66 BEHAVIORAL HEALTH

EFFECTIVE DATE: June 24, 2022

REFERENCES: 42 C.F.R. § 438.102; A.R.S § 8-512.01; A.R.S. § 36-550; A.R.S.§ 36-551; A.R.S. Title 36, Chapter 5, Article 4 and 5; A.A.C. R6-6-807; AMPM 100; AMPM Chapter 200 Behavioral Health Practice Tools; AMPM 650; Behavior Supports Manual; AMPM 960; AdSS Medical Policies 310-B, 320-O, 320-P, 320-R, 320-S, 320-U, 320-V, 320-W, 320-X, 450, 541, 580, 960, 963, 964, 1020, 1040; AdSS Operations Policies 110, 415, 417, 446, 449

PURPOSE

The purpose of this policy is to clarify expected roles and responsibilities of Qualified Vendors (QVs) related to coordinating and supporting the implementation of behavioral health services, as well as to provide additional information regarding the System of Care.

DEFINITIONS

1. “Adult Recovery Team” (ART) means a group of individuals that, following the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a member's assessment, service

planning, and service delivery. At a minimum, the team consists of the member/responsible person, advocates (if assigned), and a qualified behavioral health representative. The team may also include the member's family, physical health, behavioral health or social service providers, other agencies serving the member, professionals representing various areas of expertise related to the member's needs, or other individuals identified by the member.

2. “Child and Family Team” (CFT) means a group of individuals that includes, at a minimum, the child and their family/) Responsible Person., a behavioral health representative, and any individuals important in the child’s life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, temples, synagogues, mosques, or other places of worship/faith, agents from other service systems like the Arizona Department of Child Safety (DCS) or the Division of Developmental Disabilities (DDD). The

size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore, expand and contract as necessary to be successful on behalf of the child.

3. “Serious Mental Illness” (SMI) means a designation as specified in A.R.S. § 36-550 and determined in an individual 18 years of age or older.

4. “Support Coordinator” means a “case manager” as defined in A.R.S. § 36-551.

POLICY

A. QV ROLES AND RESPONSIBILITIES RELATED TO BEHAVIORAL HEALTH SERVICES

While the Division delegates the delivery of behavioral health services to the Administrative Services Subcontracted health plans (AdSS), the Division’s QVs play an integral role in supporting the delivery and coordination of behavioral health services. QV shall complete the

following activities to ensure members have access to coordinated and integrated services.

1. All QVs shall:
   a. Be knowledgeable of and support the System of Care and Guiding Principles outlined in AMPM 100.
   b. Play an integral role by providing input to the Planning Team and behavioral health providers regarding a member’s behavioral health needs.
   c. Implement strategies to address behavioral concerns about the member, assist in developing behavior intervention programs, and coordinate with behavioral health programs to ensure proper review of medication treatment plans.
   d. Communicate with behavioral health providers and the Planning Team as needed to ensure coordination of care. Responsibilities include but are not limited to:
      i. Identify and communicate barriers to accessing behavioral health services.

ii. Communicate the progress, or lack of progress with achieving goals outlined in a member's Behavioral Plan or Functional Behavioral Assessment.

iii. Provide the Planning Team updates regarding changes with behavioral health needs and services.

iv. Share any concerns about behavioral health symptoms or changes with behavioral health needs.

v. Complete Incident Reporting as required. Refer to Division Operations Policy Chapter 6000 for details regarding Incident Reporting requirements.

vi. Respond via email or phone communications with behavioral health providers within 2 business days.

vii. Advise or advocate on behalf of a member. The QV shall comply with the requirements under 42 C.F.R. § 438.102 and the intergovernmental Agreement between the Division and AHCCCS. The Division may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a member who is authorized

to receive services from the provider for the following:

1) The member's health status, medical care, or treatment option including any alternative treatment that may be self-administered.
2) Any information the member needs in order to decide among all relevant treatment options.
3) The risks, benefits, and consequences of treatment of no treatment.
4) The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

e. Ensure staff participation in trainings and implement recommended behavioral strategies from behavioral health professionals, as outlined in a member's planning document.

f. Attend Child and Family Team (CFT) meetings or Adult Recovery Team (ART) meetings.

g. Implement Behavior Plans (BP)/Functional Behavioral Assessments (FBAs) as described in Behavior Supports Manual.

h. Ensure timely and complete behavioral data collection and submission. Refer to Provider Manual Chapter 35 for further details regarding progress reporting requirements.

2. In addition to the above, the following applies to residential QVs:

a. Notify the Division of all hospitalizations within twenty-four hours of admission, including admission to a behavioral health facility.

b. Participate in proactive discharge planning for any hospital or emergency department admissions.

c. Ensure members attend scheduled services, as outlined in a member's Planning Document.

d. Provide environmental and programmatic safeguards and structures that protect the community and treatment for member care as well as other members, neighbors, and the community from those behaviors that endanger the community and treatment of the member, other people, or

property, and/or interfere with the rights of others. The QV shall be responsible for assuring supervision of the member as defined in the Planning Document.

B. ADULT SYSTEM OF CARE - NINE GUIDING PRINCIPLES

The 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 or substance use challenges. The ASOC is organized into a comprehensive network to create opportunities that foster rehabilitation addressing impairment, managing related symptoms, and improving health outcomes by:

1. Building meaningful partnerships with members served.
2. Addressing the member's cultural and linguistic needs, and
3. Assisting the member in identifying and achieving personal and recovery goals.

The following principles were developed to promote recovery in the adult behavioral health system. System development efforts, programs,

service provision, and stakeholder collaboration shall be guided by these Nine Guiding Principles:

1. RESPECT

   Respect is the cornerstone. Meet the individual where they are without judgment, with great patience and compassion.

2. INDIVIDUALS IN RECOVERY CHOOSE SERVICES AND ARE INCLUDED IN PROGRAM DECISIONS AND PROGRAM DEVELOPMENT EFFORTS

   An individual 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. Individuals 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

An individual 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

An individual 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

   An individual 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

   An individual 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. INDIVIDUALS IN RECOVERY DEFINE THEIR OWN SUCCESS

An individual 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. Individuals 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

An individual in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. An individual 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

An individual 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.

C. CHILD SYSTEM OF CARE - 12 GUIDING PRINCIPLES

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, teambased, natural supports, collaboration, community based, culturally competent,

individualized, strengths based, unconditional, and outcome based. In CFT Practice, 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 for each child and family based on their needs and strengths.

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), Division of Developmental Disabilities (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.

Service delivery shall 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 Serious Emotional Disturbance (SED).

ARIZONA VISION

In collaboration with the child and family and others, Arizona will 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 will be 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.

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 individuals 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 Arizona Department of Health Services (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.

D. COVERED BEHAVIORAL HEALTH SERVICES

The Division covers Title XIX/XXI behavioral health services for members eligible for ALTCS regardless of the health plan they choose. The responsibilities of the Division for providing Title XIX/XXI behavioral health services to members are outlined in the Division Medical Policy Manual (DMPM) 310-B, including additional requirements for members that have chosen the DDD Tribal Health Program (THP) as their health plan. The Division is responsible for collaborating with Tribal entities and behavioral health providers to ensure access to

services for THP members. See AdSS Medical Policy 310-B for responsibilities of the Division’s Subcontracted Health Plans providing Title XIX/XXI behavioral health services.

Title XIX/XXI Behavioral Health Services Categories/Subcategories:

1. Treatment Services: Assessment, Evaluation (non-court ordered), Screening, Counseling, Therapy, Psychophysiological Therapy and Biofeedback.
2. Rehabilitation Services: Skills Training and Development, Psychosocial Rehabilitation Living Skills Training, Cognitive Rehabilitation, Health Promotion, Psychoeducational Services, Ongoing support to maintain employment services/Job Coaching, Pre-vocational services.
3. Medical Services: Medication, Laboratory, Radiology, Medical Imaging, Medical Management.
4. Support Services: Case Management, Respite, Home Care Training/Family Support, Self-Help/Peer Services (Peer and Recovery Support), Therapeutic Foster Care for Children, Adult Behavioral Health Therapeutic Home, Unskilled Respite Care,

Behavioral Health Day Programs, Community Psychiatric Supportive Treatment Programs.

5. Behavioral Health Residential Facility Services.
6. Behavior Analysis.
7. Crisis Intervention Services (delivered through the RBHA's): Telephonic Crisis Intervention, Mobile Crisis Team Intervention, Facility Based Crisis Interventions, Emergency and Non-Emergency Medical Transportation.
8. Inpatient Services: Hospital and Behavioral Health Inpatient Facility (BHIF).

E. BEHAVIORAL HEALTH ASSESSMENT AND REFERRAL

DDD ALTCS eligible members have access to covered behavioral health services for mental, emotional, and substance use disorders without the requirement of a referral. A member, responsible person, family member or care provider may make oral, written or electronic requests for behavioral health services at any time. To avoid duplication of referrals, the QV shall communicate with the Support Coordinator prior to making direct referrals. Refer to Division Medical Policy 1620-G for details Division Behavioral Health Referrals.

A referral may be made directly by the member, prospective member, responsible person, Primary Care Physician (PCP), the health plan, or another care provider, hospital, treat and refer provider, jail, court, probation, or parole office, school or other government or community agency as specified in A.R.S. § 8-512.01. Refer to AdSS Medical Policy 580, and AdSS Operations Policy 417, and 449 for information regarding timeline requirements in place to ensure members have timely access to behavioral health services.

F. BEHAVIOR PLANS AND PROGRAM REVIEW COMMITTEE

Refer to the Behavior Supports Manual for details related to the implementation of Behavior Plans and requirements related to Article 9.

THE FOLLOWING INFORMATION APPLIES TO THE AdSS AND THEIR NETWORK OF BEHAVIORAL HEALTH PROVIDERS. THIS DOES NOT APPLY DIRECTLY TO QVS, HOWEVER, INCLUDES INFORMATION THAT MAY BE HELPFUL TO ENSURE COORDINATION OF CARE.

G. DUTY TO WARN

Behavioral health providers have a duty to protect others against a member’s potential danger to self and/or danger to others. When a

behavioral health provider determines, or under applicable professional standards, reasonably should have determined that a member poses a serious danger to self or others, the provider has a duty to take reasonable precautions to prevent harm and protect others against imminent danger of a member harming him/herself or others. Reasonable precautions include:

1. Communicating, when possible, the threat to all identifiable victims.

2. Notifying a law enforcement agency in the vicinity where the member or any potential victim resides.

3. Taking reasonable steps to initiate proceedings for voluntary or involuntary hospitalization, if appropriate and in accordance with AdSS Medical Policy 320-U.

4. Taking any other precautions that a reasonable and prudent provider would take under the circumstances.

Behavioral health providers have immunity from liability when they perform duty to warn under A.R.S. § 36-517.02. Refer to AMPM 960, AdSS 960 or A.R.S. § 36-517.02 for further details.

H. HOUSING CRITERIA FOR INDIVIDUALS DETERMINED TO HAVE AN SMI

The AHCCCS Housing Programs (AHP) consists of the permanent supportive housing and supportive health programs. The majority of AHCCCS available housing funding is reserved for members with a designation of Serious Mental Illness (SMI), although limited housing is provided for some individuals without an SMI designation who are considered to have a General Mental Health and/or Substance Use Disorder (GMHSUD) need. For persons with GMHSUD needs, housing priority is focused on persons identified with increased service utilization including crisis or emergency services and/or services addressing complex chronic physical, developmental, or behavioral conditions. For a limited number of units within the program, eligibility is further based upon receipt of specific behavioral health services such as an Assertive Community Treatment (ACT) Team.

AHP is community-based permanent supportive housing where a member should have a renewable lease, the right of entry and exit (not restricted by program), and can voluntarily select services. Housing subsidies are provided for permanent supportive housing in both scattered site units (Scattered Site Program) as well as for dedicated site-based units (Community Living Program). All subsidized rental units must meet minimum standards of health and safety, as determined by Federal Housing Quality Standards (FQS), and have a reasonable rent based on market standards. Housing subsidies are currently paid to the landlord directly on behalf of the member/household. Members are expected to pay up to 30% of their income toward their rent with the balance subsidized by the program. In addition to housing subsidies, AHP funding also provides for housing related supports and payment such as deposits, move-in assistance, eviction prevention, and damages related to member occupancy. AHP does not include any Behavioral Health Residential Facilities, Group Homes, or other licensed clinical residential settings.

Funds for these purposes are limited based on budget availability. Supportive services are critical to housing stability and the related

benefits of permanent supportive housing. AHCCCS and AHP promote a Housing First model based upon principles of permanent supportive housing provided by the Substance Abuse and Mental Health Service Administration (SAMHSA). Supportive services for members in AHCCCS subsidized housing are determined by their provider and generally provided through Medicaid and other reimbursable services supplied by the managed care health plans and their provider networks. The State allocation for AHP is for approximately 3,000 members throughout Arizona. Arizona's State Legislature allocates Non-Title XIX/XXI General Fund money to AHCCCS annually to provide permanent supportive housing.

I. OUTREACH, ENGAGEMENT AND RE-ENGAGEMENT FOR BEHAVIORAL HEALTH

Outreach includes activities designed to inform members of behavioral health services availability and to engage or refer those members who may need services. Outreach and engagement activities are essential elements of clinical practice. Behavioral health providers must reach out to vulnerable populations, establish an inviting and non-threatening environment, and reestablish contact with members who have become

temporarily disconnected from services. Refer to AdSS Medical Policy 1040 for more details.

J. PARTNERSHIP REQUIREMENTS WITH FAMILIES AND FAMILY-RUN ORGANIZATIONS IN THE CHILDREN AND CHILDREN AND ADULT BEHAVIORAL HEALTH SYSTEM

The Division recognizes the importance of the Parent/Family Support role as a viable component in the delivery of integrated services. Parent/Family Support Services may involve support activities including, but not limited to:

1. Assisting the family to adjust to the individual’s needs.
2. Developing skills to effectively interact, and/or
3. Guide the individual’s:
    a. Understanding of the causes and treatment of behavioral health issues.
    b. Understanding and effective utilization of the system, or planning long term care for the individual and the family.

Refer to AdSS Medical Policy 963

K. PEER SUPPORT/RECOVERY TRAINING, CERTIFICATION, AND CLINICAL SUPERVISION

Individuals with lived experiences of recovery are an integral part of the behavioral health workforce. Peer support services include the provision of assistance to more effectively utilize the service delivery system (e.g. assistance in developing plans of care, identifying needs, accessing supports, partnering with other practitioners, overcoming service barriers); or understanding and coping with the stressors of the member's disability (e.g. support groups, coaching, role modeling, and mentoring). These services shall only be provided by Peer and Recover Support Specialists who have completed training and certification and receive clinical supervision. Refer to ADSS Medical Policy 963 for details.

L. PRE-PETITION SCREENING, COURT ORDERED EVALUATIONS AND TREATMENT

Court-ordered treatment (COT) is the civil commitment process laid out in A.R.S. Title 36, Chapter 5, Article 4 and 5. It states that when there is a belief that, due to a person's mental disorder and their unwillingness to engage with treatment, they are:

1. Danger to self
2. Danger to others

3. Persistently or acutely disabled
4. Gravely disabled

More information about these screenings and court-ordered treatment can be found in the AdSS Medical Policy Manual 320-U.

Members may seek a voluntary evaluation at any screening agency available statewide. During the COE and COT process, members may agree to a voluntary evaluation. A voluntary evaluation occurs after a pre-petition screening is filed but before a COE is filed. It requires the person’s informed consent.

Emergency Situations: When a member is a danger to themselves or others due to their inability or unwillingness to seek voluntary mental health treatment, they may apply for emergency evaluation and admission in person. If the screening agency approves the application, it issues a pick-up order to law enforcement in the region where the member is located, requesting the member be delivered to the screening agency for evaluation.

Non-Emergency Situation: When members are not a danger to themselves or others but could be if their behavioral health issues

remain untreated, a non-emergent application can be filed through any of the following agencies.

M. REQUIREMENTS FOR BEHAVIORAL HEALTH PROVIDERS TO ASSIST INDIVIDUALS

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, as well as verification of U.S. citizenship/lawful presence prior to receiving Non-Title XIX/XXI covered behavioral health services, at the time of intake for behavioral health services. Refer to AMPM 650 for further details.

N. SECLUSION, RESTRAINT, AND EMERGENCY RESPONSE REPORTING REQUIREMENTS

All facilities are required to report seclusions, restraints and emergency responses. This applies to all state licensed behavioral health inpatient facilities, mental health agencies, out-of-state facilities and ADHS

treating members with ACC, DD and ALTCS EPD coverage. Types of restraint and seclusion include:

1. Chemical restraint: Pharmacological restraint that is not standard treatment. It helps manage the member’s behavior or restrict their movement to lower the safety risk to themselves or others.
2. Mechanical restraint: Any device, article, or garment attached or next to a member’s body that restricts the member’s movement and is not easily removed. This lowers the safety risk to themselves or others.
3. Seclusion: Involuntary confinement in a room or an area from which the member cannot leave.

Refer to AdSS Medical Manual Policy 962 for details.

O. SERIOUS MENTAL ILLNESS (SMI) ELIGIBILITY DETERMINATION

Determination of SMI requires both the qualifying SMI diagnosis and functional impairment as a result of the qualifying diagnosis. The licensed psychiatrist, psychologist, or NP of the determining entity (either the authorized AHCCCS designee or a TRBHA authorized to make the final determination) designates must make a final

determination about whether the person meets the SMI status eligibility requirements based on:

1. A face-to-face assessment or a qualified clinician's review of a face-to-face assessment (AMPM Policy 950), and
2. A review of current and historical information, if any, obtained orally or in writing by the assessor from collateral sources, and/or present or previous treating clinicians.
3. A member must have, as a result of a qualifying SMI diagnosis, dysfunction in at least one of the following four areas for most of the past 12 months. Or it must last for most of the past six months with an expected duration of at least six months:
    a. Inability to live in an independent or family setting without supervision.
    b. A risk of serious harm to self or others.
    c. Dysfunction in role performance.
    d. Risk of deterioration.

AHCCCS contracts with a specific determining entity to complete the SMI determinations. The determining entity will send the member a Notice of Decision letter by mail informing them of the final decision regarding their SMI determination. This letter will include information about their rights and how to appeal the decision. For more information, please refer to AdSS 320-P.

P. SMI GRIEVANCE AND APPEAL PROCESS

The SMI grievance process applies only to adults who have been determined to have a serious mental illness (SMI) and to all behavioral health services received by the member.

A grievance may be submitted if:

1. Rights have been violated.
2. Suspected abuse or mistreatment by staff of a provider.
3. Subjected to a dangerous, illegal, or inhuman treatment environment.

SMI grievances must be filed within 12 months of the rights violation occurring. The grievance must be filed with the agency responsible for

delivering the behavioral health services. Grievances concerning physical abuse, sexual abuse or a person's death are investigated by AHCCCS.

Q. SMI Determination Appeal Process

AHCCCS contracts with a Determining Entity to make a determination of SMI upon referral or request. Members seeking a determination of SMI and members who have been determined to have an SMI can appeal the result of the determination.

The determining entity will send a letter by mail to let the member know the final decision on their SMI determination. This letter is called a Notice of Decision. The letter will include information about your rights and how to appeal the decision. If the determining entity finds the member is not eligible for SMI services, the letter will tell why. To file an appeal, members can call the determining entity or submit a written request to appeal the decision within 60 calendar days from the date on the Notice of Decision letter.

Refer to AdSS Operations Policy Manual 446 for additional details regarding the SMI grievance process.

R. SMI Treatment Appeal Process

Persons who have been determined to have a serious mental illness can also appeal parts of their treatment plan, including:

1. A decision regarding fees or waivers.
2. The assessment report, and recommended services in the service plan or individual treatment or discharge plan.
3. The denial, reduction, suspension or termination of any service that is a covered service funded through Non-Title 19/21 funds.
4. Capacity to make decisions, need for guardianship or other protective services, or need for special assistance.
5. A decision is made that the member is no longer eligible for SMI services.

6. A PASRR determination in the context of either a preadmission screening or an annual resident review, which adversely affects the member.

To file an appeal related to any SMI treatment plan/behavioral health services, the member/responsible person must call or send a letter to the agency/health plan that made the denial, discontinuance, suspension, or reduction in services.

The member/responsible person will receive written notice from the responsible agency that your appeal was received within 5 business days of the agency's receipt. An informal conference will be held with the responsible agency within 7 business days of filing the appeal.

The informal conference must happen at a time and place that is convenient for the member/responsible person. The member/responsible person has the right to have a designated representative of their choice assist them at the conference. The member/responsible person and any other participants will be informed of the time and location of the conference in writing at least two

working days before the conference. Individuals may participate in the conference over the telephone.

For an appeal that needs to be expedited, a written notice that the appeal was received will be sent to the member/responsible person within 1 business day of the responsible agency's receipt, and the informal conference must occur within 2 business days of filing the appeal.

If the appeal is resolved to satisfaction at the informal conference, the member/responsible person will receive a written notice that describes the reason for the appeal, the issues involved, the resolution achieved and the date that the resolution will be implemented.

If there is no resolution of the appeal during this informal conference, the next step is a second informal conference with AHCCCS. The member/responsible person may waive the second level informal conference and proceed to a State Fair Hearing, however. If the second level informal conference with AHCCCS is waived, the responsible agency will assist the member/responsible person in filing a request for

State Fair Hearing at the conclusion of the health plan informal conference.

If there is no resolution of the appeal during the second informal conference with AHCCCS, the member/responsible person will be given information that will tell them how to get a State Fair Hearing. The Office of Grievance and Appeals at AHCCCS handles requests for State Fair Hearings upon the conclusion of second level informal conferences.

If an appeal is filed, any services already in place will continue, unless:

1. A qualified clinician decides that reducing or terminating services is best for you, or
2. You agree in writing to reducing or terminating services.

If the appeal is not decided in the member's favor, the responsible agency may require the member/responsible person to pay for the services received during the appeal process. If the member/responsible person still does not understand the Notice of Adverse Benefit Determination letter, they have the right to contact AHCCCS Medical Management at MedicalManagement@azahcccs.gov.

Persons determined to have a serious mental illness cannot appeal a decision to deny, suspend or terminate services that are no longer available due to a reduction in State funding.

Refer to AdSS Operations Manual Policy 944 for additional details regarding SMI appeals processes.

S. OTHER BEHAVIORAL HEALTH GRIEVANCE AND APPEAL PROCESSES

Members or their responsible person may refer to the DDD website or their DDD Health Plan websites for information about how to file grievances or appeals regarding behavioral health services that are not related to SMI determinations or SMI treatment.

T. AHCCCS DUGless PORTAL GUIDE

AHCCCS has developed a plan to help health care providers collect and report demographic and social determinants of health data. This plan reduces the number of data points care providers must report. It involves using: 1. Alternative data sources. AHCCCS has identified

current demographic elements in other AHCCCS data systems and other source agreements. 2. Social Determinants of Health ICD-10 Diagnosis codes. These diagnosis codes reported on claim submissions began April 1, 2018. 3. Demographic Portal. For those social determinant/demographic/outcome elements with no identified alternative data source or Social Determinate diagnosis identifier, AHCCCS created an online portal (DUGless) accessed directly by care providers to collect applicable identified data elements for members. Both the provider organizations that historically provided data for the DUG as well as all care providers who typically provide these types of data will provide the required information through DUGless. For more information refer to the Demographics, Social Determinants and Outcomes page on the azahcccs.gov website.

U. BEHAVIORAL HEALTH BEST PRACTICE TOOLS

AHCCCS developed a set of Behavioral Health Best Practice Tools which have been converted to formal policies in the AMPM Chapter 200. The policies/tools set the expectations for the behavioral health providers. Many of the policies include information relevant to partner agencies,

such as QVs, who participate on the Child and Family Teams (CFTs) or Adult Recovery Teams (ARTs):

1. AMPM 210 Working with the Birth through Five Population.
2. AMPM 211 Psychiatric and Psychotherapeutic Best Practices for Children Birth through Five Years of Age.
3. AMPM 220 Child and Family Team.
4. AMPM 230 Support and Rehabilitation Services for Children, Adolescents, and Young Adults.
5. AMPM 240 Family Involvement in the Children's Behavioral Health System.
6. AMPM 250 Youth Involvement in the Children's Behavioral Health System.
7. AMPM 260 The Unique Behavioral HEalth Services - Needs of Children, Youth, and Families involved with DCS.
8. AMPM 270 Children's Out of Home Services.
9. AMPM 280 Transition to Adulthood.