Mercer

Substance Abuse Prevention and Treatment

Case File Review Findings

FY 2020

Arizona Health Care Cost Containment System
Division of Grants Administration
May 2021

welcome to brighter

Contents

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Executive Summary

The State of Arizona (Arizona or State), Arizona Health Care Cost Containment System (AHCCCS) engaged Mercer Government Human Services Consulting (Mercer) to implement an independent case file review (ICR) for persons who received substance abuse treatment services through federal Substance Abuse Block Grant (SABG) funds between July 1, 2019–June 30, 2020. This report represents the most recent in an annual series of ICRs and the first conducted by Mercer.

The purpose of the annual review is to review the quality, appropriateness, and efficacy of treatment services as documented in the client records; the intent of the independent peer review process is to continuously improve the treatment services provided to individuals diagnosed with substance use disorder (SUD) within the State (see 45 CFR § 96.136) in order to ultimately improve client outcomes and recovery.

Consistent with statute, Mercer licensed clinicians (i.e., Licensed Clinical Social Worker, Doctor of Philosophy [PhD], Registered Nurse) examined the following aspects of the treatment records as part of the review process:

- Admission criteria/intake process
- Assessments
- Treatment planning, including appropriate referral, (e.g., prenatal care, tuberculosis, and HIV services)
- Documentation of implementation of treatment services
- Discharge and continuing care planning
- Indications of treatment outcomes

In addition to these statutorily required review components, Mercer also examined aspects of the treatment records related to Social Determinants of Health (SDoH), evidence-based treatment practices, peer support services, women's services, and opioid specific services.

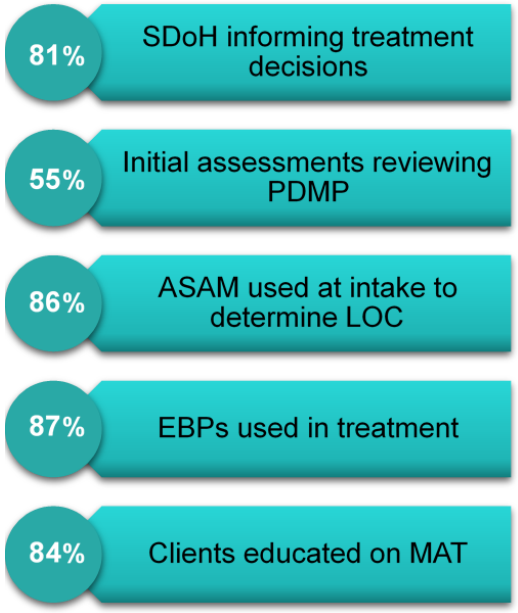
Mercer reviewed a total of 200 treatment records, provided by AHCCCS, from across the State. The files included in this review sample represented 37% of the providers in the State who receive SABG funds, which exceeds the minimum statutory requirement for this review (5%).

Overview of Key Findings

Specific findings from the ICR are presented in the body of the report, broken down by Regional Behavioral Health Authority (RBHA): Arizona Complete Health (Southern Arizona), Health Choice Arizona (Northern Arizona), and Mercy Care (Central Arizona). Key findings identify how the documentation demonstrates the overall effectiveness and quality of the SABG service delivery system in Arizona. This includes how providers are performing in the identification, engagement, and response to client needs through the provision of SUD treatment services. The following bulleted list represents a summary of the major themes found across the system.

Strengths

- Despite the fact that this is the first year the ICR has evaluated an item examining the providers' inclusion of SDoH in the initial assessment, 81% of providers are already using this important information to inform treatment decisions. Such a high percentage at the outset of tracking bodes well for future outcomes and suggests providers are incorporating emerging areas of research into current treatment approaches. Specific areas assessed include housing, employment, and education.



- An item related to the providers' review of the Prescription Drug Monitoring Program (PDMP) was also added for the first time in this year's ICR. Increased utilization of the PDMP has been a component of Federal efforts to address the opioid crisis, and primary care physicians (PCPs) and pharmacists are encouraged to review the PDMP for overutilization patterns. Fifty-five percent of the SUD charts reviewed in this year's ICR demonstrated provider review of the PDMP, which indicates room for improvement, but a promising start for the first year of evaluation.

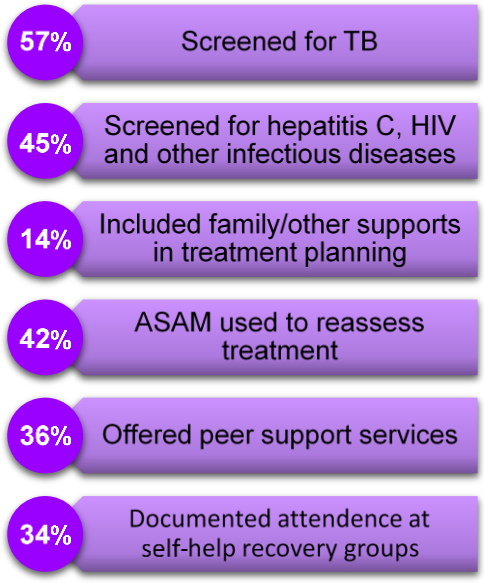
- Adoption of the American Society of Addiction Medicine (ASAM) criteria in determining the appropriate level of care (LOC) appears to be going well, with 86% of cases documenting its use during the initial assessment.

- In 87% of cases reviewed, the providers documented the use of evidenced-based practices (EBPs) in the treatment of SUD clients. The most frequently used EBPs include Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Dialectical Behavioral Therapy, and Matrix Intensive Outpatient Treatment.

- For those clients diagnosed with an Opioid Use Disorder (OUD), 84% were educated on the benefits of Medication Assisted Treatment (MAT) and offered this intervention.

Opportunities

- Documented screening for required medical conditions remains an area of needed improvement in the aggregate data. Screening for tuberculosis (TB or tuberculosis) was documented in only 57% of cases, and screening for hepatitis C, HIV, and other infectious diseases was present in only 45% of cases.



- Utilization of natural supports in the development of individual service plans (ISPs) was significantly lower than would be expected, with only 14% of cases documenting the inclusion of family or other supports in treatment planning. However, 46% (n = 87) of the reviewed files contained evidence that providers offered to include family or other supports in treatment planning, but the member declined.

- Forty-two percent of cases documented the use of ASAM criteria during the course of treatment to reassess the appropriate LOC. When compared to the use of ASAM criteria in initial assessments (86%), providers have room for additional improvement.

- For all cases reviewed, 36% (n = 71) documented that peer support services were offered as part of the treatment plan. Peer support services were actually delivered in 66% of the cases wherein they were offered (n = 47).

- The majority of cases (66%) failed to provide any documentation as to whether the client was attending self-help recovery groups (e.g., Alcoholics Anonymous or Narcotics Anonymous).

Recommendations

The following recommendations are presented as potential areas of improvement to round out the evaluation of SABG programming and services, impact practice and outcomes for clients based upon the results of the ICR and associated analysis of findings. A more detailed outline of recommendations can be found in Section 6 of this report.

1. **Develop a mechanism for feedback to specific providers**: Although all SABG SUD providers have access to the findings of the ICR, the Mercer review team noted several instances where it would be beneficial to provide feedback to a specific provider (e.g., treatment concerns, missed opportunities for intervention, etc.). The ICR, in its present form, does not allow for provider-specific feedback to the RBHAs, with the intention of having that information passed along to the provider in question. AHCCCS should consider amending the ICR process to include a feedback mechanism that would allow for “lessons learned” to be disseminated or discussed, at a minimum, with the provider collective and specific providers as indicated in the results.

2. **Encourage the ongoing use of SDoH information in treatment**: As noted previously, providers are doing a good job of investigating SDoH concerns that could impact treatment, with 81% of cases having a documented assessment of these issues. The next step should be to incorporate the SDoH findings into the treatment planning and actively work to address existing obstacles to recovery. The ICR revealed that, with the exception of transportation, most providers did not incorporate SDoH issues during the course of treatment (i.e., after the initial assessment), even when SDoH concerns were revealed in the initial assessment. AHCCCS should encourage the RBHAs to develop mechanisms for addressing SDoH concerns in treatment and use the information they are now collecting to improve treatment outcomes. Such steps would likely assist in accomplishing the goals of the Whole Person Health Initiative.

3. **Consider the inclusion of interviews in future ICRs**: The ICR currently reveals useful information related to the use of best practices and procedures by SUD treatment providers. However, a file review only conveys the information as it is documented. By incorporating live interviews with the RBHAs, clients, and/or providers, AHCCCS could collect additional, valuable information that would round-out its understanding of what is working and what needs to be improved in SUD treatment services regionally and across the State. For example, although attendance at peer support groups is not currently documented consistently by providers, interviews could shed light on the true rate of participation in such groups.

4. **Consider formal statistical validation of the ICR Tool for future independent reviews.** As use of SABG funds continues, and additional ICRs are undertaken, AHCCCS could benefit from improved information that allows for year-to-year comparisons of ICR findings. Such comparisons can only be appropriately made when a statistically validated tool is used that increases confidence in the comparability of the different years' results. AHCCCS would have the option of performing such validation in-house, or leveraging the expertise of consultants trained in the validation of clinical review tools. As an additional option, AHCCCS could consider maintaining consistency in the independent review team that performs the ICR. Such consistency, together with the use of a statistically validated tool, would decrease variability from year-to-year, and increase the State's ability to compare results and assess large-scale trends within the SUD service system.

5. **Consider changes to sampling methodology for future reviews.** As an option in future reviews, AHCCCS should consider increasing validity and reliability by using a more randomized sampling methodology. One method for achieving this would be to have the independent reviewer randomly select the sample cases to be reviewed (from the entire population of files that meet inclusion criteria) and then ask the RBHAs to supply those specific records. This would add some time to the process (when compared to having the RBHAs select files to provide), but it would increase confidence in the results and contribute to overall project validity. An additional benefit of using this sampling methodology is that the independent reviewer would have the opportunity to stratify the sample and increase the number of cases from small sub-populations (e.g., pregnant women).

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Background and Introduction

AHCCCS serves as the single State authority to provide coordination, planning, administration, regulation, and monitoring of all facets of the State public behavioral health system. AHCCCS contracts with managed care organizations, known as RBHAs, to administer integrated physical health (to select populations) and behavioral health services, including SUD treatment, throughout the State. The current RBHAs are Arizona Complete Health (Southern Arizona), Health Choice Arizona (Northern Arizona), and Mercy Care (Central Arizona). Effective July 1, 2016, AHCCCS began to administer and oversee the full spectrum of services to support integration efforts at the health plan, provider and client levels.[1]

Consistent with the requirements of 45 CFR § 96.136, AHCCCS contracted with Mercer as the independent review contractor to perform the annual SABG ICR for State Fiscal Year 2020. Mercer does not have any reviewers who are employed as treatment providers with, or who have administrative oversight for, the programs under review. Further, Mercer's peer review personnel performed this review independent (i.e., separate) from SABG funding decision makers. The Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded a SABG to AHCCCS each year since the current program was established in 1993; the block grant requires that AHCCCS produce an independent review of the treatment services provided with SABG funds on an annual basis. For the current year, AHCCCS program goals for the SABG include[2]:

- Increase the availability and service utilization of MAT options for members with a SUD.
- Ensure women have ease of access to all specialty population related SUD treatment and recovery support services.
- Increase the number of tuberculosis screenings for members entering substance abuse treatment.

Below are results from the SABG chart review relating to each of the above AHCCCS program goals.

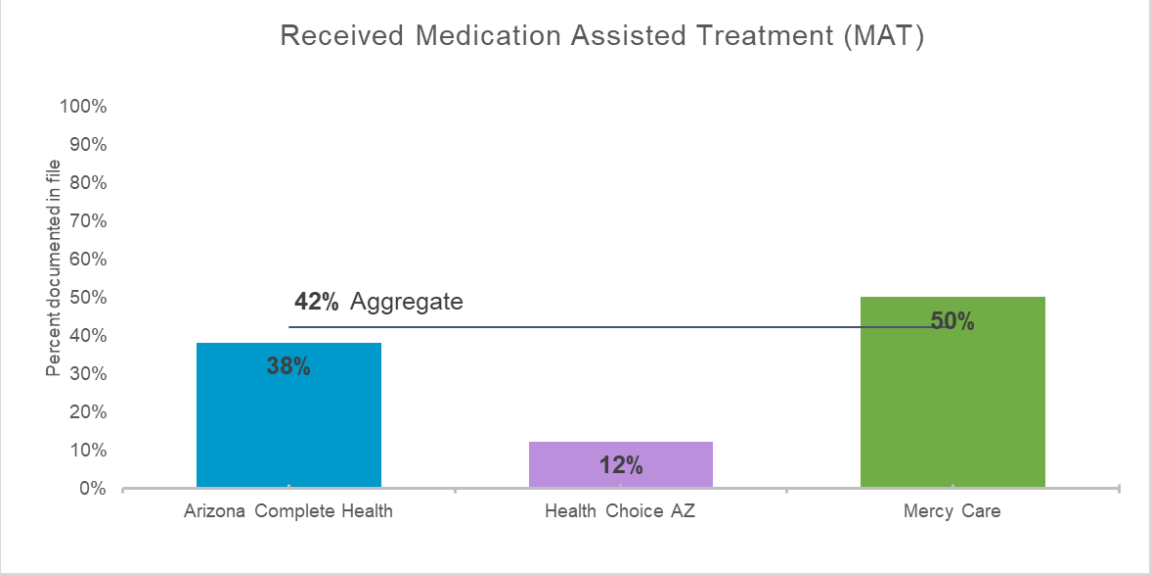
[1] State of Arizona. AHCCCS. (2020). Quality Service Review 2020.

[2] AHCCCS. (n.d.). *Substance Abuse Prevention and Treatment Block Grant (SABG).* Available at: https://www.azahcccs.gov/Resources/Grants/SABG/

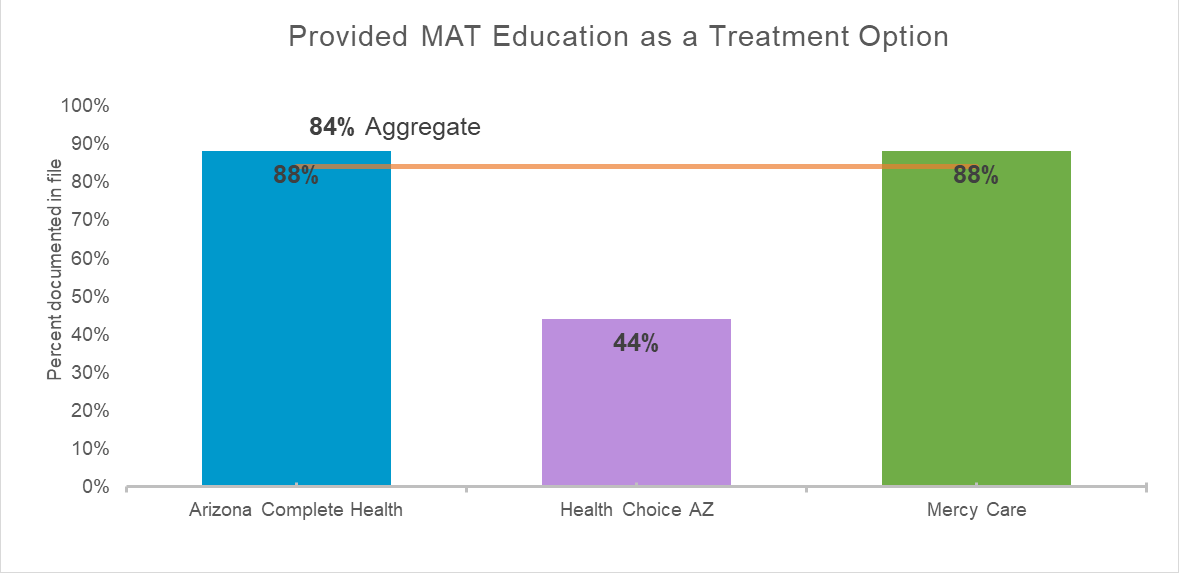
Increase the availability and service utilization of MAT options for members with a SUD

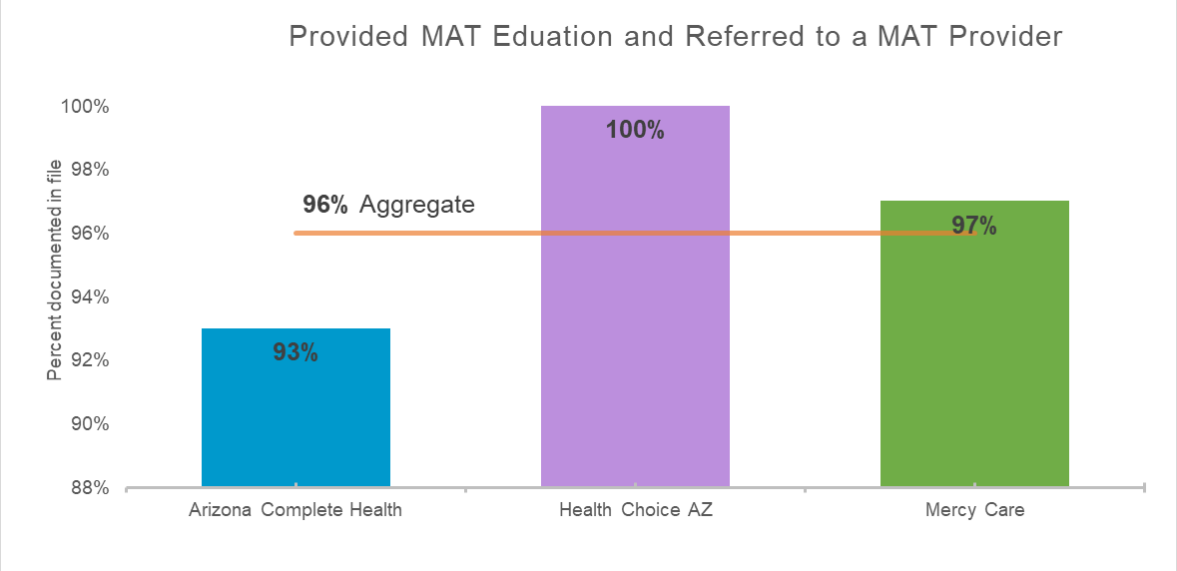
Offering MAT services promotes a "whole-patient" approach to the provision of substance use services.[3] Overall, 42% of sampled behavioral health case files (83 individuals) contained documentation that MAT was incorporated into treatment.

For members with a documented OUD, 84% were provided MAT education as a treatment option. Ninety-six percent of members receiving MAT education were referred to a MAT provider.



[3] SAMHSA, *Medication-Assisted Treatment (MAT)*, updated January 1, 2021. Available at: https://www.samhsa.gov/medication-assisted-treatment



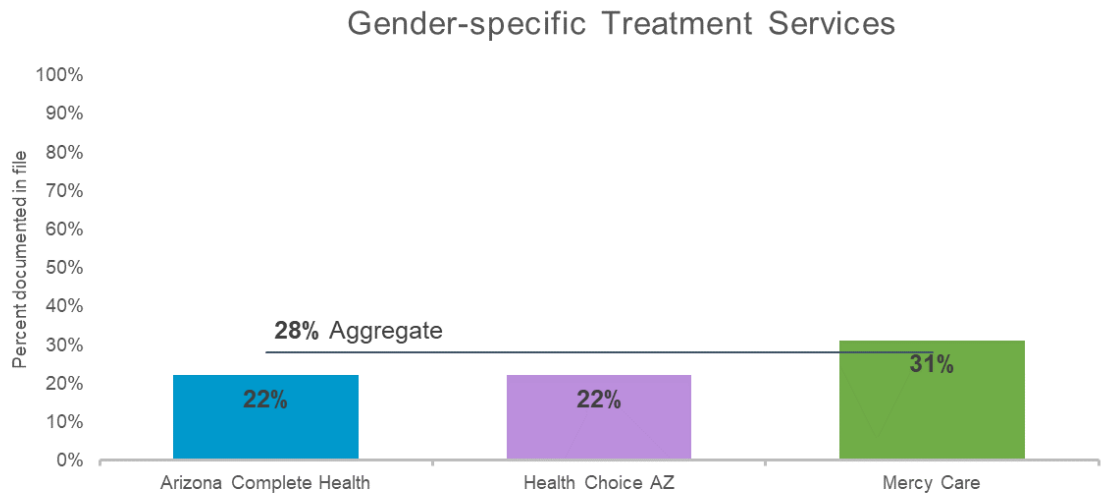


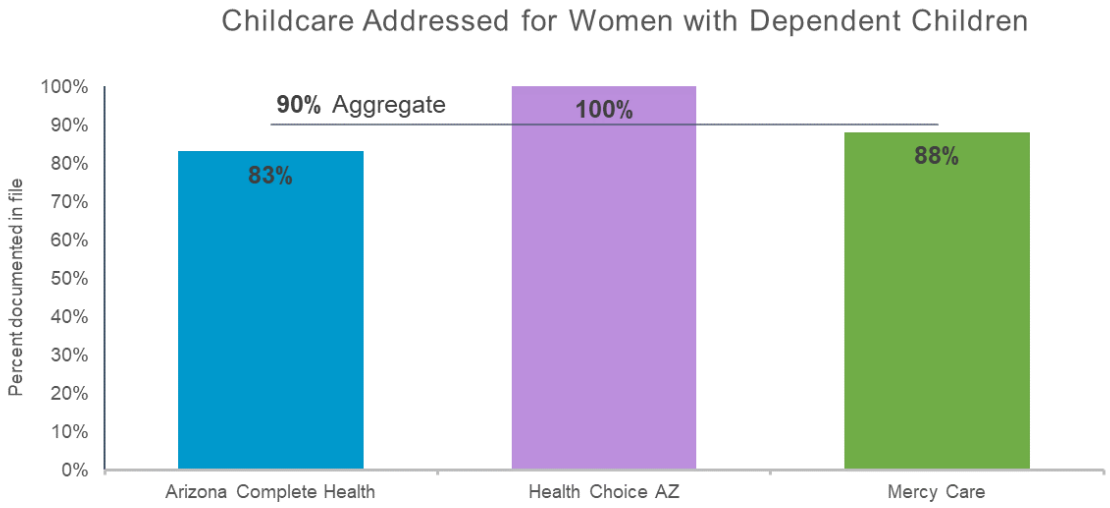
Ensure women have ease of access to all specialty population related SUD treatment and recovery support services

Women have different circumstances and experiences in regard to SUDs and treatment.[4] Allowing access to appropriate gender-based treatment can produce more favorable outcomes. One SABG

[4] National Institute on Drug Abuse, *What are the unique needs of women with substance use disorders?*, January 2018. Available at: https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/what-are-unique-needs-women-substance-use-disorders

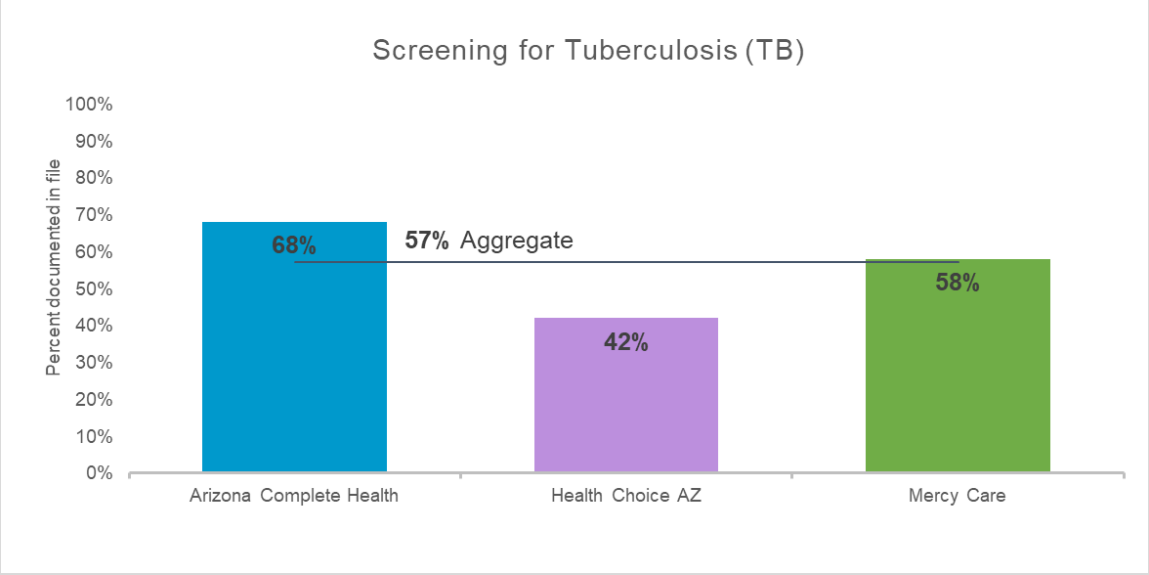
metric, *Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?,* showed that about a quarter of females in the aggregate sample had documented access to gender-specific services. A second metric, *If the female had dependent children, was there documentation to show that childcare was addressed?*, showed a higher percentage (90%) of mothers had childcare addressed by the provider. Addressing childcare removes one possible obstacle to treatment.





Increase the number of tuberculosis screenings for members entering substance abuse treatment

A third program goal and requirement of the Code of Federal Regulations 45 CFR § 96.127[5], requires entities providing substance use treatment to provide tuberculosis screening of individuals in order to prevent tuberculosis transmission. Fifty-seven percent of sampled charts documented providing tuberculosis screening for members.



Goals of the Independent Case Review

The primary objective of this review is to determine the level of quality and appropriateness of care being provided through the use of SABG funds. According to State guidance, *quality* is the provision of treatment services that, within the constraints of technology, resources, and patient/client circumstances, will meet accepted standards and practices, which will improve patient/client health and safety status in the context of recovery. *Appropriateness* means the provision of treatment services consistent with the individual's identified clinical needs and level of functioning.[6]

AHCCCS decided to assess the level of quality and appropriateness of SUD treatment in the State through an examination of clinical records maintained by programs receiving SABG funds. A team of Mercer licensed clinicians, who have expertise in managed care, block grants, SUD treatment, ASAM,

[5] eCFR, *Title 45 Section 96.127 — 96.127 Requirements regarding tuberculosis*. Available at: https://ecfr.io/Title-45/Section-96.127

[6] AHCCCS. (n.d.). *Substance Abuse Prevention and Treatment Block Grant (SABG).* Available at: https://www.azahcccs.gov/Resources/Grants/SABG/

and clinical best practices systematically reviewed each of the files selected as part of the review sample. These independent clinicians examined SUD treatment records for the presence (or absence) of previously selected, evidence-based factors that would be expected to be present in high quality, appropriate treatment (which includes engagement, planning, and discharge).

The following domains were examined to determine the level of treatment quality and appropriateness (see Appendix A for specific review items in each domain):

- Intake and Treatment Planning
- Placement Criteria and Assessment
- Best Practices
- Treatment, Support Services, and Rehabilitation Services
- Gender Specific (Female Only)
- Opioid Specific
- Discharge and Continuing Care Planning
- Re-engagement
- National Outcome Measures (NOM)

Content of Records Reviewed

Based upon the requirements of the annual ICR report to SAMHSA, AHCCCS sampled treatment records provided by the RBHAs. Behavioral health records vary from provider to provider, but typically include the following key documents and captured data elements:

- Demographic information
- Initial assessment
- Risk assessment and safety plan
- Crisis plan
- ISP
- ASAM Patient Placement Criteria
- Medication record
- Results of illicit substance use testing

- Progress notes (e.g., therapy [individual and group], case management, etc.)
- MAT documentation
- Evidence of outreach efforts
- Discharge or termination of treatment summary

Mercer used these documents, and any others contained in the individual records, to assess the level to which providers that receive SABG funds in Arizona are providing high quality engagement, planning, treatment, and discharge services to SUD clients.

3 Methodology

The review team from Mercer consisted of four licensed clinicians (one registered nurse, two master's level behavioral health providers, and one clinical psychologist). A fifth member of the team provided data analytic services and ensured consistency in the application of project standards. Finally, Mercer included a Certified Peer as part of the team to review the findings and analysis through the peer lens. All feedback resulting from this additional review have been incorporated throughout the body of this report. The files reviewed by the evaluation team during the ICR were provided by AHCCCS and were stored and accessed on the State's Secure File Transfer Protocol site. Each Mercer reviewer received a secured sign in to ensure all file protected health information was protected. Due to the COVID-19 pandemic, and consistent with public health best practices, Mercer completed all ICR activities virtually, with no onsite reviews or in-person team meetings.

Sampling

AHCCCS developed and implemented the sampling methodology for this review, and used the following inclusion criteria:

- Substance abuse clients with a substance abuse treatment service and episode of care (EOC) during fiscal year 2020: July 1, 2019, through June 30, 2020.
- Disenrolled/EOC end date before or on June 30, 2020.
- At least 18 years of age during the treatment episode.
- Were not diagnosed with a serious mental illness.
- Disenrolled due to completing treatment, declining further service, or lack of contact.
- Clients must have received substance abuse treatment during the treatment period.
- Clients must have received a counseling treatment during the treatment period.
- Clients must have been enrolled in a treatment center for at least 30 days.
- Clients must not be enrolled in a Tribal Behavioral Health Authority.

The sampling methodology used by AHCCCS excluded individuals who:

- Did not have any service encounters during the treatment episode.

- Only had assessment services during the treatment episode.
- Did not have any counseling encounters during the treatment episode.
- Only had a detoxification hospitalization encounter during the treatment episode.
- Only had services provided by an individual private provider.

Based upon these inclusion and exclusion criteria, AHCCCS supplied 310 treatment records to Mercer. Upon receipt of the review sample, Mercer randomly selected 200 files to be used in the initial review, with the remainder being held as an oversample. In 32 instances, files determined to be unusable for review purposes (e.g., an exclusion criterion was found in the file or the treatment dates were out of range) were removed from the original 200 records and replaced from the oversample.

File Review Tool

AHCCCS collaboratively reviewed the existing State tool with Mercer. As a result of this review, the following AHCCCS approved changes to the ICR tool for the 2020 review were incorporated.

New Tool Items

- Added an item to assess whether the service provider reviewed the PDMP website during the course of the treatment.
- Added an item to assess whether SDoHs were evaluated as part of the initial assessment.
- Added an item to assess whether the service provider explored the client's access to a PCP or other medical provider.

Updated Tool Items

- Changed, for clarity, the wording of items related to application of the ASAM criteria. Specifically, "revised/updated" was changed to "reassessed" when reviewing for ongoing use of ASAM criteria during the course of treatment.
- Changed, for specificity, the wording of two items related to peer support services. Specifically, added the word "certified" to the term peer support to differentiate therapeutic peer support from social-support-based offerings.
- Changed, for clarity, the wording of an item related to pain management for individuals receiving treatment for an OUD. Specifically, identified chronic pain as the health issue of concern when assessing whether providers offered alternative interventions.
- Edited, for consistency, the wording and syntax of multiple items throughout the tool. For example, made the capitalization of medications more consistent, made changes for verb/tense agreement, etc.

Following the approval of these changes by AHCCCS, the Mercer team used the updated ICR tool as the source for development of an electronic format of the tool. The e-version of the tool, which was developed in Microsoft Access, allowed the review team to record review results in a format more conducive to analyzing the data and producing useful tables for presentation.

Inter-rater Reliability

To ensure consistency in the use of the file review tool, the Mercer review team participated in two inter-rater reliability (IRR) training sessions followed by an IRR test prior to initiation of the review process. The test consisted of a vignette that approximated the information included in a SUD treatment record. Participants had the opportunity to review the clinical vignette, and were then asked to use the ICR tool to score the record consistent with the ICR Tool Instructions (Appendix A).

The Mercer project lead recorded the answers from each individual reviewer and then discussed with the team any items that yielded inconsistent results. As a result of this discussion, the team reached a consensus decision on how items would be scored. The initial review of the vignette yielded an IRR average score of 92%, while the team reached 100% agreement following discussion and consensus building.

Throughout the evaluation, which occurred during March 2021, the project lead maintained frequent contact with individual reviewers, answered questions regarding the application of the ICR Tool Instructions, and assured consistent application of the consensus methods for scoring. Additionally, in order to ensure fidelity to the scoring approach, the team met twice during the review process for group debriefs and problem solving related to the application of the ICR Tool Instructions.

Data Analysis

Mercer selected sample data from the chart listing provided by AHCCCS. Each chart included in the sample was assigned a sample ID and uploaded into a customized, password-protected Microsoft Access review tool. After each reviewer finalized his or her assigned reviews, the data was exported and aggregated into a final dataset for analysis purposes in Microsoft Excel. Data checks were performed to ensure consistent and complete data was received; results were updated as necessary. Data tables reflecting required output tables were programmed with formulas reflecting the instructions for data entry (Appendix B). Results were technically peer reviewed for accuracy and reasonableness.

Limitations

Mercer applied best practices in training and testing to foster optimal review findings for the ICR results. However, Mercer did not design the original ICR tool used in the file review process (although some modifications were made), nor did Mercer complete a separate and independent validation of the tool. Therefore, Mercer cannot attest to the reliability and validity of the tool.

Additionally, the period of review for this project (July 1, 2019–June 30, 2020) includes the advent of the worldwide COVID-19 pandemic (March 2020–present), which introduced multiple complicating

factors into the SUD treatment landscape (e.g., loss of in-person treatment, rapid implementation of telehealth practices, etc.). Although the review team was aware of these complicating factors, there is no reliable way to account fully for COVID-19's multiple impacts upon individual choices (e.g., reactions to the shift to telehealth interventions) and the resultant treatment outcomes.

Given these considerations, year-to-year results may include variability due to updates in the tool, which may have impacted validity or reliability. Further, orthogonal variables, such as the pandemic-driven shift from in-person treatment to telehealth, introduced unknown impacts on treatment outcomes that would not have been seen in any prior year's ICRs. Therefore, Mercer advises caution against the comparison of ICR findings across years without further validation and evaluation of the results.

4

Aggregate Case File Review Findings

The SABG independent chart review findings are organized throughout this section in aggregate, by RBHA and by individual evaluation measure. This also includes sample demographics, records reviewed (broken down by RBHA), and gender and age of population sampled. Additionally, statistics on the reasons for case closure, referral to the program, and SABG-funded providers sampled are included for comparison purposes, as in past year's reports.

Sample Demographics

Overall, 200 charts were reviewed for the ICR. Mercy Care provides services to the majority (67%) of the population, reflected in the number of sample cases chosen. Mercer received 65 charts from Arizona Complete Health and 58 from Health Choice AZ, which means 52% of the Arizona Complete Health charts and 57% of the Health Choice AZ charts were included in the review. This reflects a comparably sufficient sample for each of the RBHAs, based upon the records that were available for review.

Table 1-1 — Distribution of Case File Review Sample by RBHA

RBHA	Sample Cases	Percent of Sample
Arizona Complete Health	34	17%
Health Choice AZ	33	17%
Mercy Care	133	66%
Total	**200**	**100%**

AHCCCS requires that at least 5% of the providers delivering SABG services are reviewed for quality and appropriateness of treatment services. This review ensured that over 5% of SABG providers from each RBHA were reviewed (distribution included in the table below).[7]

[7] AHCCCS. (n.d.). *Substance Abuse Prevention and Treatment Block Grant (SABG).* Available at: https://www.azahcccs.gov/Resources/Grants/SABG/

Table 1-2 — SABG-Funded Treatment Providers Included in Independent Case Review			
RBHA	**SABG-Funded Treatment Providers**	**SABG-Funded Treatment Providers included in the ICR**	**Percentage of SABG Treatment providers included in the ICR**
Arizona Complete Health	24	4	17%
Health Choice AZ	17	11	65%
Mercy Care	22	8	36%
Total	**63**	**23**	**37%**

Table 1-3 shows the female and male distribution by sample by RBHA. Overall, the mean age served in the sample was 36.5 years, with a median of 34.3.

Table 1-3 — Distribution of Case File Review Sample by Gender and Age						
RBHA	**Gender**				**Age**	
	Female		**Male**			
	N	**%**	**N**	**%**	**Mean**	**Median**
Arizona Complete Health	9	26%	25	74%	35.2	33.2
Health Choice AZ	18	55%	15	45%	38.6	35.4
Mercy Care	49	37%	84	63%	36.2	33.9
Total	**76**	**38%**	**124**	**62%**	**36.5**	**34.3**

Sample Characteristics

To be included in the sample, clients must have been disenrolled or have had an episode of care with a closure date within fiscal year 2020 (July 1, 2019 to June 30, 2019) with a final case closure date no later than June 30, 2020. Closure reasons include *Client Declined Further S*ervice, *Lack of Contact*, *Treatment Completion,* and *Missing*.

The most frequent reason for case closure was *Lack of Contact* (46%), followed closely by *Treatment Completion* (40%). Reasons for case closure are included in the table below.

Table 1-4 — Distribution Based on Case Closure Reason									
		Client declined further service		**Lack of contact**		**Treatment completion**		**Missing**	
RBHA	**Sample cases**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Arizona Complete Health	34	3	9%	17	50%	13	38%	1	3%
Health Choice AZ	33	3	9%	19	58%	11	33%	0	0%
Mercy Care	133	22	17%	56	42%	55	41%	0	0%

Table 1-4 — Distribution Based on Case Closure Reason									
		Client declined further service		Lack of contact		Treatment completion		Missing	
RBHA	Sample cases	N	%	N	%	N	%	N	%
Total	**200**	**28**	**14%**	**92**	**46%**	**79**	**40%**	**1**	**1%**

Table 1-5 shows the most frequent source of referral to SUD treatment. “Criminal Justice/Correctional” includes Administrative Office of the Courts, Arizona Department of Corrections, Arizona Department of Juvenile Corrections, Jail/Prison, and Probation. “Other” includes physical health providers, State agencies, crisis, and unknown sources. Overwhelmingly, self-referral or referral by family or friends was the most frequent referral source (57%).

Table 1-5 — Source for Referral									
	Criminal Justice/ Correctional		Other Behavioral Health Provider		Self/Family/ Friend		Other		Grand Total
	N	%	N	%	N	%	N	%	N
Arizona Complete Health	6	18%	13	38%	13	38%	2	6%	34
Health Choice AZ	15	45%	2	6%	14	42%	2	6%	33
Mercy Care	17	13%	17	13%	87	65%	12	9%	133
Grand Total	**38**	**19%**	**32**	**16%**	**114**	**57%**	**16**	**8%**	**200**

Aggregate Review Findings

The tables (2-1 through 2-9) below represent the aggregate chart review findings. As noted in the Methodology section, although the measures remain primarily the same as those used in previous years, certain measures were updated and several are new during this round of review. The denominators primarily consisted of the sum of “Yes” and “No” responses and, as such, differ across the measures. The denominators of certain indicators were based on the number of “Yes” responses from a prior question when applicable. For example, the denominators for I.A.1 through 9 equate to the numerator for I.A. *Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?* Certain measures allowed for a response of “Not Applicable” (N/A); N/As are not included in any denominator, consistent with prior years’ analyses. Measures marked with an asterisk in the “N/A” column indicate that “N/A” was not a valid response option for that particular measure. Additionally, certain measures included an option for missing documentation.

Additional narrative information was collected on the following measures (See full set and description of measures in Appendix A) and is incorporated into the Findings section prior to the table.

- II.D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?
- III.A.1. The following evidence-based practices were used in treatment…Other Practices or Programs (please list in box below).
- VIII.C. Were other attempts made to re-engage the individual, such as…Other, please list other identified outreach efforts in the box below.

Measure I — Intake/Treatment Planning Key Findings

Initial Behavioral Health Assessment

Mercer reviewed 200 total records for the State, as a whole, and found 99% of the charts contained evidence that an initial behavioral health assessment was completed within 45 days of the initial appointment. As part of the initial assessment, providers successfully documented compliance with the required components of the assessment (Items A1–9) with a range of 45% to 100%. The areas of lowest performance were hepatitis C, HIV, and other infectious disease screening (45%), documentation of review of the PDMP (55%), and tuberculosis screening (57%).

Individual Service Plan (ISP)

Providers developed an ISP for the client's treatment (within 90 days of the initial appointment) in 97% of the reviewed cases. In 96% of these cases, the providers developed the ISP in congruence with the presenting concerns. Fourteen percent of ISPs were developed with the participation of the client's family or other supports (when the client consented to allow participation from these sources). Eighty-seven clients declined participation from family and other supports, or supports did not exist.

Table 2-1 — Aggregate Case File Review Findings					
I.	**Intake/Treatment Planning**				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	199	197	99%	1
	Did the behavioral health assessment:				
	A. Address substance-related disorder(s)?	197	197	100%	*
	Describe the intensity/frequency of substance use?	197	187	95%	*
	Include the effect of substance use on daily functioning?	197	154	78%	*
	Include the effect of substance use on interpersonal relationships?	197	156	79%	*
	Include a completed risk assessment?	197	196	99%	*
	Document screening for tuberculosis (TB)?	197	112	57%	*

Table 2-1 — Aggregate Case File Review Findings					
I.	**Intake/Treatment Planning**				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	Document screening for Hepatitis C, HIV, and other infectious diseases?	197	89	45%	*
	Document screening for emotional and/or physical abuse/trauma issues?	197	187	95%	*
	Documentation that review of the Prescription Drug Monitoring Program (PDMP) was completed?	108	59	55%	92
	B. Was there documentation that charitable choice requirements were followed, if applicable?	1	1	100%	199
	C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	193	188	97%	7
	Was the ISP:				
	A. Developed with participation of the family/support network?	101	14	14%	87
	Congruent with the diagnosis(es) and presenting concern(s)?	188	180	96%	*
	Measurable objectives and timeframes to address the identified needs?	188	165	88%	*
	Addressing the unique cultural preferences of the individual?	188	161	86%	*
	Were social determinants of health issues considered as part of, and incorporated into, the ISP?	187	152	81%	*

Measure II — Placement Criteria/Assessment Key Findings

ASAM Patient Placement Criteria were used at intake to determine the appropriate level of service in 86% of the cases reviewed. Of these cases, documentation showed that 90% received the LOC identified by the ASAM criteria. Providers documented the use of the ASAM criteria to reassess the proper LOC during treatment in 42% of cases. In 22% of the reviewed case files, providers documented the use of other (or additional) assessment tools during the course of treatment. These tools included:

- Clinical Outcomes in Routine Evaluation (CORE) (Used one time)
- Daily Living Activities–20 (DLA-20) (Used three times)
- Drug Abuse Screening Test (DAST) (Used three times)
- Clinical Institute Withdrawal Assessment (CIWA) (Used two times)

- Opioid Withdrawal Scale (OWS) (Used one time)
- UNCOPE Screening Instrument for Substance Abuse (Used three times)
- Outcome Rating Scale (ORS) (Used one time)

Table 2-2 — Aggregate Case Review Findings					
II.	**Placement Criteria/Assessment**				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?	200	171	86%	*
	A. If the ASAM Patient Placement Criteria were used, the level of service identified was:				
	a. Level 0.5: Early Intervention	149	1	1%	*
	b. OMT: Opioid Maintenance Therapy	149	1	1%	*
	c. Level I: Outpatient Treatment	167	80	48%	*
	d. Level II: Intensive Outpatient Treatment/Partial Hospitalization	150	37	25%	*
	e. Level III: Residential/Inpatient Treatment	152	49	32%	*
	f. Level IV: Medically Managed Intensive Inpatient Treatment	149	3	2%	*
	A. Did the member receive the level of services identified by the placement criteria/assessment?	171	154	90%	*
	B. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	200	83	42%	*
	C. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	200	44	22%	*

Measure III — Best Practices Key Findings

Eighty-seven percent of sampled behavioral health case files contained documentation that EBPs were used in treatment. Of these, CBT was the most widely used EBP (72%). MAT was documented in 42% percent of the behavioral health case files. Of the 83 individuals who received MAT, methadone was the most frequently used medication (52%). Three interventions were not documented as having been used during this review period: Adolescent Community Reinforcement Approach (ACRA), Beyond Trauma: A Healing Journey for Women, and Trauma Recovery and Empowerment Model (TREM).

Additional interventions used by providers included:

- Eye Movement Desensitization and Reprocessing (EMDR) (Used two times)
- STOP Program (Domestic Violence) (Used one time)
- Acceptance and Commitment Therapy (ACT) (Used three times)
- Accelerated Resolution Therapy (ART) (Used two times)
- Rational Emotive Behavior Therapy (REBT) (Used five times)
- Mindfulness (Used four times)
- Living In Balance (Used two times)
- Brene Brown Shame-Resilience Curriculum (Used four times)

In 36% of cases, providers offered peer support services and, in 66% of those cases, the services were provided as part of treatment. Seventeen individuals declined peer support services when the provider offered. The EBP of screening for ongoing substance use during treatment occurred in 79% of the reviewed cases.

Table 2-3 — Aggregate Case Review Findings					
III.	**Best Practices**				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	A. Were evidence-based practices used in treatment?	200	173	87%	*
	1. The following evidence-based practices were used in treatment:				
	a. Adolescent Community Reinforcement Approach (ACRA)	173	0	0%	*
	b. Beyond Trauma: A Healing Journey for Women	173	0	0%	*
	c. Cognitive Behavioral Therapy (CBT)	173	124	72%	*
	d. Contingency management	173	1	1%	*
	e. Dialectal Behavioral Therapy (DBT)	173	28	16%	*
	f. Helping Women Recover	173	8	5%	*
	g. Matrix	173	22	13%	*
	h. Moral Re-conation Therapy (MRT)	173	1	1%	*
	i. Motivational Enhancement/Interviewing Therapy (MET/MI)	173	66	38%	*
	j. Relapse Prevention Therapy (RPT)	173	11	6%	*

Table 2-3 — Aggregate Case Review Findings					
III.	**Best Practices**				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	k. Seeking Safety	173	4	2%	*
	l. SMART Recovery	173	10	6%	*
	m. Thinking for a Change	173	1	1%	*
	n. Trauma Recovery and Empowerment Model (TREM)	173	0	0%	*
	o. Trauma-Informed Care (TIC)	173	17	10%	*
	p. Wellness Recovery Action Plan (WRAP)	173	1	1%	*
	q. Other Practices or Programs(please list in box below):	173	30	17%	*
	B. Medication Assisted Treatment (MAT)	200	83	42%	*
	1. The following medication was used in treatment:				
	a. Alcohol-related				
	i. Acamprosate (Campral)	83	1	1%	*
	ii. Disulfiram (Antabuse)	83	1	1%	*
	b. Opioid-related				
	i. Subutex (buprenorphine)	83	8	10%	*
	ii. Methadone/Levo-Alpha-Acetylmethadol (LAAM)	83	43	52%	*
	iii. Narcan (naloxone)	83	5	6%	*
	iv. Vivitrol (long-acting naltrexone)	83	9	11%	*
	v. Suboxone (buprenorphine-naloxone)	83	30	36%	*
	C. Was screening for substance use/abuse conducted during the course of treatment?	200	158	79%	*
	D. Was certified peer support offered as part of treatment?	200	71	36%	17
	E. If yes to III.D, were certified peer support services used as a part of treatment?	71	47	66%	*

Measure IV — Treatment/Support Services/Rehabilitation Services Key Findings

Providers used case management as the most common service provided in the sample (72%), followed by individual therapy (71%), group therapy (67%), and family counseling (3%). For those individuals who received counseling, 46% attended more than 11 sessions; 42% attended five or fewer sessions.

Sixty-six percent of behavioral health case files did not contain documentation regarding the number of self-help or recovery group sessions completed during treatment. Of those that did document this metric (34%), 14% of cases documented zero attendance at the self-help or recovery group sessions.

Table 2-4 — Aggregate Case Review Findings					
IV.	**Treatment/Support Services/Rehabilitation Services**				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	A. The following services were used in treatment:				
	1. Individual counseling/therapy	200	141	71%	*
	2. Group counseling/therapy	199	134	67%	*
	3. Family counseling/therapy	200	5	3%	*
	4. Case management	199	143	72%	*
	B. Was there clear documentation of progress or lack of progress toward the identified ISP goals?	169	146	86%	31
	C. The number of completed counseling/therapy sessions during treatment was:				
	• 0–5 sessions	193	81	42%	*
	• 6–10 sessions	193	23	12%	*
	• 11 sessions or more	193	89	46%	*
	D. Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:				
	• No documentation	200	132	66%	*
	• 0 times during treatment	200	28	14%	*
	• 1–4 times during treatment	200	14	7%	*
	• 5–12 times during treatment	200	10	5%	*
	• 13–20 times during treatment	200	13	7%	*
	• 21 or more times during treatment	200	3	2%	*
	E. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?	80	34	43%	118
	F. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	117	107	91%	81

Table 2-4 — Aggregate Case Review Findings					
IV.	**Treatment/Support Services/Rehabilitation Services**				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	G. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	101	74	73%	97
	H. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	140	81	58%	58
	I. Does the documentation reflect that substance abuse services were provided?	198	194	98%	*
	J. Was member's access to a primary care physician (PCP) or other medical provider explored?	191	149	78%	4

Measure V — Gender Specific (female only) Key Findings

Providers documented 25 women's case files with a history of domestic violence; of these, 72% contained a safety plan. Providers documented two pregnant women in this sample; coordination of care with the PCP or obstetrician occurred in one case (50%) and education on the effects of substance use on fetal development occurred in one case (50%). This sample did not contain any women who had given birth in the past year. Of the case files for women who had dependent children, 90% documented an examination of childcare. Gender-specific services were documented in 28% of cases.

	Table 2-5 — Aggregate Case Review Findings				
V.	**Gender Specific (female only)**				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	25	18	72%	51
	B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	2	1	50%	74
	C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?	2	1	50%	74

Table 2-5 — Aggregate Case Review Findings					
V.	**Gender Specific (female only)**				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?	0	0	–	76
	E. If the female had dependent children, was there documentation to show that childcare was addressed?	31	28	90%	45
	A. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	75	21	28%	45

Measure VI — Opioid Specific Key Findings

For this sample, providers documented OUD in 65% of the cases. Of these cases, providers educated 84% of the clients on MAT as a treatment option, and 96% of those were referred to a MAT provider. Documentation showed MAT providers educated the client on overdose, naloxone, and steps to take in the event of an overdose in 44% of the cases. Education on the effects of polysubstance abuse with opioids was provided in 54% of the cases. In 90% of cases, providers referred clients with withdrawal symptoms to a medical provider.

Table 2-6 — Aggregate Case Review Findings					
VI.	**Opioid Specific**				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?	155	100	65%	*
	B. Was there documentation that the member was provided MAT education as a treatment option?	100	84	84%	*
	C. If yes to VI. B, were they referred to a MAT provider?	84	81	96%	58
	D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	50	45	90%	94
	E. If a physical health concern related to pain was identified, were alternative pain management options addressed?	39	22	56%	105
	F. If member is a pregnant female; did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?	1	0	0%	199

	Table 2-6 — Aggregate Case Review Findings				
VI.	**Opioid Specific**				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?	100	44	44%	*
	H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	100	54	54%	*

Measure VII — Discharge and Continuing Care Planning (completed only if the individual completed treatment or declined further services) Key Findings

In 55% of the reviewed cases, providers documented completion of a relapse prevention plan for clients who completed treatment or declined further services. Providers documented offering resources pertaining to community supports in 73% of these cases. For those clients engaged with other agencies, providers actively coordinated with these agencies at the time of discharge in 70% of the cases.

	Table 2-7 — Aggregate Case Review Findings				
VII.	**Discharge and Continuing Care Planning** *Completed if member completed treatment or declined further services*				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	A. Was there documentation present that a relapse prevention plan completed?	170	94	55%	*
	B. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g. crisis line)?	170	124	73%	*
	C. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?	116	81	70%	55

Measure VIII — Re-engagement (completed only if the individual declined further services or chose not to appear for scheduled services) Key Findings

In 63% of cases where the client declined further services or chose not to appear for scheduled services, providers followed up with a phone call at times when the member was expected to be available. In 56% of these cases, providers mailed a letter to the client requesting contact. Other activities taken by providers to make contact included contacting other involved agencies (54%), calling the client's emergency contact (31%), and visiting the client's home (23%). Other methods of outreach were documented in 19% of cases reviewed and include:

- Visiting the client while the individual was incarcerated.
- Visiting the client while the individual was receiving services at an agency contacting the client's attorney (for whom there was a signed release of information).
- Visiting the client while the individual was in an inpatient facility and sending an email to the client.

Table 2-8 — Aggregate Case Review Findings					
VIII.	**Re-engagement** *Completed if member declined further services or chose not to appear for scheduled services*				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	The following efforts were documented:				
	A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?	158	99	63%	*
	A. If telephone contact was unsuccessful, was a letter mailed requesting contact?	134	75	56%	24
	B. Were other attempts made to re-engage the individual, such as:				
	1. Home visit?	26	6	23%	*
	2. Call emergency contact(s)?	26	8	31%	*
	3. Contacting other involved agencies?	26	14	54%	*
	4. Street Outreach?	26	0	0%	*
	5. Other?	26	5	19%	*

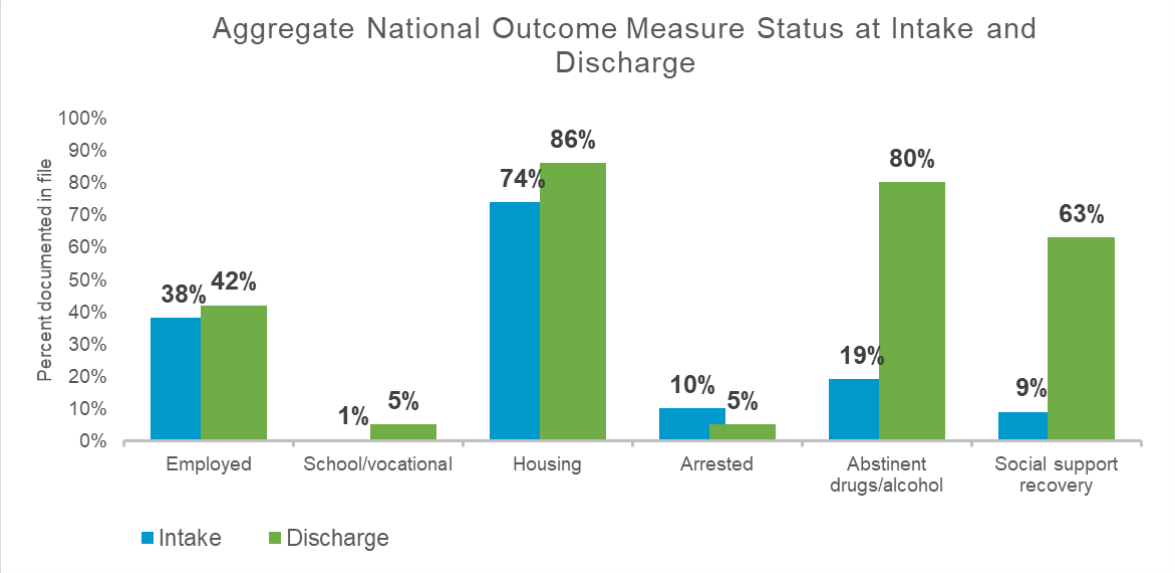
Measure IX — NOMs Key Findings

Each of the six NOMs for Measure IX are depicted in Table 2-9. Denominators reflect missing documentation of status at intake and discharge, if applicable. In general, documentation was more complete at intake than at discharge, other than *Participated in social support recovery in the preceding 30 days?* (missing information 44% of the time). This measure was absent in general in two-thirds of the files at discharge; other NOMS were not documented almost 45% at discharge.

Note that a lower number and percentage are desired for the NOM *Arrested in the preceding 30 days?* measure.

The graphs below show the results for each NOM at intake and discharge. Results for each RBHA for each NOM improved at discharge.

Table 2-9 — Aggregate Case File Review Findings						
Measure IX National Outcome Measures						
	Intake			**Discharge**		
NOMs	**Denominator**	**# Yes**	**% Yes**	**Denominator**	**# Yes**	**% Yes**
A. Employed?	198	75	38%	118	50	42%
B. Enrolled in school or vocational educational program?	195	1	0.5%	112	6	5%
C. Lived in a stable housing environment (e.g., not homeless)?	198	147	74%	114	98	86%
D. Arrested in the preceding 30 days?[8]	195	19	10%	111	6	5%
E. Abstinent from drugs and/or alcohol?	197	38	19%	110	88	80%
F. Participated in social support recovery in the preceding 30 days?	199	18	9%	68	43	63%



[8] Note that a lower number and percentage is desired for the NOM *Arrested in the preceding 30 days?*

5

Case File Review Findings

The narratives and tables below represents the chart review findings for each RBHA. The methodology is identical to the Aggregate Findings section and is repeated here. As noted in the Methodology Section, although the measures remain primarily the same as those used in previous years, certain measures were updated and several are new during this year's review. The denominators primarily consisted of the sum of "Yes" and "No" responses and, as such, differ across the measures. The denominators of certain indicators were based on the number of "Yes" responses from a prior question when applicable. For example, the denominators for I.A.1 through 9 equate to the numerator for I.A. *Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?* Certain measures allowed for a response of "Not Applicable" (N/A); N/As are not included in any denominator, consistent with prior years' analyses. Measures marked with an asterisk in the "N/A" column indicate that "N/A" was not a valid response option for that particular measure. Additionally, certain measures included an option for missing documentation.

Additional narrative information was collected on the following measures and are incorporated into the Findings section prior to the table.

- II.D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?
- III.A.1. The following evidence-based practices were used in treatment…Other Practices or Programs (please list in box below).
- VIII.C. Were other attempts made to re-engage the individual, such as…Other, please list other identified outreach efforts in the box below.

Arizona Complete Health (AzCH)

AzCH has responsibility for AHCCCS clients in the southern region of the State. Mercer reviewed provider treatment records from four separate clinics under AzCH's area of responsibility. The following highlights were observed within the data collected from these cases.

- Providers addressed SDoH issues during the initial assessment in 100% of the cases that contained an ISP, which was well above average for the State (81%).
- Although providers reassessed ASAM criteria during the course of treatment for only 50% of cases, this was above average for the State as a whole (42%).

- Screening for tuberculosis within this region, which was documented in 68% of cases, was above the average for the State (57%).
- Forty-Six percent of cases reviewed documented the involvement of natural supports in the treatment planning process, which was well above the average for the State (14%).
- AzCH produced results above the State average (36%) for clients offered certified peer support services; the providers in this region offered certified peer support to 82% of clients.

Measure I — Intake/Treatment Planning Key Findings

Initial Behavioral Health Assessment

Mercer reviewed 34 total records for AzCH and found 100% of the charts contained evidence that an initial behavioral health assessment was completed within 45 days of the initial appointment. As part of the initial assessment, providers successfully documented compliance with the required components of the assessment (Items A1–9) with a range of 36% to 100%. The areas of lowest performance were documentation of review of the PDMP (36%); hepatitis C, HIV, and other infectious disease screening (44%); and tuberculosis screening (68%).

Individual Service Plan (ISP)

Providers developed an ISP for the client's treatment (within 90 days of the initial appointment) in 89% of the reviewed cases. In 96% of these cases, the providers developed the ISP in congruence with the presenting concerns. Forty-six percent of ISPs were developed with the participation of the client's family or other supports (when the client consented to allow participation from these sources). Twelve clients declined participation from family and other supports, or supports did not exist.

Table 3-1 — AzCH Case File Review Findings

I.	Intake/Treatment Planning				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	34	34	100%	0
	Did the behavioral health assessment:				
	Address substance-related disorder(s)?	34	34	100%	*
	Describe the intensity/frequency of substance use?	34	33	97%	*
	Include the effect of substance use on daily functioning?	34	34	100%	*
	Include the effect of substance use on interpersonal relationships?	34	34	100%	*
	Include a completed risk assessment?	34	34	100%	*
	Document screening for tuberculosis (TB)?	34	23	68%	*

Table 3-1 — AzCH Case File Review Findings					
I.	**Intake/Treatment Planning**				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	Document screening for Hepatitis C, HIV, and other infectious diseases?	34	15	44%	*
	Document screening for emotional and/or physical abuse/trauma issues?	34	30	88%	*
	Documentation that review of the Prescription Drug Monitoring Program (PDMP) was completed?	11	4	36%	23
	B. Was there documentation that charitable choice requirements were followed, if applicable?	0	0	–	34
	C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	28	25	89%	6
	Was the ISP:				
	Developed with participation of the family/support network?	13	6	46%	12
	Congruent with the diagnosis(es) and presenting concern(s)?	25	24	96%	*
	Measurable objectives and timeframes to address the identified needs?	25	25	100%	*
	Addressing the unique cultural preferences of the individual?	25	25	100%	*
	Were social determinants of health issues considered as part of, and incorporated into, the ISP?	25	25	100%	*

Measure II — Placement Criteria/Assessment Key Findings

ASAM Patient Placement Criteria were used at intake to determine the appropriate level of service in 82% of the cases reviewed. Of these cases, documentation showed that 71% received the LOC identified by the ASAM criteria. Providers documented the use of the ASAM criteria to reassess the proper LOC during treatment in 50% of cases. In 26% of the reviewed case files, providers documented the use of other (or additional) assessment tools during the course of treatment. These tools included:

- CORE (Used one time)
- DLA-20 (Used three times)
- DAST (Used one time)

	Table 3-2 — AzCH Case File Review Findings				
II.	**Placement Criteria/Assessment**				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?	34	28	82%	*
	1. If the ASAM Patient Placement Criteria were used, the level of service identified was:				
	a. Level 0.5: Early Intervention	28	0	0%	*
	b. OMT: Opioid Maintenance Therapy	28	0	0%	*
	c. Level I: Outpatient Treatment	28	2	7%	*
	d. Level II: Intensive Outpatient Treatment/Partial Hospitalization	28	15	54%	*
	e. Level III: Residential/Inpatient Treatment	28	9	32%	*
	f. Level IV: Medically Managed Intensive Inpatient Treatment	28	2	7%	*
	B. Did the member receive the level of services identified by the placement criteria/assessment?	28	20	71%	*
	C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	34	17	50%	*
	D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	34	9	26%	*

Measure III — Best Practices Key Findings

Seventy-nine percent of sampled behavioral health case files contained documentation that EBPs were used in treatment. Of these, CBT was the most widely used EBP (74%). MAT was documented in 38% percent of the behavioral health case files. Of the 13 individuals who received MAT, Suboxone® was the most frequently used medication (54%). Seven interventions were not documented as having been used during this review period: ACRA, Beyond Trauma: A Healing Journey for Women, Helping Women Recover, Matrix, Moral Re-conation Therapy (MRT), Thinking for a Change, and TREM.

In 82% of cases, providers offered certified peer support services and, in 89% of those cases, the services were provided as part of treatment. Three individuals declined peer support services when the provider offered. The EBP of screening for ongoing substance use during treatment occurred in 94% of the reviewed cases.

	Table 3-3 — AzCH Case File Review Findings				
III.	Best Practices				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Were evidence-based practices used in treatment?	34	27	79%	*
	1. The following evidence-based practices were used in treatment:				
	a. Adolescent Community Reinforcement Approach (ACRA)	27	0	0%	*
	b. Beyond Trauma: A Healing Journey for Women	27	0	0%	*
	c. Cognitive Behavioral Therapy (CBT)	27	20	74%	*
	d. Contingency management	27	1	4%	*
	e. Dialectal Behavioral Therapy (DBT)	27	3	11%	*
	f. Helping Women Recover	27	0	0%	*
	g. Matrix	27	0	0%	*
	h. Moral Re-conation Therapy (MRT)	27	0	0%	*
	i. Motivational Enhancement/Interviewing Therapy (MET/MI)	27	7	26	*
	j. Relapse Prevention Therapy (RPT)	27	1	4%	*
	k. Seeking Safety	27	2	7%	*
	l. SMART Recovery	27	3	11%	*
	m. Thinking for a Change	27	0	0%	*
	n. Trauma Recovery and Empowerment Model (TREM)	27	0	0%	*
	o. Trauma-Informed Care (TIC)	27	1	4%	*
	p. Wellness Recovery Action Plan (WRAP)	27	1	4%	*
	q. Other Practices or Programs(please list in box below):	27	4	15%	*
	B. Medication Assisted Treatment (MAT)	34	13	38%	*
	1. The following medication was used in treatment:				
	a. Alcohol-related				
	i. Acamprosate (Campral)	13	0	0%	*
	ii. Disulfiram (Antabuse)	13	0	0%	*
	b. Opioid-related				
	i. Subutex (buprenorphine)	13	3	23%	*

	Table 3-3 — AzCH Case File Review Findings				
III.	**Best Practices**				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	ii. Methadone/Levo-Alpha-Acetylmethadol (LAAM)	13	5	38%	*
	iii. Narcan (naloxone)	13	2	15%	*
	iv. Vivitrol (long-acting naltrexone)	13	2	15%	*
	v. Suboxone (buprenorphine-naloxone)	13	7	54%	*
	C. Was screening for substance use/abuse conducted during the course of treatment?	34	32	94%	*
	D. Was certified peer support offered as part of treatment?	34	28	82%	3
	E. If yes to III.D, were certified peer support services used as a part of treatment?	28	25	89%	*

Measure IV — Treatment/Support Services/Rehabilitation Services Key Findings

Providers used individual therapy as the most common service provided in the sample (82%), followed by case management (79%) and group therapy (70%). Providers did not document the provision of family counseling in any of the reviewed cases (0%). For those individuals who received counseling, 57% attended more than 11 sessions; 36% attended five or fewer sessions.

Fifty-three percent of behavioral health case files did not contain documentation regarding the number of self-help or recovery group sessions completed during treatment. Of those that did document this metric, 26% of cases documented zero attendance at the self-help or recovery group sessions.

	Table 3-4 — AzCH Case File Review Findings				
IV.	**Treatment/Support Services/Rehabilitation Services**				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	A. The following services were used in treatment:				
	1. Individual counseling/therapy	34	28	82%	*
	2. Group counseling/therapy	33	23	70%	*
	3. Family counseling/therapy	34	0	0%	*
	4. Case management	33	26	79%	*
	B. Was there clear documentation of progress or lack of progress toward the identified ISP goals?	22	20	91%	12

	Table 3-4 — AzCH Case File Review Findings				
IV.	**Treatment/Support Services/Rehabilitation Services**				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	C. The number of completed counseling/therapy sessions during treatment was:				
	• 0–5 sessions	28	10	36%	*
	• 6–10 sessions	28	2	7%	*
	• 11 sessions or more	28	16	57%	*
	D. Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:				
	• No documentation	34	18	53%	*
	• 0 times during treatment	34	9	26%	*
	• 1–4 times during treatment	34	4	12%	*
	• 5–12 times during treatment	34	1	3%	*
	• 13–20 times during treatment	34	2	6%	*
	• 21 or more times during treatment	34	0	0%	*
	E. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?	15	10	67%	18
	F. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	26	22	85%	7
	G. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	16	10	63%	17
	H. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	29	23	79%	4
	I. Does the documentation reflect that substance abuse services were provided?	33	29	88%	*
	J. Was member's access to a primary care physician (PCP) or other medical provider explored?	30	27	90%	1

Measure V — Gender Specific (female only) Key Findings

Providers documented three women's case files with a history of domestic violence; of these, 67% contained a safety plan. This sample did not contain any pregnant women or women who had given birth in the past year. Of the case files for women who had dependent children, 83% documented an examination of childcare. Gender-specific services were documented in 22% of cases.

Table 3-5 — AzCH Case File Review Findings					
V.	**Gender Specific (female only)**				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	3	2	67%	6
	B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	0	0	–	9
	C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?	0	0	–	9
	D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?	0	0	–	9
	E. If the female had dependent children, was there documentation to show that childcare was addressed?	6	5	83%	3
	F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	9	2	22%	0

Measure VI — Opioid Specific Key Findings

For this sub-sample, providers documented OUD in 47% of the cases. Of these cases, providers educated 88% of the clients on MAT as a treatment option, and 93% of those were referred to a MAT provider. Documentation showed MAT providers educated the client on overdose, naloxone, and steps to take in the event of an overdose in 69% of the cases. Education on the effects of polysubstance abuse with opioids was provided in 56% of the cases. In 100% of cases, providers referred clients with withdrawal symptoms to a medical provider.

	Table 3-6 — AzCH Case File Review Findings				
VI.	**Opioid Specific**				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?	34	16	47%	*
	B. Was there documentation that the member was provided MAT education as a treatment option?	16	14	88%	*
	C. If yes to VI. B, were they referred to a MAT provider?	14	13	93%	20
	D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	15	15	100%	19
	E. If a physical health concern related to pain was identified, were alternative pain management options addressed?	4	4	100%	30
	F. If member is a pregnant female; did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?	0	0	–	34
	G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?	16	11	69%	*
	H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	16	9	56%	*

Measure VII — Discharge and Continuing Care Planning (completed only if the individual completed treatment or declined further services) Key Findings

In 58% of the reviewed cases, providers documented completion of a relapse prevention plan for clients who completed treatment or declined further services. Providers documented offered resources pertaining to community supports in 61% of these cases. For those clients engaged with other agencies, providers actively coordinated with these agencies at the time of discharge in 66% of the cases.

	Table 3-7 — AzCH Case File Review Findings				
VII.	**Discharge and Continuing Care Planning** *Completed if member completed treatment or declined further services*				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	A. Was there documentation present that a relapse prevention plan completed?	33	19	58%	*

	Table 3-7 — AzCH Case File Review Findings				
VII.	**Discharge and Continuing Care Planning** *Completed if member completed treatment or declined further services*				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	B. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g. crisis line)?	33	20	61%	*
	C. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?	32	21	66%	2

Measure VIII — Re-engagement (completed only if the individual declined further services or chose not to appear for scheduled services) Key Findings

In 30% of cases where the client declined further services or chose not to appear for scheduled services, providers followed up with a phone call at times when the member was expected to be available. In 23% of these cases, providers mailed a letter to the client requesting contact. Other activities taken by providers to make contact included, visiting the client's home (57%), contacting other involved agencies (43%), calling the client's emergency contact (29%), and, in one case, visiting the client while the individual was incarcerated.

	Table 3-8 — AzCH Case File Review Findings				
VIII.	**Re-engagement** *Completed if member declined further services or chose not to appear for scheduled services*				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	The following efforts were documented:				
	A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?	33	10	30%	*
	B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	31	7	23%	2
	C. Were other attempts made to re-engage the individual, such as:				
	1. Home visit?	7	4	57%	0
	2. Call emergency contact(s)?	7	2	29%	0
	3. Contacting other involved agencies?	7	3	43%	0
	4. Street Outreach?	7	0	0%	0

Table 3-8 — AzCH Case File Review Findings					
VIII.	**Re-engagement** *Completed if member declined further services or chose not to appear for scheduled services*				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	5. Other?	7	1	14%	0

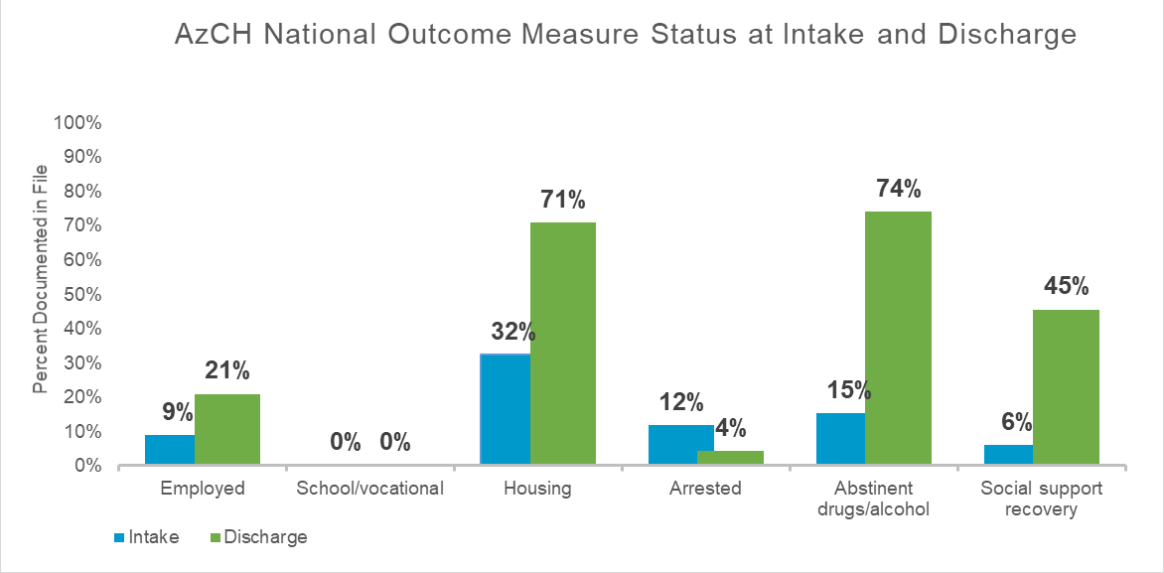
Measure IX — NOMs Key Findings

Each of the six AzCH NOMs for Measure IX are depicted in Table 3-9. The denominator is determined and compared for both intake and discharge. Denominators are impacted by missing documentation of status at intake and discharge if applicable. Approximately 40% of NOMs documentation was missing from files at discharge.

The table and graph below shows the client's status for each NOM at intake and discharge, results for AzCH for each NOM improved at discharge.

Table 3-9 — AzCH Case File Review Findings						
Measure IX National Outcome Measures						
	Intake			**Discharge**		
NOMs	**Denominator**	**# Yes**	**% Yes**	**Denominator**	**# Yes**	**% Yes**
A. Employed?	34	3	9%	24	5	21%
B. Enrolled in school or vocational educational program?	34	0	0%	24	0	0%
C. Lived in a stable housing environment (e.g., not homeless)?	34	11	32%	24	17	71%
D. Arrested in the preceding 30 days?[9]	34	4	12%	24	1	4%
E. Abstinent from drugs and/or alcohol?	33	5	15%	23	17	74%
F. Participated in social support recovery in the preceding 30 days?	34	2	6%	22	10	45%

[9] Note that a lower number and percentage is desired for the NOM *Arrested in the preceding 30 days?*


AzCH National Outcome Measure Status at Intake and Discharge
Percent Documented in File
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
9%
21%
0%
0%
32%
71%
12%
4%
15%
74%
6%
45%
Employed
School/vocational
Housing
Arrested
Abstinent drugs/alcohol
Social support recovery
Intake
Discharge

Health Choice (HC)

HC has responsibility for AHCCCS clients in the northern region of the State. Mercer reviewed provider treatment records from 11 separate clinics under HC's area of responsibility. The following highlights were observed within the data collected from these cases.

- Providers developed an ISP that was congruent with the diagnosis in 100% of the cases that contained an ISP.
- Although providers reassessed ASAM criteria during the course of treatment for only 52% of cases, this was above average for the State as a whole (42%).
- Referral to a medical provider for clients with withdrawal symptoms occurred in 100% of the cases reviewed within this region.
- Ninety-five percent of cases reviewed documented coordination with other involved agencies at the time of discharge, which was above the average for the State.

Measure I — Intake/Treatment Planning Key Findings

Initial Behavioral Health Assessment

Mercer reviewed 33 total records for HC and found 100% of the charts contained evidence that an initial behavioral health assessment was completed within 45 days of the initial appointment. As part of the initial assessment, providers successfully documented compliance with the required components of the assessment (Items A1–9) with a range of 18% to 100%. The areas of lowest performance were documentation of hepatitis C, HIV, and other infectious disease screening (18%), tuberculosis screening (42%), and review of the PDMP (43%).

Individual Service Plan (ISP)

Providers developed an ISP for the client's treatment (within 90 days of the initial appointment) in 100% of the reviewed cases. In 100% of these cases, the providers developed the ISP in congruence with the presenting concerns. Ten percent of ISPs were developed with the participation of the client's family or other supports (when the client consented to allow participation from these sources). Four clients declined participation from family and other supports, or supports did not exist.

Table 4-1 — Substance Abuse Prevention and Treatment					
HC Case File Review Findings					
I.	Intake/Treatment Planning				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	33	33	100%	0
	Did the behavioral health assessment:				

Table 4-1 — Substance Abuse Prevention and Treatment					
HC Case File Review Findings					
I.	**Intake/Treatment Planning**				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	A. Address substance-related disorder(s)?	33	33	100%	*
	Describe the intensity/frequency of substance use?	33	33	100%	*
	Include the effect of substance use on daily functioning?	33	33	100%	*
	Include the effect of substance use on interpersonal relationships?	33	33	100%	*
	Include a completed risk assessment?	33	32	97%	*
	Document screening for tuberculosis (TB)?	33	14	42%	*
	Document screening for Hepatitis C, HIV, and other infectious diseases?	33	6	18%	*
	Document screening for emotional and/or physical abuse/trauma issues?	33	32	97%	*
	Documentation that review of the Prescription Drug Monitoring Program (PDMP) was completed?	7	3	43%	26
	B. Was there documentation that charitable choice requirements were followed, if applicable?	0	0	–	33
	C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	33	33	100%	0
	Was the ISP:				
	Developed with participation of the family/support network?	29	3	10%	4
	Congruent with the diagnosis(es) and presenting concern(s)?	33	33	100%	*
	Measurable objectives and timeframes to address the identified needs?	33	32	97%	*
	Addressing the unique cultural preferences of the individual?	33	21	64%	*
	Were social determinants of health issues considered as part of, and incorporated into, the ISP?	33	21	64%	*

Measure II — Placement Criteria/Assessment Key Findings

ASAM Patient Placement Criteria were used at intake to determine the appropriate level of service in 79% of the cases reviewed. Of these cases, documentation showed that 96% received the LOC identified by the ASAM criteria. Providers documented the use of the ASAM criteria to reassess the proper LOC during treatment in 52% of cases. In 39% of the reviewed case files, providers documented the use of other (or additional) assessment tools during the course of treatment. These tools included:

- CIWA (Used two times)
- OWS (Used one time)
- ORS (Used one time)

	Table 4-2 — Substance Abuse Prevention and Treatment				
	HC Case File Review Findings				
II.	Placement Criteria/Assessment				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?	33	26	79%	*
	B. If the ASAM Patient Placement Criteria were used, the level of service identified was:				
	a. Level 0.5: Early Intervention	26	0	0%	*
	b. OMT: Opioid Maintenance Therapy	26	0	0%	*
	c. Level I: Outpatient Treatment	26	12	46%	*
	d. Level II: Intensive Outpatient Treatment/Partial Hospitalization	26	6	23%	*
	e. Level III: Residential/Inpatient Treatment	26	7	27%	*
	f. Level IV: Medically Managed Intensive Inpatient Treatment	26	1	4%	*
	C. Did the member receive the level of services identified by the placement criteria/assessment?	26	25	96%	*
	D. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	33	17	52%	*
	E. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	33	13	39%	*

Measure III — Best Practices Key Findings

Eighty-five percent of sampled behavioral health case files contained documentation that EBPs were used in treatment. Of these, CBT was the most widely used EBP (71%). MAT was documented in 12% percent of the behavioral health case files. Of the four individuals who received MAT, Suboxone was the most frequently used medication (50%). Six interventions were not documented as having been used during this review period: ACRA, Beyond Trauma: A Healing Journey for Women, Contingency Management, MRT, TREM, and Wellness Recovery Action Plan (WRAP).

Additional interventions used by providers included:

- ART (Used two times)
- ACT (Used three times)
- EMDR (Used two times)
- STOP Program (Domestic Violence) (Used one time)

In 33% of cases, providers offered certified peer support services and, in 45% of those cases, the services were provided as part of treatment. Three individuals declined peer support services when the provider offered. The EBP of screening for ongoing substance use during treatment occurred in 70% of the reviewed cases.

	Table 4-3 — Substance Abuse Prevention and Treatment				
	HC Case File Review Findings				
III.	Best Practices				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Were evidence-based practices used in treatment?	33	28	85%	*
	1. The following evidence-based practices were used in treatment:				
	a. Adolescent Community Reinforcement Approach (ACRA)	28	0	0%	*
	b. Beyond Trauma: A Healing Journey for Women	28	0	0%	*
	c. Cognitive Behavioral Therapy (CBT)	28	20	71%	*
	d. Contingency management	28	0	0%	*
	e. Dialectal Behavioral Therapy (DBT)	28	6	21%	*
	f. Helping Women Recover	28	1	4%	*
	g. Matrix	28	4	14%	*
	h. Moral Re-conation Therapy (MRT)	28	0	0%	*

	Table 4-3 — Substance Abuse Prevention and Treatment				
	HC Case File Review Findings				
III.	Best Practices				
		Denominator	# of Yes	% of Yes	# of N/A
	i. Motivational Enhancement/Interviewing Therapy (MET/MI)	28	15	54%	*
	j. Relapse Prevention Therapy (RPT)	28	8	29%	*
	k. Seeking Safety	28	1	4%	*
	l. SMART Recovery	28	2	7%	*
	m. Thinking for a Change	28	1	4%	*
	n. Trauma Recovery and Empowerment Model (TREM)	28	0	0%	*
	o. Trauma-Informed Care (TIC)	28	4	14%	*
	p. Wellness Recovery Action Plan (WRAP)	28	0	0%	*
	q. Other Practices or Programs(please list in box below):	28	9	32%	*
	B. Medication Assisted Treatment (MAT)	33	4	12%	*
	1. The following medication was used in treatment:				
	a. Alcohol-related				
	i. Acamprosate (Campral)	4	0	0%	*
	ii. Disulfiram (Antabuse)	4	1	25%	*
	b. Opioid-related				
	i. Subutex (buprenorphine)	4	1	25%	*
	ii. Methadone/Levo-Alpha-Acetylmethadol (LAAM)	4	0	0%	*
	iii. Narcan (naloxone)	4	0	0%	*
	iv. Vivitrol (long-acting naltrexone)	4	0	0%	*
	v. Suboxone (buprenorphine-naloxone)	4	2	50%	*
	C. Was screening for substance use/abuse conducted during the course of treatment?	33	23	70%	*
	D. Was certified peer support offered as part of treatment?	33	11	33%	2
	E. If yes to III.D, were certified peer support services used as a part of treatment?	11	5	45%	*

Measure IV — Treatment/Support Services/Rehabilitation Services Key Findings

Providers used individual therapy and case management as the most common services provided in the sample (91% each), followed by group therapy (64%), and family counseling (9%). For those individuals who received counseling, 39% attended more than 11 sessions; 45% attended five or fewer sessions.

Fifty-five percent of behavioral health case files did not contain documentation regarding the number of self-help or recovery group sessions completed during treatment. Of those that did document this metric, 9% of cases documented zero attendance at the self-help or recovery group sessions.

	Table 4-4 — Substance Abuse Prevention and Treatment				
	HC Case File Review Findings				
IV.	Treatment/Support Services/Rehabilitation Services				
		Denominator	# of Yes	% of Yes	# of N/A
	A. The following services were used in treatment:				
	1. Individual counseling/therapy	33	30	91%	*
	2. Group counseling/therapy	33	21	64%	*
	3. Family counseling/therapy	33	3	9%	*
	4. Case management	33	30	91%	*
	B. Was there clear documentation of progress or lack of progress toward the identified ISP goals?	32	32	100%	1
	C. The number of completed counseling/therapy sessions during treatment was:				
	• 0–5 sessions	33	15	45%	*
	• 6–10 sessions	33	5	15%	*
	• 11 sessions or more	33	13	39%	*
	D. Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:				
	• No documentation	33	18	55%	*
	• 0 times during treatment	33	3	9%	*
	• 1–4 times during treatment	33	6	18%	*
	• 5–12 times during treatment	33	6	18%	*
	• 13–20 times during treatment	33	0	0%	*
	• 21 or more times during treatment	33	0	0%	*

	Table 4-4 — Substance Abuse Prevention and Treatment				
	HC Case File Review Findings				
IV.	Treatment/Support Services/Rehabilitation Services				
		Denominator	# of Yes	% of Yes	# of N/A
	E. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?	24	16	67%	9
	F. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	23	23	100%	10
	G. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	22	22	100%	11
	H. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	30	26	87%	3
	I. Does the documentation reflect that substance abuse services were provided?	33	33	100%	*
	J. Was member's access to a primary care physician (PCP) or other medical provider explored?	29	25	86%	3

Measure V — Gender Specific (female only) Key Findings

Providers documented nine women's case files with a history of domestic violence; of these, 78% contained a safety plan. This sample did not contain any pregnant women or women who had given birth in the past year. Of the case files for women who had dependent children, 100% documented an examination of childcare. Gender-specific services were documented in 22% of cases.

	Table 4-5 — Substance Abuse Prevention and Treatment				
	HC Case File Review Findings				
V.	Gender Specific (female only)				
		Denominator	# of Yes	% of Yes	# of N/A
	A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	9	7	78%	9
	B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	0	0	–	18
	C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?	0	0	–	18
	D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?	0	0	–	18
	E. If the female had dependent children, was there documentation to show that childcare was addressed?	9	9	100%	9
	F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	18	4	22%	0

Measure VI — Opioid Specific Key Findings

For this sub-sample, providers documented OUD in 47% of the cases. Of these cases, providers educated 44% of the clients on MAT as a treatment option, and 100% of those were referred to a MAT provider. Documentation showed MAT providers educated the client on overdose, naloxone, and steps to take in the event of an overdose in 22% of the cases. Education on the effects of polysubstance abuse with opioids was provided in 22% of the cases. In 100% of cases, providers referred clients with withdrawal symptoms to a medical provider.

	Table 4-6 — Substance Abuse Prevention and Treatment				
	HC Case File Review Findings				
VI.	Opioid Specific				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?	19	9	47%	*
	B. Was there documentation that the member was provided MAT education as a treatment option?	9	4	44%	*

	Table 4-6 — Substance Abuse Prevention and Treatment				
	HC Case File Review Findings				
VI.	Opioid Specific				
		Denominator	# of Yes	% of Yes	# of N/A
	C. If yes to VI. B, were they referred to a MAT provider?	4	4	100%	13
	D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	4	4	100%	15
	E. If a physical health concern related to pain was identified, were alternative pain management options addressed?	6	5	83%	13
	F. If member is a pregnant female; did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?	0	0	–	33
	G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?	9	2	22%	*
	H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	9	2	22%	*

Measure VII — Discharge and Continuing Care Planning (completed only if the individual completed treatment or declined further services) Key Findings

In 54% of the reviewed cases, providers documented completion of a relapse prevention plan for clients who completed treatment or declined further services. Providers documented offered resources pertaining to community supports in 69% of these cases. For those clients engaged with other agencies, providers actively coordinated with these agencies at the time of discharge in 95% of the cases.

	Table 4-7 — Substance Abuse Prevention and Treatment				
	HC Case File Review Findings				
VII.	Discharge and Continuing Care Planning *Completed if member completed treatment or declined further services*				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Was there documentation present that a relapse prevention plan completed?	26	14	54%	*

	Table 4-7 — Substance Abuse Prevention and Treatment				
	HC Case File Review Findings				
VII.	**Discharge and Continuing Care Planning** *Completed if member completed treatment or declined further services*				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	B. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g. crisis line)?	26	18	69%	*
	C. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?	19	18	95%	7

Measure VIII — Re-engagement (completed only if the individual declined further services or chose not to appear for scheduled services) Key Findings

In 86% of cases where the client declined further services or chose not to appear for scheduled services, providers followed up with a phone call at times when the member was expected to be available. In 67% of these cases, providers mailed a letter to the client requesting contact. Other activities taken by providers to make contact included, contacting other involved agencies (55%), calling the client's emergency contact (45%), and visiting the client's home (9%). In one case, the provider visited the client while the individual was receiving services at an agency and, in one other case, the provider contacted the client's attorney (for whom there was a signed release of information).

	Table 4-8 — Substance Abuse Prevention and Treatment				
	HC Case File Review Findings				
VIII.	**Re-engagement** *Completed if member declined further services or chose not to appear for scheduled services*				
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**
	The following efforts were documented:				
	A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?	21	18	86%	*
	B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	18	12	67%	3
	Were other attempts made to re-engage the individual, such as:				
	1. Home visit?	11	1	9%	0

	Table 4-8 — Substance Abuse Prevention and Treatment				
	HC Case File Review Findings				
VIII.	Re-engagement *Completed if member declined further services or chose not to appear for scheduled services*				
		Denominator	# of Yes	% of Yes	# of N/A
	2. Call emergency contact(s)?	11	5	45%	0
	3. Contacting other involved agencies?	11	6	55%	0
	4. Street Outreach?	11	0	0%	0
	5. Other?	11	2	18%	0

Measure IX — NOMs Key Findings

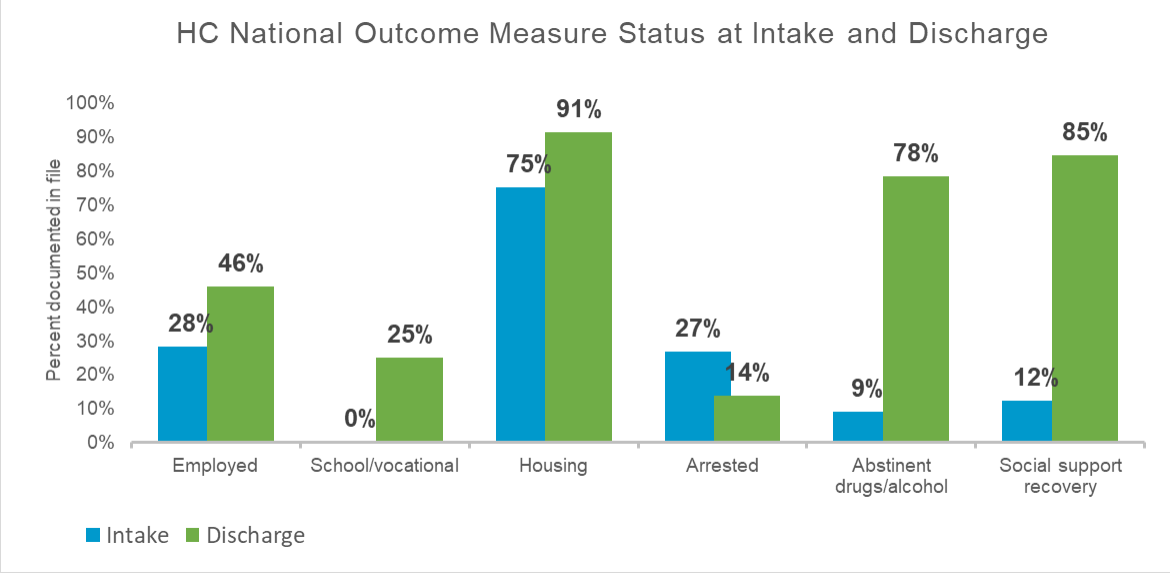
Each of the six HC NOMs for Measure IX are depicted in Table 4-9. Denominators are impacted by missing documentation of status at intake and discharge if applicable. Approximately half of the NOM documentation for *Participated in social support recovery in the preceding 30 days?* was not present in the file for intake and two-thirds was missing at discharge. Approximately a third of NOMs documentation was missing from files at discharge.

The graphs below show the client's status for each NOM at intake and discharge. Results for HC for each NOM improved at discharge.

Table 4-9 — HC Case File Review Findings						
Measure IX National Outcome Measures						
	Intake			Discharge		
NOMs	Denominator	# Yes	% Yes	Denominator	# Yes	% Yes
A. Employed?	32	9	28%	24	11	46%
B. Enrolled in school or vocational educational program?	31	0	0%	20	5	25%
C. Lived in a stable housing environment (e.g., not homeless)?	32	24	75%	23	21	91%
D. Arrested in the preceding 30 days?[10]	30	8	27%	22	3	14%

[10] Note that a lower number and percentage is desired for the NOM *Arrested in the preceding 30 days?*

Table 4-9 — HC Case File Review Findings						
Measure IX National Outcome Measures						
E. Abstinent from drugs and/or alcohol?	33	3	9%	23	18	78%
F. Participated in social support recovery in the preceding 30 days?	33	4	12%	13	11	85%



Mercy Care (MC)

MC has responsibility for AHCCCS clients in the central region of the State. Mercer reviewed provider treatment records from eight separate clinics under MC's area of responsibility. The following highlights were observed within the data collected from these cases.

- Providers educated OUD clients on the benefits of MAT in 88% of the cases reviewed, which was above average for the State (84%).
- Although the only pregnant women within this year's review sample came from this region, 100% received education on the effects of substance use on fetal development.
- One-hundred percent of charitable choice providers in this region documented that the requirements of this program were followed during the course of treatment.
- Providers in this region completed an appropriate risk assessment for 100% of the clients reviewed.

Measure I — Intake/Treatment Planning

Initial Behavioral Health Assessment

Mercer reviewed 133 total records for MC and found 98% of the charts contained evidence that an initial behavioral health assessment was completed within 45 days of the initial appointment (one case was scored "N/A", which indicates there was no documentation of an initial assessment, but the case was closed within 45 days of the first appointment). As part of the initial assessment, providers successfully documented compliance with the required components of the assessment (Items A1–9) with a range of 52% to 100%. The areas of lowest performance were documentation of hepatitis C, HIV, and other infectious disease screening (52%), review of the PDMP (58%), and tuberculosis screening (58%).

Individual Service Plan (ISP)

Providers developed an ISP for the client's treatment (within 90 days of the initial appointment) in 98% of the reviewed cases. In 95% of these cases, the providers developed the ISP in congruence with the presenting concerns. Eight percent of ISPs were developed with the participation of the client's family or other supports (when the client consented to allow participation from these sources). Seventy-one clients declined participation from family and other supports, or supports did not exist.

Table 5-1 — Substance Abuse Prevention and Treatment					
MC Case File Review Findings					
I.	Intake/Treatment Planning				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	132	130	98%	1
	Did the behavioral health assessment:				
	Address substance-related disorder(s)?	130	130	100%	*
	Describe the intensity/frequency of substance use?	130	121	93%	*
	Include the effect of substance use on daily functioning?	130	87	67%	*
	Include the effect of substance use on interpersonal relationships?	130	89	68%	*
	Include a completed risk assessment?	130	130	100%	*
	Document screening for tuberculosis (TB)?	130	75	58%	*
	Document screening for Hepatitis C, HIV, and other infectious diseases?	130	68	52%	*
	Document screening for emotional and/or physical abuse/trauma issues?	130	125	96%	*
	Documentation that review of the Prescription Drug Monitoring Program (PDMP) was completed?	90	52	58%	43
	B. Was there documentation that charitable choice requirements were followed, if applicable?	1	1	100%	132
	C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	132	130	98%	1
	Was the ISP:				
	Developed with participation of the family/support network?	59	5	8%	71
	Congruent with the diagnosis(es) and presenting concern(s)?	130	123	95%	*
	Measurable objectives and timeframes to address the identified needs?	130	108	83%	*
	Addressing the unique cultural preferences of the individual?	130	115	88%	*
	Were social determinants of health issues considered as part of, and incorporated into, the ISP?	129	106	82%	*

Measure II — Placement Criteria/Assessment Key Findings

ASAM Patient Placement Criteria were used at intake to determine the appropriate level of service in 88% of the cases reviewed. Of these cases, documentation showed that 93% received the LOC identified by the ASAM criteria. Providers documented the use of the ASAM criteria to reassess the proper LOC during treatment in 37% of cases. In 17% of the reviewed case files, providers documented the use of other (or additional) assessment tools during the course of treatment. These tools included:

- CIWA (Used more than ten times)
- DAST (Used two times)
- OWS (Used more than five times)
- UNCOPE Screening Instrument for Substance Abuse (Used three times)

	Table 5-2 — Substance Abuse Prevention and Treatment				
	MC Case File Review Findings				
II.	Placement Criteria/Assessment				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?	133	117	88%	*
	B. If the ASAM Patient Placement Criteria were used, the level of service identified was:				
	a. Level 0.5: Early Intervention	95	1	1%	*
	b. OMT: Opioid Maintenance Therapy	95	1	1%	*
	c. Level I: Outpatient Treatment	113	66	58%	*
	d. Level II: Intensive Outpatient Treatment/Partial Hospitalization	96	16	17%	*
	e. Level III: Residential/Inpatient Treatment	98	33	34%	*
	f. Level IV: Medically Managed Intensive Inpatient Treatment	95	0	0%	*
	C. Did the member receive the level of services identified by the placement criteria/assessment?	117	109	93%	*
	D. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	133	49	37%	*
	E. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	133	22	17%	*

Measure III — Best Practices Key Findings

Eighty-nine percent of sampled behavioral health case files contained documentation that EBPs were used in treatment. Of these, CBT was the most widely used EBP (71%). MAT was documented in 50% percent of the behavioral health case files. Of the 66 individuals who received MAT, methadone was the most frequently used medication (58%). Six interventions were not documented as having been used during this review period: ACRA, Beyond Trauma: A Healing Journey for Women, Contingency Management, Thinking for a Change, TREM, and WRAP.

Additional interventions used by providers included:

- Brene Brown Shame-Resilience Curriculum (Used four times)
- Living In Balance (Used three times)
- Mindfulness (Used four times)
- REBT (Used five times)

In 24% of cases, providers offered certified peer support services and, in 53% of those cases, the services were provided as part of treatment. Twelve clients declined the use of peer support services when providers offered. The EBP of screening for ongoing substance use during treatment occurred in 77% of the reviewed cases.

	Table 5-3 — Substance Abuse Prevention and Treatment				
	MC Case File Review Findings				
III.	Best Practices				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Were evidence-based practices used in treatment?	133	118	89%	*
	1. The following evidence-based practices were used in treatment:				
	a. Adolescent Community Reinforcement Approach (ACRA)	118	0	0%	*
	b. Beyond Trauma: A Healing Journey for Women	118	0	0%	*
	c. Cognitive Behavioral Therapy (CBT)	118	84	71%	*
	d. Contingency management	118	0	0%	*
	e. Dialectal Behavioral Therapy (DBT)	118	19	16%	*
	f. Helping Women Recover	118	7	6%	*
	g. Matrix	118	18	15%	*
	h. Moral Re-conation Therapy (MRT)	118	1	1%	*

	Table 5-3 — Substance Abuse Prevention and Treatment				
	MC Case File Review Findings				
III.	Best Practices				
		Denominator	# of Yes	% of Yes	# of N/A
	i. Motivational Enhancement/Interviewing Therapy (MET/MI)	118	44	37%	*
	j. Relapse Prevention Therapy (RPT)	118	2	2%	*
	k. Seeking Safety	118	1	1%	*
	l. SMART Recovery	118	5	4%	*
	m. Thinking for a Change	118	0	0%	*
	n. Trauma Recovery and Empowerment Model (TREM)	118	0	0%	*
	o. Trauma-Informed Care (TIC)	118	12	10%	*
	p. Wellness Recovery Action Plan (WRAP)	118	0	0%	*
	q. Other Practices or Programs(please list in box below):	118	17	14%	*
	B. Medication Assisted Treatment (MAT)	133	66	50%	*
	1. The following medication was used in treatment:				
	a. Alcohol-related				
	i. Acamprosate (Campral)	66	1	2%	*
	ii. Disulfiram (Antabuse)	66	0	0%	*
	b. Opioid-related				
	i. Subutex (buprenorphine)	66	4	6%	*
	ii. Methadone/Levo-Alpha-Acetylmethadol (LAAM)	66	38	58%	*
	iii. Narcan (naloxone)	66	3	5%	*
	iv. Vivitrol (long-acting naltrexone)	66	7	11%	*
	v. Suboxone (buprenorphine-naloxone)	66	21	32%	*
	C. Was screening for substance use/abuse conducted during the course of treatment?	133	103	77%	*
	D. Was certified peer support offered as part of treatment?	133	32	24%	12
	E. If yes to III.D, were certified peer support services used as a part of treatment?	32	17	53%	*

Measure IV — Treatment/Support Services/Rehabilitation Services Key Findings

Providers used group therapy as the most common service provided in the sample (68%), followed by case management (65%), individual therapy (62%), and family counseling (2%). For those individuals who received counseling, 45% attended more than 11 sessions; 42% attended five or fewer sessions.

Seventy-two percent of behavioral health case files did not contain documentation regarding the number of self-help or recovery group sessions completed during treatment. Of those that did document this metric, 12% of cases documented zero attendance at the self-help or recovery group sessions.

When there was a documented lack of progress in treatment, providers sought consultation or changed the treatment approach in 20% of the cases reviewed.

	Table 5-4 — Substance Abuse Prevention and Treatment				
	MC Case File Review Findings				
IV.	Treatment/Support Services/Rehabilitation Services				
		Denominator	# of Yes	% of Yes	# of N/A
	A. The following services were used in treatment:				
	1. Individual counseling/therapy	133	83	62%	*
	2. Group counseling/therapy	133	90	68%	*
	3. Family counseling/therapy	133	2	2%	*
	4. Case management	133	87	65%	*
	B. Was there clear documentation of progress or lack of progress toward the identified ISP goals?	115	94	82%	18
	C. The number of completed counseling/therapy sessions during treatment was:				
	• 0–5 sessions	132	56	42%	*
	• 6–10 sessions	132	16	12%	*
	• 11 sessions or more	132	60	45%	*
	D. Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:				
	• No documentation	133	96	72%	*
	• 0 times during treatment	133	16	12%	*
	• 1–4 times during treatment	133	4	3%	*
	• 5–12 times during treatment	133	3	2%	*

	Table 5-4 — Substance Abuse Prevention and Treatment				
	MC Case File Review Findings				
IV.	Treatment/Support Services/Rehabilitation Services				
		Denominator	# of Yes	% of Yes	# of N/A
	• 13–20 times during treatment	133	11	8%	*
	• 21 or more times during treatment	133	3	2%	*
	E. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?	41	8	20%	91
	F. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	68	62	91%	64
	G. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	63	42	67%	69
	H. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	81	32	40%	51
	I. Does the documentation reflect that substance abuse services were provided?	132	132	100%	*
	J. Was member's access to a primary care physician (PCP) or other medical provider explored?	132	97	73%	0

Measure V — Gender Specific (female only) Key Findings

Providers documented nine women's case files with a history of domestic violence; of these, 69% contained a safety plan. Providers documented two pregnant women in this sample; coordination of care with the PCP or obstetrician occurred in one case (50%) and education on the effects of substance use on fetal development occurred in one case (50%). This sample did not contain any women who had given birth in the past year. Of the case files for women who had dependent children, 88% documented an examination of childcare. Gender-specific services were documented in 31% of cases.

	Table 5-5 — Substance Abuse Prevention and Treatment				
	MC Case File Review Findings				
V.	Gender Specific (female only)				
		Denominator	# of Yes	% of Yes	# of N/A
	A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	13	9	69%	36
	B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	2	1	50%	47
	C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?	2	1	50%	47
	D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?	0	0	–	49
	E. If the female had dependent children, was there documentation to show that childcare was addressed?	16	14	88%	33
	F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	48	15	31%	1

Measure VI — Opioid Specific Key Findings

For this sub-sample, providers documented OUD in 74% of the cases. Of these cases, providers educated 88% of the clients on MAT as a treatment option, and 97% of those were referred to a MAT provider. Documentation showed MAT providers educated the client on overdose, naloxone, and steps to take in the event of an overdose in 41% of the cases. Education on the effects of polysubstance abuse with opioids was provided in 57% of the cases. In 84% of cases, providers referred clients with withdrawal symptoms to a medical provider.

	Table 5-6 — Substance Abuse Prevention and Treatment				
	MC Case File Review Findings				
VI.	Opioid Specific				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?	102	75	74%	*
	B. Was there documentation that the member was provided MAT education as a treatment option?	75	66	88%	*

	Table 5-6 — Substance Abuse Prevention and Treatment				
	MC Case File Review Findings				
VI.	Opioid Specific				
		Denominator	# of Yes	% of Yes	# of N/A
	C. If yes to VI. B, were they referred to a MAT provider?	66	64	97%	25
	D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	31	26	84%	60
	E. If a physical health concern related to pain was identified, were alternative pain management options addressed?	29	13	45%	62
	F. If member is a pregnant female; did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?	2	1	50%	88
	G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?	75	31	41%	*
	H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	75	43	57%	*

Measure VII — Discharge and Continuing Care Planning (completed only if the individual completed treatment or declined further services) Key Findings

In 55% of the reviewed cases, providers documented completion of a relapse prevention plan for clients who completed treatment or declined further services. Providers documented offered resources pertaining to community supports in 77% of these cases. For those clients engaged with other agencies, providers actively coordinated with these agencies at the time of discharge in 65% of the cases.

	Table 5-7 — Substance Abuse Prevention and Treatment				
	MC Case File Review Findings				
VII.	Discharge and Continuing Care Planning *Completed if member completed treatment or declined further services*				
		Denominator	# of Yes	% of Yes	# of N/A
	A. Was there documentation present that a relapse prevention plan completed?	111	61	55%	*

	Table 5-7 — Substance Abuse Prevention and Treatment				
	MC Case File Review Findings				
VII.	Discharge and Continuing Care Planning *Completed if member completed treatment or declined further services*				
		Denominator	# of Yes	% of Yes	# of N/A
	B. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g. crisis line)?	111	86	77%	*
	C. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?	65	42	65%	46

Measure VIII — Re-engagement (completed only if the individual declined further services or chose not to appear for scheduled services) Key Findings

In 68% of cases where the client declined further services or chose not to appear for scheduled services, providers followed up with a phone call at times when the member was expected to be available. In 66% of these cases, providers mailed a letter to the client requesting contact. Other activities taken by providers to make contact included, contacting other involved agencies (63%), visiting the client's home (13%), and calling the client's emergency contact (13%). In one case, the provider visited the client while the individual was in an inpatient facility and, in one other case, the provider sent an email to the client.

	Table 5-8 — Substance Abuse Prevention and Treatment				
	MC Case File Review Findings				
VIII.	Re-engagement *Completed if member declined further services or chose not to appear for scheduled services*				
		Denominator	# of Yes	% of Yes	# of N/A
	The following efforts were documented:				
	A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?	104	71	68%	*
	B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	85	56	66%	19
	C. Were other attempts made to re-engage the individual, such as:				
	1. Home visit?	8	1	13%	0
	2. Call emergency contact(s)?	8	1	13%	0

Table 5-8 — Substance Abuse Prevention and Treatment					
MC Case File Review Findings					
VIII.	Re-engagement *Completed if member declined further services or chose not to appear for scheduled services*				
		Denominator	# of Yes	% of Yes	# of N/A
	3. Contacting other involved agencies?	8	5	63%	0
	4. Street Outreach?	8	0	0%	0
	5. Other?	8	2	25%	0

Measure IX — NOMs Key Findings

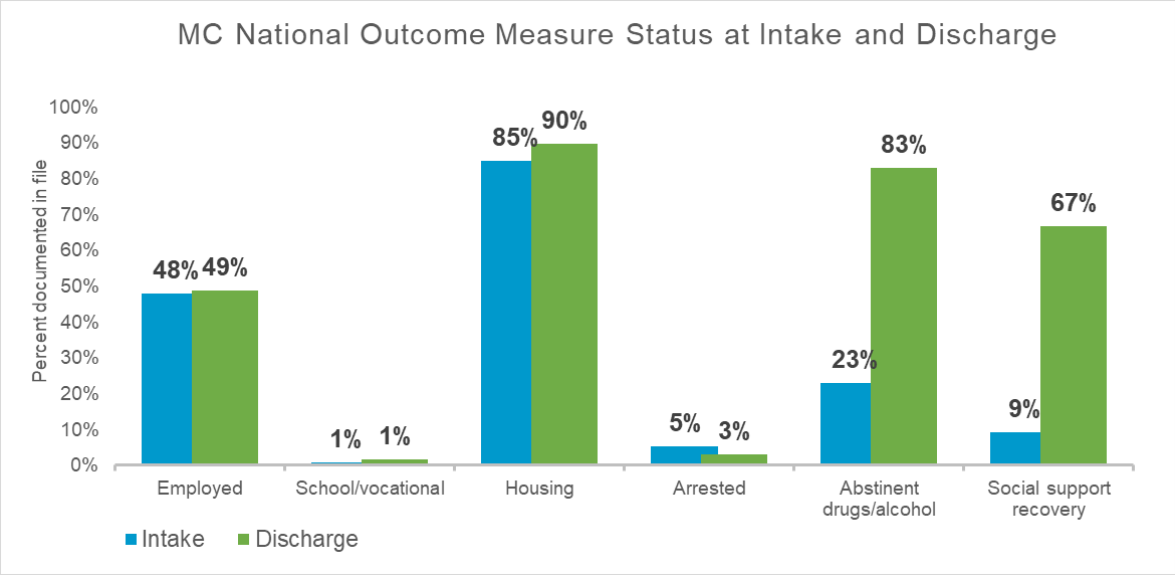
Each of the six MC NOMs for Measure IX are depicted in Table 5-9. The denominator is determined and compared for both intake and discharge. Denominators are impacted by missing documentation of status at intake and discharge if applicable. Half of the NOM documentation for *Participated in social support recovery in the preceding 30 days?* was not present in the file for intake and three-quarters were missing at discharge. For NOMS other than this measure, NOMs documentation was about 99% complete at intake and almost half complete at discharge.

The table and graph below shows the client's status for each NOM at intake and discharge. Results for MC for each NOM improved at discharge.

Table 5-9 — MC Case File Review Findings						
Measure IX National Outcome Measures						
	Intake			Discharge		
NOMs	Denominator	# Yes	% Yes	Denominator	# Yes	% Yes
A. Employed?	132	63	48%	70	34	49%
B. Enrolled in school or vocational educational program?	130	1	1%	68	1	1%
C. Lived in a stable housing environment (e.g., not homeless)?	132	112	85%	67	60	90%
D. Arrested in the preceding 30 days?[11]	131	7	5%	65	2	3%

[11] Note that a lower number and percentage is desired for the NOM *Arrested in the preceding 30 days?*

Table 5-9 — MC Case File Review Findings							
Measure IX National Outcome Measures							
E.	Abstinent from drugs and/or alcohol?	131	30	23%	64	53	83%
F.	Participated in social support recovery in the preceding 30 days?	132	12	9%	33	22	67%



6
Recommendations

Based upon the results of the ICR and associated analysis of findings, Mercer recommends the following areas of improvement for AHCCCS' consideration.

1. **Develop a mechanism for feedback to providers**: Although all SABG SUD providers have access to the findings of the ICR, the Mercer review team noted several instances where it would be beneficial to provide feedback to a specific provider (e.g., treatment concerns, missed opportunities for intervention, etc.). The ICR, in its present form, does not allow for provider-specific feedback to the RBHAs; such feedback could be provided with the intention of having that information passed along to the provider in question. AHCCCS should consider amending the ICR process to include a feedback mechanism that would allow for "lessons learned" to be disseminated to specific providers.

   A potential vehicle for this feedback could be the ICR tool. AHCCCS could amend the ICR tool to include an additional section that would allow reviewers to identify important information related to the documented care in the record (e.g., treatment issues, missed opportunities, quality of care concerns, etc.). At the conclusion of the ICR, the comments could be compiled (by provider) and given to the RBHAs to pass along to the individual agencies, with the intent of having the providers make necessary adjustments in practices and procedures. When feedback is provided with specific examples, which are relevant to the receiver of the feedback, the recommendation is more likely to lead to improvements in behavior.[12]

   The addition of a comment and feedback process would likely add to the ICR timeline, but such additional time could lead to desired improvements in provider treatment to the SUD population. Mercer suggests the benefits of this additional work may be worth the added effort.

2. **Encourage the ongoing use of SDoH information in treatment**: As noted previously, providers are doing a good job of investigating SDoH concerns that could impact treatment, with 81% of cases having a documented assessment of these issues. The next step should be to incorporate the SDoH findings into treatment and actively work to address existing obstacles to recovery. The ICR revealed that, with the exception of transportation, most providers did not address SDoH issues during the course of treatment (i.e., after the initial assessment), even when SDoH concerns were revealed in the initial assessment. AHCCCS should encourage the RBHAs to develop mechanisms for addressing SDoH concerns in treatment and use the information they are

[12] Westberg, J. & Jason, H. (2001). Fostering Reflection and Providing Feedback. New York, NY: Springer Publishing Company.

now collecting to improve treatment outcomes. Such steps would likely assist in accomplishing the goals of the Whole Person Health Initiative.

As with all emerging trends within behavioral health care, provider education will play an important role in making SDoH an integral part of SUD treatment planning. One option for AHCCCS to consider is requiring (at a minimum encouraging) the RBHAs to make the integration of SDoH a priority in any educational offerings provided to their respective networks. The RBHAs should be encouraged to continue or leverage any SDoH focused trainings they may have already begun offering.

As mentioned previously, an item related to the examination of SDoH factors in the initial assessment was included in this year's ICR for the first time. Another option for AHCCCS to consider is expanding the number of items that focus on SDoH treatment considerations in future ICRs. This will provide a fuller understanding of how providers are addressing these issues throughout each phase of the service delivery process (e.g., engagement, planning, treatment, and discharge) and the system, and will provide the opportunity to track potential improvements over time.

3. **Consider the inclusion of interviews in future ICRs**: The ICR currently reveals useful information related to the use of best practices and procedures by SUD treatment providers. However, a file review only conveys the information as it is documented. By incorporating live interviews with the RBHAs, clients, and providers, AHCCCS could collect additional, valuable information that would round-out its understanding of what works and what needs to be improved in SUD treatment services within the State. For example, although attendance at peer support groups is not currently documented consistently by providers, interviews could shed light on the true rate of participation in such groups.

   Other AHCCCS-sponsored projects that focus on the improvement of behavioral health care service delivery have used live interviews to great effect. The Quality Services Review, which focuses on behavioral health care service delivery to the Serious Mental Illness population, has included individual interviews with service recipients and other stakeholders for the past eight years. This project could serve as a model for the ICR and provide valuable insight into potential areas of improvement for the SUD treatment system.

4. **Consider formal statistical validation of the ICR Tool for future independent reviews.** As use of SABG funds continues, and additional ICRs are undertaken, AHCCCS could benefit from improved information that allows for year-to-year comparisons of ICR findings. Such comparisons can only be appropriately made when a statistically validated tool is used that increases confidence in the comparability of the different years' results. AHCCCS would have the option of performing such validation in-house, or leveraging the expertise of consultants trained in the validation of clinical review tools. As an additional option, AHCCCS could consider maintaining consistency in the independent review team that performs the ICR. Such consistency, together with the use of a statistically validated tool, would decrease variability from year-to-year, and increase the State's ability to compare results and assess large-scale trends within the SUD service system.

5. **Consider changes to sampling methodology for future reviews.** As an option in future reviews, AHCCCS should consider increasing validity and reliability by using a more randomized sampling methodology. One method for achieving this would be to have the independent reviewer randomly select the sample cases to be reviewed (from the entire population of files that meet inclusion criteria) and then ask the RBHAs to supply those specific records. This would add some time to the process (when compared to having the RBHAs select files to provide), but it would increase confidence in the results and contribute to overall project validity. Mercer currently uses this sampling methodology in support of the Priority Mental Health Services review, which is conducted annually for AHCCCS.

   An additional benefit of using this sampling methodology is that the independent reviewer would have the opportunity to stratify the sample and increase the number of cases from small sub-populations that are reviewed. For example, this year's review included only two pregnant women (only one of which was diagnosed with an OUD). This small representation within the sample makes it difficult to draw conclusions for this group. By using appropriate sampling methodology, the independent reviewer could increase the representation of sub-populations in the sample while maintaining the randomness necessary for increased validity and reliability.

Appendix A

Case File Review Tool

Table 6-1 — Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	# of Yes	% of Yes	# of N/A	# of No Documentation
I	Intake/Treatment Planning					
	A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?					
	Did the behavioral health assessment:					
	1. Address substance-related disorder(s)?					
	2. Describe the intensity/frequency of substance use?					
	3. Include the effect of substance use on daily functioning?					
	4. Include the effect of substance use on interpersonal relationships?					
	5. Was a risk assessment completed?					
	6. Document screening for tuberculosis (TB)?					
	7. Document screening for Hepatitis C, HIV and other infectious diseases?					
	8. Document screening for emotional and/or physical abuse/trauma issues?					
	9. Documentation that review of the Prescription Drug Monitoring Program (PDMP) was completed?					

Table 6-1 — Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**	**# of No Documentation**
	B. Was there documentation that charitable choice requirements were followed, if applicable?					
	C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?					
	Was the ISP:					
	1. Developed with participation of the family/support network?					
	2. Congruent with the diagnosis(es) and presenting concern(s)?					
	3. Measurable objectives and timeframes to address the identified needs?					
	4. Addressing the unique cultural preferences of the individual?					
	5. Were social determinants of health issues considered as part of, and incorporated into, the ISP?					
II	**Placement Criteria/Assessment**					
	A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?					
	1. If the ASAM Patient Placement Criteria were used, the level of service identified was:					
	Level 0.5: Early Intervention					
	OMT: Opioid Maintenance Therapy					
	Level I: Outpatient Treatment					
	Level II: Intensive Outpatient Treatment/Partial Hospitalization					
	Level III: Residential/Inpatient Treatment					

Table 6-1 — Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**	**# of No Documentation**
	Level IV: Medically Managed Intensive Inpatient Treatment					
	B. Did the member receive the level of services identified by the placement criteria/assessment?					
	C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?					
	D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment? If yes, please list in box below:					
III	**Best Practices**					
	A. Were evidence-based practices used in treatment?					
	1. The following evidence-based practices were used in treatment:					
	Adolescent Community Reinforcement Approach (ACRA)					
	Beyond Trauma: A Healing Journey for Women					
	Cognitive Behavioral Therapy (CBT)					
	Contingency management					
	Dialectal Behavioral Therapy (DBT)					
	Helping Women Recover					
	Matrix					
	Moral Re-conation Therapy (MRT)					
	Motivational Enhancement/Interviewing Therapy (MET/MI)					
	Relapse Prevention Therapy (RPT)					
	Seeking Safety					
	SMART Recovery					
	Thinking for a Change					

Table 6-1 — Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**	**# of No Documentation**
	Trauma Recovery and Empowerment Model (TREM)					
	Trauma-Informed Care (TIC)					
	Wellness Recovery Action Plan (WRAP)					
	Other Practices or Programs(please list in box below):					
	B. Medication Assisted Treatment (MAT)					
	1. The following medication was used in treatment:					
	❖ Alcohol-related					
	Acamprosate (Campral)					
	Disulfiram (Antabuse)					
	❖ Opioid-related					
	Subutex (buprenorphine)					
	Methadone/Levo-Alpha-Acetylmethadol (LAAM)					
	Narcan (naloxone)					
	Vivitrol (long-acting naltrexone)					
	Suboxone (buprenorphine-naloxone)					
	C. Was screening for substance use/abuse conducted during the course of treatment?					
	D. Was certified peer support offered as part of treatment?					
	If yes to III.I.D, were certified peer support services used as a part of treatment?					
IV	**Treatment/Support Services/Rehabilitation Services**					
	A. The following services were used in treatment:					

Table 6-1 — Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**	**# of No Documentation**
	Individual counseling/therapy					
	Group counseling/therapy					
	Family counseling/therapy					
	Case management					
	B. Was there clear documentation of progress or lack of progress toward the identified ISP goals?					
	C. The number of completed counseling/therapy sessions during treatment was:					
	0–5 sessions					
	6–10 sessions					
	11 sessions or more					
	D. Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:					
	No documentation					
	0 times during treatment					
	1–4 times during treatment					
	5–12 times during treatment					
	13–20 times during treatment					
	21 or more times during treatment					
	E. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?					
	F. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?					
	G. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?					

Table 6-1 — Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**	**# of No Documentation**
	H. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?					
	I. Does the documentation reflect that substance abuse services were provided?					
	J. Was member's access to a primary care physician (PCP) or other medical provider explored?					
V	**Gender Specific (female only)**					
	A. If there was a history of domestic violence, was there evidence that a safety plan was completed?					
	B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?					
	C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?					
	D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?					
	E. If the female had dependent children, was there documentation to show that childcare was addressed?					
	F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?					
VI	**Opioid Specific**					
	A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?					

Table 6-1 — Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	# of Yes	% of Yes	# of N/A	# of No Documentation
	B. Was there documentation that the member was provided MAT education as a treatment option?					
	C. If yes to VI B, were they referred to a MAT provider?					
	D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?					
	E. If a physical health concern related to pain was identified, were alternative pain management options addressed?					
	F. If member is a pregnant female; did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?					
	G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?					
	H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?					
VII	Discharge and Continuing Care Planning (completed only if member completed treatment or declined further services)					
	A. Was there documentation present that a relapse prevention plan completed?					
	B. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g. crisis line)?					
	C. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?					
VIII	Re-engagement					

Table 6-1 — Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**	**# of No Documentation**
	(completed only if member declined further services or chose not to appear for scheduled services)					
	The following efforts were documented:					
	A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?					
	B. If telephone contact was unsuccessful, was a letter mailed requesting contact?					
	C. Were other attempts made to re-engage the individual, such as:					
	Home visit?					
	Call emergency contact(s)?					
	Contacting other involved agencies?					
	Street Outreach?					
	Other, *please list other identified outreach efforts in the box below*					

IX	National Outcome Measures						
		At Intake			At Discharge		
		Yes	No	Missing	Yes	No	Missing
A.	Employed?						
B.	Enrolled in school or vocational educational program?						
C.	Lived in a stable housing environment (e.g., not homeless)?						
D.	Arrested in the preceding 30 days?						
E.	Abstinent from drugs and/or alcohol?						
F.	Participated in social support recovery in the preceding 30 days?						

Appendix B

Case File Review Methodology

The methodology for making review determinations is comparable to prior years to promote consistency over the continuum of the SABG periods. Methodology was slightly updated based on consultation with AHCCCS. Review team members used this methodology to perform the primary IRR and review process. This methodology was also used to program the formulas used for the analysis.

Indicator	Instructions
I. Intake/Treatment Planning	
A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	• Yes: A comprehensive behavioral health assessment has been performed within 45 days of the initial appointment. • No: No comprehensive behavioral health assessment has been performed within 45 days of the initial appointment. • No: A behavioral health assessment has been performed within 45 days of the initial appointment but is not present in the file. • N/A: No comprehensive behavioral health assessment is present in the file and the case.
Did the behavioral health assessment:	
1. Address substance-related disorder(s)	• Yes: The assessment addressed substance-related disorder(s) within 45 days of the initial appointment. • No: The assessment addressed substance-related disorder(s) within 45 days of the initial appointment.
2. Describe the intensity/frequency of substance use?	• Yes: The assessment described the intensity/frequency of substance use within 45 days of the initial appointment. • No: The assessment did not describe the intensity/frequency of substance use within 45 days of the initial appointment.
3. Include the effect of substance use on daily functioning?	• Yes: The assessment included the effect of substance use on daily functioning within 45 days of the initial appointment. • No: The assessment did not include the effect of substance use on daily functioning within 45 days of the initial appointment.
4. Include the effect of substance use on interpersonal relationships?	• Yes: The assessment addressed the intensity/frequency of substance use within 45 days of the initial appointment. • No: The assessment did not address the intensity/frequency of substance use within 45 days of the initial appointment.

Indicator	Instructions
5. Was a risk assessment completed?	• Yes: The assessment included a completed risk assessment. The risk assessment may be part of the behavioral health assessment or exist on separate RBHA- or provider-specific forms. The risk assessment must be completed within the first 45 days of the initial appointment. • No: The assessment or file did not include a completed risk assessment or the risk assessment was not completed within 45 days of the initial appointment.
6. Document screening for tuberculosis (TB)?	• Yes: The assessment included documentation of screening for TB. Acceptable documentation includes information on testing, education, referrals for screening and services, follow-up counseling addressing identified services, or an evaluation of history, risk factors, and/or screening tools. The screening must be completed within the first 45 days of the initial appointment. • No: The assessment did not include documentation for screening of TB or the documentation was not completed within 45 days of the initial appointment.
7. Document screening for Hepatitis C, HIV and other infectious diseases?	• Yes: The assessment included documentation of screening for Hepatitis C, HIV, and other infectious diseases. Acceptable documentation includes information on testing, education, referrals for screening and services, follow-up counseling addressing identified services, an evaluation of history, risk factors, and/or screening tools. • No: The assessment did not include documentation of screening for Hepatitis C, HIV, and other infectious diseases.
8. Document screening for emotional and/or physical abuse/trauma issues?	• Yes: The assessment documented screening for emotional and/or physical abuse/trauma issues within 45 days of the initial appointment. • No: The assessment did not document screening for emotional and/or physical abuse/trauma issues within 45 days of the initial appointment.
9. Document that review of the Prescription Drug Monitoring Program (PDMP) was completed?	• Yes: The assessment documented that a review of the PDMP was completed for those clients receiving MAT or other medication services. • No: The assessment did not document that a review of the PDMP was completed for those clients receiving MAT or other medication services. • N/A: The client was not receiving MAT or other medications as part of SUD treatment services.
B. Was there documentation that charitable choice requirements were followed, if applicable?	• Yes: The assessment documented within 45 days of the initial appointment that charitable choice requirements were followed and applicable. • No: The assessment did not include documentation that charitable choice requirements were followed when applicable or were not followed within 45 days of the initial appointment. • N/A: Charitable choice requirements were not applicable for the provider.

Indicator	Instructions
C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	• Yes: An ISP was completed within 90 days of the initial appointment and in the file. Note: an interim ISP is not acceptable documentation for this measure. • No: An ISP was not completed within 90 days of the initial appointment or was not contained in the file. • N/A: No ISP was completed and the case was closed within 90 days of the initial appointment.
Was the ISP:	Measures below apply only if there is an ISP completed within 90 days of the initial appointment.
1. Developed with participation of the family/support network?	• Yes: There is documentation that the ISP was developed with active input of the client's family/support network. Documentation may include verbal or written efforts to solicit their input. • No: There is no documentation that staff tried to seek input from the client's family/support network. • N/A: There is no family/support network and/or the client chose not to engage others in the process.
2. Congruent with the diagnosis(es) and presenting concern(s)?	• Yes: The scope, intensity, and duration of services offered are congruent with the diagnosis(es). • No: The scope, intensity, and duration of services offered are not congruent with the diagnosis(es).
3. Measurable objectives and timeframes to address the identified needs?	• Yes: The objectives and timeframes on the ISP are measurable and address the identified needs. • No: The objectives and timeframes on the ISP are not measurable and do not address the identified needs.
4. Addressing the unique cultural preferences of the individual?	• Yes: The ISP addresses one or more unique cultural preferences of the individual including language, customs, traditions, family, age, gender identity, ethnicity, race, sexual orientation, and socioeconomic class. • No: The ISP does not address any cultural preferences of the individual.
5. Were social determinants of health issues considered as part of, and incorporated into, the ISP?	• Yes: The ISP addresses one or more social determinants of health issues (e.g., housing, employment, health, etc.). • Yes: The ISP does not address social determinants of health issues.
II. Placement Criteria/Assessment	
A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?	• Yes: An ASAM tool was completed to determine the level of care at intake. A provider-created tool is acceptable. • No: No ASAM tool or evidence of an ASAM tool was completed at intake or found in the file.

Indicator	Instructions
1. If the ASAM Patient Placement Criteria were used, the level of service identified was:	If an ASAM tool was completed at intake, choose the level of service identified by the tool. At least one level must be chosen. • Level 0.5: Early Intervention • OMT: Opioid Maintenance Therapy • Level I: Outpatient Treatment • Level II: Intensive Outpatient Treatment/Partial Hospitalization • Level III: Residential/Inpatient Treatment • Level IV: Medically Managed Intensive Inpatient Treatment
B. Did the member receive the level of services identified by the placement criteria/assessment?	• Yes: An ASAM tool was completed at intake and the member received the level of services identified by the placement criteria/assessment. • No: An ASAM tool was completed at intake but the member did not receive the level of services identified by the placement criteria/assessment.
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	• Yes: An ASAM tool was updated and the dimensions reassessed after intake and during the course of treatment. The tool results (level of care) may remain the same as long as it has been reassessed. • No: An ASAM tool was not updated after intake/during the course of treatment.
D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	• Yes: One or more non-ASAM multi-dimensional placement criteria were used after intake and during treatment. • No: No other assessment tool was used after intake/during the course of treatment.
If yes, please list in box below:	List the name(s) of the other assessment tool(s) used during the course of treatment.
III. Best Practices	
A. Were evidence-based practices used in treatment?	• Yes: Documentation exists that evidence-based practices were incorporated into treatment. • No: No documentation exists that evidence-based practices were used in treatment. • No documentation: There is indication that evidence-based practices were used in treatment but not enough documentation available to confirm. For example, the specific treatment intervention was not mentioned in progress notes.

Indicator	Instructions
1. The following evidence-based practices were used in treatment:	Select which evidence-based practice were used in treatment. Choose all that apply. • Adolescent Community Reinforcement Approach (ACRA) • Beyond Trauma: A Healing Journey for Women • Cognitive Behavioral Therapy (CBT) • Contingency management • Dialectal Behavioral Therapy (DBT) • Helping Women Recover • Matrix • Moral Re-conation Therapy (MRT) • Motivational Enhancement/Interviewing Therapy (MET/MI) • Relapse Prevention Therapy (RPT) • Seeking Safety • SMART Recovery • Thinking for a Change • Trauma Recovery and Empowerment Model (TREM) • Trauma-Informed Care (TIC) • Wellness Recovery Action Plan (WRAP)
Other Practices or Programs (please list in box below):	• Yes: An evidence-based practice not listed in the above question was incorporated into treatment. • No: No other evidence-based practice other than those listed above were incorporated into treatment.
Listed other practices/programs	List the name(s) of the other evidence-based practice(s) indicated in the question above.
B. Medication Assisted Treatment (MAT)	• Yes: For individuals undergoing substance abuse treatment, documentation exists that MAT was incorporated into treatment. • No: No documentation exists that MAT was incorporated into treatment.
1. The following medication was used in treatment:	If MAT was used in treatment, select which alcohol-related medication(s) were used in treatment. Choose all that apply. • Acamprosate (Campral) • Disulfiram (Antabuse)
	If MAT was used in treatment, select which opioid-related medication(s) were used in treatment. Choose all that apply. • Subutex (buprenorphine) • Methadone/Levo-Alpha-Acetylmethadol (LAAM) • Narcan (naloxone) • Vivitrol (long-acting naltrexone) • Suboxone (buprenorphine-naloxone)

Indicator	Instructions
C. Was screening for substance use/abuse conducted during the course of treatment?	• Yes: Documentation exists that screening for substance use/abuse occurred during the course of treatment. • No: No documentation exists that screening for substance use/abuse occurred during the course of treatment.
D. Was certified peer support offered as part of treatment?	• Yes: Documentation exists that certified peer support (e.g., coaches, peer specialists) was offered as part of treatment. Evidence of certification is not required but the peer support offered should be more formal and less of a social support group. • No: No documentation exists that certified peer support (e.g., coaches, peer specialists) was offered as part of treatment. • N/A: Peer support was offered to the client and the client declined.
If yes to III.I.D, were certified peer support services used as a part of treatment?	• Yes: Certified peer support services were offered and were accepted and used. • No: Certified peer support services were offered and accepted, but not used.
IV. Treatment/Support Services/Rehabilitation Services	
A. The following services were used in treatment:	Select which service(s) were used in treatment. Choose all that apply. • Individual counseling/therapy • Group counseling/therapy • Family counseling/therapy • Case management
B. Was there clear documentation of progress or lack of progress toward the identified ISP goals?	• Yes: Documentation of progress or lack of progress toward the identified ISP goals exists in the record. • No: No documentation exists that screening for substance use/abuse occurred during the course of treatment. • N/A: No ISP exists or services provided are recent but no change in progress is indicated.
C. The number of completed counseling/therapy sessions during treatment was:	Select the number of completed counseling/therapy sessions during treatment. Choose one response only. • 0–5 sessions • 6–10 sessions • 11 sessions or more
D. Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:	Select the number of instances the client reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.). Choose No Documentation when the client was referred to a group but did not attend. • 0 times during treatment • 1–4 times during treatment • 5–12 times during treatment • 13–20 times during treatment • 21 or more times during treatment

Indicator	Instructions
E. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?	• Yes: The chart showed documentation of lack of progress towards the identified goal and evidence that the provider revised the treatment approach and/or sought consultation in order to enact symptomatic improvement. • No: The chart showed documentation of lack of progress towards the identified goal but no evidence that the provider revised the treatment approach and/or sought consultation in order to enact symptomatic improvement. • N/A: Documentation of symptomatic improvement exists in the file.
F. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	• Yes: The client was unemployed at intake and the chart showed documentation of employment opportunity discussion(s). • No: The client was unemployed at intake and the chart did not show documentation of employment opportunity discussions(s). • N/A: The client was employed at intake or unemployed but an employment discussion was irrelevant (i.e. client participates in a vocational program or is retired).
G. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	• Yes: The client was not involved in an educational or vocational training program at intake but involvement in such a program was explored. • No: The client was not involved in an educational or vocational training program at intake and the chart did not show documentation of such a discussions. • N/A: The client was involved in an educational or vocational training program at intake or not involved but a discussion was irrelevant (i.e. client is employed).
H. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	• Yes: The client was not involved in a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation) at intake but involvement in such a program was explored. • No: The client was not involved in a meaningful community activity at intake and involvement in such a program was not discussed with the client. • N/A: The client was involved in a community activity at intake or not involved but a discussion was irrelevant (i.e. client is employed).
I. Does the documentation reflect that substance abuse services were provided?	• Yes: Documentation exists that substance abuse services were provided. • No: No documentation exists of the provision of substance abuse services.
J. Was member's access to a primary care physician (PCP) or other medical provider explored?	• Yes: A discussion about the client's access to a PCP or other medical provider(s) was documented. • No: No documentation exists about whether the client's access to a PCP or other medical provider(s) was discussed.

Indicator	Instructions
V. Gender Specific (female only)	
A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	• Yes: Client is female, a history of domestic violence exists, and documentation of a safety plan is contained in the file. • No: Client is female, a history of domestic violence exists, but no documentation of a safety plan is contained in the file. • N/A: Client is female but a history of domestic violence does not exist.
B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	• Yes: Client is a pregnant female and documentation exists showing efforts at coordination with the client's PCP and/or obstetrician. • No: Client is a pregnant female and documentation does not exist showing coordination with the client's PCP and/or obstetrician. • N/A: Client is female but not pregnant.
C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?	• Yes: Client is a pregnant female and documentation exists showing client was educated on the effects of substance use on fetal development. • No: Client is a pregnant female and documentation does not exist showing client was educated on the effects of substance use on fetal development. • N/A: Client is female but not pregnant.
D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?	• Yes: Client is a female with a child less than one year of age and documentation exists showing a screening was completed for postpartum depression/psychosis. • No: Client is a female with a child less than one year of age and no documentation exists showing a screening was completed for postpartum depression/psychosis. • N/A: Client is female but does not have a child less than one year of age.
E. If the female had dependent children, was there documentation to show that childcare was addressed?	• Yes: Client is a female with dependent children and documentation exists showing that childcare was addressed. • No: Client is a female with dependent children but no documentation exists showing that childcare was addressed. • N/A: Client is female with no dependent children.
F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	• Yes: Client is a female and documentation exists showing female-specific treatment services were offered and/or provided (i.e. women's-only group therapy sessions, female peer support). • No: Client is a female but no documentation exists showing female-specific treatment services were offered and/or provided. • N/A: Client is female and turned down female-specific services.
VI. Opioid Specific	
A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?	• Yes: Documentation exists showing client had an OUD diagnosis. • No: No documentation exists showing an OUD diagnosis.

Indicator	Instructions
B. Was there documentation that the member was provided MAT education as a treatment option?	• Yes: Client has a documented OUD diagnosis and documentation exists showing client was offered MAT education. • No: Client has a documented OUD diagnosis but no documentation exists showing client was offered MAT education.
C. If yes to VI B, were they referred to a MAT provider?	• Yes: Client has a documented OUD diagnosis and documentation exists showing client was offered MAT and referred to a MAT provider. • No: Client has a documented OUD diagnosis and documentation exists showing client was offered MAT but was not referred to a MAT provider. • N/A: Client has a documented OUD diagnosis and documentation exists showing client was not offered MAT.
D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	• Yes: Client has a documented OUD diagnosis and documentation exists showing client had withdrawal symptoms that were addressed by referral and/or intervention by a medical provider. • No: Client has a documented OUD diagnosis but no documentation exists showing client's withdrawal symptoms were addressed by referral and/or intervention by a medical provider. • N/A: Client has a documented OUD diagnosis but no withdrawal symptoms.
E. If a physical health concern related to pain was identified, were alternative pain management options addressed?	• Yes: Client has a documented OUD diagnosis and documentation exists showing client received alternative pain management options for an identified physical health concern related to pain. • No: Client has a documented OUD diagnosis and documentation exists showing client had an identified physical health concern related to pain but did not receive alternative pain management options. • N/A: Client has a documented OUD diagnosis but no pain-related physical health concerns.
F. If member is a pregnant female; did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?	• Yes: Client is a pregnant female with a documented OUD diagnosis and documentation exists showing client received education about the safety of methadone and/or buprenorphine during the course of pregnancy. • No: Client is a pregnant female with a documented OUD diagnosis but no documentation exists showing client received education about the safety of methadone and/or buprenorphine during the course of pregnancy. • N/A: Client has a documented OUD diagnosis but is not a pregnant female.
G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?	• Yes: Client has a documented OUD diagnosis and documentation exists showing client received relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose. • No: Client has a documented OUD diagnosis but no documentation exists showing client received relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose.

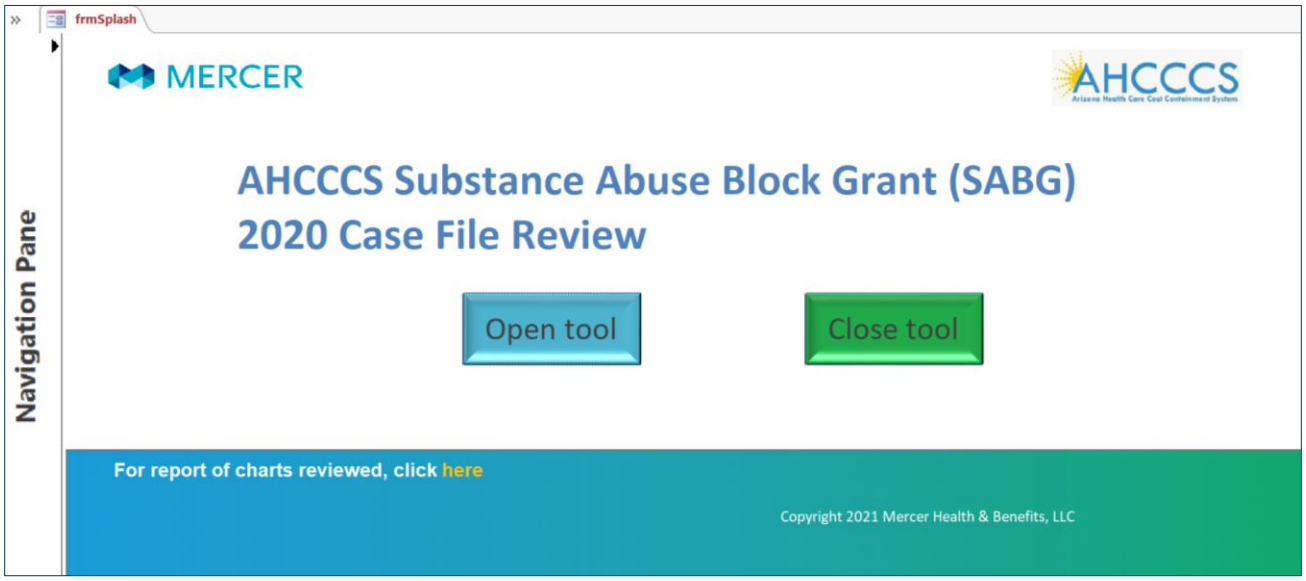
Indicator	Instructions
H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	• Yes: Client has a documented OUD diagnosis and documentation exists showing client received information on the effects of polysubstance use with opioids. • No: Client has a documented OUD diagnosis but no documentation exists showing client received information on the effects of polysubstance use with opioids.
VII. Discharge and Continuing Care Planning	
A. Was there documentation present that a relapse prevention plan completed?	• Yes: Client completed treatment or declined further services and documentation of a completed relapse prevention plan exists. • No: Client completed treatment or declined further services but no documentation of a completed relapse prevention plan exists.
B. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g. crisis line)?	• Yes: Client completed treatment or declined further services and documentation exists that staff offered at least one resource pertaining to community supports, including recovery self-help, and/or other individualized support services (e.g. crisis line). • No: Client completed treatment or declined further services but no documentation exists that staff offered at least one resource pertaining to community supports, including recovery self-help, and/or other individualized support services (e.g. crisis line).
C. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?	• Yes: Client completed treatment or declined further services and documentation exists that staff actively coordinated with other involved agencies at the time of discharge. • No: Client completed treatment or declined further services but no documentation exists that staff actively coordinated with other involved agencies at the time of discharge. • N/A: Client completed treatment or declined further services and there were no other involved agencies at the time of discharge.
VIII. Re-engagement	
A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?	• Yes: Client declined further services or chose not to appear for scheduled services and documentation exists that the client (or legal guardian) was contacted by telephone at times when the client was expected to be available (e.g., after work or school). • No: Client declined further services or chose not to appear for scheduled services but was not contacted by telephone at times when the client was expected to be available (e.g., after work or school).
B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	• Yes: Client declined further services or chose not to appear for scheduled services and documentation exists that telephone contact was unsuccessful but a letter was mailed requesting contact. • No: Client declined further services or chose not to appear for scheduled services and documentation exists that although telephone contact was unsuccessful, no letter was mailed requesting contact. • N/A: Client declined further services or chose not to appear for scheduled services and documentation exists that client was contacted successfully through means other than a telephone call or letter.

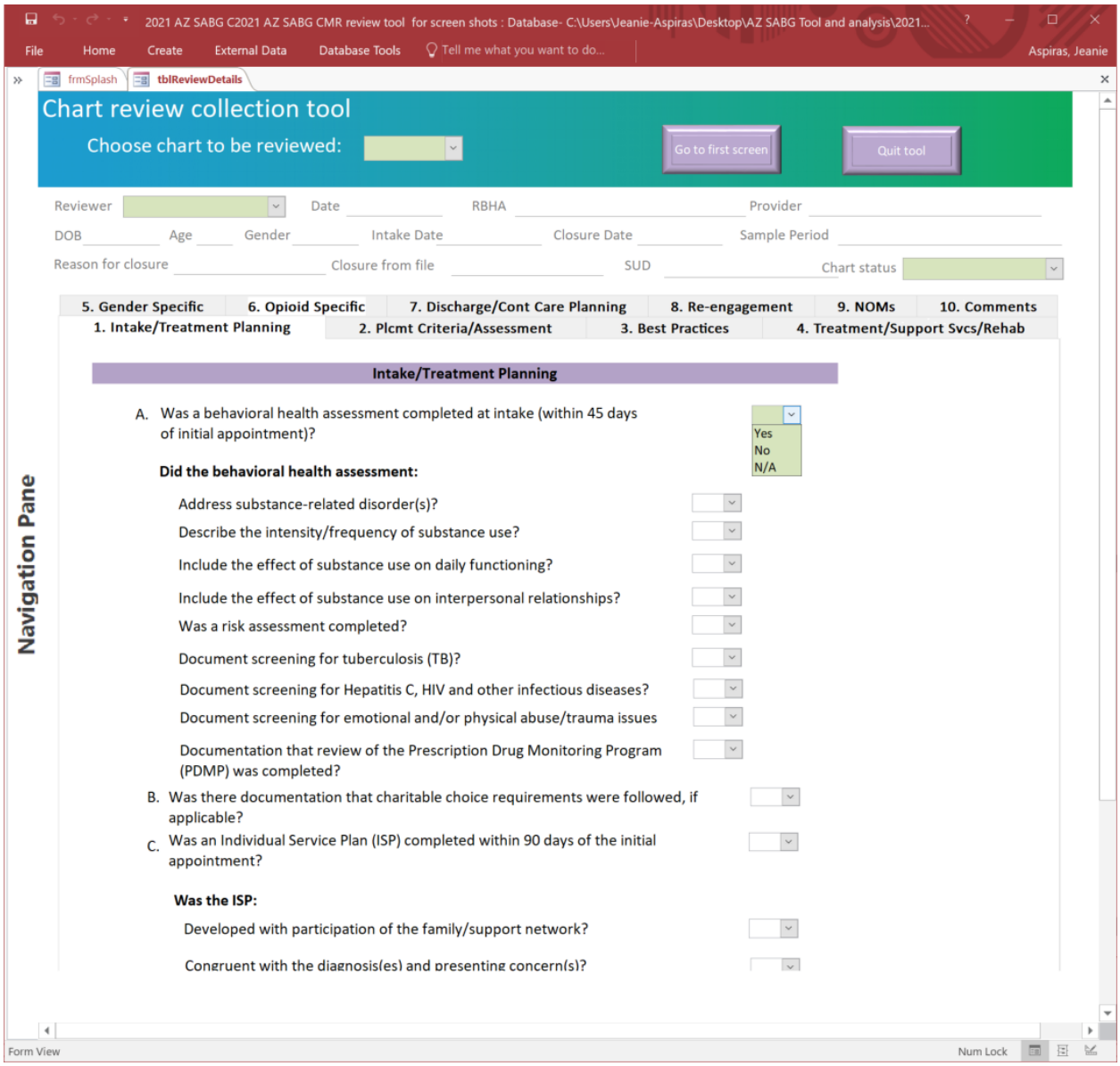
Indicator	Instructions
C. Were other attempts made to re-engage the individual, such as:	• Yes: Client declined further services or chose not to appear for scheduled services and documentation exists that the following attempts at re-engaging were made. Select all that apply. - Home visit - Call emergency contact(s) - Contacting other involved agencies - Street Outreach - Other • N/A: Other means of re-engagement not listed above were successful or not applicable to the client.
Other, please list other identified outreach efforts in the box below	List other identified outreach efforts.
IX. National Outcome Measures (NOMs)	
A. Status at Intake	• Yes: For each NOM, client's status at intake. - Employed? - Enrolled in school or vocational educational program? - Lived in a stable housing environment (e.g., not homeless)? - Arrested in the preceding 30 days? - Abstinent from drugs and/or alcohol? - Participated in social support recovery in the preceding 30 days? • Missing: No documentation of the NOM at intake
B. Status at Discharge	• Yes: For each NOM, client's status at discharge. - Employed? - Enrolled in school or vocational educational program? - Lived in a stable housing environment (e.g., not homeless)? - Arrested in the preceding 30 days? - Abstinent from drugs and/or alcohol? - Participated in social support recovery in the preceding 30 days? • Missing: No documentation of the NOM at discharge.

Appendix C

Case File Electronic Review Tool

Reviewers used an Access review tool pre-populated with relevant chart data. Below are sample screen shots of the tool.




2021 AZ SABG C2021 AZ SABG CMR review tool for screen shots : Database- C:\Users\Jeanie-Aspiras\Desktop\AZ SABG Tool and analysis\2021...
File
Home
Create
External Data
Database Tools
Tell me what you want to do...
Aspiras, Jeanie
frmSplash
tblReviewDetails
Chart review collection tool
Choose chart to be reviewed:
Go to first screen
Quit tool
Reviewer
Date
RBHA
Provider
DOB
Age
Gender
Intake Date
Closure Date
Sample Period
Reason for closure
Closure from file
SUD
Chart status
5. Gender Specific
6. Opioid Specific
7. Discharge/Cont Care Planning
8. Re-engagement
9. NOMs
10. Comments
1. Intake/Treatment Planning
2. Plcmt Criteria/Assessment
3. Best Practices
4. Treatment/Support Svcs/Rehab
Navigation Pane
Intake/Treatment Planning
A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?
Yes
No
N/A
Did the behavioral health assessment:
Address substance-related disorder(s)?
Describe the intensity/frequency of substance use?
Include the effect of substance use on daily functioning?
Include the effect of substance use on interpersonal relationships?
Was a risk assessment completed?
Document screening for tuberculosis (TB)?
Document screening for Hepatitis C, HIV and other infectious diseases?
Document screening for emotional and/or physical abuse/trauma issues
Documentation that review of the Prescription Drug Monitoring Program (PDMP) was completed?
B. Was there documentation that charitable choice requirements were followed, if applicable?
C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?
Was the ISP:
Developed with participation of the family/support network?
Congruent with the diagnosis(es) and presenting concern(s)?
Form View
Num Lock

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