SECTION VII: Behavioral Health Services

OVERVIEW

Care1st will cover behavioral health services consistent with the information below. AHCCCS Covered Behavioral Health Services Guide has a complete list of covered services.

AVAILABLE BEHAVIORAL HEALTH SERVICES*

- Behavioral Health Counseling & Therapy (Individual, Group, and Family)
- Behavioral Health Screening, Mental Health Assessment and Specialized Testing
- Rehabilitation Services
  - Skills Training and Development
  - Cognitive Rehabilitation
  - Behavioral Health Prevention/Promotion Education
  - Psycho Educational Services and Ongoing Support to Maintain Employment
- Other Professional (Traditional Healing, Auricular Acupuncture***)
- Medical Services**
  - Medication Services
  - Lab, Radiology and Medical Imaging
  - Medication Management
  - Electro-Convulsive Therapy
- Support Services
  - Case Management
  - Behavior Coaching
  - Personal Care
  - Home Care Training (Family)
  - Self Help/Peer Services
  - Home Care Training to Home Care Client (HCTC)
  - Respite Care****
  - Supportive Housing *
  - Sign Language or Oral Interpretive Services
  - Transportation
- Crisis Intervention Services
- Inpatient Services (Hospital & Behavioral Health Inpatient Facility)
- Residential Services
- Behavioral Health Day Programs (Supervised, Therapeutic, Medical)

*Services may be available through federal block grants
**See the Care1st Drug List for further information on covered medications.
***Services not available with TXIX/XXI funding, but may be provided based upon available grant funding and approved use of general funds.
****No more than 600 hours of respite care per contract year. The 12 months will run from Oct 1 through September 30 of the next year.

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SYSTEM VALUES AND GUIDING PRINCIPLES

All healthcare services must be delivered in accordance with AHCCCS system values and adhere to the following vision and principles:

Children's System of Care

1. Arizona's 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.

2. Arizona's Twelve Principles:
    - 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.
    - 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.
    - Collaboration with others – When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, the child's Child Protective Service and/or Division of Developmental Disabilities 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.
        - 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.
        - Best practices – Competent individuals who are adequately trained and supervised provide behavioral health services. They are delivered in accordance with guidelines adopted by ADHS that incorporate evidence-based "best practice." Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of

a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.

- 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 need.
- Timeliness – Children identified as needing behavioral health services are assessed and served promptly.
- 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.
- 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.
- 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.
- 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.

- 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.

Adult System of Care

1. Provision of Person Centered Care – Services are provided that meets the member where they are without judgment, with great patience, and compassion.
2. Individualized Treatment and Choice - Persons in Mental health and/or Substance recovery choose services and are included in rpogram decisions that are based on their individual and unique treatment needs, Program Development Efforts. A person in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.
3. Focus on Individual as a Whole Person. Every member 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 increased Automony. Members find 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. Every member 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. Treatment decisions are made through a collaborative partnership with the member who is the driving force in their treatment. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expands understanding and empathy, and leads to the creation of optimum protocols and outcomes.
7. Strengths–Based, Flexible, Responsive Services Reflective of an Individual's Cultural Preferences. All members can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life and in daily functioning.
8. Hope Is the Foundation for The Journey Towards Recovery. A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and

unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

GENERAL AND INFORMED CONSENT TO TREATMENT

General Requirements
As per AHCCCS AMPM 320-Q General and Informed Consent, each member has the right to participate in decisions regarding their behavioral health care, including the right to refuse treatment. It is important for members seeking behavioral health services to agree to those services and be made aware of the service options and alternatives available to them as well as specific risks and benefits associated with these services.

Any member, aged 18 years and older, in need of behavioral health services must give voluntary general consent to treatment, demonstrated by the member's or legal guardian's signature on a general consent form, before receiving behavioral health services.

For members under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency (including foster care givers A.R.S. 8.514.05(C)) must give general consent to treatment, demonstrated by the parent, legal guardian, or a lawfully authorized custodial agency representative's signature on a general consent form prior to the delivery of behavioral health services.

Service Refusal
Any member aged 18 years and older or the member's legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency, after being fully informed of the consequences, benefits and risks of treatment, has the right not to consent to receive behavioral health services.

Medication Refusal
Any member aged 18 years and older or the member's legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency has the right to refuse medications unless specifically required by a court order or in an emergency situation.

Emergency
Providers treating members in an emergency are not required to obtain general consent prior to the provision of emergency services. Providers treating members pursuant to court order must obtain consent, as applicable, in accordance with A.R.S. Title 36, Chapter 5.

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Documentation
All evidence of informed consent and general consent to treatment must be documented in the comprehensive clinical record as per AMPM Policy 940 Medical Records and Communication of Clinical Information for:

- General Consent to Treatment
- Psychotropic Medications
- Electroconvulsive Therapy
- Consent for Complementary and Alternative Treatment (CAM)
- Use of Telemedicine
- Application for A Voluntary Evaluation
- Research
- Admission for medical detoxification, an inpatient facility or a residential program (for members determined to have a Serious Mental Illness); and
- Procedures or services with known substantial risks or side effects

General Consent
Administrative functions associated with a behavioral health member's enrollment do not require consent, but before any services are provided, general consent must be obtained. General consent is usually obtained during the intake process and represents a member's, or if under the age of 18, the member's parent, legal guardian or lawfully authorized custodial agency representative's written agreement to participate in and to receive non-specified (general) behavioral health services.

In addition to general and informed consent for treatment, state statute (A.R.S. §15-104) requires written consent from a child's parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted in reference to a school based prevention program.

Informed Consent
Prior to obtaining informed consent, an appropriate behavioral health representative, as identified in R9-21-206.01(c), must present the facts necessary for a member to make an informed decision regarding whether to agree to the specific treatment and/or procedures. Documentation that the required information was given, and that the member agrees or does not agree to the specific treatment, must be included in the comprehensive clinical record, as well as the member/guardian's signature when required.

Required Information
In all cases where informed consent is required, informed consent must include at a minimum:

- Behavioral health 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;

- Information about the member's diagnosis and the proposed treatment, including the intended outcome, nature and all available procedures involved in the proposed treatment;
- The risks, including any side effects, of the proposed treatment, as well as the risks of not proceeding;
- The alternatives to the proposed treatment, particularly alternatives offering less risk or other adverse effects;
- That any consent given may be withheld or withdrawn in writing or orally at any time. When this occurs the provider must document the member's choice in the medical record;
- The potential consequences of revoking the informed consent to treatment; and
- A description of any clinical indications that might require suspension or termination of the proposed treatment.

Documenting Informed Consent

- Members, or if applicable the client's parent, guardian or custodian shall give informed consent for treatment by signing and dating an acknowledgment that he or she has received the information and gives informed consent to the proposed treatment.
- When informed consent is given by a third party, the identity of the third party and the legal capability to provide consent on behalf of the member, must be established. If the informed consent is for psychotropic medication or telemedicine and the member, or if applicable, the member's guardian refuses to sign an acknowledgment and gives verbal informed consent, the medical practitioner shall document in the member's record that the information was given, the client refused to sign an acknowledgment and that the client gives informed consent to use psychotropic medication or telemedicine.

Providing Informed Consent

When providing information that forms the basis of an informed consent decision for the circumstances identified above, the information must be:

- Presented in a manner that is understandable and culturally appropriate to the member, parent, legal guardian or an appropriate court; and
- Presented by a credentialed behavioral health practitioner or a registered nurse. It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which that are not possible or practicable, information may be provided by another credentialed behavioral health practitioner or registered nurse.

Psychotropic Medications, Complementary and Alternative Treatment and Other Services with Substantial Risks or Side Effects

Unless treatments and procedures are court ordered, providers must obtain written informed consent, and if written consent is not obtainable, providers must obtain oral

informed consent. If oral informed consent is obtained instead of written consent from the member, parent or legal guardian, it must be documented in written fashion. Informed consent is required in the following circumstances:

- Prior to the initiation of any psychotropic medication or initiation of Complementary and Alternative Treatment (CAM). The use of AMPM Exhibit 310-V-1, Informed Consent/Assent for Psychotropic Medication Treatment Form is recommended as a tool to review and document informed consent for psychotropic medications.
- Prior to the delivery of behavioral health services through telemedicine
- Prior to the delivery of any other procedure or service with known substantial risks or side effects.

Electroconvulsive Therapy (ECT), Research Activities, Voluntary Evaluation And Procedures Or Services With Known Substantial Risks Or Side Effects

Written informed consent must be obtained from the member, parent or legal guardian, unless treatments and procedures are under court order, in the following circumstances:

- Before the provision of ECT
- Prior to the involvement of the member in research activities
- Prior to the provision of a voluntary evaluation for a member. The use of AMPM Exhibit 320-Q-1, Application for Voluntary Evaluation Application for Voluntary Evaluation is required for members determined to have a Serious Mental Illness and is recommended as a tool to review and document informed consent for voluntary evaluation of all other populations; and
- Prior to the delivery of any other procedure or service with known substantial risks or side effects.

Informed Consent for Telemedicine and Telehealth

Before a health care provider delivers health care via telemedicine or telehealth, verbal or written informed consent from the member or their health care decision maker must be obtained. As per AMPM Policy 320-I Telehealth and Telemedicine, informed consent may be provided by the behavioral health provider involved in the direct provision of services. When providing informed consent it must be communicated in a manner that the member and/or legal guardian can understand and comprehend.

Exceptions to this consent requirement include:

- If the telemedicine interaction does not take place in the physical presence of the member,
- In an emergency situation in which the member or the member's health care decision maker is unable to give informed consent, or
- To the transmission of diagnostic images to a health care provider serving as a consultant or the reporting of diagnostic test results by that consultant.

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Revocation of Informed Consent
If informed consent is revoked, treatment must be promptly discontinued, except in cases in which abrupt discontinuation of treatment may pose an imminent risk to the member. In such cases, treatment may be phased out to avoid any harmful effects.

Special Requirements For Children
In accordance with A.R.S. § 36-2272, except as otherwise provided by law or a court order, no person, corporation, association, organization or state-supported institution, or any individual employed by any of these entities, may procure, solicit to perform, arrange for the performance of or perform mental health screening in a nonclinical setting or mental health treatment on a minor without first obtaining the written or oral consent of a parent or a legal custodian of the minor child. If the parental consent is given through telemedicine, the health professional must verify the parent's identity at the site where the consent is given. This does not apply when an emergency exists that requires a person to perform mental health screening or provide mental health treatment to prevent serious injury to or save the life of a minor child.

Non-emergency Situations
In cases where the parent is unavailable to provide general or informed consent and the child is being supervised by a caregiver who is not the child's legal guardian (e.g., grandparent) and does not have power of attorney, general and informed consent must be obtained from one of the following:

- Lawfully authorized legal guardian;
- Foster parent, group home staff or other person with whom the Department of Economic Security/Department of Child Safety (DES/DCS)
- Government agency authorized by the court.

If someone other than the child's parent intends to provide general and, when applicable, informed consent to treatment, the following documentation must be obtained and filed in the child's comprehensive clinical record:

Individual/Entity	**Documentation**
Legal Guardian	Copy of court order assigning custody
Relatives	Copy of power of attorney document
Other member/agency	Copy of court order assigning custody
DCS out-of-home placements (for children removed from the home by DCS), such as: Foster home, group home, kinship, other member/agency in whose care DCS has placed the child.	Copy of Notice to Provider-Educational and Medical (DCS Form FC-069)

- For any child who has been removed from the home by DCS, the foster parent, group home staff, foster home staff, relative or other member or agency in whose care the child is currently placed may give consent for the following behavioral health services: Evaluation and treatment for emergency conditions that are not life threatening; and
- Routine medical and dental treatment and procedures, including early periodic screening, diagnosis and treatment services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (including behavioral health services and psychotropic medications).

Any minor who has entered into a lawful contract of marriage, whether or not that marriage has been dissolved subsequently emancipated youth or any homeless minor may provide general and, when applicable, informed consent to treatment without parental consent (A.R.S. § 44-132).

Emergency Situations
In emergency situations involving a child in need of immediate hospitalization or medical attention, general and, when applicable, informed consent to treatment is not required.

Any child, 12 years of age or older, who is determined upon diagnosis of a licensed physician, to be under the influence of a dangerous drug or narcotic, not including alcohol, may be considered an emergency situation and can receive behavioral health care as needed for the treatment of the condition without general and, when applicable, informed consent to treatment.

Informed Consent During Involuntary Treatment
At times, involuntary treatment can be necessary to protect safety and meet needs when a member, due to mental disorder, is unwilling or unable to consent to necessary treatment. In this case, a court order may serve as the legal basis to proceed with treatment. However, capacity to give informed consent is situational, not global, as an individual may be willing and able to give informed consent for aspects of treatment even when not able to give general consent. Individuals should be assessed for capacity to give informed consent for specific treatment and such consent obtained if the individual is willing and able, even though the individual remains under court order.

PHARMACY MANAGEMENT

Psychotropic Medication: Prescribing And Monitoring
Psychotropic medication will be prescribed by a licensed psychiatrist psychiatric nurse practitioner, licensed physician assistant, or other physician trained or experienced in the use of psychotropic medication. The prescribing clinician must have seen the member and is familiar with the member's medical history or, in an emergency, is at least familiar with the member's medical history.

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When a member on psychotropic medication receives a yearly physical examination, the results of the examination will be reviewed by the physician prescribing the medication. The physician will note any adverse effects of the continued use of the prescribed psychotropic medication in the member's record.

Whenever a prescription for medication is written or changed, a notation of the medication, dosage, frequency or administration, and the reason why the medication was ordered or changed will be entered in the member's record.

Assessments

Reasonable clinical judgment, supported by available assessment information, must guide the prescription of psychotropic medications. To the extent possible, candidates for psychotropic medications must be assessed prior to prescribing and providing psychotropic medications. Psychotropic medication assessments must be documented in the person's comprehensive clinical record and must be scheduled in a timely manner.

Behavioral health medical professionals (BHMPs) can use assessment information that has already been collected by other sources and are not required to document existing assessment information that is part of the person's comprehensive clinical record.
At a minimum, assessments for psychotropic medications must include:

- An adequately detailed medical and behavioral health history
- A mental status examination
- A diagnosis
- Target Symptoms
- A review of possible medication allergies
- A review of previously and currently prescribed psychotropic medications including any noted side effects and/or potential drug-drug interactions
- All current medications prescribed by the PCP and medical specialists and current over the counter (OTC) medications, including supplements currently being taken for the appropriateness of the combination of the medications;
- For sexually active females of childbearing age, a review of reproductive status (pregnancy)
- For post-partum females, a review of breastfeeding status
- Psychotropic medication monitoring parameters (heart rate, blood pressure, weight, BMI, labs, including serum levels, as indicated)
- A review of the recipient's profile in the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program (CSPMP) database when initiating a controlled substance (i.e. amphetamines, opiates, benzodiazepines, etc.) that will be used on a regular basis or for short term addition of agents when the member is known to be receiving opioid pain medications or another controlled substance from a secondary prescriber.

Annual Assessments
Reassessments must ensure that the provider prescribing psychotropic medication notes in the member's record:

- The reason for the use of each medication and the effectiveness of that medication
- The appropriateness of the current dosages
- An updated medication list that includes all prescribed medications, dose and frequency prescribed by the PCP and medical specialists, OTC medications, and supplements being taken
- Any side effects such as weight gain and/or abnormal involuntary movements if treated with an anti-psychotic medication;

Informed Consent
Informed consent must be obtained from the member and/or legal guardian for each psychotropic medication prescribed. When obtaining informed consent, the BHMP must communicate in a manner that the member and/or legal guardian can understand and comprehend. It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which this is not, possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience. Documentation must be completed on AMPM Policy 310-V, Exhibit 310-V-1, Informed Consent/Assent for Psychotropic Medication Treatment.

The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent. If Informed Consent for Psychotropic Medication Treatment is not used to document informed consent, the essential elements for obtaining informed consent must be documented in the member's individual comprehensive clinical record in an alternative fashion.

For more information regarding informed consent, please see section on General and Informed Consent to Treatment and AHCCCS AMPM Policy 320-Q General and Informed Consent.

Prior Authorization Criteria for Behavioral Health Drugs
Care1st must apply the AHCCCS PA criteria as those specified on the AHCCCS website for medications listed on the AHCCCS Behavioral Health Drug List that require prior authorization prior to dispensing the medication. When a medication on the AHCCCS Behavioral Health Drug List is subject to PA but no PA criteria is specified, Care1st may elect to establish PA criteria based on clinical appropriateness, scientific evidence, and standards of practice that include, but are not limited, to all of the following:

- Food and Drug Administration (FDA) approved indications and limits,
- Published practice guidelines and treatment protocols,

- Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes,
- Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmaco-economic studies, and
- Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-date)

Quantity Limits

- Opioid prescriptions: For adults, limited to not more than a 5-day supply days for initial fill. For minors, except in case of cancer, other chronic disease (see 310-V) or traumatic injury, all fills limited to a 5-day supply or less days. See AHCCCS Policy 310-V for a list of diagnoses that are exempt from these opioid quantity limits for adults and minors.

Psychotropic Medication Monitoring

Psychotropic medications are known to affect health parameters. Depending on the specific psychotropic medication(s) prescribed, these parameters must be monitored according to current national guidelines, taking into account-individualized factors. At a minimum, these must include:

On initiation of any medication and at each BHMP evaluation and monitoring visit:

- Heart Rate
- Blood Pressure
- Weight

On initiation of any medication and at least every six months thereafter, or more frequently as clinically indicated:

- Body Mass Index (BMI)

On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated:

- Fasting glucose
- Lipids
- Complete Blood Count (CBC)
- Liver function
- Lithium level, including with any significant change in dose
- Thyroid function, including within one month of initiation of lithium or a thyroid medication
- Renal function, including within one month of initiation of lithium
- Valproic acid or divalproex level, including with any significant change in dose
- Carbamazepine level, including with any significant change in dose
- Abnormal Involuntary Movements (AIMS), including for members on any antipsychotic medication

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Children are more vulnerable than adults with regard to developing a number of antipsychotic induced side effects. These included higher rates of sedation, extrapyramidal side effects (except for akathisia), withdrawal dyskinesia, prolactin elevation, weight gain and at least some metabolic abnormalities. (Journal of Clinical Psychiatry 72:5 May 2011)

Type of Medication	Monitoring Action
Controlled Substances	Prescribers should check the Arizona Pharmacy Board's Controlled Substance Prescription Monitoring Program (CSPMP) when prescribing a controlled substance (i.e. amphetamines, opiates, benzodiazepines, etc.). Medical decision-making regarding the results should be documented in the medical record. Health Plans may consider members for single pharmacy/provider locks. Send requests for consideration to Care1st Pharmacy Department at 602-778-8387. The Health Plan also does monthly monitoring for poly-pharmacy and poly-prescribers. Please see AMPM 310-FF for the specifics of this program. • Opioid prescriptions: For adults, limited to a 5 day supply or less days for initial fill. For minors, except in case of cancer, other chronic disease (See AMPM 310-V for a list of exempt diagnoses) or traumatic injury, all fills limited to 5 days or less. See AHCCCS Policy 310-V for a list of diagnoses that are exempt from these opioid quantity limits for adults and minors.
Opiate dependence medications	It is not necessary that a behavioral health medical practitioner must always perform a psychiatric assessment on a member who is being referred to an Opiate Maintenance program prior to that referral, as the Opiate Maintenance Program medical practitioner is the treating physician who will make the determination as to the appropriateness of opiate maintenance medications. Methadone and other opiate dependence medications, such as buprenorphine, are provided as per federal and licensure standards. When opiate dependence medications are discontinued, they are tapered in a safe manner in order to minimize the risks of relapse and physiologic jeopardy.

Transition of medications when person loses medication benefit	Providers ensure that members who need to be dis-enrolled or who lose their Care1st medication benefit while receiving psychotropic medications, including methadone, are monitored by an appropriate medical professional who gradually and safely decreases the medication, or continues to prescribe the medication until an alternate provider has assumed responsibility for the member.
Medications during transitions between ACC, RBHAs, agencies or prescribers	It is the responsibility of the member's current prescriber, including the PCP, to ensure that persons transitioning have adequate supplies of medications to last until the appointment with the next prescriber. It is the responsibility of the provider assuming the person's care to ensure that the person is scheduled with an appointment within clinically appropriate time frames such that the person does not run out of medications, does not experience a decline in functioning and in no case longer than 30 days from identification of need.

CRISIS INTERVENTION SERVICES

Crisis intervention services are provided to a member for the purpose of stabilizing or preventing sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior. Crisis intervention services are delivered in a variety of settings, such as hospital emergency departments, face-to-face at a member's home, over the telephone or in the community. These intensive and time limited services may include screening (i.e. triage and arranging for the provision of additional crisis services) assessing, evaluating or counseling to stabilize the situation, medication stabilization and monitoring, observation, and/or follow-up to ensure stabilizations, and/or therapeutic and supportive services to prevent, reduce, or eliminate a crisis situation.

In the event crisis intervention services are needed this is provided through the local county crisis line:

- Maricopa
  1-800-631-1314 or 1-800-327-9254 (TTY)
- Pima and Pinal
  1-866-495-6735 or 1-877-613-2076 (TTY)
- Apache, Coconino, Gila, Mohave, Navajo and Yavapai
  1-877-756-4090 or 1-800-327-9254 (TTY)

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REFERRAL & INTAKE PROCESS

To facilitate a member's access to behavioral health services in a timely manner, Care1st maintains an effective process for the referral for behavioral health services that includes:

- Engaging with the member/Health Care Decision Maker, and designated representative;
- Communicatingthe process for making referrals, including self-referrals, ensuring that the referral process maximizes member and family voice and choice of services providers;
- Keeping Information or documents collected in the referral process confidential and protected in accordance with applicable federal and state statues, regulations, and policies;
- Ensuring the accurate collection of all required information and that members who have difficulty communicating due to a disability, or who require language services, are afforded appropriate accommodations to assist them in fully expressing their needs; and
- Collecting sufficient information about the member to determine the urgency of the situation and subsequently scheduling an assessment within the required timeframes and with an appropriate provider.

PCP Behavioral Health Screening and Referral

- PCPs are to screen adults for depression, anxiety, substance use/misuse, and suicide risk on an annual basis or whenever the member evidences symptoms
- PCPs are to use standardized screening tools (e.g. ACES, PHQ-2, PHQ-9, CAGE, GAD-7, C-SSRS)
- Additional resources on screening/tool kits can be found on the Care1st website.
- The medical record will reflect screening results and timely referral to a behavioral health provider if needed. A PCP must provide three culturally and linguistically appropriate behavioral health provider referrals.
- In addition to treating physical health conditions, a PCP may treat behavioral health conditions within their scope of practice.
- If the PCP practice uses an integrated services healthcare delivery model, with onsite behavioral health professionals, an in-house referral and intake and assessment session is expected to occur within 7 days for routine situations, and immediately for urgent situations. Based upon the behavioral health assessment, the behavioral health professional will determine if an individual's behavioral health needs can be addressed within the integrated care provider, or if the individual requires more extensive or specialized services beyond the scope of the integrated care provider practice (e.g. longer term psychotherapy, neuropsychological testing).
- If the PCP does not have onsite behavioral health professionals, or if the integrated behavioral health provider's assessment determines that the member requires specialized service beyond the scope of the services provided at the

integrated care practice, then the PCP is expected to provide at least three culturally and linguistically appropriate behavioral health provider referrals, connect the member with the member's chosen behavioral health provider, and track the member's subsequent appointment with that provider.

- For PCPs prescribing medications to treat Substance Use Disorders (SUDs), the PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the Medication Assisted Treatment (MAT) model and coordinate care with the behavioral health provider.

PCP Referral to Behavioral Health Services

A PCP is able to refer a member to behavioral health services in a variety of ways. These include:

- Referring to an Outpatient Clinic Provider (PT 77) for specific services (i.e. peer support, counseling, etc.) as an intake/assessment and treatment plan must be completed indicating the service(s) to be provided are medically necessary.
- Contacting the provider service line at 602.778.1800 or 1.866.560.4042.
- Referring to the provider directory: www.care1staz.com>Providers>Our Network
- Contacting the Care Coordination line Monday-Friday 8 a.m.-5 p.m. at 602.778.8301
- Submitting a referral to Care Management by using the Care1st Care Management Referral Form, which can be found at https://care1staz.com/az/providers/frequentlyusedforms.asp
- Establishing a collaborative relationship with neighboring contracted behavioral health providers

Member Self-Referral to Behavioral Health Services

A member may self-refer for behavioral health services. An intake/assessment and treatment plan must be completed indicating the service(s) to be provided are medically necessary. A member may obtain information regarding contracted behavioral health providers by contacting the provider service line at 602.778.1800 or 1.866.560.4042 or going to the Care1st website at www.care1staz.com.

PCP/Member Self-Referral to Specialty Providers

A PCP/member may refer directly to a specialty provider for behavioral health services. Examples of specialty providers include, but are not limited to, the following: Community Service Agencies (CSAs). Meet Me Where I Am (MMWIA) Providers, or Employment Network Providers (i.e. Wedco. Beacon Group, Focus Employment Services).

An intake/assessment and treatment plan must be completed indicating the service(s) to be provided are medically necessary. Specialty providers may engage in assessment and service/treatment planning activities to support timely access to medically necessary behavioral health services. Specialty providers will provide documentation to the Behavioral Health Home for inclusion in the comprehensive Behavioral Health Home clinical record.

Referral To A Provider For A Second Opinion

Title XIX/XXI health care members are entitled to a second opinion. Upon a Title XIX/XI eligible healthcare member's request or at the request of the treating physician, Care1st must provide for a second opinion from a healthcare professional within the network, or arrange for the healthcare member to obtain one outside the network when an in-network provider is not available, at no cost to the member.

Accepting Referrals

Providers are required to accept referrals for behavioral health services 24 hours a day, 7 days a week. The following information will be collected from referral sources:

- Date and time of referral
- Information about the referral source including name, telephone number, fax number, affiliated agency and relationship to the member being referred
- Name of the member being referred, address, telephone number, gender, age, date of birth and, when applicable, name and telephone number of parent or legal guardian
- Whether or not the member, parent or legal guardian is aware of the referral
- Include a summary of any identified special needs for assistance due to impaired mobility, visual/hearing impairments or development or cognitive impairment
- Accommodations due to cultural uniqueness and/or the need for interpreter services
- Information regarding payment source (i.e. AHCCCS, private insurance, Medicare or self-pay) including the name of the AHCCCS health plan or insurance company
- Name, telephone number and fax number of AHCCCS primary care provider (PCP) or other PCPC as applicable
- Reason for referral including identification of any potential risk factors such as recent hospitalization, evidence of suicidal or homicidal thoughts, pregnancy, and current supply of prescribed psychotropic medications; and
- The names and telephone numbers of individuals the member, parent or guardian may wish to invite to the initial appointment with the referred member.

While the information listed above will facilitate evaluating the urgency and type of practitioner the person may need to see, timely triage and processing of referrals should not be delayed because of missing or incomplete information. When psychotropic medications are a part of an enrolled member's treatment or has been identified as a need by the referral source, the behavioral health providers must respond as outlined in AHCCCS ACOM Policy 417 Appointment Availability, Monitoring and Reporting.

Member's and referrals sources may contact Care1st Customer Service line at 602.778.1800 or 1.866.560.4042 for additional assistance.

SECTION VII: Behavioral Health Services

RESPONDING TO REFERRALS

Documenting and Tracking Referrals

Care1st or subcontracted providers will document and track all referrals for behavioral health services including, at a minimum, the following information:

- Member's name and, if available, AHCCCS information
- Name and affiliation of referral source
- Date of birth
- Type of referral (immediate, urgent, routine)
- Date and time the referral was received
- If applicable, date and location of first available appointment and, if different, date and location of actual scheduled appointment
- Final disposition of the referral.

Follow-Up for No Shows

When a request for behavioral health services is initiated but the member does not appear for the initial appointment, the provider must attempt to contact the member and implement engagement activities.

Final Dispositions to Stakeholder Referral Sources

Within 30 days of receiving the initial intake evaluation, or if the member declines behavioral health services, the behavioral health provider must notify the following applicable referral sources the final disposition:

- AHCCCS health plans
- AHCCCS PCPs
- Department of Child Safety and adoption subsidy
- Arizona Department of Economic Security/Division of Developmental Disabilities
- Arizona Department of Corrections
- Arizona Department of Juvenile Corrections
- Administrative Offices of the Court
- Arizona Department of Economic Security/Rehabilitation Services Administration
- Arizona Department of Education and affiliated school districts

The final disposition must include:

- Date the member was seen for the initial assessment and
- Name and contact information of the provider who will assume primary responsibility for the behavioral health care, or
- If no services were provided, the reason why.

The member's authorization to release information will be obtained prior to communicating the final disposition to the referral sources referenced above as per AMPM Policy 550-Member Records and Confidentiality.

SECTION VII: Behavioral Health Services

Eligibility Screening

Behavioral health providers are required to assist members with applying of 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 receive Non-Title XIX/XXI covered behavioral health services, at the time of intake for behavioral health services.

The individual conducting the intake interview must request the supporting documentation listed below and explain to the applicant supporting documentation will only be used for the purpose of assisting in applying for Title XIX/XXI benefits through AHCCCS:

- Verification of gross family income for the last month and current month (e.g., pay check stubs, social security award letter, retirement pension letter)
- For those who have other health insurance, bring the corresponding health insurance card (e.g., Medicare card)
- For all applicants, documentation to prove United States citizenship or immigration status and identity in accordance with AHCCCS Eligibility Policy and Procedure Manual.
- For those who pay for dependent care (e.g., adult or child daycare), proof of the amount paid for the dependent care

Verification of out-of-pocket medical expenses

Eligibility status is essential for identification of the types of behavioral health services a member may be able to access.

A member who is not eligible for Title XIX/XXI covered services may still be eligible for Non-Title XIX/XXI services including services through the Substance Abuse Block Grant (SABG), the Mental Health Block Grant (MHBG), or the Projects for Assistance in Transition from Homelessness (PATH) Program. See AMPM Policy 320-T regarding non-discretionary federal grants and the delivery of behavioral health services. An individual may also be covered under another health insurance plan, including Medicare.

Intake-Behavioral Health

During the intake, the behavioral health provider will collect, review and disseminate certain information to members seeking behavioral health services. Examples can include:

- The collection of contact information, insurance information, the reason why the member is seeking services and information on any accommodations the member may require to effectively participate in treatment services (i.e., need for oral interpretation or sign language services, consent forms in large font, etc.).

- The collection of required demographic information and completion of client demographic information sheet, including the behavioral health member's primary/preferred language;
- The completion of any applicable authorizations for the release of information to other parties;
- The review and completion of a general consent to treatment;
- The collection of financial information, including the identification of third party payors and information necessary to screen and apply for Title XIX/XXI eligibility;
- The review and dissemination of Care1st's Notice of Privacy Practices (NPP) and the AHCCCS HIPAA Notice of Privacy Practices (NPP) in compliance with 45 CFR 164.520 (c)(1)(B); and
- The review of the rights and responsibilities as a member of behavioral health services, including an explanation of the grievance and appeal process.

Behavioral health providers conducting intake interviews will approach the member/ the member's Health Care Decision Maker, and designated representative in a strength-based manner and possess a clear understanding of the information that needs to be collected. Behavioral Health Providers will be trained in accordance with ACOM Policy 407.

Behavioral health providers will contact the member, and where applicable, designated representative and initiate outreach and engagement activities if the member does not appear for the intake appointment.

Referral And Intake Guidelines

It may be necessary for a Care1st member to be referred to another provider for medically necessary services

Referrals must meet the following conditions:

- The referral must be requested by a participating provider
- The service must be in accordance with the requirements of the member's benefit plan (covered benefit) and treatment needs.
- The member must be enrolled with Care1st on the date of service (s) and eligible to receive the service.
- The behavioral health services must be included on the member's service plan or interim service plan.

If out of network services are not prior authorized, the referring and servicing providers may be responsible for the cost of the service. The member may not be billed if the provider fails to follow Care1st's policies. Both referring and receiving providers must comply with Care1st's policies, documents, and requirements that govern referrals (paper or electronic) including prior authorization. Failure to comply may result in delay in care for the member, a delay or denial of reimbursement or costs associated with the referral being changed to the referring provider.

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Referrals are a means of communication between two providers servicing the same member. Although Care1st encourages the use of its referral form, it is recognized that some providers use telephone calls and other types of communication to coordinate the member's medical care. This is acceptable to Care1st as long as the communication between providers is documented and maintained in the member's medical records.

Referring Provider's Responsibilities

- Confirm that the required service is covered under the member's benefit plan prior to referring the member.
- Confirm that the receiving provider is contracted with Care1st
- Obtain prior authorization for services that require prior authorization or are performed by a non-participating provider.
- For behavioral health services, the services need to be documented on the member's individual service plan.

Receiving Provider's Responsibilities

Providers may render services to members for services that do not require prior authorization or single case agreements when the provider has received a completed referral (or has documented the referral in the member's medical record). The provider rendering services based on the referral is responsible to:

- Schedule and deliver the medically necessary services in compliance with Care1st's requirements and standards related to appointment availability
- Verify the member's enrollment and eligibility for the date of service. If the member is not enrolled with Care1st on the date of service, Care1st will not render payment regardless of referral or prior authorization status.
- Verify that the service is covered under the member's benefit plan.
- Verify that the prior authorization has been obtained, if applicable, and includes the prior authorization number on the claim when submitted for payment.
- Inform the referring provider of the consultation or service by sending a report and applicable medical records to allow the referring provider to continue the member's care.

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OUTREACH, ENGAGEMENT, REENGAGEMENT AND CLOSURE

The behavioral health system must provide outreach activities to inform the public of the benefits and availability of behavioral health services and how to access them. Care1st will disseminate information to the general public, other human service providers, school administrators and teachers and other interested parties regarding the behavioral health services that are available to eligible members. Outreach activities conducted by Care1st include, but are not limited to:

- Participation in local health fairs or health promotion activities;
- Involvement with local schools;
- Involvement with Outreach Activities for military veterans, such as Arizona Veterans Stand Down Coalition events,
- Development of Outreach program and activities for first responders (i.e. policy, fire, EMT),
- Development of Outreach programs tomembers experiencing homelessness;
- Development of outreach programs to members who are at risk, are identified as a group with high incidence or prevalence of behavioral health issues or are underserved;
- Publication and distribution of informational materials;
- Liaison activities with local and county jails, county detention facilities, and local and county DCS offices and programs;
- Regular interaction with agencies that have contact with pregnant women/teenagers who have a substance use disorder;
- Development and implementation of outreach programs that identify members with co-morbid medical and behavioral health disorders and those who have been determined to have a Serious Mental Illness (SMI) within Care1st geographic service area, including members who reside in jails, homeless shelters, county detention facilities or other settings;
- Provision of information to behavioral health advocacy organizations, and
- Development and coordination of outreach programs to Native American tribes in Arizona to provide services for tribal members.

Engagement

Behavioral Health Providers will actively engage the following in the treatment planning process by including the following:

- The member and/or member’s legal guardian;
- The member's family / significant others, if applicable and amenable to the member;
- Other agencies/providers as applicable; and,

- For members with a Serious Mental Illness who are receiving Special Assistance the person (guardian, family member, advocate or other) designated to provide Special Assistance.

Re-Engagement
Re-engagement efforts will be made for members who have withdrawn from participation in the treatment process prior to the successful completion of treatment, refused services or failed to appear for a scheduled service based on a clinical assessment of need. All attempts to re-engage members who have withdrawn from treatment, refused services or failed to appear for a scheduled service must be documented in the comprehensive clinical record. The behavioral health provider must attempt to re-engage the member by:

- Communicating in the member's preferred language;
- Contacting the member or the member's legal guardian by telephone, at times when the member may reasonably be expected to be available (e.g., after work or school);
- Whenever possible, contacting the member or the member's legal guardian face-to-face, if telephone contact is insufficient to locate the member or determine acuity and risk; and
- Sending a letter to the current or most recent address requesting contact, if all attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues. The provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record.

If the above activities are unsuccessful the Behavioral health provider will make further attempts to re-engage the following populations: children, pregnant women/teenagers with substance use disorder, and any member determined to be at risk of relapse, decompensation, deterioration or a potential harm to self or others. Further attempts include at a minimum: contacting the member/guardian/designated representative face-to-face, and contacting natural supports for whom the member has given permission to the provider to contact. All attempts to re-engage these member must be clearly documented in the comprehensive clinical record.

If face-to-face contact with the member is successful and the member appears to meet clinical standards as a danger to self, danger to others, persistently and acutely disabled or gravely disabled the provider must determine whether it is appropriate, and make attempts as appropriate, to engage the member to seek inpatient care voluntarily. If this is not a viable option for the member and the clinical standard is met, initiate the pre-petition screening or petition for treatment process.

Follow-Up After Significant and/or Critical Events
Providers are to document in the clinical record any follow-up activities that are conducted to maintain engagement within the following timeframes:

- Discharged from inpatient services in accordance with the discharge plan and within 7 daysof the members' release to ensure member stabilization, medication adherence, and to avoid re-hospitalization;
- Involved in a behavioral health crisis within timeframes based upon the person's clinical needs, but no later than 7 days;
- Refusing prescribed psychotropic medications within timeframes based upon the person's clinical needs and individual history; and
- Changes in the level of care

Ending an Episode of Care For Member's in Behavioral Health System
Under certain circumstances, it may be appropriate or necessary to disenroll a member or end an episode of care from services after re-engagement efforts have been expended. Ending the episode of care can occur due to clinical or administrative factors involving the enrolled person. The episode of care can be ended for both Non-Title XIX and Title XIX individuals, but Title XIX eligible member no longer in an episode of care for behavioral health services remain enrolled with AHCCCS. When a member is disenrolled or has an episode of care ended, notice and appeal requirements may apply.

Clinical Factors
Treatment Completed:
A member's episode of care must end upon completion of treatment. A Non-Title XIX person would also be dis-enrolled at treatment completion. Prior to ending the episode of care or dis-enrolling a person following the completion of treatment, the behavioral health provider and the member or the member's legal guardian must mutually agree that behavioral health services are no longer needed.

Further Treatment Declined:
A member's episode of care must be ended if the member or the member's legal guardian decides to refuse ongoing behavioral health services. A Non-Title XIX person would also be dis-enrolled from services.

Prior to ending the episode of care or dis-enrolling a member for declining further treatment, the behavioral health provider must ensure the following:

- All applicable and required re-engagement activities have been conducted and clearly documented in the member's comprehensive clinical record; and
- The member does not meet clinical standards for initiating the pre-petition screening or petition or petition or petition for treatment process

Lack of Contact:

- A member's episode of care may be ended if Care1st or behavioral health provider is unable to locate or make contact with the person after ensuring that all applicable and required re-engagement activities have been conducted. A Non-Title XIX individual would also be dis-enrolled from services.

Administrative Factors:

Eligibility/Entitlement Information Changes Including:

- Loss of Title XIX/XXI eligibility, if other funding is not available to continue services; and
- member s who become or are enrolled as elderly or physically disabled (EPD) under the Arizona Long Term Care System (ALTCS) must be dis-enrolled after ensuring appropriate coordination and continuity of care with the ALTCS program contractor. (Not applicable for developmentally delayed ALTCS members ALTCS/DD whose behavioral health treatment is provided through the T/RBHA system.)

Behavioral health providers may dis-enroll Non-Title XIX/XXI eligible persons for non-payment of assessed co-payments, under the following conditions:

- The person is not eligible as a person determined to have a Serious Mental Illness (SMI)
- Attempts at reasonable options to resolve the situation, (e.g., informal discussions) do not result in resolution. All efforts to resolve the issue must be documented in the person's comprehensive clinical record

Out-of-State Relocations:

- A member's episode of care must be ended for a person who relocates out-of-state after appropriate transition of care. A Non-Title XIX individual would also be disenrolled. This does not apply to member s placed out-of-state for purposes of providing behavioral health treatment.

Inter-T/RBHA Transfers:

- A member who relocates to another ACC or T/RBHA and requires ongoing behavioral health services must be closed from one ACC or T/RBHA and transferred to the new ACC or T/RBHA. Services must be transitioned.

Arizona Department of Corrections Confinements:

- A member age 18 or older must be disenrolled upon acknowledgement that the member has been placed in the long-term control and custody of a correctional facility.

Children Held At County Detention Facilities

- Children who become incarcerated should not automatically have their Episode of Care closed.

Inmates of public institutions:

- Members who become incarcerated should not automatically have their Episode of Care closed.

Deceased Persons:

- A member's episode of care must be ended following acknowledgement that the person is deceased, effective on the date of the death. The Non-Title XIX member would be disenrolled from the system.

Crisis Episodes:

- The behavioral health provider conducts all applicable and required re-engagement activities and such attempts are unsuccessful; or the behavioral health provider and the member or the member's legal guardian mutually agrees that ongoing behavioral health services are not needed; a Non-Title XIX member would be dis-enrolled from the system.
- For members who are enrolled as a result of a crisis episode, the member 's episode of care would end if the following conditions have been met:
- The behavioral health provider conducts all applicable and required re-engagement activities and such attempts are unsuccessful; or
- The behavioral health provider and the member or the member's legal guardian mutually agrees that ongoing behavioral health services are not needed; a Non-Title XIX member would be dis- enrolled from the system.

One-Time Consultations: For members who are in the system for the purpose of a one-time consultation, the member's episode of care may be ended if the behavioral health provider and the member or the member's legal guardian mutually agrees that ongoing behavioral health services are not needed. The Non-Title XIX individual would also be dis-enrolled.

Collection of Demographic and Clinical Data Timeframes

Demographic and clinical data will be collected starting at the first date of service. A demographic record must be collected within 45 days of the first service and submitted to AHCCCS within 55 days. Additional clinical data may be collected at subsequent assessment and service planning meetings with the member (e.g. education, vacation) as well as during periodic and annual updates and at time of closure. Demographic and clinical data recorded in the member's behavioral health medical record must match the demographic file on record with AHCCCS.

Providers are required to submit demographic data directly to AHCCCS. Information on specific data elements is available at https://www.azahcccs.gov/PlansProviders/Demographics/.

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Behavioral Health Providers are encouraged to utilize demographic and clinical data to improve operational efficiency and gain information about the members who receive behavioral health services. Providers may consider:

- Utilizing and integrating collected demographic data into the member's assessments;
- Monitoring the nature of the provider's behavioral health member population; and
- Evaluating the effectiveness of the provider's services towards improving the clinical outcomes of members enrolled in the AHCCCS system

At times, technical problems or other issues may occur in the electronic transmission of the clinical and demographic data from the behavioral health provider to AHCCCS. Any questions about the portal or the data fields in the portal should be submitted to DHCM/DAR Information Management/Data Analytics Unit Manager and Data Analysis and Research Manager. In addition, support can be obtained at ISDCustomerSupport@azahcccs.gov or 602-417-4451.

Serving Member's Previously Enrolled in the Behavioral Health System
Some members who have ended their episode of care or were dis-enrolled may need to re-enter the behavioral health system. The process used is based on the length of time that a person has been out of the behavioral health system.

For members not receiving services for less than 6 months:

- If the member has not received a behavioral health assessment in the past 6 months, conduct a new behavioral health assessment and revise the member's service plan as needed. If the member has received a behavioral health assessment in the last six months and there has not been a significant change in the member's behavioral health condition, behavioral health providers may utilize the most current assessment. Review the most recent service plan (developed within the last six months) with the member, and if needed, coordinate the development of a revised service plan with the person's clinical team.
- If the member presents at a different ACC, T/RBHA or provider, obtain new general and informed consent to treatment.
- If the member presents at a different ACC, T/RBHA or provider, obtain new authorizations to disclose confidential information.
- Submit new demographic and enrollment data

For members not receiving services for 6 months or longer:

- Conduct a new intake, behavioral health assessment and service plan
- Obtain new general and informed consent to treatment
- Obtain new authorizations to disclose confidential information
- Submit new demographic and enrollment data

SECTION VII: Behavioral Health Services

ASSESSMENT AND SERVICE PLANNING

Overview
Care1st supports a model for assessment, service planning, and service delivery that is strength-based, member-centered, family-friendly, culturally and linguistically appropriate, and clinically sound. The model incorporates the concept of a "team", established for each member receiving behavioral health services. For children, this team is the Child and Family Team (CFT) and for adults, this team is the Adult Recovery Team (ART). The model is based on four equally important components:

- Input from the member/Health Care Decision Maker/designated representative regarding his/her individual needs, strengths, and preferences,
- Input from other persons involved in the member's care who have integral relationships with the member,
- Development of a therapeutic alliance between the member/Health Care Decision Maker/designated representative and behavioral health provider that promotes an ongoing partnership built on mutual respect and equality, and
- Clinical expertise/qualifications of individual(s) conducting the assessment, Treatment/Service Planning, and service delivery.

At a minimum, the functions of the CFT and ART include:

- Ongoing engagement of the member/Health Care Decision Maker/designated representative, family and others who are significant in meeting the behavioral health needs of the member, including their active participation in the decision-making process and involvement in treatment;
- An assessment process is conducted to elicit information on the strengths, needs and goals of the individual member and his/her family, identify the need for further or specialty evaluations, and support the development and updating of a service plan which effectively meets the member's/family's needs and results in improved health outcomes.
- Continuous evaluation of the effectiveness of treatment through the CFT and ART process, the ongoing assessment of the member/Health Care Decision Maker and designated representative resulting in modification to the service plan, if necessary;
- Provision of all covered services as identified on the Treatment/Service plan, including assistance in accessing community resources, as appropriate and, for children, services which are provided in accordance with the Arizona Vision and 12 Principles, and for adults, services which are provided in accordance with the 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems;
- Ongoing collaboration, including the communication of appropriate clinical information, important to achieving positive outcomes (e.g., primary care

providers, school, child welfare, juvenile or adult probation, other involved service providers);
- Oversight to ensure continuity of care by taking the necessary steps (e.g., clinical oversight, development of facility discharge plans, or after-care plans, transfer of relevant documents) to assist members who are transitioning to a different treatment program, (e.g., inpatient to outpatient setting), changing behavioral health providers and/or transferring to another service delivery system (e.g., out-of-area, out-of-state or to an Arizona Long Term Care System (ALTCS) Contractor); and
- Development and implementation of transition plans prior to discontinuation or modification of behavioral health services.

Assessments
Providers perform and document behavioral health assessments and treatment planning functions in a team based approach and that includes the required elements found in this section. All members being served in the public behavioral health system must have a behavioral health assessment upon an initial request for services. For individuals who continue to receive behavioral health services, updates to the assessment must occur at least annually.

Behavioral health assessments must be utilized to collect necessary information that will inform providers of how to plan for effective care and treatment of the member. Care1st does not mandate that a specific assessment tool or format be used but requires certain minimum elements. Providers must collect and submit all required demographic information.

The initial and annual assessment must be completed by a behavioral health professional (BHP) or behavioral technician (BHT) under the clinical oversight of a BHP, who is trained on the minimum elements of a behavioral health assessment and meets requirements all credentialing and re-credentialing requirements. If an assessment is conducted and documented by a BHT, a BHP must review and sign the assessment information that was documented by the BHT.

Minimum elements of the behavioral health assessment
The following minimum elements must be included in a comprehensive behavioral health assessment and documented in the comprehensive clinical record.
- Presenting issues/concerns that triggered the request for behavioral health services
- What the member hopes to accomplish by receiving behavioral health services
- History of past (and current, if applicable) behavioral health treatment
- Psychiatric history, including history of previous psychiatric hospitalization(s) and psychotropic medication trial(s);
- Evaluation for the Social Determinants of Health using a standardized, validated tool (e.g. Patient-Centered Assessment

Method (PCAM), Health Leads Screening Toolkit, Hennepin County Medical Center Life Style Overview, or Protocol for Responding to and Assessment Patients' Assets, Risks, and Experiences (PRAPARE));

- Medical history;
- Current medications, including over the counter (OTC) medications;
- Allergies and other adverse reactions;
- Developmental history for children/youth under the age of 18 and with other populations if clinically relevant;
- Family history;*
- Educational history/status;*
- Employment history/status;
- Housing status/living environment;
- Social history;*
- Legal history, including custody/guardianship status, pending litigation, Court Ordered Evaluation/Court Ordered Treatment (COE/COT) history, criminal justice history, and any history of sex offender adjudication;
- Substance abuse history including type of substance, duration, frequency, route of administration, longest period of sobriety, and previous treatment history;
- Standardized substance use screen for children age 11 to 18 and referral for comprehensive assessment when screened positive;
- Substance use screen for adults age 18 and older using the American Society of Addiction Medicine (ASAM) Second Edition – Revised of Patient Placement Criteria (ASAM PPC-2R);
- Labs/ Diagnostics, if applicable;
- Mental Status Examination;
- Risk Assessment: the potential risk of harm to self or others based on self-reports, clinical symptoms, personality factors, past history, substance abuse, criminogenic factors, etc.;
- Any language or communication issues that need to be considered for effective treatment
- Brief summary/Bio-Psycho-Social formulation;
- ICD-10 diagnoses; and
- Date, begin, and end time of the assessment and printed name, signature, and professional credential of the provider completing the behavioral health assessment.
- If a privileged BHT completes the assessment, the assessment must also include a printed name, signature, professional credential, date and time of the privileged BHP who reviewed the assessment information. *(*Additionally, the BHP must*

confirm that sexual abuse/behavior information was documented as part of the person's Family, Educational, and Social History.)

For members for or identified as needing ongoing psychotropic medications for a behavioral health condition, the assessor must establish an appointment with a licensed medical practitioner with prescribing privileges. If the assessor is unsure regarding a member's need for psychotropic medications, then the assessor must review the initial assessment and treatment recommendations with her/her clinical supervisor or a licensed medical practitioner with prescribing privileges.

Members with substance use disorders, primarily opioid addiction, may be appropriately referred to Medication Assisted Treatment (MAT). MAT services are a combination of medications and counseling/behavioral therapies to provide a "whole patient" approach to the treatment of substance use disorders. Care1st contracts with network providers to specifically prescribe and/or dose medications to normalize brain chemistry, block the euphoric effects of alcohol and opioids, relieve physiological cravings and normalize body functions without the negative effects of the used drug. Care1st members may solely receive behavioral health services from contracted MAT providers; members may also receive behavioral health services from one agency and receive MAT services from another provider. Providers involved are required to provide care coordination to optimize treatment outcomes for these members.

Serving Member's Previously Enrolled in the Behavioral Health System

Some members who have ended their episode of care or were dis-enrolled may need to re-enter the behavioral health system. The process used is based on the length of time that a person has been out of the behavioral health system.

For members not receiving services for less than 6 months:

- ☐ If the member has not received a behavioral health assessment in the past 6 months, conduct a new behavioral health assessment and revise the member's service plan as needed. If the member has received a behavioral health assessment in the last six months and there has not been a significant change in the member's behavioral health condition, behavioral health providers may utilize the most current assessment. Review the most recent service plan (developed within the last six months) with the member, and if needed, coordinate the development of a revised service plan with the person's clinical team.
- ☐ If the member presents at a different ACC, T/RBHA or provider, obtain new general and informed consent to treatment.

Other Assessments (Children Only)

A Strengths, Need, Culture Discovery (SNCD) is required for all enrolled children. Identified strengths, needs and cultural considerations are shared among the members of the CFT, and incorporated into the service planning process. Results of this assessment are incorporated into the development of the child and family's service plan.

For children not determined to be high needs, the completion of a SNCD assessment will be documented within the CFT meeting notes and will be considered in the development of the child and family's service plan. For children determined to have high needs, the SNCD shall be a separate 'stand-alone' document maintained in the child's record.

Crisis planning is required for all children; however, the focus of the crisis plan may look slightly different depending on the level of need and service intensity for the child and family. The level of need and service intensity is based on the screenings and assessment.

- Low acuity and level of need
  - At this level of intensity (i.e. CASII score of 0,1,2 or 3), crisis plans may not be imminently needed, however they assist with identifying what could go wrong that would hinder successful implementation of the service plan;
  - The CFT will develop a proactive specific plan to address these identified issues;
  - The plan will include specific interventions and response strategies to support the child/family during a crisis situation;
  - The plan will identify steps to prevent crisis situations from occurring and establish safety criteria.
  - Crisis planning for children not identified as having high needs will be documented in the CFT notes and inform the overall service plan.
- High acuity and level of need
  - Crisis planning and a formal crisis plan is required for children/adolescents determined to be high needs (i.e. CASII level of 4, 5 or 6). It is critical to identify crisis or safety issues that could affect the child or family's stability.
  - The plan will include a thorough functional assessment, specific interventions, and response strategies that support the child/family during a crisis situation (reactive plan),

prevent crisis situations from occurring (proactive plan), and establish safety criteria.
- Crisis Planning will include other involved agency representatives.
- The CFT will review the Plan regularly to ensure it sufficiently meets the needs of the child and family, especially following a crisis situation. The Plan may require daily 24-hour responsiveness.

Required For All Title XIX/XXI Members:

- Primary Care Provider (PCP) name and contact information.
- Involvement with other agencies (e.g., Probation, Division of Developmental Disabilities).

Required For Children Age 0 To 5

Developmental screening for children age 0-5 with a referral for further evaluation when developmental concerns are identified. These evaluations could be by the child's PCP, the Arizona Early Intervention Program (AzEIP) for children age birth to three, or the public school system for children age three to five.

The presence of one or more of the following criteria is to be used to evaluate if a child birth to five is considered high needs case management and requires further assessment and targeted services.

a. Other agency involvement; specifically: Arizona Early Intervention Program (AzEIP), Department of Child Safety (DCS), and/or Division of Developmental Disability (DDD); and/or
b. Out of home placement (within past six months); and/or
c. Psychotropic medication utilization (two or more psychotropic medications); and/or
d. Evidence of severe psycho-social stressors (e.g. family member serious illness, disability, death, job loss, eviction).

Required For Children Age 6 through 18

Care1st requires its contracted providers to have policies and procedures in place to ensure that staff (i.e. case managers, clinicians, etc.) implement and administer the Child and Adolescent Service Intensity Instrument (CASII) for all children receiving services between the ages of 6 through 18. Behavioral health provider staff will complete training prior to the administration of the CASII and it will be recorded in Relias. All staff administering the CASII will pass initial and ongoing IRR testing.

The CASII will be completed within the initial 30-day assessment and updated annually or anytime there is a change in the child's needs. A final CASII should be completed as part of the disenrollment process from behavioral health services.

Required For Children Age 6 to 18 With CASII Score of 4 or Higher

- Strength, Needs and Culture Discovery Document
- Referral to a High Needs Case Manager (HNCM)

High Needs Case Management (HNCM)

Children that are considered high needs are to be referred to a high needs case manager. The following options are offered when assigning an agency to provide high needs case management:

a. Option 1: The member's originally assigned provider offers high needs case management. In these situations, the family may be offered to receive high needs case management and other needed services through a single provider agency. In these circumstances, the provider serves as the designated health home for that child.
b. Option 2: The originally assigned provider does not offer high needs case management necessitating an external referral to another provider agency to access high needs case management services. In this situation the family has two additional options:
    i. Responsibility for all services can be transferred to the high needs case management provider agency and this provider will become the member's designated health home. This option is ideal as it streamlines the coordination of care and medical record documentation under one entity; OR
    ii. The child and family can choose to remain with the originally assigned provider (i.e. maintain established relationship, better alignment with family preferences or needs) and only receive high needs case management from the high needs case management provider agency. In these circumstances, the originally assigned provider shall function as the member's designated health home. Contractors shall be responsible for ensuring timely and efficient care coordination between all involved provider agencies. This may include referral expectations and allowable exceptions based on family preference.

Behavioral Health Providers are to ensure that caseload ratios are within the indicated parameters and will notify the RBHA and/or Care1st when barriers exist to meeting the establishment requirements. Caseloads are submitted to the RBHA and/or Care1st (for those agencies not contracted with the RBHAs) on a monthly basis. The RBHAs then share this information with Care1st and the other AHCCCS Complete Care Contractors. Collectively these are monitored for compliance. When an issue of noncompliance has occurred the RBHA and Care1st partner together to develop and address the need for a corrective action plan.

HNCM caseload requirements are as follows:

- For a full FTE (1.0), have a caseload ratio of high needs children not less than 1:8 and not more than 1:20, with 1:15 being the desired target.
  The caseload cap is 20 to allow for continuity of care for children who have been receiving high needs case management, but are not ready to begin transition from that level of care and for high needs case management siblings.

Transition Age Youth

Providers are expected to follow the AHCCCS Behavioral Health Guidance Tool: Transition to Adulthood Practice Tool, which requires that transition planning begins when the youth reaches the age of 16. In addition, providers delivering care to Transition Age Youth will provide and/or refer members to child Providers who utilize the Transition To Independence (TIP) model of care into their service delivery.

Providers are encouraged to utilize identified First Episode Psychosis (FEP) centers, which have implemented evidence-based practices and track outcomes for children with specialized healthcare needs such as Transition Aged Youth: FEP Programs. Providers will coordinate with FEP Centers through Child & Family Team or Adult Recovery Team process.

When appropriate for members, who are uninsured or underinsured and have been determined to have an FEP, behavioral health providers will refer and assist in coordinating care to MHBG providers. The MHBG is allocated from the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide mental health treatment services to adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED). Each Regional Behavioral Health Authority receives funding as a pass through grant to ensure access to covered behavioral health services.

Funding targets the following populations:

- Adults (18 and older) with a serious mental illness (SMI)
- Children (17 and under) with a serious emotional disturbance (SED)
- Individuals experiencing a Frist Episode of Psychosis (FEP)

Providers will have an established process for ensuring that staff that provide service delivery to adolescents, young adults and their families have been trained and understand how to implement the practice elements outlined in Care1st Policy 550: Transition Age Youth as well as AHCCCS: Transition to Adulthood Practice Tool. Verification of training completion must be documented in Relias.

COORDINATION OF CARE WITH OTHER GOVERNMENTAL AGENCIES

Arizona Department of Child Safety (DCS)

When a child receiving behavioral health services is also receiving services from DCS, the provider must work towards effective coordination of services with the DCS Specialist. Providers are expected to:

- Coordinate the development of the behavioral health service plan with the DCS case plan to avoid redundancies and/or inconsistencies.
- Provide the DCS Specialist and the juvenile court with preliminary findings and recommendations on behavioral health risk factors, symptoms and service needs for hearing.
- Perform an assessment and identify behavioral health needs of the child, the child's parents and family and provide necessary behavioral health services, including support services to temporary caretakers.
- As appropriate, engage the child's parents, family, temporary caretakers and DCS Specialist in the behavioral health assessment and service planning process as members of the Child and Family Team (CFT).
- Attend team meetings such as Team Decision Meetings (TDM) for the purpose of providing input about the child and family's behavioral health needs. When it is possible, TDM and CFT meetings should be combined.
- Coordinate necessary services to stabilize in-home and out-of-home placements provided by DCS.
- Coordinate provision of behavioral health services in support of family reunification and/or other permanency plans identified in DCS.
- Coordinate activities and service delivery that supports the child and family Plans and facilitates adherence to established timeframes.
- Coordinate actives that include coordination with the adult service providers rendering services to adult family members.

DCS Arizona Families F.I.R.S.T (Families in Recovery Succeeding Together-AFF) Program

Providers are to coordinate with parents/families referred through the Arizona Families F.I.R.S.T (AFF) program and participate in the family's CFT to coordinate services for the family and temporary caretakers.

The AFF Program provides expedited access to substance abuse treatment for parents and caregivers referred by DCS and the ADES/Family Assistance Administration (FAA) Jobs Program. AHCCCS participates in statewide implementation of the program with DCS. Providers are too coordinate the following:

Accept referrals for Title XIX and Title XXI eligible and enrolled members and families referred through AFF:

- Accept referrals for Title XIX and Title XXI eligible and enrolled members and families referred through the AFF program
- Accept referrals for Non-Title XIX/XXI members and families referred through the AFF Program and provide services, if eligible
- Ensure that services made available to members who are Non-Title XIX/XXI eligible are provided by maximizing available federal funds before expending state funding as required in the Governor's Execution Order 2008-01

- Collaborate with DCS, the ADES/FAA Jobs Program and substance use disorder treatment providers to minimize duplication of assessments
- Develop procedures for collaboration in the referral process to ensure effective service delivery through the behavioral health system. Appropriate authorizations to release information will be obtained prior to releasing information

Arizona Department Of Education (ADE), Schools, Or Other Local Educational Authorities

AHCCCS has delegated the functions and responsibilities as a State Placing Agency to Care1st for members in the Northern and Central GSA under A.R.S. §15-1181 for children receiving special education services pursuant to A.R.S. §15-761 et seq. This includes the authority to place a student at a Behavioral Health Inpatient Facility, which provides care, safety, and treatment.

Providers are to collaborate with schools and help a child achieve success in schools as follows:

- Work with the school and share information to the extent permitted by law and authorized by the child's parent or legal guardian as outlined in AMPM Policy 550.
- For children receiving special education services, actively consider information and recommendations contained in the Individualized Education Program (IEP) during the ongoing assessment and service planning;
- For children receiving special education services, participate with the school in developing the child's IEP and share the behavior treatment plan interventions, if applicable;
- Inviting teachers and other school staff to participate in the CFT if agreed to by the child andHealth Care Decision Maker;
- Understand the IEP requirements as described in the Individuals with Disabilities Education Act (IDEA) of 2004
- Support accommodation for students with disabilities who qualify under Section 504 of the Rehabilitation Act of 1973, and
- Ensure that transitional planning occurs prior to and after discharge of an enrolled child from any out-of-state placement.

Behavioral health providers will collaborate with schools to provide appropriate behavioral health services in school settings, identified as Place of Service (POS) 03 and submit reports as specified by Care1st.

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Department of Economic Security: Arizona Early Intervention Program (AzEIP)

Providers will coordinate member care with AzEIP as follows:

- Ensure that children birth to three years of age are referred to AzEIP in a timely manner when information obtained in the child's behavioral health assessment reflects developmental concerns,
- Ensure that children found to require behavioral health services as part of the AzEIP evaluation process receive appropriate and timely service delivery, and
- Ensure that, if an AzEIP team has been formed for the child, the behavioral health provider coordinates team functions to avoid duplicative processes between systems.

Courts and Corrections

Behavioral health providers collaborate and coordinate care for members with behavioral health needs and for members involved with:

- Arizona Department of Corrections (ADOC)
- Arizona Department of Juvenile Corrections (ADJC)
- Administrative Offices of the Court (AOC), or
- County Jails System

Behavioral health providers will coordinate member care as follows:

- Work in collaboration with the appropriate staff involved with the member. Invite probation or parole representatives to participate in the development of the Service Plan and all subsequent planning meetings for the CFT and ART with the member's/Health Care Decision Maker's approval

- Actively consider information and recommendations contained in probation or parole case plans when developing the Service Plan

- Ensure that the Behavioral health provider evaluates and participates in transition planning prior to the release of eligible members and arranges and coordinates enrolled member care upon the member's release.

Care1st and the Arizona Department of Corrections (ADOC) have an established mutually agreed upon protocol to ensure effective and efficient delivery of behavioral health services. The Collaborative Protocol between Care1st and Arizona Department of Corrections (ADC) defines the respective roles and responsibilities of each party and is available upon request. Providers are expected to have staff, who deliver services to adults, review and provide training on this protocol. All training competed is required to be documented in Relias.

Care1st and the Arizona Department of Juvenile Corrections (ADJC) have an established mutually agreed upon protocol to ensure effective and efficient delivery of behavioral health services. The Collaborative Protocol between Care1st and Arizona Department of

Juvenile Corrections defines the respective roles and responsibilities of each party and is available on upon request. Providers are expected to have staff, who deliver services to children, review and provide training on this protocol. All training competed is required to be documented in Relias.

Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA)
The purpose of RSA is to work with individuals with disabilities to achieve increased independence or gainful employment through the provision of comprehensive rehabilitative and employment support services.

Providers must coordinate member care by:

- Working in collaboration with the vocational rehabilitation (VR) counselors or employment specialists in the development and monitoring of the member's employment goals;
- Ensuring that all related vocational activities are documented in the comprehensive clinical record;
- Inviting RSA staff to be involved in planning for employment programming to ensure that there is coordination and consistency with the delivery of vocational services; and
  Participating and cooperating with RSA in the development and implementation of a Regional Vocational Service Plan inclusive of RSA services available to adolescents.

SMI ELIGIBILITY DETERMINATION

General Requirements
As per AMPM 320-P Serious Mental Illness Eligibility Determination, this section applies to:

- Members who are referred for, request or have been determined to need an eligibility determination for SMI;
- Members determined to be SMI for whom a review of the determination is indicated; and
- Care1st, subcontracted providers and the AHCCCS Determining Entity (Crisis Response Network).

All members must be evaluated for SMI eligibility by a qualified assessor (as defined in A.A.C. R9-21-101(B)), and have an SMI determination made by the Crisis Response Network, if:

- The member requests an SMI determination; or
- A guardian/legal representative who is authorized to consent to inpatient treatment pursuant to A.R.S. 14-5312.01 for the member makes a request on their behalf; or

- An Arizona Superior Court issues an order instructing the person to undergo an SMI evaluation.

The SMI eligibility determination record must include all of the documentation that was considered during the review of the determination as well as any current and/or historical treatment records used in consideration of the determination. All documentation used in consideration of the determination must be maintained in hardcopy or electronic format.

Computation of time is as follows:

- Day Zero: Initial assessment date with a qualified clinician regardless of time of the assessment
- Day One: The next business day after the initial assessment is completed. The initial assessment and all other required documents must be provided to CRN as soon as practicable, but no later than 11:59PM on Day One. The qualified clinician will notify Care1st Care Management that an SMI eligibility application has been submitted.
- Day Three: The third business day after the initial assessment is completed. CRN will complete the final determination no later than Day Three.
- **Determination Due Date:** Three business days after Day Zero, excluding weekends and holidays, and is the date that the determination decision will be rendered. This date is amended if an extension is approved in accordance with Care1st policy.

Process For Completion Of The Initial SMI Evaluation

Upon receipt of a referral, request, or identification of the need for an SMI determination, Care1st, Care1st providers, designated Department of Corrections (DOC) or Arizona Department of Juvenile Corrections (ADJC) staff person will schedule an appointment for an initial meeting with the person and a qualified clinician (as per AMPM Policy 950 Credentialing and Recredentialing Process). This is to occur no later than 7 days after receiving the request or referral.

During the initial meeting with the person by a qualified assessor, they must:

- Make a clinical assessment whether the member is competent enough to participate in an evaluation;
- Obtain written consent from the person or, if applicable, the member's guardian to conduct an evaluation;
- Provide to the member and, if applicable, the member's guardian, the information required in A.A.C. R9-21-301(D)(2), a client rights brochure, and the appeal notice required by A.A.C. R9-21-401(B); and
- Obtain a release of information for any documentation that would assist in the determination
- Conduct an assessment if one has not been completed within the last six months

- Complete the SMI Determination Form as per AMPM Exhibit 320-P-1 Serious Mental Illness Determination which must be signed and dated by a licensed clinician

Upon completion of the initial evaluation, submit all information to the Determining Entity within one business day.

- Notify Care1st care management of the submission.

If, during the initial meeting with the member, the assessor is unable to obtain sufficient information to determine whether the applicant is SMI, the assessor must:

- Request the additional information in order to make a determination of whether the member is SMI and obtain an authorization for the release of information, if applicable
- Refer the member for a psychiatric evaluation for further diagnostic and functional clarification.

Criteria For SMI Eligibility Determination

The determination of SMI requires both a qualifying SMI diagnosis and functional impairment, or risk of deterioration, as a result of the qualifying diagnosis (see Exhibit 320-P-2, Serious Mental Illness Qualifying Diagnosis).

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

- Inability to live in an independent or family setting without supervision – neglect or disruption of ability to attend to basic needs. Needs assistance in caring for self.
- A risk of serious harm to self or others – seriously disruptive to family and/or community. Pervasively or imminently dangerous to self or others' bodily safety. Regularly engages in assaultive behavior. Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others in the person's care. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan. Affective disruption causes significant damage to the person's education, livelihood, career, or personal relationships.
- Dysfunction in role performance – frequently disruptive or in trouble at work or at school. Frequently terminated from work or suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised work or school setting. Performance significantly below expectation for cognitive/developmental level. Unable to work, attend school, or meet other developmentally appropriate responsibilities; or
- Risk of Deterioration for SMI Eligibility
    - A qualifying diagnosis with probable chronic, relapsing and remitting course.

- Co-morbidities (like mental retardation, substance dependence, personality disorders, etc.).
- Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (life-threatening or debilitating medical illnesses, victimization, etc.).
- Other (past psychiatric history; gains in functioning have not solidified or are a result of current compliance only; court-committed; care is complicated and requires multiple providers; etc.).

The following reasons are not sufficient in and of themselves for denial of SMI eligibility:

- An inability to obtain existing records or information; or
- Lack of a face-to-face psychiatric or psychological evaluation.

Member with Co-occurring Substance Abuse

For members who have a qualifying SMI diagnosis and co-occurring substance abuse, for purposes of SMI determination, presumption of functional impairment is as follows:

- For psychotic diagnoses (bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder and psychotic disorder NOS) functional impairment is presumed to be due to the qualifying psychiatric diagnosis;
- For other major mental disorders (bipolar disorders, major depression and obsessive compulsive disorder), functional impairment is presumed to be due to the psychiatric diagnosis, unless:
  - The severity, frequency, duration or characteristics of symptoms contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis; or
  - The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the person is abusing substances or experiencing symptoms of withdrawal from substances.
- For all other mental disorders not covered above, functional impairment is presumed to be due to the co-occurring substance use unless:
  - The symptoms contributing to the functional impairment cannot be attributed to the substance abuse disorder; or
  - the functional impairment is present during a period of cessation of the co-occurring substance use of at least 30 days; or

The functional impairment is present during a period of at least 90 days of reduced use unlikely to cause the symptoms or level of dysfunction.

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A Complete SMI Determination Packet Includes:

- Crisis Response Network Consent for Assessment Form
- SMI Determination Form
- Comprehensive assessment that must be dated within 6 months of the submission- CRN has an example form that may be used
- Psychiatric evaluation or psychiatric evaluation and management visit that addresses the current and recurrent functional impairments, risk of deterioration and qualifying diagnoses of the individual
- Recent hospital records or treatment records demonstrating individual's level of functioning and evidence of deterioration
- Waiver of the Three Day Determination Form- applicants are encouraged to waive their right to a 3 day determination so that CRN can pursue historical treatment records and have additional time to review the requests
- Demographic Form (optional) to assist CRN with contacting the individual and other involved parties during the determination process
- Releases of Information Form for CRN to communicate with emergency contact, family members or prior inpatient and outpatient providers

Submission Of The SMI Determination Request

- All requests are submitted through the Crisis Response Network SMI Provider Submission Portal or by CRN fax (844-611-4752)
- Clinical contact should be the clinician most familiar with the individual's clinical history and who can address the effect of substance use on clinical presentation, if applicable. In most cases this would be the behavioral health medical provider. This contact is used to obtain additional information and if there is a potential denial, to discuss appeal or reconsideration.
- Packets must be complete, dated and signed
- Additional documents can be submitted as updates to the original submission

SMI Eligibility Determination For Inmates In The Department of Correction (DOC)

An SMI eligibility designation/determination is done for purposes of determining eligibility for community-based behavioral health services. The Arizona Department of Health Services (ADHS) recognizes the importance of evaluating and determining the SMI eligibility for inmates in the Department of Corrections (DOC) with impending release dates in order to appropriately coordinate care between the DOC and the community based behavioral health system. Inmates of DOC pending release within 6 months, who have been screened or appear to meet the diagnostic and functional criteria, will now be permitted to be referred for an SMI eligibility evaluation and determination. Inmates of DOC whose release date exceeds 6 months are not eligible to be referred for an SMI eligibility evaluation and determination.

Completion Process of Final SMI Eligibility Determination
The licensed psychiatrist, psychologist, or nurse practitioner designated by Crisis Response Network must make a final determination as to whether the member meets the eligibility requirements for SMI status based on:

- A face-to-face assessment or reviewing a face-to-face assessment by a CRN qualified assessor (see AMPM Policy 950 Credentialing and Recredentialing Processes); and
- 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.

The following must occur if the designated reviewing psychiatrist, psychologist, or nurse practitioner has not conducted a face-to-face assessment and has a disagreement with the current evaluating or treating qualified behavioral health professional or behavioral health technician (that cannot be resolved by oral or written communication):

- Disagreement regarding diagnosis: Determination that the member does not meet eligibility requirements for SMI status must be based on a face-to-face diagnostic evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The resolution of (specific reasons for) the disagreement shall be documented in the person's comprehensive clinical record.
- Disagreement regarding functional impairment: Determination that the member does not meet eligibility requirements must be documented by the psychiatrist, psychologist, or nurse practitioner in the member's comprehensive clinical record to include the specific reasons for the disagreement and will include a clinical review with the qualified clinician.

If there is sufficient information to determine SMI eligibility, the person shall be provided written notice of the SMI eligibility determination within three (3) business days of the initial meeting with the qualified assessor.

Issues Preventing Timely Completion of SMI Eligibility Determination
The time to initiate or complete the SMI eligibility determination may be extended no more than 20 days if the member agrees to the extension and:

- There is substantial difficulty in scheduling a meeting at which all necessary participants can attend;
- The member fails to keep an appointment for assessment, evaluation or any other necessary meeting;
- The member is capable of, but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation;
- The member or the member's guardian and/or designated representative requests an extension of time;
- Additional documentation has been requested, but has not yet been received; or
- There is insufficient functional or diagnostic information to determine SMI eligibility within the required time periods.

NOTE: Insufficient diagnostic information is understood to mean that the information available to the reviewer is suggestive of two or more equally likely working diagnoses, only one of which qualifies as SMI, and an additional piece of existing historical information or a face-to-face psychiatric evaluation is likely to support one diagnosis more than the other.

Crisis Response Network must:

- Document the reasons for the delay in the member's eligibility determination record when there is an administrative or other emergency that will delay the determination of SMI status; and
- Not use the delay as a waiting period before determining SMI status or as a reason for determining that, the member does not meet the criteria for SMI eligibility (because the determination was not made within the time standards).

Notification of SMI Eligibility Determination

1. If the member is determined SMI, the SMI status must be reported to the member or their legal guardian by CRN in writing, including notice of the member's right to appeal the decision (as outlined in ACOM Policy 444).

2. If the eligibility determination results in a denial of a SMI status, CRN will provide written notice of the decision and include:

a. The reason for denial of SMI eligibility (as outlined in AMPM Exhibit 320-P-1),

b. The right to appeal (as outlined in ACOM Policy 414 and ACOM Policy 444), and

c. The statement that Title XIX/XXI eligible members will continue to receive needed Title XIX/XXI covered services. In such cases, the member's behavioral health category assignment must be assigned based on criteria in the AHCCCS Technical Interface Guidelines.

Re-Enrollment or Transfer

If the member's status is SMI at disenrollment or transition to another ACC, TRBHA or Tribal ALTCS, the member's status will continue as SMI. A member will retain their SMI status unless a determination is made by CRN that the member no longer meets criteria.

Review of SMI Eligibility

Care1st care manager, or contracted behavioral health providers may seek a review of a member's SMI eligibility from CRN:

a. As part of an instituted, periodic review of all members determined to have a SMI,

b. When there has been a clinical assessment that supports that the member no longer meets the functional and/or diagnostic criteria, or

c. As requested by a member who has been determined to meet SMI eligibility criteria, or their legally authorized representative.

A review of the determination may not be requested by the Care1st or their contracted behavioral health providers within six months from the date a member has been determined SMI eligible.

SMI Decertification
There are two established methods for removing a SMI designation, one clinical and the other an administrative option, as follows:

1. A member who has a SMI designation or an individual from the member's clinical team may request a SMI Clinical Decertification from the AHCCCS designee, which conducts SMI determinations. A SMI Clinical Decertification is a determination that a member who has a SMI designation no longer meets SMI criteria. If, as a result of a review, the member is determined to no longer meet the diagnostic and/or functional requirements for SMI status:

a. CRN will ensure that written notice of the determination and the right to appeal is provided to the affected member with an effective date of 30 days after the date the written notice is issued,
b. Care1st requires that services are continued in the event an appeal is timely filed, and that services are appropriately transitioned as part of the discharge planning process.

PARTNERSHIPS WITH FAMILIES AND FAMILY-RUN ORGANIZATIONS IN THE CHILDREN'S BEHAVIORAL HEALTH SYSTEM

Effective Family Participation In Service Planning And Delivery
Through the Child and Family Team (CFT) process, parents/caregivers and youth are treated as full partners in the planning, delivery and evaluation of services and supports. Parents/caregivers and youth are equal partners in the local, regional, tribal and state representing the family perspective as participants in systems transformation. Care1st subcontracted providers must:

- Ensure that families have access to information on the CFT process and have the opportunity to fully participate in all aspects of service planning and delivery.
- Approach services and view the enrolled child in the context of the family rather than isolated in the context of treatment.
- Recognize that families are the primary decision-makers in service planning and delivery.

- Provide culturally and linguistically relevant services that appropriately respond to a family's unique needs.
- Assess the family's need for family support partner and make family support available to the CFT when requested.
- Provide information to families on how they can contact staff at all levels of the service system
- Work with Care1st to develop training in family engagement and participation, roles and partnerships for provider staff, parents/caregivers, youth and young adults.

Responsibilities Of Care1st and Providers

Family members, youth and young adults must be involved in all levels of the behavioral health system, whether it is serving on boards, committees and advisory councils or as employees with meaningful roles within the system. To ensure that family members, youth and young adults are provided with training and information to develop the skills needed, Care1st and its subcontracted providers must:

- Support parents/caregivers, youth and young adults in roles that have influence and authority.
- Establish recruitment, hiring and retention practices for family, youth and young adults within the agency that reflect the cultures and languages of the communities served.
- Provide training for families, youth and young adults in cultural competency.
- Assign resources to promote family, youth and young adult involvement including committing money, space, time, personnel and supplies; and
- Demonstrate a commitment to shared decision making.
- Ensure that service planning and delivery is driven by family members, youth and young adults.
- Support requests for services from family members, youth and young adults that respond to their unique needs, including providing information/educational materials to explore various service options.
- Obtain consent, which allows families, youth and young adults to opt out of some services and choose other appropriate services.
- Provide contact information and allow contact with all levels of personnel within the agency for families, youth and young adults.
- Make a Family Support Partner (FSP) available to the family when requested by the CFT.

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Responsibilities of Care1st

- Support family, youth and young adults in roles that have influence and promote shared responsibility and active participation.
- Assign resources to promote family, youth and young adult involvement including committing money, space, time, personnel and supplies;
- Involve parents/caregivers, youth and young adults as partners at all levels of planning and decision making, including delivery of services, program management and funding; and
- Develop and make available to providers, policies and procedures specific to these requirements.

Organizational Commitment to Employment to Family Members

Care1st subcontracted providers must demonstrate commitment to employment of parents/caregivers, and young adults by:

- Providing positions for parents/caregivers and young adults that value the first person experience.
- Providing compensation that values first-person experience commensurate with professional training.
- Establishing and maintaining a work environment that values the contribution of parents/caregivers, youth and young adults.
- Providing supervision and guidance to support and promote professional growth and development of parent/caregivers and young adults in these roles.
- Providing the flexibility needed to accommodate parents/family members and young adults employed in the system, without compromising expectations to fulfill assigned tasks/roles.
- Promoting tolerance of the family, youth and young adult roles in the workplace.
- Committing to protect the integrity of these roles.
- Developing and making available to providers policies and procedures specific to these requirements

Adherence Measurements

Adherence to this section will be measured through the use of one or more of the following:

- Analysis of the behavioral health system, including the Annual Network Inventory and Analysis of Family Roles and System of Care Practice Reviews.
- Other sources as required by the AHCCCS/ACC contracts

TRAINING REQUIREMENTS

All Behavioral Health (BH) providers must have access to Relias Learning. This is the Learning Management System used by the ACC Plans and their contracted BH providers through the Arizona Association of Health Plans (AzAHP). Agencies must manage and

maintain their Relias Learning portal. This includes activating and deactivating users as well as enrollment and disenrollment of courses/events. All contracted Care1st BH Providers must be set up to use Relias Learning to report all training activities for their staff to include but not limited to:

Attendance, course completion and training content for:

- Technology based/Online Courses
- Web Conferences
- Live Training, Seminars, Conferences and/or Events

Requesting Relias Access for newly contracted Providers:

1. Provider representative makes a request, for Relias access, to the Care1st Workforce Development Administrator. The request should include the following information:
    a. Provider Agency Name
    b. Contract Start Date
    c. Address
    d. Key WFD Contact
        i. Name
        ii. Phone Number
        iii. Email Address
    e. Contract Type (ACC)
    f. Provider Type (GMH/SU, Children's, Integrated Health Home, etc.)
    g. Number of Users (# employees at the agency who need Relias access)
    h. List of Health Plans provider is contracted with (if known).

Required Training

Providers must ensure that all staff who work in programs that support, oversee, or are paid by the Care1st contract have access to Relias and are enrolled in the AzAHP Training Plans listed below. (This includes licensed and unlicensed personnel. All are required to attend and complete all pre-service, ongoing and annual in-service training programs described and required by specific AHCCCS policies to include full time/part time, direct care, clinical, administrative and support staff).

Exceptions:

Any staff member(s) hired for temporary services working less than 90 days is required to complete applicable training at the discretion of the provider.
Any staff member(s) hired as an intern or Independent Contractor (IC) is required to complete applicable training at the discretion of the provider.

AzAHP Core Training Plan (First 90 Days)

1. Welcome to Relias (Due within 7 days of hire)

2. AzAHP – Limited English Proficiency (LEP) (1.0hrs)
3. AzAHP – AHCCCS 101 (2.0hrs)
4. AzAHP – Quality of Care Concern (1hrs)
5. AzAHP – Client Rights, Grievances and Appeals (1.25hrs)
6. AzAHP – Cultural and Linguistically Appropriate Services (CLAS) Standards (1.0hrs)
7. Corporate Compliance: The Basics (0.5hrs)
8. Cultural Competence (0.5hrs)
9. Customer Service (0.5hrs)
10. Ethical Decisions Making: The Basics (0.5hrs)
11. Integrating Primary Care with Behavioral Healthcare (1.25hrs)
12. Medicare and Medicaid Fraud and Abuse Prevention (2.0hrs)
13. Personalized Learning: Understanding the HIPAA Regulations
14. AHCCCS – NEO – Employment Rehabilitation

AzAHP – Core Training (Annual)

1. Personalized Learning: Understanding the HIPAA Regulations Due: January 31st
2. Ethical Decisions Making: The Basics (0.5hrs) Due: March 31st
3. Abuse and Neglect: What to Look For and How to Respond (1.5hrs) Due: April 30th
4. Corporate Compliance: The Basics (0.5hrs) Due: May 31st
5. Cultural Competence (0.5hrs) Due: June 30th
6. AzAHP – Cultural and Linguistically Appropriate Services (CLAS) Standards (1.0hrs) Due: Sept 30th
7. AHCCCS – health Plan Fraud (0.5) Due: October 31st
8. AzAHP – Quality of Care Concern (1hrs) Due: December 31st

Competency Training

- Providers will ensure that before providing services to members each licensed and unlicensed staff person is qualified, knowledgeable and capable to provide services as required by AHCCCS policy and, as relevant to their job duties and responsibilities, and consistent with their contract with Care1st
- Specific situations may necessitate the need for additional trainings. For example, specific job description requirements, quality improvement initiatives that may require focused training efforts and/or new regulations that affect the public behavioral health system [e.g. MMA, the Affordable Care Act (ACA) and Deficit Reduction Act (DRA)]. Additional trainings may be required, as determined by geographic service area identified needs.

Required Training for Provider Staff Delivering Services to Children

The following specific training areas and practice tools apply directly to provider staff delivering services to children and their families:

- Arizona Children's System of Care Vision and Twelve Principles;

- AHCCCS CFT Practice Protocol;
- CASII or ECSII (as directed under Targeted Investment or AHCCCS);
- Working with the Birth through Five Population;
- Children's Out of Home Services
- Family and Youth Involvement in the Children's Behavioral Health System
- Support and Rehabilitation Services for Children, Adolescents and Young Adults
- Transition to Adulthood
- Psychiatric and Psychotherapeutic Best Practices for Children Birth through Five Years of Age; and
- Unique Needs of Children Involved with Department of Child Safety (DCS); and
- Youth Involvement in the Children's Behavioral Health System.

Workforce Development Plan and Implementation Progress Report
Providers are to develop, implement and submit an Annual Workforce Development and Training Plan that describes the training and workforce development priorities for the year. The training plan will be submitted on October 31.

The Workforce Development Plan (WFD) will include the following:

- Short- and long-term strategic WFD capacity and capability requirements (e.g. addressing health professional shortage areas, and integrated care);
- Forecast of anticipated workforce capacity (size, job types, etc.) and capability (skills and workforce support) needs;
- Specific WFD goals;
- Description of the actions to be taken to implement WFD initiatives, such as programs to recruit members to seek employment in various roles within the ACC health care system; and
- Description of how stakeholders, members, families, and the general public will be involved in the development and implementation of the WFD plan.

Providers are to ensure:

- All ACC required training content or competency descriptions are incorporated into the appropriate orientation, education, or training program, and evaluation processes and are made available to provider personnel,
- Providers have processes for documenting training, verifying the qualifications, skills, and knowledge of personnel, and retaining required training, and competency transcripts and records.

SECTION VII: Behavioral Health Services

PEER /RECOVERY SUPPORT TRAINING, CREDENTIALING AND SUPERVISION REQUIREMENTS

Peer Support Specialist/Recovery Support Specialist Qualifications
Individuals seeking to be certified and employed as Peer Support Specialists/Recovery Support Specialists
must:

- Be self-identified as a "peer"; and
- Meet the requirements to function as a behavioral health paraprofessional, behavioral health technician, or behavioral health professional.

Individuals meeting the above criteria may be certified as a Peer Support Specialist/Recovery Support Specialist by completing training and passing a competency test through an AHCCCS/OIFA approved Peer Support Employment Training Program. AHCCCS/OIFA will oversee the approval of all credentialing materials including curriculum and testing tools. Individuals are certified by the agency in which he/she completed the Peer Support Employment Training Program; however, credentialing through an AHCCCS/OIFA approved Peer Support Employment Training Program is applicable statewide, regardless of which program a person has gone through for credentialing. Some agencies may wish to employ individuals prior to the completion of credentialing through a Peer Support Employment Training Program. However, required trainings must be completed prior to delivering behavioral health services. An individual must be credentialed as a Peer Support Specialist/Recovery Support Specialist under the supervision of a qualified individual prior to billing Peer Support Services.

Peer Support Employment Training Program Approval Process
A Peer Support Employment Training Program must submit their program curriculum, competency exam, and exam scoring methodology (including an explanation of accommodations or alternative formats of program materials available to individuals who have special needs) to AHCCCS/OIFA, and AHCCCS/OIFA will issue feedback or approval of the curriculum, competency exam and exam scoring methodology in accordance with Peer Support Employment Training Curriculum Standards.

Approval of curriculum is binding for no longer than three years. Three years after initial AHCCCS approval and thereafter, the program must resubmit their curriculum for review and re-approval to AHCCCS. If a program makes substantial changes (meaning change to content, classroom time, etc.) to their curriculum or if there is an addition to required elements during this three-year period, the program must submit the updated content to AHCCCS/OIFA for review and approval. AHCCCS/OFIA will base approval of the curriculum, competency exam and exam scoring methodology only on the elements included in this updated content. If a Peer Support Employment Training Program requires regional or culturally specific training exclusive to a GSA or tribal community, the specific training cannot prevent employment or transfer of Peer Support Specialist/Recovery Support Specialist approval based on additional elements or standards.

SECTION VII: Behavioral Health Services

Competency Exam

Individuals seeking credentialing and employment as a Peer/Recovery Support Specialist must complete and pass a competency exam with a minimum score of 80% upon completion of required training. Each Peer Support Employment Training Program has the authority to develop a unique competency exam. However, all exams must include at least one question related to each of the curriculum core elements listed in Subsection E of Peer Support Employment Training Curriculum Standards. If an individual does not pass the competency exam, the Peer Support Employment Training Program may require that the peer repeat or complete additional training prior to taking the competency exam again. For individuals certified in another state, credentials must be sent to AHCCCS/OIFA. The individual must demonstrate their state's credentialing standards meet those of AHCCCS prior of recognition of their credential.

Peer Support Employment Training Curriculum Standards

. A Peer Support Employment Training Program curriculum must include the following core elements:

a. Concepts of Hope and Recovery

i. Instilling the belief that recovery is real and possible,
ii. The history of the recovery movement and the varied ways that behavioral health issues have been viewed and treated over time and in the present,
iii. Knowing and sharing one's story of a recovery journey and how one's story can assist others in many ways,
iv. Mind-Body-Spirit connection and holistic approach to recovery, and
v. Overview of the Individual Service Plan (ISP) and its purpose.

b. Advocacy and Systems Perspective

i. Overview of state and national behavioral health system infrastructure and the history of Arizona's behavioral health system,
ii. Stigma and effective stigma reduction strategies: countering self-stigma; role modeling recovery and valuing the lived experience,
iii. Introduction to organizational change - how to utilize person-first language and energize one's agency around recovery, hope, and the value of peer support,
iv. Creating a sense of community; creating a safe and supportive environment.
v. Forms of advocacy and effective strategies – consumer rights and navigating the behavioral health system, and
vi. Introduction to the Americans with Disabilities Act (ADA).

c. Psychiatric Rehabilitation Skills and Service Delivery

i. Strengths based approach; identifying one's own strengths and helping others identify theirs; building resilience,
ii. Distinguishing between sympathy and empathy, emotional intelligence,

iii. Understanding learned helplessness; what it is, how it is taught and how to assist others in overcoming its effects,
iv. Introduction to motivational interviewing; communication skills and active listening,
v. Healing relationships – building trust and creating mutual responsibility,
vi. Combating negative self-talk: noticing patterns and replacing negative statements about one's self; using mindfulness to gain self-confidence and relieve stress,
vii. Group facilitation skills, and
viii. Introduction to Culturally & Linguistically Appropriate Services (CLAS) Standards. The role of culture in recovery.

d. Professional Responsibilities of the Peer Support Employee and Self Care in the Workplaceinclude: Qualified

i. Professional boundaries and ethics - the varied roles of the helping professional, collaborative supervision and the unique role of the Peer/Recovery Support Specialist,
ii. Confidentiality laws and information sharing – understanding the Health Insurance Portability and Accountability Act (HIPAA),
iii. Responsibilities of a mandatory reporter; what to report and when,
iv. Understanding common signs and experiences of mental illness, substance abuse, addiction and trauma, orientation to commonly used medications and potential side effects,
v. Guidance on proper service documentation, billing and using recovery language throughout documentation,
vi. Self-care skills and coping practices for helping professionals, the importance of ongoing supports for overcoming stress in the workplace, resources to promote personal resilience; and, understanding burnout and using self-awareness to prevent compassion fatigue, vicarious trauma and secondary traumatic stress.

e. Qualified peers must receive training on all of the elements listed above prior to delivering any covered healthcare services.

Peer support employment training programs must not duplicate training required of peers for employment with a licensed agency or Community Service Agency (CSA). Training elements in this section must be specific to the peer role in the public healthcare system and instructional for peer interactions.

While peer support employment training programs must not duplicate training required of licensed agencies or CSAs, it is possible that licensed agencies and/or CSAs may consider training completed as part of the peer support employment training program as meeting the agency and AHCCCS training requirements.

Supervision of Certified Peer Support Specialist/Recovery Support Specialist
Supervision is intended to provide support to Peer Support Specialists/Recovery Support Specialists in meeting treatment needs of behavioral health recipients receiving care from Peer Support Specialists/Recovery Support Specialists. Supervision provides an opportunity for growth within the agency and encouragement of recovery efforts.

Agencies employing Peer Support Specialists/Recovery Support Specialists must have a qualified individual (behavioral health professional (BHP) or behavioral health technician (BHT)) level staff memeber designated to provide Peer Support Specialist/Recovery Support Specialist supervision. Supervision must be documented and inclusive of both clinical and administrative supervision.

The individual providing supervision must also have completed Peer Support Employement Training and pass a competency test through an approved Peer Support Employment Training Program.

Process for Submitting Evidence of Credentialing
Agencies employing Peer Support Specialists/Recovery Support Specialists who are providing peer support services are responsible for keeping records of required qualifications and credentialing. Care1st ensures that Peer Support Specialists/Recovery Support Specialists meet qualifications and have credentialing, as described in this section.

TELEPHONIC CONSULTATION SERVICES

A Care1st psychiatrist may provide a telephonic psychiatric consultation for PCPs who have diagnostic or treatment concerns or questions of a general nature. The PCP initiates this type of consult by calling Member Services Line and requesting a general psychiatric consultation.

FACE-TO-FACE CONSULTATION SERVICES

A PCP can arrange for a member to have a face-to-face consultation with a Care1st psychiatrist if clinically indicated. The expectation is that the PCP will continue to manage the member's psychotropic medications following the consultation if deemed appropriate. The member must have been seen by the PCP prior to requesting this type of consultation. The PCP may use the Behavioral Health Services Referral Form and check the "One Time Consultation" box for assistance in referring the member for consultation.

COORDINATION OF CARE

A member who is receiving psychotropic medication management services from their PCP may also receive non-medication management services through a behavioral health provider. Close coordination of care and regular communication between the PCP and the

behavioral health provider is essential. AHCCCS requires PCPs to respond to a behavioral health provider requests for information within 10 business days of receiving the request. The response should include all pertinent information regarding diagnoses, medication, laboratory results, last PCP visit and any recent hospitalizations.

Conversely, relevant behavioral health information from a behavioral health provider should be forwarded to a member's PCP at the initiation of treatment, periodically during ongoing treatment, in response to sentinel events such as a suicide attempt or a psychiatric hospital admission, and upon discharge from behavioral health services. PCPs must document or initial signifying review of a member's behavioral health information when received from a behavioral health provider.

PCPs are responsible for establishing a medical record when behavioral health information is received, even if the PCP has not yet seen the assigned member. In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member's medical record as soon as one is established.

TRANSFER OF CARE

A transfer of care referral should be initiated from the PCP to a behavioral health provider for evaluation and continued medication management services when the member has not responded to treatment within six months, has experienced an acute increase in the severity of symptoms, or has presented with additional behavioral health symptoms indicative of a disorder other than depression, anxiety or ADHD. Transfer of care to behavioral health should also occur following a sentinel event, such as a suicide attempt or psychiatric hospitalization, when there are co-morbid emotional, physical, sexual or substance abuse issues or at the member's request.

PCPs should use the Behavioral Health Services Referral Form, check the "Ongoing Behavioral Health Services" box, and fax to Care1st when transferring a member's care to a behavioral health provider.. The referral form includes a "Reason for Referral" section where the PCP describes the reason for transfer, including all diagnostic information. Current psychotropic medications should be listed under "Additional Information" and the PCP should designate whether the member has an adequate supply of these medications for the next 30 days. If not, the timeframes for dispensing and refilling medications during the transition period should be noted.

The PCP must ensure that a member has access to sufficient medication, by prescription or refill, until their first appointment with the behavioral health provider who will be continuing medication management services. PCPs may use the Pharmacy Prior Authorization Form located on our website under the Forms section of the Provider menu to request interim or "bridge" medication for the member until their first behavioral health medication appointment.

When a member attends the behavioral health intake appointment, the intake clinician may request medical records if clinically indicated. The intake clinician will fill out a request for medical records, have the member sign a release of information and fax or mail the request to the PCP. Upon receipt of a request for medical records or for additional medical information, the PCP must respond within 10 business days to ensure all pertinent information is received by the behavioral health provider prior to the member's first scheduled appointment with the behavioral health provider. This response should include all pertinent information regarding the reason for transfer, current diagnoses and medications, laboratory results, medication history, last date psychotropic medication was prescribed, last PCP visit and any recent hospitalizations.

Confidential medical records that are mailed to the behavioral health provider should be marked confidential and sealed appropriately. When medical records are faxed to the behavioral health provider, they are received on a confidential fax line and delivered directly to the assigned clinician and/or prescriber. Every precaution should be taken by the PCPs office staff to ensure the confidentiality of a member's medical record.

Note: A release of information from the member is required for any communication regarding substance abuse or HIV treatment.

Continuity of care is vital when transferring a member's behavioral health care from the PCP to a behavioral health provider, so PCPs are encouraged to call Care1st's Care Management Team to assist in the transition process. The Care Management Team will contact the member (or the member's parent or legal guardian) to verify that a behavioral health intake and medication appointment has been scheduled with the behavioral health provider. The care manager will discuss any member concerns regarding the transfer of care, confirm that sufficient medication is available, and if not, assist the member in obtaining a prescription for the required medication. After the intake and medication appointment has been scheduled, a follow up call will be made to the member and the behavioral health provider within 30 days to confirm that behavioral health services are in place. The member's behavioral health disposition will then be reported to their PCP by phone and/or fax.

OUT OF STATE PLACEMENT

It may be necessary to consider an out-of-state placement for a child or young adult to meet the member's unique circumstances or clinical needs.

The following circumstances must exist in order to consider an out-of-state placement for a member:

1. The CFT or ART will explore all applicable and available in-state services and placement options and,
    a. Determine that the services do not adequately meet the specific needs of the member, or
    b. In-state facilities decline to accept the member.

2. The member's family/guardian is in agreement with the out-of-state placement (for minors and members between 18 and under 21 years of age under guardianship),
3. The out-of-state placement is registered as an AHCCCS provider,
4. Prior to placement, ensure the member has access to non-emergent medical needs by an AHCCCS registered provider,
5. The out-of-state placement meets the Arizona Department of Education Academic Standards, and
6. A plan for the provision of non-emergency medical care must be established.

Prior authorization and approval from AHCCCS is required for all out-of-state placements.

PRE-PETITION SCREENING, COURT-ORDERED EVALUATION, AND COURT-ORDERED TREATMENT

At times, it may be necessary to initiate civil commitment proceedings to ensure the safety of a member, or the safety of other members, due to a member's mental disorder when that member is unable or unwilling to participate in treatment. In Arizona, state law permits any responsible member to submit an application for pre-petition screening when another member may be, as a result of a mental disorder:

- A danger to self (DTS);
- A danger to others (DTO);
- Persistently or acutely disabled (PAD); or
- Gravely disabled (GD).

If the person who is the subject of a court ordered commitment, proceeding is subject to the jurisdiction of an Indian Tribe rather than the state, the laws of that tribe, rather than state law, will govern the commitment process. Information about the tribal court process and the procedures under state law for recognizing and enforcing a tribal court order can be found in this section under Court-Ordered Treatment for American Indian Tribal Members in Arizona.

Pre-petition screening includes an examination of the member's mental status and/or other relevant circumstances by a designated screening agency. Upon review of the application, examination of the member and review of other pertinent information, a licensing screening agency's medical director or designee will determine if the member meets criteria for DTS, DTO, PAD, or GD as a result of a mental disorder.

If the pre-petition screening indicates that the person may be DTS, DTO, PAD, or GD, the screening agency will file an application for a court-ordered evaluation. Based on the immediate safety of the person or others, an emergency admission for evaluation may be necessary. The screening agency, upon receipt of the application shall act as prescribed within 48 hours of the filing of the application excluding weekends and holidays as described in A.R.S. §36-520.

Based on the court-ordered evaluation, the evaluating agency may petition the court-ordered treatment on behalf of the member. A hearing, with the member and his/her legal representative and the physician(s) treating the member, will be conducted to determine whether the member will be released and/or whether the agency will petition the court for court-ordered treatment. For the court to order ongoing treatment, the member must be determined, as a result of the evaluation, to be DTS, DTO, PAD, or GD. Court-ordered treatment may include a combination of inpatient and outpatient treatment. Inpatient treatment days are limited contingent on the member's designation as DTS, DTO, PAD, or GD. Members identified as:

- DTS may be ordered up to 90 inpatient days per year;
- DTO and PAD may be ordered up to 180 inpatient days per year; and
- GD may be ordered up to 365 inpatient days per year.

If the court orders a combination of inpatient and outpatient treatment, a mental health agency may be identified by the court to supervise the member's outpatient treatment. In some cases, the mental health agency may be the AHCCCS Complete Care (ACC) contractor; however, before the court can order a mental health agency to supervise the member's outpatient treatment, the agency medical director must agree and accept responsibility by submitting a written plan to the court.

At every stage of the pre-petition screening, court-ordered evaluation, and court-ordered treatment process, a member will be provided an opportunity to change his/her status to voluntary. Under voluntary status, the member is no longer considered to be at risk for DTS/DTO and agrees in writing to receive a voluntary evaluation.

County agencies and Care1st contracted agencies responsible for pre-petition screening and court-ordered evaluations may use the following forms prescribed in 9 A.A.C. 21, Article 5:

- Application for Involuntary Evaluation
- Application for Voluntary Evaluation (English/Spanish)
- Application for Emergency Admission for Evaluation
- Petition for Court-Ordered Evaluation
- Petition for Court-Ordered Treatment
- Affidavit, Addendum No. 1 and Addendum No. 2

In addition to court ordered treatment as a result of civil action, an individual may be ordered by a court for evaluation and/or treatment upon: 1) conviction of a domestic violence offense; or 2) upon being charged with a crime when it is determined that the individual is court ordered to treatment, or programs, as a result of being charged with a crime and appears to be an "alcoholic."

SECTION VII: Behavioral Health Services

Licensing Requirements
Behavioral health providers who are licensed by the Arizona Department of Health Services and Licensing Services as a court-ordered evaluation or courter-ordered treatment agency must adhere to Division of Licensing Services requirements.

County Contracts
Arizona Counties are responsible for managing, providing, and paying for pre-petition screening and court-ordered evaluations and are required to coordinate provision of behavioral health services with AHCCCS. Some counties contract with RBHAs to process pre-petition screenings and petitions for court-ordered evaluations. (See Arizona Revised Statutes A.R.S. §§ 36-545.04, 36-545.06 and 36-545.07). For additional information regarding behavioral health services refer to 9 A.A.C. 22, 2, &12. Refer to ACOM policy 437 for clarification regarding financial responsibility for the provision of medically necessary behavioral health services rendered after completion of a Court Ordered Evaluation.

The Northern Arizona Geographic Service Area is comprised of Apache, Navajo, Coconino, Yavapai, and Mohave Counties. Care1st is not contracted with the county governments in this GSA to provide pre-petition screenings and court-ordered evaluation services. Care1st has been informed either by the counties or by their subcontractors that the counties have made the following arrangements for pre-petition screening and court ordered evaluation services:

- Apache County has made arrangements with Little Colorado Behavioral Health Services, Inc. to accept pre-petition screenings and to assist with the court ordered evaluation process
- Navajo County has contracted with ChangePoint Integrated Health , Inc. to provide pre-petition screenings and court-ordered evaluations
- Coconino County has an intergovernmental agreement with AHCCCS for these services. In-turn, AHCCCS contracts with Health Choice Integrated Care to provide pre-petition screening and court ordered evaluation services. HCIC has contracted with The Guidance Center, Inc. to be the lead provider for pre-petition screenings and court-ordered evaluations. Encompass Health Services may provide pre-petition screenings in the northern part of Coconino County
- Yavapai County has contracted with Pronghorn Psychiatry to provide pre-petition screenings and court-ordered evaluations
- Mohave County has contracted with Mohave Mental Health Centers, Inc. to provide pre-petition screening

The Central Arizona Geographic Service area is comprised of Maricopa, Gila, and Pinal county. Care1st has been informed either by the counties or by their subcontractors that the counties have made the following arrangements for pre-petition screening and court ordered evaluation services:

- Maricopa County has an intergovernmental agreement with AHCCCS for these services. In-turn, AHCCCS contracts with Mercy Maricopa to provide pre-petition screening and court ordered evaluation services.
- Pinal County has made arrangements with Horizon Health & Wellness to provide pre-petition screenings and court-ordered evaluations.
- In Gila County, Community Bridges Inc. is the designated screening agency; however other behavioral health agencies may be granted permission upon request to the Gila County Attorney's Office

Based upon the county of location of the person to be screened and or evaluated behavioral health providers should contact the entities listed above to refer for pre-petition screening or court-ordered evaluation.

Pre-Petition Screening

Any behavioral health provider that receives an application for court-ordered evaluation (see AMPM Policy 320-U, Exhibit 320-U-1) must immediately refer the applicant for pre-petition screening and petitioning for court-ordered evaluation to a Care1st designated pre-petition screening agency or county facility.

The pre-petition screening agency must follow these procedures:

- Provide pre-petition screening within forty-eight hours excluding weekends and holidays;
- Prepare a report of opinions and conclusions. If pre-petition screening was not possible, the screening agency must report reasons why the screening was not possible, including opinions and conclusions of staff members who attempted to conduct the pre-petition screening;
- Have the medical director or designee of the pre-petition screening agency review the report if, it indicates that there is no reasonable cause to believe the allegations of the applicant for the court-ordered evaluation;
- Prepare a petition for court-ordered evaluation and file the petition if the pre-petition screening agency determines that the person, due to a mental disorder, including a primary diagnosis of dementia and other cognitive disorders, is DTS, DTO, PAD, or GD**.** AMPM Policy 320-U, Exhibit 320-U-3, documents pertinent information for court-ordered evaluation;
- If the pre-petition screening agency determines that there is reasonable cause to believe that the person, without immediate hospitalization, is likely to harm himself/herself or others, the pre-petition screening agency must ensure completion of AMPM Policy 320-U, Exhibit 320-U-2, and take all reasonable steps to procure hospitalization on an emergency basis;
- Contact the county attorney prior to filing a petition if it alleges that a person is DTO.

Emergent/Crisis Petition Filing Process For Contractors Contracted as Evaluating Agencies

When it is determined that there is reasonable cause to believe that the person being screened is in a condition that without immediate hospitalization is likely to harm themselves or others, an emergent application can be filed. The petition must be filed at the appropriate agency as determined by the Evaluating Agency.

- Only applications indicating DTS and/or DTO can be filed on an emergent basis.
- The applicant must have personally seen or witnessed the behavior of the person that is a danger to self or others and not base the application on second hand information.
- The applicant must complete the Application for Involuntary Evaluation Exhibit 320-U-1 as per AMPM Policy 320-U.
- The applicant and all witnesses identified in the application as direct observers of the dangerous behavior, may be called to testify in court if the application results in a petition for COE Within 48 hours of receipt of AMPM Policy 320-U, Exhibit 320-U-2 and all corroborating documentation necessary to successfully complete a determination, the admitting physician will determine if enough evidence exists for an emergency admission for evaluation. If there is enough evidence to support the emergency admission for evaluation, the facility is not currently operating at or above its allowable member capacity, and the person does not require medical transportation to the appropriate facility.
- If the person requires a medical facility, or if placement cannot be arranged within 48 hours after the approval of AMPM Policy 320-U, Exhibit 320-U-2, the Medical Director of the Contractor will be consulted arrange for a review of the case.
- An AMPM Policy 320-U, Exhibit 320-U-2, may be discussed by telephone with the facility admitting physician, the referring physician and a police officer to facilitate transportation of the person to be evaluated.
- A person proposed for emergency admission for evaluation may be apprehended and transported to the facility under the authority of law enforcement using the written AMPM Policy 320-U, Exhibit 320-U-2.
- A 23 hour emergency admission for evaluation begins at the time the person is detained involuntarily by the admitting physician who determines there is reasonable cause to believe that the person, as a result of a mental disorder, is a DTS or DTO and that during the time necessary to complete prescreening procedures the person is likely, without immediate hospitalization, to suffer harm or cause harm to others.
- During the emergency admission period of up to 23 hours the following will occur:
    a. The person's ability to consent to voluntary treatment will be assessed.
    b. The person shall be offered and receive treatment to which he/she may consent. Otherwise, the only treatment administered involuntarily will

be for the safety of the person or others, i.e. seclusion/restraint or pharmacological restraint in accordance with A.R.S § 36-513.

c. The psychiatrist will complete the Evaluation within 24 hours of determination that the person no longer requires involuntary evaluation.

Court-Ordered Evaluation

If the pre-petition screening indicates that the person may be DTS, DTO, PAD, or GD, the screening agency will file an application for a court-ordered evaluation. The procedures for court-ordered evaluations are outlined below:

Care1st and its subcontracted behavioral health provider must follow these procedures:

- A person being evaluated on an inpatient basis must be released within seventy-two hours (excluding weekends and holidays) if further evaluation is not appropriate, unless the person makes application for further care and treatment on a voluntary basis;
- A person who is determined to be DTO, DTS, PAD, or GD as a result of a mental disorder must have a petition for court-ordered treatment prepared, signed and filed by designated agency's medical director or designee; and
- Title XIX/XXI funds must not be used to reimburse court-ordered evaluation services.

Voluntary Evaluation

Any Care1st contracted behavioral health provider that receives an application for voluntary evaluation must immediately refer the member to the facility responsible for voluntary evaluations in the region/area where the member is located. The evaluation agency must obtain the member's informed consent prior to the evaluation (see AMPM Policy 320-U, Exhibit 320-U-7) and provide evaluation at a scheduled time and place within five days of the notice that the member will voluntarily receive an evaluation. For inpatient evaluations, the evaluation agency must complete evaluations in less than seventy-two hours of receiving notice that the person will voluntarily receive an evaluation; and if a behavioral health provider conducts a voluntary evaluation service as described in this section, the comprehensive clinical record must include:

- A copy of the application for voluntary evaluation, AMPM Policy 320-U, Exhibit 320-U-7 A completed informed consent form (see AMPM Policy 320-Q) and
- A written statement of the member's present medical condition.

Court-Ordered Treatment Following Civil Proceedings Under A.R.S. Title 36

Based on the court-ordered evaluation, the evaluating agency may petition for court-ordered treatment. The behavioral health provider must follow these procedures:

- Upon determination that an individual is DTS, DTO, GD, or PAD, and if no alternatives to court-ordered treatment exist, the medical director of the agency

that provided the court-ordered evaluation must file a petition for court-ordered treatment (see AMPM Policy 320-U, Exhibit 320-U-4)
- Any behavioral health provider filing a petition for court-ordered treatment must do so in consultation with the person's clinical team prior to filing the petition;
- The petition must be accompanied by the affidavits of the two physicians who conducted the examinations during the evaluation period and by the affidavit of the applicant for the evaluation (see AMPM Policy 320-U, Exhibit 320-U-5);
- A copy of the petition, in cases of grave disability, must be mailed to the public fiduciary in the county of the patient's residence, or the county in which the person was found before evaluation, and to any person nominated as guardian or conservator; and
- A copy of all petitions must be mailed to the superintendent of the Arizona State Hospital.

Persons Who Are Title XIX/XXI Eligible And/Or Determined To Have SMI
When a person referred for court-ordered treatment is Title XIX/XXI eligible and/or determined or suspected to have a Serious Mental Illness, the behavioral health provider will:
- Conduct an evaluation to determine if the person has a Serious Mental and conduct a behavioral health assessment to identify the person's service needs in conjunction with the person's clinical team
- Provide necessary court-ordered treatment and other covered behavioral health services in accordance with the person's needs, as determined by the person's clinical team, the behavioral health member, family members, and other involved parties; and
- Perform, either directly or by contract, all treatment required by A.R.S. Title 36, Chapter 5, Article 5 and 9 A.A.C. 21, Article 5.

Transfer from one behavioral health provider to another
A member ordered by the court to undergo treatment can be transferred from one behavioral health provider to another behavioral health provider if:
- The member does not have a court appointed guardian;
- The medical director of the receiving behavioral health provider accepts the transfer; and
- The consent of the court for the transfer is obtained as necessary
- In order to coordinate a transfer of a person under court-ordered treatment to ALTCS or another ACC, the behavioral health member's clinical team will coordinate with Care1sts' Court Coordinator/Liaison.

Court-Ordered Treatment For Persons Charged With Or Convicted Of A Crime
Care1s or its providers may be responsible for providing evaluation and/or treatment services when an individual has been ordered by a court due to:
- Conviction of a domestic violence offense; or

- Upon being charged with a crime when it is determined that the individual is court ordered to treatment, or programs, as a result of being charged with a crime and appears to be an "alcoholic."

Domestic Violence Offender Treatment
Domestic violence offender treatment may be ordered by a court when an individual is convicted of a misdemeanor domestic violence offense. Although the order may indicate that the domestic violence (DV) offender treatment is the financial responsibility of the offender under A.R.S. § 13-3601.01, Care1st will cover DV services with Title XIX/XXI funds when the person is Title XIX/XXI eligible, the service is medically necessary, required prior authorization is obtained if necessary, and/or the service is provided by an in-network provider. For Non-TXIX/XXI eligible persons' court ordered for DV treatment, the individual can be billed for the DV services.

Court ordered substance abuse evaluation and treatment
Substance abuse evaluation and/or treatment (i.e., DUI services) ordered by a court under A.R.S. § 36-2027 is the financial responsibility of the county, city, town or charter city whose court issued the order for evaluation and/or treatment. Accordingly, if ADHS/AHCCCS or Care1st receives a claim for such services, the claim will be denied and the provider is to bill the responsible county, city or town.

Court-Ordered Treatment for American Indian Tribal Members in Arizona
Arizona tribes are sovereign nations, and tribal courts have jurisdiction over their members residing on reservation. Tribal court jurisdiction, however, does not extend to tribal members residing off the reservation or to state court ordered evaluation or treatment ordered because of a behavioral health crisis occurring off reservation. Although some Arizona tribes have adopted procedures in their tribal codes, which are similar to Arizona law for court ordered evaluation and treatment, each tribe has its own laws which must be followed for the tribal court process. Tribal court ordered treatment for American Indian tribal members in Arizona is initiated by tribal behavioral health staff, the tribal prosecutor or other person authorized under tribal laws. In accordance with tribal codes, tribal members who may be a danger to themselves or others and in need of treatment due to a mental health disorder are evaluated and recommendations are provided to the tribal judge for a determination of whether court ordered treatment is necessary. Tribal court orders specify the type of treatment needed.

Additional information on the history of the tribal court process, legal documents and forms as well as contact information for the tribes, Care1st liaison(s), and tribal court representatives can be found on the AHCCCS web page titled, Tribal Court Procedures for Involuntary Commitment -Information Center.

Since many tribes do not have treatment, facilities on reservation to provide the treatment ordered by the tribal court, tribes may need to secure treatment off reservation for tribal

members. To secure court ordered treatment off reservation, the court order must be "recognized" or transferred to the jurisdiction of the state.

The process for establishing a tribal court order for treatment under the jurisdiction of the state is a process of recognition, or "domestication" of the tribal court order (see A.R.S. § 12-136). Once this process occurs, the state recognized tribal court order is enforceable off reservation. The state recognition process is not a rehearing of the facts or findings of the tribal court. Treatment facilities, including the Arizona State Hospital, must provide treatment, as identified by the tribe and recognized by the state. AMPM Policy 320-U, Exhibit 320-U-6, A.R.S. § 12-136 Domestication or Recognition of Tribal Court Order is a flow chart demonstrating the communication between tribal and state entities. Care1st and its providers must comply with state recognized tribal court orders for Title XIX/XXI and Non-Title XIX SMI persons. When tribal providers are also involved in the care and treatment of court ordered tribal members, Care1st and its providers must involve tribal providers to ensure the coordination and continuity of care of the members for the duration of court ordered treatment and when members are transitioned to services on the reservation, as applicable.

This process must run concurrently with the tribal staff's initiation of the tribal court ordered process in an effort to communicate and ensure clinical coordination with the Caer1st. This clinical communication and coordination with Care1st is necessary to assure continuity of care and to avoid delays in admission to an appropriate facility for treatment upon state/county court recognition of the tribal court order. The Arizona State Hospital should be the last placement alternative considered and used in this process.

A.R.S. § 36-540 (B) states, "The Court shall consider all available and appropriate alternatives for the treatment and care of the patient. The Court shall order the least restrictive treatment alternative available." Care1st will partner with American Indian tribes and tribal courts in their geographic service areas to collaborate in finding appropriate treatment settings for American Indians in need of behavioral health services. Due to the options, American Indians have regarding their health care, including behavioral health services, payment of behavioral health services for AHCCCS eligible American Indians may be covered through a T/RBHA, ACC, or IHS/638 provider. See on the AHCCCS website under Tribal Court Procedures for Involuntary Commitment-Tribal Court Procedures for Involuntary Commitment for a diagram of payment structures.

FISCAL RESPONSIBILITY

Benefit Coordination for Behavioral Health Services and Physical Health Services is outlined in Policy 432 of the AHCCCS Contractor Operations Manual (ACOM). The policy is located at the following website: http://www.azahcccs.gov/shared/ACOM/Chapter400.aspx > select policy 432.