66 BEHAVIORAL HEALTH

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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, Articles 4 and 5; A.A.C. R6-6-807~~,~~; A.A.C. R9-10-225, R910-316, and R9-21-20;~~4AMPM 100; AMPM Chapter 200 Behavioral Health Practice Tools; AMPM 650; Behavior Supports Manual; AMPM 960; AdSS Medical Policies, Chapters 300 and 900;~~ Division and AdSS Medical Policies 960, 962, 1020, and 1040; AdSS Operations Policy 446; ~~300 310-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 set forth the~~clarify expected~~ role~~s~~ and responsibilities of Qualified Vendors ~~(QVs)~~ related to coordinating and supporting the implementation of behavioral health services, and~~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 or the Division of Developmental Disabilities. 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.

~~2.~~3. "Determining Entity" means an entity designated by AHCCCS and authorized to make Serious Emotional Disturbance and Serious Mental Illness eligibility determinations.

4. "Member" means the same as "Client" as defined in A.R.S. § 36-551

5. "Mental Health Agency" means a regional authority, service provider, inpatient facility, or outpatient treatment center licensed to provide behavioral health observation/stabilization services (Crisis Facility), licensed to perform Seclusion and Restraint as specified in A.A.C. R9-10-225, R9-10-226, R9-10-316 and R9-10-1012.

6. "Planning Document" means a written plan developed through an

assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such services and supports.

7. "Serious Emotional Disturbance" means a designation for individuals from birth up to age 18 who currently or at any time during the past year have had a diagnosable mental or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current version of the Diagnostic and Statistical Manual of Mental Disorders that resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

~~3.~~8. "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.~~9. "Support Coordinator" means a "case manager" as defined in A.R.S. § 36-551.

POLICY

A. QUALIFIED VENDOR ROLE~~S~~ 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 Qualified Vendors~~QVs~~ play an integral role in supporting the delivery and coordination of behavioral health services.

1. Qualified Vendors~~QV~~ shall complete the following activities to ensure members have access to coordinated and integrated behavioral health services: ~~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.
   d. Assist in developing behavior intervention programs.
   e. Coordinate with behavioral health programs to ensure proper review of medication treatment plans.
   f. 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.

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

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

~~Complete Incident Reporting as~~ specified in~~required.~~

~~Refer to Division Operations Policy Chapter 6000 for details regarding Incident Reporting requirements~~.

iii. Respond to~~via~~ email or voice mail~~phone~~ communications received from~~with~~ behavioral health providers within two~~2~~ business days.

~~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)~~1) ~~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.~~

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

Document.

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

i. Implement Behavior Plans/ ~~(BP)/~~Functional Behavioral Assessments ~~(FBAs)~~ as required in A.A.C. Chapter 6, Article 9, and as described in the Division ~~-~~Behavior Supports Manual.

~~Ensure timely collection and submission of 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 activities listed above, the following applies to Qualified VendorsQVs providing Community Residential Servicesresidential QVs:~~

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

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

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

~~Behavioral Supported Group Homes must Pprovide 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~~.

k. Ensure~~The QV shall be responsible for assuring~~ supervision of the member as defined in the Planning Document.

~~k.~~l. Behavioral Supported Group Homes are required to~~must~~ 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 may endanger the community and treatment of the member, other people or property, and/or interfere with the rights of others.

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 their~~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, team based, 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. Behavioral health services use~~utilize~~~~They~~ treatment modalities and programs that are evidence based and supported by Substance Abuse and Mental Health Services Administration (SAMSHA) or other nationally recognized organizations.~~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<u>s</u>'~~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 the child and family's primary language. ~~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 eligible ALTCS 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 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. Refer to~~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, Personal Care, 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, Community Psychiatric Supportive Treatment Programs, Permanent Supportive Housing.

5. Intensive Outpatient and Behavioral Health Day Programs.

~~5.~~6. Behavioral Health Residential Facility Services.

~~6.~~7. Behavior Analysis.

~~7.~~8. 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.~~9. Inpatient Services: Hospital, ~~and~~ Behavioral Health Inpatient Facility (BHIF), and Partial Hospitalization.

E. BEHAVIORAL HEALTH ASSESSMENT AND REFERRAL

1. 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 regarding Division behavioral health referrals.
2. A referral may be made directly by the member, ~~prospective member,~~ responsible person, primary care physician, 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.~~
3. After receiving a referral, behavioral health providers complete a behavioral health assessment. A service plan is developed utilizing the Adult Behavioral Health Service Delivery System –

Nine Guiding Principles, and the Arizona Vision and Twelve Principles for Children's Behavioral Health Service Delivery, as specified in AMPM ~~Policy~~ 100. Service plans encompass a description of all covered services that are deemed medically necessary and based on member voice and choice. Behavioral health assessments and service plans are updated at least once annually, or more often as necessary, based on clinical needs or upon significant life events. Refer to AdSS Medical Policy 320-O~~580~~ for additional ~~more~~ information regarding behavioral health assessments and service planning requirements.

~~3.~~4. Refer to~~, and~~ AdSS Operations Policy 417 and 449 for information regarding timeline requirements in place to ensure members have timely access to behavioral health services.

~~**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.~~

F. DUTY TO WARN AND LIABILITIES OF BEHAVIORAL HEALTH PROVIDERS IN PROVIDING BEHAVIORAL HEALTH SERVICES ~~**DUTY TO WARN**~~

1. Arizona Revised Statutes impose a duty to warn and protect when there is an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such threat. ~~Behavioral health providers have a duty to~~ Under A.R.S. § 36-517.02, ~~to protect others against a member's potential danger to self and/or danger to others. When~~ if a behavioral health provider determines, or under applicable professional standards~~,~~ reasonably should have determined, that a patient~~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 patient~~member~~ harming themselves~~/herself~~ or others.
2. This statute further provides that any duty of a behavioral health provider to take reasonable precautions to prevent harm threatened by a patient is discharged when the behavioral health provider:

~~Reasonable precautions include:~~

a. Communicates,~~Communicating,~~ when possible, the threat to all identifiable victims.

b. Notifies~~Notifying~~ a law enforcement agency in the vicinity where the patient~~member~~ or any potential victim resides.

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

d. Takes~~Taking~~ any other precautions that a reasonable and prudent behavioral health provider would take under the circumstances.

3. The statute also provides immunity from liability when the behavioral health provider discloses confidential communications by or relating to a patient under certain circumstances: The behavioral health provider has no liability resulting from disclosing a confidential communication made by or relating to a patient when a patient has explicitly threatened to cause serious harm to a person or when the behavioral health provider reasonably concludes that a patient is likely to cause harm, and the behavioral health provider discloses a confidential

communication made by or relating to the patient to reduce the risk of harm.

~~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.~~

G. HOUSING CRITERIA FOR INDIVIDUALS DETERMINED TO HAVE A SERIOUS MENTAL ILLNESS~~N SMI~~

1. 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) designation, 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.

2. 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), and in projects where a portion of the units have been set aside to serve AHP members (Project Based Voucher). All subsidized rental units must meet or exceed all federal Housing Quality Standards (HQS) ~~minimum standards~~ of health and safety, as well as any additional State requirements, and have a reasonable rent based on market standard. ~~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 percent ~~%~~ of their income toward their rent with the balance

subsidized by the program.

3. 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. Behavioral Health Residential Facilities, Group Homes, or other licensed clinical residential settings are not eligible for AHP participation.

~~3.~~4. 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~~.

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

1. 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 re-establish contact with members who have become temporarily disconnected from services.
2. Outreach activities include disseminating information to the general public, human services providers, including municipal, county, and state governments, school administrators, first responders, teachers, veterans, and other interested parties regarding the behavioral health services that are available to eligible members.

3. Behavioral health providers engage members in active treatment planning processes by including:
   a. The member and responsible person,
   b. The member's family or significant others if applicable and amenable to the member,
   c. Other agencies or providers as applicable, and
   d. Individuals designated to provide Special Assistance for members determined to have an SMI who are receiving Special Assistance as specified in AdSS Medical Policy 320-R.
4. Behavioral health providers engage incarcerated members with high incidence or prevalence of behavioral health issues or who are underserved as specified in AMPM 1022.
5. Behavioral health providers engage members experiencing homelessness by including the following:
   a. Completion of an AHCCCS approved health related social needs screening tool,
   b. Utilization of the associated Z Codes to the members record, especially those related to housing instability, and
   c. Provide assistance with the completion of housing

applications to address housing stabilization and support ongoing engagement in services.

6. Behavioral health providers re-engage members who have withdrawn from treatment, refused services, or failed to appear for a scheduled service.

~~6.~~7. If a member appears to meet clinical standards as a danger to self or others, or they are persistently and acutely disabled or gravely disabled, the care provider determines whether to attempt to engage the member to seek inpatient care voluntarily. If that is not a viable option, and the clinical standard is met, the care provider may initiate the pre-petition screening or petition for treatment process for court-ordered evaluation and court-ordered treatment. Refer to Division Medical Policy 1040 for additional requirements ~~and details~~ regarding outreach, engagement and re-engagement.

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

The Division recognizes the importance of the peer-to-peer relationship of family members~~member~~ and ~~Parent/~~Family Support

Service role as a viable component in the delivery of integrated services. ~~Parent/~~Family Support Services may involve support activities that includ~~e~~ing, ~~but not limited to~~:

a. **Helping**~~Assisting~~ the family ~~to~~ adjust to the individual's needs,

b. Developing skills to effectively interact~~, and/~~ or guide the individual~~'s~~,

c. Understanding of the causes and treatment of behavioral health challenges~~issues~~,

d. Understanding and effective utilization of the system, and~~or~~

~~d.~~e. Planning for ongoing and future support(s) for the individual and the family. Refer to AdSS Medical Policy 964 for additional information. ~~Understanding and effective utilization of the system, or planning long term care for the individual and the family.~~

~~Refer to AdSS Medical Policy 9643~~

J. 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 are~~shall only be~~ provided by Peer and Recovery Support Specialists who have completed training and certification, and receive clinical supervision. Refer to AdSS Medical Policy 963 for additional information. ~~for details.~~

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

1. Court-ordered evaluation (COE) and court-ordered treatment (COT) is the civil commitment process laid out in A.R.S. Title 36, Chapter 5, Articles 4 and 5. It states that any responsible individual~~ person~~ may submit an application requesting an agency to conduct a Pre-Petition Screening when another individual is alleged to be, as a result of~~there is a belief that, due to a person's~~ a mental disorder, a danger to self, a danger to others, is persistently or acutely disabled, or is gravely disabled. ~~and their unwillingness to engage with treatment, they are~~:

~~1. Danger to self~~

~~2. Danger to others~~

~~3. Persistently or acutely disabled~~

~~4.~~1. ~~Gravely disabled~~

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

2. Members may seek a voluntary evaluation at any screening agency available statewide.

3. During the COE and COT process, an individual~~members~~ may agree to a voluntary evaluation. A voluntary evaluation occurs after a Pre-Petition Screening is filed but before a COE is filed, and~~. It~~ requires the individual's~~person's~~ informed consent.

~~In Arizona, COT is behavioral or mental health treatment that is ordered by a superior (county) court according to the Arizona Revised Statute Title 36 processes.~~

~~4.~~ An individual who is unwilling ~~to~~ or unable to provide consent to receive behavioral health services can be ordered by an Arizona Superior ~~the~~ Court to undergo mental health treatment if, because of a mental disorder, the individual is determined to be a danger to self~~themselves~~, a danger to others, is persistently or acutely disabled, or is gravely disabled.~~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.~~

Refer to AdSS Medical Policy ~~Manual~~ 320-U for additional requirements related to COE and COT.

L. AHCCCS 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 additional information. ~~for further details.~~

M. OUT-OF-STATE PLACEMENT FOR BEHAVIORAL HEALTH TREATMENT

1. When considering ~~inIt may be necessary to consider~~ an out-of-state placement for behavioral health treatment to meet a~~the~~ member's unique circumstances or clinical needs, the following should be taken into consideration:~~.~~

   a. All ~~The decision to place a member in out-of-state placement for behavioral health treatment is examined by the member's health plan and the Division after the CFT or the ART have reviewed all~~ other in-state options have been reviewed, including~~. Other options may include~~ single case agreements with in-state providers or the development of a Service Plan that incorporates a combination of support services and clinical interventions.

   b. The

~~2. The following factors may lead theto a member's CFT or ART to consider the temporary out-of-state placement:~~

~~The~~ member requires specialized programming not currently available in Arizona to effectively treat a specified behavioral health condition.

c. An out-of-state placement's approach to treatment incorporates and supports the unique cultural heritage of the member.

d. A lack of current in-state bed capacity.

e. The geographic proximity of the out-of-state placement supports and facilitates family involvement in the member's treatment.

2. Prior to placing a member in an out-of-state facility for behavioral health treatment the following criteria must be met:~~,~~ ~~the CFT or ART ensures that:~~

a. The member or member's~~'s~~ Responsible Person is in agreement with the out-of-state placement.

b. The out-of-state placement is registered as an AHCCCS provider.

c. There is a plan in place to ensure the member has access to non-emergency medical needs by an AHCCCS registered provider.

d. The out-of-state placement meets the Arizona Department of Education Academic Standards for members up to the age of 21 years.

3. Services provided out-of-state must meet the same requirements as those rendered in-state. Refer to Division Medical Policy 450 for additional requirements for out-of-state placements, ~~for behavioral health,~~ including documentation requirements, Service Plan requirements, and notification to AHCCCS requirements.

~~M.~~N. SECLUSION AND~~,~~ RESTRAINT~~, AND EMERGENCY RESPONSE~~ REPORTING REQUIREMENTS

1. **Seclusion and restraint~~AR~~ shall only be used to the extent permitted by and in compliance with A.A.C. R9-10-225, A.A.C. R9-10-316, and A.A.C. R9-21-204.**

2. All providers~~facilities~~ are required to report seclusions and ~~,~~ restraints~~, and emergency responses~~ in accordance with Division Medical Policy 962. This applies to all state licensed behavioral

health inpatient facilities, mental health agencies, out-of-state facilities, and the Arizona State Hospital ~~, and ADHS~~ providing behavioral health services to ~~treating~~ Division members~~. with ACC, DD and ALTCS EPD coverage. All interventions used during each incident of seclusion or restraint must be documented in a single individual report, including all required components of each type of intervention used to manage the behavior.~~

~~Types of seclusion and restraint include :~~

~~- Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a Member to move their arms, legs, body, or head freely.~~

~~- A drug or medication when it is used as a restriction to manage a Member's behavior or restrict the Member's freedom of movement and is not a standard treatment or dosage for the Member's condition as specified in 42 CFR 482.13 (e)(1)(i)(B). Chemical Restraints shall be interpreted and applied in compliance with the Center for Medicaid Services (CMS) State Operations Manual, Appendix A at A-0160 for Regulations and Interpretive Guidelines for Hospitals.~~

~~A Restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a Member for the purpose of conducting routine physical examinations or tests, or to protect the Member from falling out of bed or to permit the Member to participate in activities without the risk of physical harm. This does not include a physical escort.~~

~~Involuntary solitary confinement of a Member in a room or an area where the Member is prevented from leaving as specified in A.A.C. R9-10-101.~~

~~For member determined to have a Serious Mental Illness, includes:~~

- ~~Restriction of a Member to a room or area through the use of locked doors, or any other device or method which precludes a Member from freely exiting the room or area, or which a Member reasonably believes precludes their unrestricted exit.~~

~~In the case of an inpatient facility, confining a Member to the facility, the grounds of the facility, or a ward of the facility does not constitute Seclusion.~~

i. ~~In the case of a community residence, restricting a Member to the residential site, according to specific provisions of a service plan or court order, does not constitute Seclusion, as specified in A.A.C. R9-21-101(B).~~

3. Seclusion and Restraint Reports involving Division Members are submitted through the AHCCCS QM Portal within five business days of the incident using AMPM Policy 962 Attachment A or the agency's electronic medical record that includes all elements listed on AMPM 962 Attachment A.

4. Seclusion and Restraint Reports are sent to the Division's geographically assigned Independent Oversight Committees (IOC) for review to determine if the use of seclusion or restraint was inappropriate or unlawful, or may be used in a more effective or appropriate fashion.

5. iF the IOC determines that the use of seclusion or restraint was inappropriate or unlawful, the IOC may take whatever action is

necessary in accordance with IOC Regulations and A.A.C. R9-21-204, if applicable.

~~If the AHCCCS OHR or any IOC determines that SAR has been used in violation of any applicable law or rule, the AHCCCS OHR or IOC may take whatever action is appropriate in accordance with their applicable regulation(s) and, if applicable, A.A.C. R9-21-204.~~

~~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.~~

~~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.~~

2. ~~Seclusion: Involuntary confinement in a room or an area from which the member cannot leave.~~

O. SERIOUS EMOTIONAL DISTURBANCE AND **SERIOUS MENTAL ILLNESS ~~(SMI)~~ ELIGIBILITY DETERMINATIONS**

1. The Division shall require all behavioral health providers

to follow a standardized process for the referral, assessment, evaluation, and determination of SED and SMI eligibility as specified in Division Medical Policy 320-P.

~~2.~~ An ~~Determination of~~ SED or SMI determination requires both the qualifying ~~SMI~~ diagnosis and functional impairment as a result of the qualifying diagnosis. The licensed psychiatrist, psychologist, or nurse practitioner~~NP~~ of the determining entity ~~(either the authorized AHCCCS designee or a TRBHA authorized to make the final determination) designates must~~ makes the ~~a~~ final SED or SMI eligibility determination. ~~about whether the person meets the SMI status eligibility requirements based on:~~

~~a. 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. The determining entity will send a Notice of Decision letter by mail informing the member of the final decision regarding their SED or SMI eligibility determination. The letter will include

information about the member's rights and the appeal process. If the Determining Entity finds the member is not eligible for SED or SMI services the letter will explain why.

4. Members seeking a determination of SMI and members who have been determined to have an SMI can appeal the results of the determination.

5. To meet the functional criteria for SED status, as a result of a qualifying diagnosis, requires dysfunction in at least one of the following four domains for most of the past six months or for most of the past three months with an expected continued duration of at least three months:
   a. Seriously disruptive to family or community,
   b. Dysfunction in role performance,
   c. Child and Adolescent Level of Care Utilization System recommended level of care 4, 5, or 6, or
   d. Risk of deterioration.
6. The Division shall not allow the following reasons alone to be sufficient for denial of SED eligibility:
   a. An inability to obtain existing records or information, or

~~b.~~ b. Lack of a face-to-face psychiatric or psychological evaluation.

7. To meet the functional criteria for SMI status, as a result of a qualifying SMI diagnosis, requires dysfunction in at least one of the following four domains for most of the past 12 months or for most of the past six months with an expected continued duration of at least six months:

a. Inability to live in an independent or family setting without supervision,

b. Seriously disruptive to family or community, ~~A risk of harm to self or others.~~

c. Dysfunction in role performance, or

d. Risk of deterioration.

8. The Division shall not allow the following reasons alone to be sufficient for denial of SMI eligibility:

a. An inability to obtain existing records or information, or

b. Lack of a face-to-face psychiatric or psychological evaluation.

9. Refer to Division Medical Policy 320-P for the required presumption of functional impairment for members with co-

occurring substance use when assessing for SED or SMI eligibility.

~~3. 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. The is letter will include information about their rights and how to appeal process the decision. For more nformation., please refer to AdSS 320-P.~~

P. SERIOUS MENTAL ILLNESS~~SMI~~ GRIEVANCE AND APPEAL PROCESS

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

1. A grievance may be submitted if:
   a. Rights have been violated;
   b. Suspected abuse or mistreatment by staff of a provider;
   c. Subjected to dangerous, illegal, or inhuman treatment environment; or
   d. Member death that occurs in a mental health agency or as a result of an action of a person employed by a mental health agency.

~~SMI grievances must be filed within 12 months of the rights violation occurring.~~

2. The grievance must be filed with the agency responsible for delivering the behavioral health services.
3. Grievances concerning physical abuse, sexual abuse, or a member's~~person's~~ death are investigated by AHCCCS. Refer to AdSS Operations Policy 446 for additional requirements regarding SMI grievances and investigations.

~~SMI Determination Appeal Process~~

~~AHCCCS contracts with a determining entity to make a determination of SMI designation 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.~~

Q. SERIOUS MENTAL ILLNESS~~SMI~~ TREATMENT APPEAL PROCESS

~~**Treatment Appeal Process**~~

1. Persons who have been determined to have an SMI ~~serious mental illness~~ can also appeal parts of their treatment plan, including:
   a. A decision regarding fees or waivers.
   b. The assessment report, and recommended services in the service plan or individual treatment or discharge plan.
   c. The denial, reduction, suspension or termination of any service that is a covered service funded through Non-Title XIX/XXI~~19/21~~ funds.
   d. Capacity to make decisions, need for guardianship or other protective services, or need for special assistance.

e. A decision is made that the member is no longer eligible for SMI services.

f. A Pre-Admission Screening and Resident Review~~PASRR~~ determination in the context of either a preadmission screening or an annual resident review~~,~~ which adversely affects the member.

2. 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.

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

b. 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.

c. The responsible agency will inform 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.

3. 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 one~~1~~ business day of the responsible agency's receipt, and the informal conference must occur within two~~2~~ business days of filing the appeal.

4. 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.

5. If there is no resolution of the appeal during this informal conference, the next step is a second informal conference with AHCCCS.

6. The member/responsible person may waive the second level informal conference and proceed to a State Fair Hearing~~,~~ ~~however~~.
7. 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.
8. If there is no resolution of the appeal during the second informal conference with AHCCCS, the member/responsible person will be given information regarding~~that will tell them~~ how to request~~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.
9. If an appeal is filed, any services already in place will continue~~,~~ unless:
    a. A qualified clinician decides that reducing or terminating services is best for the member~~you~~, or
    b. ~~You~~The member/responsible person~~The Responsible Person~~ agree~~s~~ in writing to reduc~~inge~~ or terminate ~~ing~~ services.

9. 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.

10. Individuals~~Persons~~ determined to have an SMI ~~serious mental illness~~ cannot appeal a decision to deny, suspend, reduce, or terminate services that are no longer available due to a reduction in State funding. Refer to AdSS Operations ~~Manual~~ Policy ~~94~~44 for additional information~~details~~ regarding SMI appeals processes.

~~**R. 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 on filingabout how to file grievances or appeals regarding behavioral health services that are not related to SMI determinations or SMI treatment.~~

~~**S.**~~ R. **AHCCCS DUGless PORTAL GUIDE**

1. AHCCCS has developed a plan to help ~~health~~ care providers collect and report demographic and social determinants of health and outcome data, commonly referred to as the Demographic User Guide (DUG). This plan reduces the number of data points care providers must report by~~. It involves~~ using:
   a. Alternative data sources. AHCCCS has identified current demographic elements in other AHCCCS data systems and other source agreements.
   b. Social Determinants of Health ICD-10 Diagnosis codes. ~~These diagnosis codes reported on claim submissions began April 1, 2018.~~
   c. Demographic Portal.
2. For those social determinant/demographic/outcome elements with no identified alternative data source or Social Determinants of Health diagnosis identifier, AHCCCS created an online portal (DUGless) accessed directly by care providers to collect applicable identified data elements for members.
3. All care providers~~Both the provider organizations~~ and provider agencies that typically~~historically~~ provide~~d~~ these types of data ~~for the DUG as well as all care providers who typically provide these~~

~~types of data~~ will provide the required information through DUGless.

4. The requirements, definitions, and values for submission of the identified data elements are specified in the AHCCCS DUGless Portal Guide (DPG). Required information is collected by AHCCCS health care providers. Data and information are recorded and reported to managed care organizations to assist in monitoring and tracking. For more information refer to the Demographics, Social Determinants and Outcomes page on the AHCCCS website~~azahcccs.gov website~~.

S. BEHAVIORAL HEALTH BEST PRACTICE TOOLS

AHCCCS has developed a set of Behavioral Health Best Practice Tools to be used by all behavioral health providers and are located in Division Medical Policies 580 through 587. ~~which have been converted to formal policies in the AMPM Chapter 200.~~ These policies also~~The policies/tools set the expectations for the behavioral health providers. Many of the policies~~ include information relevant to partner agencies, such as Qualified Vendors~~QVs~~, who participate in CFT and ART.~~on the Child and Family Teams (CFTs) or Adult Recovery Teams (ARTs):~~

~~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.~~