Practice Requirements, which further outlines expectations.

5. Fidelity Monitoring:
   The Contractor shall complete monitoring of fidelity to the EBP with the Supported Employment provider with completing monitoring of fidelity to the EBP. Refer to section on Fidelity Monitoring, which further specifies expectations related to the ongoing monitoring of EBP implementation. Specific information is provided below as it relates to the implementation of the EBP of SE. Supported Employment providers shall participate in AHCCCS funded, third-party fidelity monitoring, utilizing the SAMHSA SE Kit for evaluation. Below are scoring thresholds that will be utilized in the assessment of SE implementation:
   a. High Fidelity Implementation: 66 - 75,
   b. Moderate Fidelity Implementation: 56 - 65, and
   c. Insufficient Fidelity Implementation: 55 & below.

D. CONSUMER OPERATED SERVICES (COS)/PEER RUN ORGANIZATION

The Contractor and organizations that operate as Consumer Operated Services (COS)/Peer Run Organizations shall utilize the SAMSHA COS Kit as a framework for developing and implementing all aspects of COS/PRO services.

1. Staffing
   The Contractor and organization shall ensure that peers account for the majority (51% or more) of the organization/agency board. The organization staff shall consist primarily of peers who assume primary responsibility for service delivery and administrative functions of the organization.

2. Operations
   The organization, to the best of their ability, shall maintain a referral system to other COS organizations, behavioral health services, and community resources utilized by members. The Contractor shall ensure that the organization maintains formal, written policies and procedures to address grievances and appeals, along with a process by which members needs and preferences are utilized in the direction and implementation of services and supports offered within the organization. COS organizations shall maintain policies and procedures which support a safe, inclusive environment and offer reasonable accommodations to support members in utilization of supports. The Contractor shall ensure the COS organization services are implemented utilizing concepts identified within the SAMHSA COS Kit such as the peer principle, helper's principle, empowerment, choice, recovery, spiritual growth as a framework. The Contractor shall ensure the concepts of peer support, education, and advocacy as outlined within the SAMHSA COS Kit are implemented within the delivery of services to members.

3. Eligibility
   The Contractor shall ensure that members who request support from a COS organization receive timely access to services.

4. Intake and Evaluation Process
   Refer to section on Intake and Evaluation Process, which further outlines expectations.

5. Fidelity Monitoring
   The Contractor shall complete monitoring of fidelity to the EBP with COS Organization with completing monitoring of fidelity to the EBP. Refer to section on Fidelity Monitoring, which further specifies expectations related to the ongoing monitoring of EBP implementation. Specific information is provided below as it relates to the implementation of the EBP of COS. COS providers shall participate in AHCCCS funded, third party fidelity monitoring, utilizing the SAMHSA COS Kit for evaluation. Below are scoring thresholds that will be utilized in the assessment of SE COS implementation:
   a. High Fidelity Implementation: 187-208,
   b. Moderate Fidelity Implementation: 167 - 186, and
   c. Insufficient Fidelity Implementation: 166 & below.

E. CONTRACTOR AND PROVIDER PRACTICE REQUIREMENTS

1. Referrals
   In coordination and notification with the member and clinical team as part of treatment planning, at minimum referrals shall be considered from the following sources:
   a. The member/Health Care Decision Maker (HCDM),
   b. SMI eligibility determination vendor (for newly or pending SMI Eligibility Determinations),
   c. PROs,
   d. Behavioral health or medical providers,
   e. Emergency rooms,
   f. Level 1 inpatient facilities,
   g. Level 2 Behavioral Health Residential Facilities (BHRFS),
   h. Probation/parole,
   i. Health plan,
   j. Projects for Assistance in Transition from Homelessness (PATH),
   k. Tribal referrals, including TRBHA,
   l. IHS/638 Tribal facilities,
   m. Statewide Housing Administrator, and/or
   n. Other referral sources
   o. Coordinated Entry System leads.

2. Intakes and Evaluation Process
   The program or service team shall develop and implement a standardized intake and evaluation process for members which includes at minimum:
   a. Orientation to the program or service team, and supports available; this includes providing an overview of services and what the member can expect, overview of the agency's mission and values, and reviewing relevant policies and procedures with the member,
   b. Documentation of the member/HCDM's agreement to engage in services,
   c. An assessment and treatment plan completed and signed in accordance with AMPM Policy 320-O, or a referral with a copy of the member's service plan, which identifies the service as needed,
   d. All providers are required to comply with AMPM Policy 320-R for assessing and notification of members who meet special assistance criteria, and
   e. Additional specifications as outlined within each EBP identified within this policy.

3. Outreach, Engagement, and Re-Engagement
   The provider shall develop and implement outreach, engagement, and re-engagement processes and policies, as specified in AMPM Policy 1040, to ensure attempts are made to engage/re-engage members in treatment to address needs. The processes and policies shall explicitly indicate the length of time without contact from the member that is required prior to service closure, how many attempts are needed, and what types of attempts (phone, text, home visit, mail) are required prior to termination of services. All attempts shall be documented in the member's medical record.

4. Fidelity Monitoring
   a. The Contractor shall work with providers to establish eligibility criteria for the targeted services described in and based on the information provided within this Policy and in accordance with all other applicable AHCCCS policy. Once the criteria are defined, the Contractor shall submit to AHCCCS for approval prior to the provider initiating services to members. The criteria for each EBP shall be submitted to AHCCCS as specified in Contract,
   b. The Contractor shall develop a collaborative monitoring oversight process with other Managed Care Organizations that are contracted with the provider to reduce provider burden and duplicative efforts,
   c. The Contractor shall ensure that providers receive initial and ongoing training related to the applicable EBP, position specific training, and identified trends based on fidelity reviews. The Contractor and providers shall maintain training attendance records, which shall be made available to AHCCCS upon request,
   d. The Contractor shall ensure the dedicated providers are utilizing the SAMHSA "evaluating your program" on an annual basis for ongoing, internal fidelity monitoring,
   e. The Contractor shall ensure that providers shall participate in AHCCCS funded, third party fidelity monitoring, utilizing the SAMHSA Kit for evaluation. Scoring thresholds are identified within each EBP identified within this policy, and
   f. In the event a provider is found to score "Insufficient Fidelity Implementation" as identified in the applicable "Fidelity Monitoring" Section, the Contractor shall submit the Evidence-Based Practice Remediation Plan as specified in Contract. If the provider fails to comply with the fidelity requirements, AHCCCS may apply administrative action as specified in ACOM Policy 408 and AMPM Policy 920.

5. All EBP program staff shall receive the necessary training, support, and technical assistance from the Contractor and provider agency to consistently carry out the duties specified within the SAMHSA EBP Toolkit to ensure fidelity requirements are met. This may include ongoing training from the provider, Contractor, or third-party professional resources specific to their position and EBP.

For FFS members, Quality-of-Care Concerns (QOC) due to identification of any of the fidelity monitoring deficiencies as specified in this policy, shall be reported to the DFSM Quality Management (QM) portal as outlined in AMPM Policy 830.

For MCO members, Quality of Care Concern (QOC) identified due to any of the fidelity monitoring deficiencies as specified in this policy, shall be reported to the Quality Management Portal as outlined in AMPM Policy 960 and AMPM Policy 961.