Section 1115 SMI/SED Demonstration Implementation Plan
July 23, 2019

Overview: The implementation plan documents the state's approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on "Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]" over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state's implementation plan.

Memorandum of Understanding: The state Medicaid agency should enter into a Memorandum of Understanding (MOU) or another formal agreement with its State Mental Health Authority, if one does not already exist, to delineate how these agencies will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED. This MOU should be included as an attachment to this Implementation Plan.

State Point of Contact: Please provide the contact information for the state's point of contact for the implementation plan.

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1. Title page for the state's SMI/SED demonstration or SMI/SED components of the broader demonstration

The state should complete this transmittal title page as a cover page when submitting its implementation plan.

State	Alabama
Demonstration name	*1115 SMI/SED Demonstration Implementation Plan*
Approval date	*TBD – Waiver to be submitted March 1, 2021*
Approval period	*TBD*
Implementation date	*Requested effective date October 1, 2021*

2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state's SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place "NA" in the summary cell if a prompt does not pertain to the state's demonstration. Answers are meant to provide details beyond the information provided in the state's special terms and conditions. Answers should be concise, but provide enough information to fully answer the question.

This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	*Current Status:* Alabama statute and Alabama Medicaid administrative code currently require licensure of all hospitals operating and/or participating in Medicaid within the state. In addition psychiatric facilities serving individuals 65 or older and psychiatric facilities serving individuals 21 and younger are currently required to be accredited by the Joint Commission (AL 9.2 Chapter 5, Rule 560 and Chapter 41, Rule 560).
	Future Status: Alabama Medicaid will amend the administrative code to include rules for hospitals in the demonstration region serving individuals 21-64 and include requirements for licensure in the state as well as accreditation.
	Summary of Actions Needed: Administrative code changes will be completed within the first quarter of post-implementation.
1.b Oversight process (including unannounced visits) to ensure participating hospital and	*Current Status:* As noted on 1.a above, inpatient psychiatric facilities must be accredited by the Joint Commission and have deemed status.

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residential settings meet state's licensing or certification and accreditation requirements	*Future Status:* Alabama Medicaid and the Alabama Department of Mental Health (ADMH) will develop an oversight process of the IMDs participating in the Demonstration that will complement the current Joint Commission process.
	Summary of Actions Needed: Oversight process development and any associated administrative code changes will be completed within the first quarter of post-implementation.
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	*Current Status:* Alabama Medicaid has rules in place to ensure that level of care need is met prior to admission as well as in regard to continued stays within inpatient settings for adults 65 or older. The state's current vendor for these services is Comagine. **Rule No. 560-X-5-.04. Certification of Need for Service.** (1) Certification of need for services is a determination which is made by a physician regarding the Medicaid recipient's treatment needs for admission to the facility. (2) The physician must certify for each applicant or recipient that inpatient services in a mental hospital are or were needed. (3) The certification must be made at the time of admission. No retroactive certifications will be accepted. (4) For individuals applying for Medicaid while in the hospital, the certification must be made before Medicaid can authorize payment. (5) The physician must complete the PSY-5 form, which is the certification of need for care. This form must be kept in the patient's record. (6) The PSY-6 form, or acceptable equivalent approved by Medicaid, which is the recertification of need for continued inpatient services for each applicant or recipient, must be completed by a physician, a physician assistant, or a nurse practitioner acting under the supervision of a physician. (7) The PSY-6 form, or acceptable equivalent must be completed at least every 60 days after initial certification. This form must be kept in the patient's record. (8) The physician must complete an assessment note in the patient's record within 24 hours of a patient's return from any leave status. **Rule No. 560-X-5-.10. Inpatient Utilization Review** (1) The determination of the level of care will be made by a licensed nurse of the hospital staff. (2) Five percent of all admissions and concurrent stay charts will be retrospectively reviewed by the Medicaid Agency or designee on a monthly basis. (3) For an individual who applies for Medicaid while in the facility, a Psychiatric Admission form must be signed by the attending physician at the time application for Medicaid is made. (4) The following information shall be included on the Psychiatric Admission Form: (a) Recipient information: 1. admitting diagnosis; 2. events leading to hospitalization;

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	3. history of psychiatric treatment; 4. current medications; 5. physician orders; 6. presenting signs and symptoms. (b) Events leading to present hospitalization (c) History and physical (d) Mental and physical capacity (e) Summary of present medical findings including prognosis (f) Plan of care. (5) Medicaid's Psychiatric Criteria for Age 65 or Over will be utilized in reviewing whether the admission and continued stay were appropriately billed. **Rule No. 560-X-5-.07. Utilization Review (UR) Plan.** As a condition of participation in the Title XIX Medicaid program, each psychiatric facility shall: (1) Have in effect a written UR Plan that provides for review of each recipient's need for services that the facility furnishes to him. This written UR Plan must meet the requirements under 42 C.F.R Section 456.201 through Section 456.245; (2) Maintain recipient information required for the UR Plan under 42 C.F.R. Section 456.211, which shall include the certification of need for service and the plan of care; and (3) Provide a copy of the UR Plan and any subsequent revisions to Medicaid for review and approval. **Rule No. 560-X-5-.10. Inpatient Utilization Review** (1) The determination of the level of care will be made by a licensed nurse of the hospital staff. (2) Five percent of all admissions and concurrent stay charts will be retrospectively reviewed by the Medicaid Agency or designee on a monthly basis. (3) For an individual who applies for Medicaid while in the facility, a Psychiatric Admission form must be signed by the attending physician at the time application for Medicaid is made. (4) The following information shall be included on the Psychiatric Admission Form: (a) Recipient information: 1. admitting diagnosis; 2. events leading to hospitalization; 3. history of psychiatric treatment; 4. current medications; 5. physician orders; 6. presenting signs and symptoms. (b) Events leading to present hospitalization

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	(c) History and physical (d) Mental and physical capacity (e) Summary of present medical findings including prognosis (f) Plan of care. (5) Medicaid's Psychiatric Criteria for Age 65 or Over will be utilized in reviewing whether the admission and continued stay were appropriately billed. **Rule No. 560-X-5-.11. Continued Stay Reviews.** (1) The hospital's utilization review personnel will be responsible for performing continued stay reviews on recipients who require continued inpatient hospitalization. (2) The initial continued stay review should be performed on the date assigned by Medicaid. Subsequent reviews should be performed at least every 90 days from the initial CSR date assigned, provided the patient is approved for continued stay. Each continued stay review date assigned should be recorded in the patient's record. (3) If the facility's utilization review personnel determine the patient does not meet the criteria for continued stay, the case should be referred to the facility's psychiatric advisor. If the advisor finds that the continued stay is not needed, the hospital's utilization review procedure for denial of a continued stay should be followed. (4) If a final decision of denial is made, the hospital must notify the recipient and the attending physician within two days of the adverse determination. Medicaid should be notified in writing within 10 days after the denial is made. (5) The facility's utilization review personnel shall be responsible for phoning Medicaid with a report whenever patients are placed on leave status or return from leave. A brief summary describing the outcome of the therapeutic leave should be addressed at this time for patients returning from any leave status. As part of the state's Medicaid Emergency Psychiatric Demonstration (MEPD) program, participating IMDs, the state created and successfully implemented similar requirements for enrollees served within an IMD during the demonstration period.
	Future Status: The state plans to reinstate certificate of need forms utilized during the MEPD demonstration. The existing vendor contract for inpatient utilization management (CON confirmation) is scheduled to be (re)procured prior to demonstration implementation and the contract will be updated to reflect the SMI demonstration tasks that will be under contract with the vendor.
	Summary of Actions Needed: Update utilization review vendor contract during upcoming procurement. This procurement is anticipated to be complete prior to implementation of the SMI/SED demonstration.
1.d Compliance with program integrity	*Current Status:* In order to receive reimbursement under Medicaid, participating psychiatric hospitals must be enrolled to participate in Alabama Medicaid. Provider enrollment processes fully comply with 42 CFR Part 45 Subparts B&E.

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requirements and state compliance assurance process	*Future Status:* Continued operation of current requirements.
	Summary of Actions Needed: N/A – milestone requirements already met.
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	*Current Status:* Upon patient admission, an attending physician conducts a thorough mental and physical examination of the patient to determine the admitting diagnosis, any contributing factors and to develop a plan of care that will stabilize the patient and provide for a smooth transition to any post-acute care needed. This information, along with an estimate of the number of days needed for stabilization, is recorded on the Psychiatric Admission Form and signed by the physician. The standardized Psychiatric Admission Form documents, at minimum, the following information: 1. Events leading to present hospitalization 2. Diagnosis 3. History and physical, including any evidence of substance abuse 4. Mental and physical capacity 5. Summary of present medical findings, including prognosis 6. Plan for stabilization to include estimated number of inpatient days needed to stabilize the patient The anticipated discharge plan is also identified upon admission. This includes an assessment of the anticipated aftercare living arrangement/placement and services required upon discharge.
	Future Status: The State will continue to leverage these processes developed for the MEPD demonstration.
	Summary of Actions Needed: N/A – milestone requirements already met.
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	*Current Status:* IMD inpatient providers within the demonstration region currently survey each individual served upon discharge. These surveys are provided to families by the nursing staff, with results tabulated electronically. Results are utilized to identify potential performance improvement projects.
	Future Status: Providers will continue satisfaction survey process.
	Summary of Actions Needed: N/A-milestone requirements already met.
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out	*Current Status:* Alabama administrative code requires that psychiatric hospitals have in effect a written discharge planning process that applies to all patients and includes the following minimum components: • Identification at an early stage of hospitalization all patients who are likely to suffer adverse health

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intensive pre-discharge planning, and include community-based providers in care transitions.	consequences upon discharge if there is no adequate discharge planning. • Discharge planning evaluation conducted by a registered nurse, social worker, or other appropriately qualified personnel to develop or supervise the development of the evaluation. • An evaluation of the likelihood a patient will need post-hospital services, the availability of the services and the patient's capacity for self-care or being cared for in the environment from which he or she entered the hospital. • Completion of the discharge evaluation process on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge. • Development of a discharge plan, with requirement for the hospital to arrange for the initial implementation of the plan. • Requirement for the hospital to transfer or refer patients, along with necessary medical information, to appropriate licensed facilities, agencies or outpatient services for follow up or ancillary care. Additionally, the Alabama Department of Mental Health (ADMH) requires community mental health centers (CMHCs) to have follow-up appointments within 72 hours for individuals hospitalized under civil or forensic commitment. The state encourages CMHCs to conduct follow-up appointment within 72 hours for all other inpatient psychiatric admissions. The State also contracts with primary case management entities (PCCM-E), through the Alabama Coordinated Health Network (ACHN), which are tasked with providing discharge planning supports. PCCM-Es are contractually required to establish processes to assist enrollees in transitioning from a facility to community setting. Minimum discharge planning requirements include reviewing daily census at inpatient settings to identify enrollees needing support at discharge and collaborating with hospital or facility discharge planners, care coordinators, and behavioral health staff in preparation for the individual's return to the community. Further, the IMDs that will participate in the Demonstration operate a bridge team that serves as a bridge between hospitalization and outpatient services. A multi-disciplinary team of IMD professionals provides time-limited, intensive follow-up and support services designed to prevent decompensation and re-hospitalization. Finally, the ADMH and Alabama Hospital Association are leading a collaborative committee with broad-based representation from CMHCs, law enforcement, advocacy groups, hospitals and state agencies. This committee and its associated workgroups are exploring strategies to increase continuity of care for transitions between inpatient and outpatient settings. The committee is exploring strategies such as utilization of crisis centers, appropriate and safe housing and workforce development. One of the workgroups of this committee is dedicated to discharge placements. Specifically, this workgroup is charged with addressing all issues from the time patients are assessed for discharge to their placement in the community. Examples of issues being discussed by the committee include minimum standards

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	for community services and availability of information on community resources. This workgroup is developing resources to identify community resources to be made available as part of the discharge planning process.
	Future Status: Continued operation of current requirements, programming, and workgroup activity.
	Summary of Actions Needed: N/A – milestone requirements already met.
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	*Current Status:* As part of the MEPD Demonstration, the state developed mandated admission forms for use by participating IMDs. As part of this process, the anticipated discharge plan is started upon admission. This includes an assessment of the anticipated aftercare living arrangement/placement and services required upon discharge. Additionally, the State has focused on initiatives to increase the availability of evidence-based housing models for individuals with SMI. For example, from October 2017 through February 2018, ADMH convened local leaders and experts in affordable housing and services from across the state to form the Housing Leadership Group (HLG). An outcome of the HLG was development of the Alabama Permanent Supportive Housing Strategic Plan which is a five-year plan offering strategic objectives and action steps to help maintain, increase, and better utilize permanent supportive housing (PSH) for persons with SMI across the state of Alabama. The goals of the PSH Strategic Plan include: • *Goal 1:* Develop the infrastructure necessary to access PSH. o Create staffing infrastructure for housing coordinators at the state and regional levels to support assessment and referral processes, leverage existing relationships, and build new local partnerships to access housing. o Improve the mental health system's ability to identify, through assessments, persons with SMI who have the greatest housing and service needs and persons who are ready to move on to less restrictive settings. o Build a sustainable referral process, including a plan for staffing a mental health system that makes timely, actionable, consumer-driven housing referrals for persons with SMI at the highest need for which they are eligible. • *Goal 2:* Maximize and maintain existing housing resources. o Preserve existing set-aside units for persons with SMI. o Fully utilize available housing units that are set aside or prioritized for persons with disabilities. o Reduce barriers to accessing and maintaining housing through education to stakeholders about accommodations. • *Goal 3:* Develop new PSH housing and rapid re-housing opportunities. o Identify capital and rental assistance opportunities. o Assess feasibility of strategies to convert existing ADMH residential programs to PSH. • *Goal 4:* Establish priority populations for PSH.

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	○ Work to adopt the following list as the priority populations for PSH and rapid re-housing (RRH) including persons with SMI who also have forensic histories, ID/DD, co-occurring substance use disorders, persons with high-cost high-need services, and those with medically complex diagnoses. • *Goal 5:* Ensure sufficient capacity in services to successfully support diverse populations in PSH. ○ Expand PSH capacity to move persons from forensic residential programs into PSH and move those from Bryce Hospital who are ready to move into forensic residential programs by increasing services and supports for this population. ○ Transition up to 50 persons with SMI and medically complex conditions from residential group homes and state hospitals by providing HCBS services and supports. ○ Identify the top 100 high cost ADMH Medicaid recipients to better understand their patterns of services utilization, the relationship between service utilization and housing status, and to develop enhanced PSH capacity as a cost-reducing health care intervention. • *Goal 6*: Implement and oversee the PSH Strategic Plan. ○ Build and sustain collaboration between affordable housing and behavioral health system partners at both the state and local levels.
	Future Status: ADMH is working toward implementing the aforementioned five-year strategic plan to implement evidence-based housing models.
	Summary of Actions Needed: Implementation of five-year strategic plan.
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community- based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	*Current Status:* The IMDs that will participate in the Demonstration will conduct follow-up calls within 72 hours of a patient's discharge. Data on successful outreach is regularly tracked. As previously mentioned, ADMH also requires CMHCs to have follow-up appointments within 72 hours for individuals hospitalized under civil or forensic commitment. The state encourages CMHCs to conduct follow-up appointment within 72 hours for all other inpatient psychiatric admissions. Additionally, PCCM-Es are contractually required to develop a Transitional Care Program to support enrollees identified as needing care coordination services when discharged from an inpatient or residential setting to ensure continued management of care. As part of this program, PCCM-E transitional care nurses are required to: • Complete a face-to-face health risk and psychosocial assessment within ten days of discharge to ensure appropriate home-based support and services are available. • Develop a care plan to address identified needs. • Implement medication reconciliation in concert with the physician and transitional pharmacist within ten days of discharge. • Educate enrollees regarding medical management and provide referrals to resources within ten days of

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	discharge. • Provide transitional care services until all goals are met. • Ensure proper transition and coordination with ADMH, Medicaid and CMHCs.
	Future Status: Continued operation of current requirements.
	Summary of Actions Needed: N/A - milestone requirements already met.
2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	*Current Status:* ADMH launched the Stepping Up Initiative in 2018. The state expanded the program beyond serving those in jails, to emergency rooms as well. The goal of Alabama's Stepping Up Initiative is to reduce the number of people with SMI in jails and emergency rooms. In June 2018, ADMH released a Request for Proposal (RFP) for CMHCs to apply for an award of $50,000. This award supported intensive case management services to screen, assess, develop a case plan for and link clients to appropriate, necessary mental health (i.e., group/individual mental health counseling, crisis intervention, and court advocacy) and social services (i.e., housing, transportation, food); recruitment for and facilitation of a local planning committee to create supportive local policies, and community outreach to mobilize community support. Additionally, the IMDs that will participate in the Demonstration provide hospital consultation services for patients who need a psychiatric consult at Mobile area hospitals including Providence, Springhill, USA and USA Children's and Women's, and Thomas Hospital in Fairhope. Their psychiatrists work with primary care physicians, specialists, nurses and hospital staff to communicate, coordinate and integrate medical and psychiatric care that maximizes the benefit to their mutual patients. If an AltaPointe patient is admitted to any local hospital and needs psychiatric care as well as medical care, the hospital psychiatrist will be a participating-IMD psychiatrist. Additionally, participating IMDs operate crisis response teams (CRTs) that travel to patients in the counties in which the Demonstration will operate (Mobile, Baldwin and Washington). CRT members work with family members, law enforcement and hospital emergency room personnel to diffuse any imminent danger and stabilize the patient. Team members encourage patients in crisis to cooperate with appropriate follow-up treatment so they may avoid unnecessary or involuntary hospitalization.
	Future Status: ADMH has a goal of incorporating a Stepping Up program in every Alabama county by the end of Fiscal Year 2022. The state legislature allotted $1.8 million for Fiscal Year 2021, to expand the program by an additional 28 counties.
	Summary of Actions Needed: The Stepping Up program is currently being expanded into multiple additional counties throughout the state by the end of SFY 22.

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2.e Other State requirements/policies to improve care coordination and connections to community-based care	*Current Status:* Alabama offers multiple Targeted Case Management (TCM) programs, including the following targeted to Medicaid enrollees with behavioral health conditions: • Mentally ill adults: Medicaid-eligible individuals age 18 and over who have been diagnosed with mental illness. • Disabled Children: Medicaid-eligible individuals age 0-21 and who are considered disabled. • Individuals with a Diagnosed Substance Use Disorder: Medicaid-eligible individuals of any age who have been diagnosed with a substance use disorder. • Disabled Children with Autism Spectrum Disorder (ASD) or Serious Emotional Disturbance (SED) and Severely Mentally Ill Adults – High Intensity Care Coordination: Medicaid-eligible individuals age 0-20 or until the individual reaches age 21 who have ASD or SED or an adult with a severe mental illness and requires high intensity care coordination. o Includes youth with multi-system involvement and/or previous institutional level of care. TCM services include: • Needs assessment • Case planning • Service arrangement • Social support • Reassessment and follow-up • Monitoring
	Future Status: Continued operation of current requirements.
	Summary of Actions Needed: N/A - milestone requirements already met.
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental	*Current Status:* The Alabama Department of Mental Health's Division of Mental Health and Substance Abuse partners with community providers to deliver a comprehensive array of evidence-based prevention, treatment and recovery-based peer support services throughout the state. ADMH's responsibilities encompass contracting for services, monitoring service contracts, as well as evaluating and certifying service programs according to regulations

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health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports.	established in the Alabama Administrative Code. In addition, the division manages ADMH's three mental health facilities: Bryce Hospital, Mary Starke Harper Geriatric Psychiatry Center, and Taylor Hardin Secure Medical Facility. There are now 19 public, non-profit regional mental health boards (called 310 Boards based on ACT 310 of the 1967 Regular Session of the Alabama Legislature). There are 24 community mental health centers in the 19 service areas, 19 being the 310 Board community mental health centers (CMHC) and 5 being community mental health centers that are operational under a 310 Board CMHC. Expectations for providing minimum continuum of care services for a community mental health provider or a community mental health center is outlined fully in the Alabama Department of Mental Health Mental Illness Community Programs within the Administrative Code – Chapter 580-2-9, Program Standards The following offices under the Division of Mental Health and Substance Abuse share in the roll of ensuring provider network adequacy for behavioral health services in Alabama and will assist in providing data for the initial and ongoing assessment of the availability of mental health services in the demonstration region: The ADMH **Office of MSHA Certification** conducts reviews of mental health and substance abuse community providers to secure compliance with the Program Operations Administrative Code. In addition to conducting onsite reviews, the staff provides technical assistance to providers to enhance compliance with the Administrative Code. The ADMH **Office of Deaf Services** is responsible for developing and implementing programs that meet the linguistic and cultural needs of consumers who are deaf or hard of hearing. Deaf Services work to ensure that communication barriers are eliminated. Services are designed to be affirmative, supportive and culturally competent. The ADMH **Office of Mental Illness Community Programs** serves as the primary liaison between the department and community mental health providers. This office manages all aspects of mental health treatment by interacting with community providers. Coordination of mental health services includes ensuring quality programs exist for our priority populations of adults with Serious Mental Illness (SMI) and children/adolescents with Serious Emotional Disturbance (SED). This office ensures quality standards are met, the flow of funds and services are efficient, and requirements attached to federal funds are in place. The ADMH **Office of MHSA Peer Programs** is managed by a consumer and provides information, technical support, and assistance to consumers and consumer organizations throughout the state. This office ensures that consumers have a voice in the ADMH planning process, management and service delivery system. Each year more than 800 consumers attend the Alabama Recovery Conference to learn about timely issues, consumer empowerment and self-advocacy. The ADMH MHSA **Office of Pharmacy** provides administrative support and coordination for ADMH's overall

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	pharmaceutical operations including monitoring of expenditures, formulary maintenance and coordinating with community and facility pharmacists. Under SAMHSA, the Pharmacy Office serves as the State Opioid Treatment Authority administrator in conjunction with the Office of Substance Abuse Treatment Services and the Office of Certification. This office also works directly with consumers, families and consumer groups to resolve pharmacy related problems and medication accessibility issues. The ADMH **Office of Substance Abuse Prevention Services** manages all aspects of substance use disorder prevention including services for people of all ages, the Strategic Prevention Framework, the Alabama Epidemiological Outcomes Workgroup, Synar (Tobacco Sales to Minors Program), state incentive grant, regional information clearinghouses and coalition development/support. The ADMH **Office of MHSA Quality Improvement & Risk Management** collects input related to patient care and outcomes from stakeholders, and coordinates activities for performance improvement efforts across the facilities and certified community programs. QIRM measures indicators related to standards of care and consumer satisfaction in facilities and community programs to identify trends, problems or opportunities for improvement. The ADMH **Office of Substance Abuse Treatment Services** manages all aspects of substance use disorder treatment by interacting with community providers. Coordination of services includes ensuring quality programs exist for distinct populations such as adolescents, adults, and persons with co-occurring disorders (mental illnesses and substance use disorders). This office also manages opioid treatment programs and prescribed Medicaid services. For years, ADMH has monitored the utilization of public mental health services through analyzing service data reported to ADMH. This data, in conjunction with periodic survey of the providers, allowed ADMH to identify trends in service utilization by the consumers. Other sources of data utilized by ADMH include the U.S. Bureau of Census, the National Uniform Reporting System (URS), Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Surveys, ADMH web-based housing inventory (MICRS), ADMH web-based commitment system (Gateway), Child Adolescent Needs and Strengths (CANS) functional assessment tool, ADMH certification results from provider site visits, HUD Point in Time count, Housing Needs Assessments, and hospital and community Performance Improvement data sets. Another very valuable measure ADMH has for identification of gaps in the service delivery continuum for children and adolescents is through its participation in the Case Review Committee of the Multiple Need Child Office. This staffing occurs monthly with legislatively mandated child-serving agencies charged with developing plans for children

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	who have multiple needs and who are at risk of placement in a more restrictive setting. ADMH has exchanged service data with other state agencies, including but not limited to the Alabama Medicaid Agency, Department of Public Health, ALL Kids, Juvenile and Adult Corrections, the Administrative Office of the Courts, Department of Education, and Department of Human Resources, to provide a comprehensive array of publicly funded services to adults and children/adolescents through memoranda of understanding, intergovernmental service agreements, or informal relationships. Also, ADMH worked with the Administrative Office of the Courts to match the ADMH mental health database with mental health court participants. Because Community Mental Health Centers are expected to offer a broad array of services to a demographically and psychiatrically diverse population, the following additional requirements regarding the overall operation of the agency must be met: • Staff capable of providing specialty outpatient services to children, adolescents, adults, and older adults. • Should be able to demonstrate community outreach efforts designed to promote access from all age groups with particular emphasis on those who are seriously mentally ill or severely emotionally disturbed. • The number of recipients both total and by service type and the services provided are acceptable for the time period that the agency has been operational and are roughly proportionate to the number of consumers and types of services provided by agencies similarly certified. • The provider can demonstrate appropriate response to consumers for whom a petition for involuntary commitment has been issued and/or who have been hospitalized at a state psychiatric hospital. • At the end of the first year of operation, the agency must have served at least 100 consumers and the services provided should be proportionate to the average of those agencies that are similarly certified. The community mental health centers work with a variety of public and private resources to obtain services and supports needed by SMI and SED consumers in the community. Case Management services are essential to successful maintenance of persons who have SMI and SED in the community. Adult case managers and supervisors are trained either locally through an approved training curriculum or at training sessions provided by Jefferson-Blount-St. Clair Mental Health/Mental Retardation Authority (JBS). All Child and Adolescent case managers and their supervisors are trained through an ADMH and Medicaid approved training curriculum. ADMH contracts with JBS Mental Health Authority to provide these trainings. These sessions held by JBS, to include C&A In-Home Intervention, occur about every two months. The certification standards require successful completion of this training prior to provision of services. In FY20, 8,332 adults and 3,446 children and adolescents had received case management services. Every community mental health center has case management services for adults and children and adolescents. The following services must be delivered within the Case Management Program:

Prompts	Summary
	• A systematic determination of the specific human service needs of each consumer. • The development of a systematic consumer coordinated written plan that is developed within 30 days of first face-to-face case management service unless services terminate earlier and that lists the actions necessary to meet the needs of each consumer. • Assisting the consumer through crisis situations and/or arranging for the provision of such assistance by other professional/personal caregivers. • The direct delivery, or the arrangement for, transportation to needed services if the consumer is unable to transport him or herself. • Establishing links between the consumer and service providers or other community resources. • Advocating for and developing access to needed services on the consumer's behalf when the consumer himself is unable to do so alone. • Monitoring of the consumer's access to, linkage with, and usage of necessary community supports as specified in the case plan. • Systematic reevaluation (at 6 months after the original case plan was developed and intervals of 12 months thereafter) of the consumer's human service needs and the consumer's progress toward planned goals so that the established plans can be continued or revised.
	Future Status: Alabama Medicaid, in partnership with ADMH, will continue to monitor provider network capacity on an annual basis.
	Summary of Actions Needed: Alabama Medicaid will submit an updated Provider Network Template annually and conduct outreach in areas where gaps in services are noted.
3.b Financing plan	*Current Status* Please refer to Financing Plan below.
	Future Status: Please refer to Financing Plan below.
	Summary of Actions Needed: Please refer to Financing Plan below.
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	*Current Status:* The Alabama Incident Management System (AIMS) is a computer software program that allows the Alabama Department of Public Health (ADPH) to monitor hospitals, nursing homes, and ambulance resources. IMDs participating in this demonstration enter bed availability daily. This database is utilized to confirm bed capacity when processing applications for and inpatient certificate of need. AIMS is a secure, encrypted, web-based program that allows and encourages ongoing, real-time communication between healthcare facilities including Hospitals, Nursing Homes, Community Health Centers, Medical Needs Shelters, Healthcare Coalitions members (HCC), and local, area and state Emergency Operations Centers (EOC),

Prompts	Summary
	representing nearly 500 organizations utilizing AIMS and over 2,000 users. Under normal conditions, healthcare facilities utilize AIMS to share information including status updates of organizational resources (beds, staff, facility operating systems, and fuel) and communicate any resource needs and/or capabilities to provide assistance. When emergency conditions begin to stress the surge capacity and capability of local response systems, coalition partners and EOC staff are able provide support and coordination of resource requests through AIMS. Additional operational features include the use of Reporting Forms to collect surveillance data specific to each of Alabama's nine Healthcare coalitions and/or state-wide. Reporting Forms are customized based on Public Health events such as Heat Related Injuries, Influenza, Hurricanes Florence and Michael, E.D. Psych Reporting, and Surges in Emergency Rooms. AIMS also includes a People Tracking module to track individuals entering and discharging healthcare facilities and Public Health Medical Needs Shelters throughout the state.
	Future Status: Continue operation of AIMS and participation among demonstration providers.
	Summary of Actions Needed: N/A-milestone requirements already met.
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	*Current Status:* October 1, 2010, the Child and Adolescent Needs and Strength (CANS) Functional Assessment Tool was implemented state-wide. The CANS is being used statewide for children and adolescents receiving services through the public mental health system. This transformation tool, consistent with system of care values and principles, focuses on the needs of the children and families. The CANS-Comprehensive provides a common language, objective criteria to support decisions about intervention plans and intensity of services, monitors progress through outcome measures, and supports quality improvement initiatives. Information from the CANS-Comprehensive will support decisions at multiple levels – direct services, supervision, program management, and system management. For community mental health providers, the CANS for Alabama Comprehensive Multisystem Assessment (5 to Adulthood) or the EC-CANS for Alabama Comprehensive Multisystem Assessment (0 to 4 Years) tools is being utilized. In October 2018, the use of the CANS was expanded to include those providers certified through the ADMH Mental Illness Program Standards. At this time, all providers serving children and adolescents through either a contract or certification through ADMH utilize the CANS for treatment planning purposes. Alabama Administrative Code (580-2-9-.06) establishes minimum requirements for intake documentation. An Intake must include the following information, as appropriate: • Family history • Educational history • Relevant medical background

Prompts	Summary
	• Employment/vocational history • Psychological/psychiatric treatment history • Military history • Legal history • Alcohol/drug abuse history • Mental status examination • History of trauma • Thoughts and behavior related to suicide • Thoughts and behavior related to aggression In addition, an assignment of a diagnosis (latest DSM version) substantiated by an adequate diagnostic database and, when indicated, a report of a medical examination is required. The diagnosis must be signed by a licensed physician, a licensed psychologist, a licensed professional counselor, a certified registered nurse practitioner, or licensed physician's assistant. A consumer unknown to the provider must be seen face-to-face by a licensed physician, certified registered nurse practitioner, or licensed physician's assistant prior to writing a prescription for psychotropic medication, except in the case of a documented emergency. The intake must also include a description/summarization of the significant problem(s) that the consumer is experiencing, including those that are to be treated and those that impact upon treatment; a description of how linguistic support services will be provided to consumers who are deaf or have limited English proficiency including a signed waiver of free language assistance if the consumer who is deaf or who has limited English Proficiency has refused interpreting or translating services. If a family member is used to interpret, such should be documented in the consumer record. No one under the age of 18 can be used as interpreters; and a written treatment plan that completed by the fifth (5th) face-to-face outpatient service, within ten (10) working days after admission in all day programs and residential programs, or within other Mental Health Chapter 580-2-9 time limits that may be specified under program specific requirements.
	Future Status: ADMH is currently reviewing potential assessments for use with adults and plans to implement a standardized tool in the future.
	Summary of Actions Needed: ADMH is currently reviewing potential assessments for use with adults and plans to implement a standardized tool in the future.
3.e Other state	*Current Status:* The Alabama Department of Mental Health has begun the process to create a full Behavioral Health

Prompts	Summary
requirements/policies to improve access to a full continuum of care including crisis stabilization	Crisis Continuum, which will include crisis diversion centers, with three centers created across the state in the next fiscal year. ADMH requested and received $18 million for Fiscal Year 2021, to establish and stand up the first pilot Crisis Diversion Centers in the state. These centers would be a designated place for communities, law enforcement, first responders, and hospitals to take an individual that is in mental health or substance abuse crisis. At the center, the individual could receive stabilization, evaluation, and psychiatric services. These centers will: • Reduce the number of hospitalizations and arrests • Reduce the frequency of admissions to hospitals • Help individuals in crisis achieve stability • Achieve sustained recovery and provide linkage to community agencies and organizations, psychiatric and medical services, crisis prevention, and intervention services. ADMH announced contracts that will result in 3 crisis diversion centers opening in Montgomery, Mobile, and Huntsville counties. These centers are expected to be operational in the second quarter of 2021. Community Mental Health Centers (CMHCs) train their local community partners, such as, but not limited to, schools, courts, detention facilities, and child-welfare, on services and resources for diversion. Such diversion services include certified peer specialists, intensive care coordinators, in-home teams, ACT teams, court liaisons, school-based mental health collaboration, drop-in centers, supported employment programs, and FEP team. Staff are trained in engagement and outreach, so they can be the front line in actively engaging with the sites of potential hospitalization diversion such as emergency rooms, courts, detention facilities, and private inpatient acute units. All CMHCs have funded Juvenile Court Liaisons (JCL) who work directly with the courts to divert kids that come to the courts' attention to the most appropriate resources. In circumstances when hospitalization is warranted, the JCL serves as a care coordinator and remains involved with the youth consumer and their family and the program in which they are receiving inpatient care to assist with the care coordination back to the community and with the needed resources for a smooth transition. With the closures of three state psychiatric hospitals from 2012-2015, a similar process for adults with SMI was implemented. Since the number of SMI adults served is significantly higher, the efforts for reduction of hospitalization is carried out at a local, regional, and state level. At the local level, each CMHC has a point person for the involved entities. There are also four UR Coordinators, one assigned to each region. Through the DMH Mental Illness Community Programs, staff work with key partners and the DMH Civil Commitment Protocol Process as implemented. Starting in December 2016, ADMH staff, State Hospital Staff, and CMHC staff participate in a monthly care coordination process of an extended treatment planning process in which all committed individuals placed in the three state hospitals are staffed.

Prompts	Summary
	Future Status: Expanded access to crisis services through the Crisis Diversion Centers.
	Summary of Actions Needed: Award contracts and support Crisis Diversion Center Implementation.
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported programs	*Current Status:* Supported Employment/Individual Placement and Support (SE/IPS) SE/IPS services are in the process of being more fully developed by ADMH in Alabama. Currently, ADMH and the Department of Rehabilitation Services collaborate to provide vocational supports and services for employment; however, employment numbers remain relatively low with 13.2% of adults with mental illness employed as of 2016 data. In FY 2014 SAMSHA awarded ADMH a five-year SE grant that supports three IPS pilot programs at AltaPointe Health, the Chilton-Shelby Mental Health Center, and Montgomery Area Mental Health Authority with the aim of increasing the number of persons with SMI working towards competitive employment. IPS is an evidence-based approach that uses employment specialists who explore individualized employment goals, make connections with local employers who offer competitive employment opportunities, help persons with résumé development and interview training, and provide job coaching to obtain and maintain jobs based on the consumer's preferences.
	Future Status: Continued operation of current requirements.
	Summary of Actions Needed: N/A - milestone requirements already met.
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	*Current Status* An increased focus in Alabama has been on development of a system with more focus on integrated behavioral health and primary care. ADMH works closely with the Alabama Primary Health Care Association (APHCA) and are engaged to expand and enhance the efforts of providers around care coordination. At this time, each behavioral health provider has to ensure the linking of primary health care needs and that has been delegated to the local (310 Board) community planning process. There is a variety of avenues that behavioral health providers have implemented to meet the primary health care needs of the individuals they serve. This ranges from linking behavioral health consumers to needed providers, to co-location of primary care providers in a community provider location or a behavioral health provider in a primary health care location, to some early stages of behavioral health providers hiring their own primary health care providers, to developing a more integrated care system of behavioral health providers and primary health care providers in the same location. At present, ADMH and APHCA are exploring strategies for move toward a more integrated system that ensures the individuals providers serve are able to receive needed care for both their mental health and primary health care needs.

Prompts	Summary
	Additionally, the participating IMD provider in this demonstration also operates an FQHC and integrates physical health and behavioral health care in that setting. The FQHC and outpatient providers in this system of care also utilize telehealth consultation to enhance services in both the FQHC and specialty BH outpatient sites.
	Future Status: Milestone met
	Summary of Actions Needed: N/A-milestone met.
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	*Current Status:* Alabama provides access to a full continuum of behavioral health services to both youth and adults, including but not limited to: **Assertive Community Treatment (ACT)/ Program for Assertive Community Treatment (PACT)** These teams provide case management, mental health and substance use treatment (provided via the ADMH Substance Abuse Division), basic living skills, vocational rehabilitation, and in some areas of the state peer support services, via multi-disciplinary teams for persons with SMI and co-occurring substance use disorders (SUDs).18 ACT/PACTs are funded via block grant funds from the Substance Abuse and Mental Health Services Administration, and serve persons who are at high risk for admission or readmission to state psychiatric facilities, community-based acute psychiatric hospitals, and jails. The composition of ACT/PACTs may vary by region and provider, however the base model is three full-time team members including a master's-level clinician, a licensed nurse, and a case manager, plus a part-time psychiatrist, and in some areas, a peer support specialist. There are 15 ACT teams across the state and 2 PACT teams in the Birmingham area. ACT teams have a one-to-twelve staff-to-persons-served ratio while PACT teams have a one-to-ten staff-to-persons-served ratio. The Jefferson-Blount-St. Clair Mental Health Authority and the University of Alabama at Birmingham's Mental Health Center administer the two PACT teams in the Birmingham area and both teams work with persons they serve to access supportive housing. **Basic Living Skills** These are services provided to individuals or groups in order to improve a person's capacity for independent living. Services include support in the skills necessary for successful transitions to PSH and for sustaining their own apartment. Basic Living Skills are provided as part of ACT/PACT service, in in-home intensive (IHI) treatment models (see below) for both adults and children with SMI, and as part of outpatient services and day programs. **Certified Peer Specialists (CPS)/ Youth CPSs, Family Peers, Peer Support Specialists, and Peer Bridgers** Peer support providers are individuals uniquely qualified by their own lived experience to support other persons with mental illness and their family members. Peer supports have been in place in Alabama since 1994, starting at Greil Hospital, and have continued to expand to community-based supports via the shifting of funds from hospitals to

Prompts	Summary
	community services and supports. Peer bridgers support adults transitioning from hospitals in the Birmingham area and at 18 CMHCs and in some residential programs throughout the state. Current peer supports are funded in some models such as ACT/PACT via block grant funds from the Substance Abuse and Mental Health Services Administration (SAMHSA). Recently, ADMH sought more funding for peer supports by working with the Alabama Department of Medicaid to seek federal reimbursement by adding CPS to its latest Medicaid state plan amendment. There are an estimated 50 full- and part-time CPSs, peer support specialists, and peer bridgers across the state ADMH has pilots underway to expand the use of youth-certified peer specialists and include certified peers on supportive employment teams. JBS Mental Health Authority and Hill Crest Behavioral Health Services in Birmingham have been piloting a youth peer project with adolescent girls in a psychiatric residential treatment facility. ADMH has been working with the Chilton-Shelby Mental Health Center in Calera and AltaPointe Health in Mobile to pilot programs that include certified peer specialists on supportive employment teams. Statewide Outreach Peers provided recovery support to 612 individuals in the community in FY 2019 and connected 227 individuals to treatment services. **Day Program Services** Day programs are designed to bridge acute treatment and less intensive services by increasing community living skills via basic living supports, and addressing consumers' clinical needs. Day program services are available across all ADMH CMHC regions and are a longstanding program model in Alabama, funded by Medicaid. **First Episode Psychosis (FEP) Teams** FEP teams are trained to provide support to transition-age youth experiencing the first symptoms of mental illness, who are also often at risk for homelessness. FEP teams are an evidence-based practice that provides timely detection of psychosis/illness, acute care during or following periods of crisis, and recovery-oriented services offered over the first few years following the onset of SMI. Currently, ADMH has three approved community mental health centers contracted to provide full-fidelity FEP team services: JBS Mental Health covering Jefferson County serves one of the largest populations of transition-age youth experiencing homelessness in the state; Wellstone, Inc. covering Madison County, and AltaPointe Health Systems covering Mobile County. All three of these FEP teams are funded via the SAMHSA Mental Health Block Grant. **Intensive Day Treatment** This is an active, intermediate-level treatment that specifically addresses a consumer's impairments, deficits, and clinical needs. An initial screening to evaluate the appropriateness of the consumer's participation in the program and to develop an individualized treatment plan is conducted by the CMHC. Various services must be available and

Prompts	Summary
	provided as indicated by the results of the initial screening including: Medication evaluation and management, individual, group, and family therapy, coping skills training, and family and consumer education. **In-Home Intensive (IHI) Treatment (children/youth)/ In-Home Intervention Teams (adults)** These home-based services are provided by a team to youth and adults who need temporary additional support during times of increased symptoms or during transition from a more intense level of service. IHI teams are funded by Alabama Medicaid, and work to defuse crisis situations, stabilize housing, and prevent out-of-home placement for youth. Teams are composed of a rehabilitative services professional (master's level clinician) and a case manager. Services include individual or family counseling, crisis intervention, mental health consultation, basic living skills (as described above), family support, case management, and medication monitoring. There are currently a total of 83 teams, with 32 serving adults and 51 that serve children/youth. **Housing Initiatives** **Alabama's Supportive Housing - Evidence Based Practice (EBP) initiative** provides for the development, operation, and supervision of housing units and associated supportive services for adults with SMI who would not otherwise have a viable housing arrangement. Providers operate the housing and supportive services in a manner consistent with the principles of evidence-based permanent supportive housing (PSH) included in ADMH training (Housing First Principles). Key service functions include but are not limited to the provision of case management with low staff-to-participant ratio, apartment set-up costs, and rental assistance. Providers offer this housing in the community, not in a treatment setting. The focus of this EBP housing model is to establish and maintain a place to live rather than to receive treatment. This housing is provided without regard to an individual's agreement to participate in specific treatment services. Currently, there are 324 Supportive Housing - EBP units. **Projects for Assistance in Transition from Homelessness (PATH)** PATH funds are awarded annually to ADMH by SAMHSA and allocated to five CMHCs in urban areas of the state including Birmingham, Huntsville, Mobile, Montgomery, and Tuscaloosa. Alabama's PATH programs are focused on serving adults and youth with SMI and co-occurring SUDs who are homeless or at risk for homelessness. Services include outreach, screening and diagnostic treatment services, community mental health services, alcohol and drug treatment, case management services, supportive and supervisory services in residential settings, referrals for primary health care services, job training, educational services, and housing search supports. ADMH and CMHC providers of PATH services regularly collaborate with local CoC lead agencies. The Alabama Rural Coalition for the Homeless (ARCH) (also one of the eight CoCs) regularly collaborates with all the other seven CoCs and more broadly with the Alabama HUD field office regarding PATH programs across the state.

Prompts	Summary
	Future Status: Fully implemented Crisis Centers.
	Summary of Actions Needed: Award and implementation of Crisis Center contracts.
4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	*Current Status:* Alabama's **First Episode of Psychosis (FEP)** program addresses youth and young adults experiencing symptoms of early psychosis, which have been named the NOVA programs. In FY20, ADMH contracted with three community health centers to provide FEP team services: JBS Mental Health Authority covering Jefferson County, Wellstone, Inc. covering Madison County, and AltaPointe Health Systems covering Mobile County. This program utilizes well-researched and evidenced based practices to help youth and young adults recover, stay on track in school, locate and maintain employment, and strengthen their relationships with family and support networks. The targeted parameters for the NOVA program are individuals aged 15-25 years experiencing their first episode of psychosis and who have a willingness to participate in the program for a period of two years. The FEP programs provide a coordinated array of recovery-oriented services and supports to the individual and their family. Services include family support through Multi-Family Groups, Youth and Family Peer Supports, Supported Employment and Education (using the Individual Placement and Support (IPS) model), Case Management, Cognitive Behavioral Therapy, and Low Dose Anti-Psychotic medications, as needed. The coordinated care approach emphasizes shared decision-making and working with individuals to reach their recovery goals. The NOVA programs collaborate with other state agencies to include the Alabama Department of Rehabilitation Services, as well as the state IPS program as a means of meeting the clients overall Vocational and Educational needs. **School-Based Mental Health Collaborative** is a program in the Office of Mental Illness Community Programs. The success of the collaborative is now being seen all over the state, with 71 school systems and 19 community mental health authorities participating. The collaborative reaches children and adolescents directly in schools every day to assist with mental health issues. New funds for FY21 will allow the addition of 15 school systems to the collaboration. The aim is to achieve greater integration of mental health services between the mental health centers and the public schools and to increase the utilization of evidence-based practices. The integration of these services will foster continuity of care and ensure sustained gains in academic and developmental domains for children, youth, and their families.
	Future Status: Continued operation of FEP (NOVA) and School-Based Mental Health Collaborative programs.
	Summary of Actions Needed: N/A-milestone requirement met.

Prompts	Summary
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
F.a Increase availability of non- hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	*Current Status:* **Mobile Crisis Teams, Crisis Response Teams, and Crisis Diversion Centers** Mobile response teams focus on defusing crises related to SMI and trauma by working with families and consumers along with law enforcement and hospital emergency departments. These teams provide on-site assessments and de-escalation techniques during crisis situations that help avert unnecessary hospitalizations or involuntary admissions and also educate persons in coping skills and problem-solving to avoid future crises. There are nine mobile crisis teams across the state and six other crisis response teams across Alabama, one of which is a mental health court team. These teams are funded via block grant dollars. The Alabama Department of Mental Health has begun the process to create a full Behavioral Health Crisis Continuum, which will include crisis diversion centers, with three centers created across the state in the next fiscal year. ADMH requested and received $18 million for Fiscal Year 2021, to establish and stand up the first pilot Crisis Diversion Centers in the state. These centers would be a designated place for communities, law enforcement, first responders, and hospitals to take an individual that is in mental health or substance abuse crisis. At the center, the individual could receive stabilization, evaluation, and psychiatric services. These centers will: • Reduce the number of hospitalizations and arrests • Reduce the frequency of admissions to hospitals • Help individuals in crisis achieve stability • Achieve sustained recovery and provide linkage to community agencies and organizations, psychiatric and medical services, crisis prevention, and intervention services. ADMH announced contracts that will result in 3 crisis diversion centers opening in Montgomery, Mobile, and Huntsville counties. These centers are expected to be operational in the second quarter of 2021. **Consumer-Run Services/Drop-In Centers** These services are supported by ADMH block grant funds although not covered/funded under ADMH CMHC

Prompts	Summary
	contracts. Consumer-run services and drop-in centers are an important resource for persons for peer interaction and support and can provide the opportunity for persons to attain leadership and advocacy skills. There are four consumer-run drop-in centers around the state, and each serves an average of 94 persons per day. Consumer-run services and drop-in centers provide an alternative, non-residential environment for persons with SMI. The program may offer recreational activities, socialization, individual or group educational activities, mutual support group meetings, information and referrals, or other similar services. In Alabama, the drop-in centers are consumer-led and consumer-driven, with a requirement that at least 50 percent of board requirement be consumers. ADMH contracts directly with the boards of these drop-in centers through the ADMH Office of Peer Programs, using SAMHSA Mental Health Block Grant dollars.
	Future Status: The State will annually monitor access to non-residential crisis stabilization services through processes described in Milestone #3 (3a) and in partnership with an agreed upon methodology.
	Summary of Actions Needed: Annual monitoring.
F.b Increase availability of on- going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	*Current Status:* As described in previous sections (3a, 4c, Fa) within this template, and as outlined in the attached *Overview of the Assessment of the Availability of Mental Health Services* template, Alabama offers a comprehensive continuum of community-based services.
	Future Status: Continued operation of current programming.
	Summary of Actions Needed: Alabama Medicaid will annually review updated information from the *Assessment of the Availability of Mental Health Services* Template to identify geographic shortage areas and conduct targeted outreach to non-Medicaid enrolled providers in those areas.

Prompts	Summary
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[1] The HIT Plan should also describe, among other items, the: • *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* • *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.* *Please complete* all *Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period	One Health Record® system was created as Alabama's health information exchange (HIE) through a federal grant awarded to the state in 2009. Under the guidance of the Alabama Medicaid Agency and its health care providers and stakeholders, One Health Record® has emerged as an interoperable, bi-directional data exchange system between providers, hospitals and others within Alabama and in other states. Participating providers are able to query the HIE's various clinical document repository via interoperable, data exchange protocols from within their electronic health record system to access patient health data from other providers. Providers without an EHR system can access a secured provider portal for the patient clinical records and for the DIRECT secure messaging (DSM) system. One Health Record® seamlessly and securely connects doctors, hospitals, clinics and other healthcare providers so patient information is available in real time, regardless of location. Participants can query the system from within their electronic health record (EHR) systems to access patient health data from other participants. One Health Record® also offers a provider portal with both a clinical viewer and Direct Messaging for the secure transmission of PHI over the Internet. ADT's (Admission, Discharge, and Transfer) are HL7 messages used by providers connected to the health information exchange to improve the patient's coordination of care. ADT's are triggered when a patient is registered and admitted to a hospital and will follow a patient within the healthcare system until transferred or discharged. When Alabama's One Health Record® receives the ADT message, it generates an alert to the patient's designated provider(s) for follow-up care management. Alabama One Health Record® can accommodate the provider's receipt of the ADT in any one, or combination of, various options available for our core services HIE platform. As of September 1, 2020 Alabama has the following numbers of participating entities:

Prompts	Summary
	• 484 Connected Facilities • 30 Connected Hospitals • 307 Connected Ambulatory Clinics • 10 Connected ACO's • 7 Connected ACHN Regions • 26 State HIE Connections (Point-to-point, and PCDH network) • 3 State Agencies • 3 Connected Federal Agencies (VA, Dod, & SSA) • 4 VA Hospitals in Alabama (1255 Veterans Administration (VA) Hospitals and Clinics nationwide) Hospitals and facilities in Covington, Dallas, Escambia, Fayette, Geneva, Houston, Jefferson, Lauderdale, Limestone, Marion, Mobile, Tallapoosa, and Tuscaloosa counties are now in the process of connecting to One Health Record®.
Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	Alabama's State Medicaid Health IT Plan is closely aligned with the Alabama's Department of Mental Health (ADMH) Division of Mental Health and Substance Abuse IT planning efforts. Both Departments work closely together to align efforts in all operational areas including the expansion, promotion, and utilization of health information technology systems and infrastructure by providers.
Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[2] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of	Alabama Medicaid implemented a system transformation in 2019 that included the establishment of a managed care system, combining Family Planning Care Coordination services, Patient 1st (State Plan Amendment(SPA)) Care Coordination services, Health Home (SPA) functions, and Maternity Care (1915(b) Waiver) functions into single, region specific Primary Care Case Management Entities (PCCM-E) throughout the state. The applicability of standards referenced in the Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B do not apply to these PCCM entities.

Prompts	Summary
the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	

Prompts	Summary
To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact. [3] *Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."*[4]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e- referrals from physician/mental health provider to physician/mental health provider	*Current State:* AltaPointe's two IMD facilities, as well as their outpatient treatment programs, in the proposed demonstration region utilize Netsmart, a certified electronic health record. All community mental health centers in Alabama currently use an EMR, with eight out of 23 using Netsmart. Netsmart provides closed loop referral capabilities as well as secure messaging which is currently being utilized by AltaPointe.
	Future State: Milestone met
	Summary of Actions Needed: N/A - milestone requirements already met.
1.2 Closed loop referrals and e- referrals from institution/hospital/clinic to physician/mental health	*Current State:* AltaPointe's two IMD facilities, as well as their outpatient treatment programs, in the proposed demonstration region utilize Netsmart, a certified electronic health record. Information exchange between inpatient providers is seamless in that both inpatient and outpatient records can be accessed by AltaPointe inpatient and outpatient providers. All community mental health centers in Alabama currently use an EMR, with eight out of 23 using Netsmart. Netsmart provides closed loop referral capabilities as well as secure messaging

Prompts	Summary
provider	which is currently being utilized by AltaPointe.
	Future State: Milestone met
	Summary of Actions Needed: N/A - milestone requirements already met.
1.3 Closed loop referrals and e- referrals from physician/mental health provider to community based supports	*Current State:* Alabama's One Health Record® offers an encrypted, HIPAA compliant messaging service, called Direct Messaging. The service provides providers with an auditable stream of communications that requires no special software or Electronic Health Record (EHR) system. Direct Messaging is compliant with all relevant standards both current and emerging. AltaPointe's two IMD facilities, as well as their outpatient treatment programs, in the proposed demonstration region utilize Netsmart, a certified electronic health record. Netsmart provides closed loop referral capabilities as well as secure messaging which is currently being utilized by AltaPointe.
	Future State: Milestone met
	Summary of Actions Needed: N/A - milestone requirements already met.
Electronic Care Plans and Medical Records (Section 2)	
2.1 The state and its providers can create and use an electronic care plan	*Current State:* The participating IMDs and CMHC serving the demonstration region currently utilize an EHR (Netsmart) that includes the individualized treatment plan and discharge plans within the electronic record.
	Future State: Milestone met
	Summary of Actions Needed: N/A - milestone requirements already met.
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	*Current State:* The comprehensive inpatient and CMHC provider participating in this demonstration has an EHR and allows access to both inpatient and outpatient clinical notes, including treatment plans, to the care teams serving an individual. The majority of patients served within the IMD who have need for follow-up care, will receive that care from the same provider. Therefore both the outpatient and inpatient teams will have real time access to treatment plans as well as other clinical documentation such as assessments and medication information.
	Future State: Milestone met.
	Summary of Actions Needed: N/A - milestone requirements already met.

Prompts	Summary
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State:* The comprehensive inpatient and CMHC provider participating in this demonstration has an EHR and allows access to both youth and adult inpatient and outpatient clinical notes, including treatment plans, to the care teams serving an individual. Therefore, as an individual transitions from youth-oriented services to adult behavioral health services the new treatment teams will have real time access to treatment plans as well as other clinical documentation such as assessments, therapy notes, and medication information.
	Future State: Milestone met.
	Summary of Actions Needed: N/A - milestone requirements already met.
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State:* The comprehensive inpatient and CMHC provider participating in this demonstration has an EHR and allows access to both youth and adult inpatient and outpatient clinical notes, including treatment plans, to the care teams serving an individual. Therefore, as an individual transitions from youth-oriented services to adult behavioral health services the new treatment teams will have real time access to treatment plans as well as other clinical documentation such as assessments, therapy notes, and medication information.
	Future State: Milestone met.
	Summary of Actions Needed: N/A - milestone requirements already met.
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	*Current State:* Any licensed provider with Internet access can participate in One Health Record®. To fully benefit from a health information exchange, most doctors, hospitals and other providers link to an HIE via an electronic medical record system. One Health Record® can provide admission, discharge and Transfer (ADT) notification to participating providers. Alabama One Health Record® can provide a provider portal for querying and viewing clinical document documents.
	Future State: Milestone met
	Summary of Actions Needed: N/A - milestone requirements already met.
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of	*Current State:* Consents are captured in both the demonstration's provider EHR and the Alabama One Health Record® HIE.
	Future State: Milestone met.

Prompts	Summary
sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	*Summary of Actions Needed:* N/A - milestone requirements already met.
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	*Current State:* All clinical documentation components are included in the participating provider's EHR. One Health Record® has the capability to link with the provider EHR and behavioral health providers are a priority group for linkage with the HIT system.
	Future State: Behavioral health providers, including CMHCs, are linked to Alabama's One Health Record®.
	Summary of Actions Needed: The state will continue to provide technical assistance to providers so that they may link their EHR to the One Health Record® HIE.
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	*Current State:* Behavioral health providers are currently leveraging telehealth to support collaborative care in FQHC settings, providing psychiatric consultation to primary care via telehealth. In addition, the CMHC in the demonstration region currently provides crisis intervention supports to emergency departments in the region via telehealth.
	Future State: Milestone met.
	Summary of Actions Needed: N/A - milestone requirements already met.
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can	*Current State:* The participating behavioral health provider monitor utilization patterns to identify clients at risk. These clients then receive outreach by a clinical team.
	Future State: Milestone met.

Prompts	Summary
notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment[5])	*Summary of Actions Needed:* N/A - milestone requirements already met.
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	*Current State:* Alabama's First Episode of Psychosis (FEP) program addresses youth and young adults experiencing symptoms of early psychosis. The NOVA programs that DMH contracts with are operated by JBS Mental Health Authority covering Jefferson County, Wellstone, Inc. covering Madison County, and AltaPointe Health Systems covering Mobile County. These FEP programs utilizes well-researched and evidenced based practices to help youth and young adults recover, stay on track in school, locate and maintain employment, and strengthen their relationships with family and support networks. The targeted parameters for the NOVA programs are individuals aged 15-25 years experiencing their first episode of psychosis and who demonstrate a willingness to participate in the program for a period of two years. The FEP programs provide a coordinated array of recovery-oriented services and supports to the individual and their family. Services include family support through Multi-Family Groups, Youth and Family Peer Supports, Supported Employment and Education (using the Individual Placement and Support (IPS) model), Case Management, Cognitive Behavioral Therapy, and Low Dose Anti-Psychotic medications, as needed. The coordinated care approach emphasizes shared decision-making and working with individuals to reach their recovery goals. The NOVA programs collaborate with other state agencies to include the Alabama Department of Rehabilitation Services, as well as the state IPS programs as a means of meeting the clients overall Vocational and Educational needs. Providers, including the IMD/CMHC participating in the demonstration utilizes an EHR, with access to clinical health information available to members of the first episode psychosis team.
	Future State: Milestone met.
	Summary of Actions Needed: N/A - milestone requirements already met.
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker	*Current State:* Alabama One Health Record® has linkage capabilities; however, the state currently utilizes its eligibility database to identify relatives. At the provider level, surveyed participating demonstration providers have this linkage capability within their EHR.
	Future State: Milestone met.

Prompts	Summary
medical records	*Summary of Actions Needed:* N/A-milestone requirements already met.
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	*Current State:* Participating demonstration providers are utilizing EHRs that capture multiple episodes of care and have a process to ensure these episodes are linked to the correct patient.
	Future State: Milestone met
	Summary of Actions Needed: N/A-milestone requirements already met.

Section 3: Relevant documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.