Arizona

UNIFORM APPLICATION
FY 2024 SUPTRS Block Grant Report

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

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Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

I: State Information

State Information

I. State Agency for the Block Grant

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III. Expenditure Period

State Expenditure Period

From	7/1/2022
To	6/30/2023

Block Grant Expenditure Period

From	10/1/2020
To	9/30/2022

IV. Date Submitted

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Footnotes:

II: Annual Update

Table 1 Priority Area and Annual Performance Indicators - Progress Report

Priority #: 1

Priority Area: Youth Underage ATOD (Prevention)

Priority Type: SAP

Population(s): PP, Other (LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disablities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Reduce the amount of Arizona students with high risk (defined as the percentage of students who have more than a specified number of risk factors operating in their lives; 8th grade: 8 or more risk factors, 10th & 12th grades: 9 or more risk factors) from 32.0% in 2020 to 30.0%, as measured by the 2022 Arizona Youth Survey.

Objective:

Increase the use of prevention strategies that address community, family, school, and peer/individual risk factors through the use of evidence based practices and strategies that address both risk factors and ATOD use.

Strategies to attain the goal:

Provide education to increase awareness of available evidence based practices that address community, family, school, and peer/individual risk factors, and provide training on how to choose EBPs based on community need. Activities to include:

Enhancing the ability of local community coalitions to more effectively provide prevention services for ATOD including organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building and networking

Provide alternatives of ATOD use for youth including drug free dances and parties, Youth/adult leadership/mentor activities, community drop-in centers and community service activities.

Establish or change written and unwritten community standards and codes and attitudes that factor into ATOD use, including promoting the establishment or review of alcohol, tobacco and drug use policies in schools, technical assistance to communities to maximize local enforcement, procedures governing availability and distribution of alcohol, tobacco, and other drug use, modifying alcohol and tobacco advertising practices, and product pricing strategies.

Provide ATOD education and educational opportunities that involve two-way communication and is distinguished from information dissemination by the fact that interaction between the educator/facilitator and the participants is the basis of its activities, including education to affect critical life and social skills, decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.

Provide awareness and knowledge of the nature and extent of local and state ATOD use, abuse and addiction and their effects on individuals, families and communities, and increase awareness of available prevention programs and services through clearinghouse/information resource center(s), resource directories, media campaigns, brochures, radio/TV public service announcements, speaking engagements, and health fairs/health promotion.

Identify those who have indulged in illegal/age-inappropriate use of ATOD in order to assess if their behavior can be reversed through education, including student assistance programs, and driving while under the influence/driving while intoxicated education programs.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Performance Indicators to measure success on a yearly basis

Baseline Measurement: The percentage of Arizona students with high risk (defined as the percentage of students who have more than a specified number of risk factors operating in their lives; 8th grade: 8 or more risk factors, 10th & 12th grades: 9 or more risk factors) is 32.0%, according to the

2020 Arizona Youth Survey.

First-year target/outcome measurement: Reduce the amount of Arizona students with high risk (defined as the percentage of students who have more than a specified number of risk factors operating in their lives; 8th grade: 8 or more risk factors, 10th & 12th grades: 9 or more risk factors) from 32.0% in 2020 to 31.0%, as measured by the 2022 Arizona Youth Survey.

Second-year target/outcome measurement: Reduce the amount of Arizona students with high risk (defined as the percentage of students who have more than a specified number of risk factors operating in their lives; 8th grade: 8 or more risk factors, 10th & 12th grades: 9 or more risk factors) from 31.0% in 2020 to 30.0%, as measured by the 2022 Arizona Youth Survey.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Arizona Youth Survey (AYS)

New Data Source*(if needed)*:

Description of Data:

Data obtained from the Pre and Post Tests (Adolescent Core Measure) from the AYS.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

AYS is released every two years and has an impact on annual reporting.

https://www.azcjc.gov/Programs/Statistical-Analysis-Center/Arizona-Youth-Survey

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:
Year 1 and year 2 targets as written conflict. Year 1 target is to reduce to 31% by 2022, while the year 2 target is to reduce to 30% by 2022. The 2022 AYS reports that 30.06% of students are considered high risk (more than a specified number of risk factors operating in their lives for their grade level).

Outreach

Outreach has been conducted in a variety of ways from prevention contractors. The following are examples of outreach efforts tailored to the populations served while implementing safety procedures to reduce the risk of COVID-19. Due to spikes in COVID-19 cases during the reporting period, outreach approaches across the state had to be shifted from in person events to virtual and social media outlets.

Overall, prevention contractors conducted outreach through community presentations, attending other community coalition meetings, council meetings, other prevention trainings such as suicide prevention trainings, naloxone trainings, use of resource centers, tabling events joining with other community events such as MLK day, Indigenous People's Day events, drug takeback days and Red Ribbon Week, other holidays such as 4th of July and Veteran's Day events, etc. Additionally, social media outreach and formal campaigns including flyers, radio and TV ads, billboards, public service announcements were implemented. Various promotional materials were distributed with the coalitions' names and/or prevention messaging.

One TRBHA created a youth prescription drug prevention campaign with messaging that instilled cultural pride that aired at a local Harkins theater. Additionally, they purchased medical lockboxes to educate community members about safety that were distributed throughout the year at various events. Community back to school events were also held with supplies that contained prevention messaging in calendars and notebooks for the upcoming school year, that shared messages on opioid prevention and opportunities for education and prevention activities.

Another TRBHA conducted outreach in a variety of ways including flyers, community events, video messaging, Intranet, emails, and texts.

They implemented procedures to reduce the risk of COVID-19 to protect its residents. When this happened, outreach shifted primarily to emails, phones, and video messaging through the Internet—these were in place during this project year.

The TRBHA developed a mobile app that connects community members to events, workshops, services and other resources. As of November 2022, the mobile application is in process of launching on the mobile app stores for internal testing before public launch. They also created a cohort of team representatives within the behavioral health services division to plan and streamline outreach media efforts.

Outreach took place through almost monthly awareness initiatives—focusing on different substances or other topics during the month and 27 community events that included our innovative strategy of drive-thru events. In addition, 12 family focused fun nights occurred provided opportunities for education and outreach.

Collaboration

AZ prevention contractors work in many collaborative ways with each other as well as with other types of organizations and other sectors. One TRBHA reported establishing strong collaborations with schools in the community as well as those out of the community where members of the community attend. The development of a mobile app has included collaboration among their department and the interdepartmental coalition of community leaders, the Suicide Gap Analysis Workgroup. They have continued to operate throughout the COVID-19 pandemic including various safeguards to protect community health. They collaborated with the community's Elders, Head Start Programs, Boys and Girls Club, District Services Centers, Health and Behavioral Health programs, law enforcement and other first responders, community social services, and other organizations to ensure a broad reach of messaging and services.
Another TRBHA, collaborated with the Maricopa County Sherriff's Office (MCSO) to install a prescription drop box at the Itom Hiapsi tribal building. Other collaboration activities included education and take back opportunities at the Día del Nino event April 27th and the National Take back day, Fentanyl Awareness Day May 10, and Spooktacular Red Ribbon outreach in the community. They also collaborated twice with both Sonoran Prevention Works and Blue Cross Blue Shield's mobile Medicated Assisted Treatment (MAT) clinic to bring a day of free access to MAT, prevention, and other services to target community members who can't or won't endure the stigma associated with tribal treatment programs including the homeless and non-tribal community members.

Targeted Interventions

Prevention contractors focused interventions to meet the needs of the communities that they serve, with a focus on youth, and parents.

One TRBHA reported implementing virtually five sessions of Botvins Life Skills took place. Limited curriculum delivery was able to take place during the program year due to the COVID-19 pandemic. A total of 24 (unduplicated) youth participated in the Botvins Life Skills sessions. The Prevention Program is beginning to transition back to doing Botvins in person at schools. As for parents, the delivery of Active Parenting, 0-5 Active Parenting, and Teen Active Parenting has been delivered virtually with great participation and turnout. A total of 37 (unduplicated) sessions took place with 33 (unduplicated parents attending. In addition, 4 Parenting as Prevention workshops took place with 17 parents in attendance.

In serving the general community, the following workshops took place:
• 5 Substance Use Prevention with youth as audience. 49 youth participants
• 3 Tobacco/Vaping. 16 participants
• 1 Rx 360. 6 participants
• 13 Opioid Safety. 88 participants
• 7 Methamphetamine. 11 participants
• 9 Marijuana. 25 participants
• 3 Heroin and other opioids. 7 participants
• 12 Dangers of Fentanyl. 143 participants
• 4 Current Drug Trends. 16 participants

Another TRBHA reported the development and dissemination of the Yo'olam (I am victorious) documentary, which highlighted resilience protective factors through culture. They also worked with Sonoran Prevention Works to deliver Narcan training to a specific demographic of community members who have family members that are current users or at risk of using. Fentanyl education was also held with MCSO at a youth town hall where the documentary, Dead on Arrival was viewed and discussed. Approximately 15 youth and parent/guardians attended.

Prevention contractors under the Governor's Office of Youth Faith and Family (GOYFF) offered substance use evidence based and evidence informed prevention programs for adults which included: Triple P Parenting, PAX Tools training, Active Parenting, ACCI Life Skills curriculum, QPR Suicide Intervention Training, Strengthening Protective Factors Training for Parents, Everyday Parenting, Parenting Life Skills.
For the youth population, GOYFF contractors offered Too Good For Drugs, Botvin's Life Skills Training, Seeking Safety, THRIVE, RULER, ACCI Life Skills curriculum, RAW Program, Mind Matters
● Trauma Informed Care: ACEs Community of Practice, Trauma-informed Care Trainings, Trauma 101, ACE, Trauma and Building Resilient Communities presentation
● Coalition Membership and participation - collaborations and partnerships
● Community Presentations: Drug Trends, AZ Drug Summit, Underage Drinking and Refusal Skills, "Distracted Driving" presentation,

Underage Drinking presentation, substance use presentations
● Drug specific prevention workshops - Vaping, Rx360, The Rise of Fentanyl, Naloxone, Killer Among Us-Fentanyl presentation, GEAR Up (presentations and activities on 5 substances: methamphetamine, underage drinking, marijuana, and opioids)
● Events: Health fairs, movie screenings, Community Engagement Mural painting, recreational activities
● Information dissemination: health fairs, social media and website postings, printed, radio and television PSAs and interviews, resource directories,
● Mindfulness Activities: Stress management skills building, breathing techniques, mindfulness rooms and training
● School-based activities: The Dicey Decisions activity, Red Ribbon Week, morning announcements, after school activities and clubs, mentoring, peer support groups, tabling events

One of the TRBHAs provided information dissemination, targeting grief and anxiety due to the unprecedented death toll in the community and ongoing COVID-19 pandemic. This included traditional gardening and use of cultural plants and foliage for healing as a protective factor against substance use.

Outcomes Measured

Outcomes were measured in various ways across the various prevention contractors.

Although all prevention contractors had challenges in programming and measuring outcomes during the public health emergency, TRBHAs in particular were challenged to conduct activities in person. It was, can in places still is, common for tribal nations to be shut down and to continue social distances measures for extended periods of time. Although workshops took place virtually, this made survey administration difficult.
Not all participants had the proper and sufficient technology to access Survey Monkey or simply did not take the survey. The TRBHA is working on strategies to encourage survey response for those activities they continue to provide virtually as the public health emergency continues.

However, many prevention contractors were able to adjust their implementation and evaluation methods to gather outcomes. Some outcomes collected include:

96% of participants indicated that the information was useful.
87% of participants indicated they learned new information about youth alcohol and substance use.
93% of participants indicated that they intend to talk to their children or children they interact about consequences and dangers of alcohol and substance use.
90% of participants indicated that they have knowledge to connect to community resources related to youth alcohol and substance use prevention.
Specific to youth outcomes, the following were measured:
100% of participants indicated they learned how alcohol and drugs can be harmful
89% of participants indicated that they wanted to more about the dangers of drugs and alcohol.
90% of participants indicated that because of what they have learned they have decided not to use alcohol.
100% of participants indicated that because of what they have learned they have decided not to use drugs.

Additional measures include:
youth perception of risk/harm of cigarettes, e-cigarettes/vaping, marijuana, marijuana concentrates, underage drinking, binge drinking, Rx drugs, other community trend drugs, and polysubstance use, youth attitude of cigarettes, e-cigarettes/vaping, marijuana, marijuana concentrates, underage drinking, binge drinking, Rx drugs, other community trend drugs, and polysubstance use, parent-child communication about alcohol and drug use, youth report of seeing, reading, watching, or listening to a prevention message, past 30-day use of alcohol, cigarettes, other tobacco products, e-cigarettes/vaping, marijuana, Rx drugs, Rx pain relievers, Rx stimulants, other illegal drugs, age of first use among youth for alcohol, cigarettes, e-cigarettes, marijuana, Rx drugs, other illegal drugs, youth attitude about employer workplace drug screening

Specific to adult outcomes, the following were measured:
adult perception of risk/harm of cigarettes, e-cigarettes/vaping, marijuana, marijuana concentrates, underage drinking, binge drinking, Rx drugs, other community trend drugs, and polysubstance use, adult disapproval of youth use of cigarettes, e-cigarettes/ vaping, marijuana, marijuana concentrates, underage drinking, binge drinking, Rx drugs, other community trend drugs, and polysubstance use, parent-child communication about alcohol and drug use, adult perception of family functioning, adult perception of family cohesion, adult/parent/caregiver report stress.
Prevention contractors identified barriers and actions/progress toward addressing the identified barriers.

For GOYFF and its contractors, a primary challenge of the reporting period was connecting with individuals due to COVID-19. To address this barrier, the organizations funded under SABG program Trauma-Informed Substance Abuse Prevention Program (TISAPP) modified programming in an effort to be responsive to changes and restrictions. Organizations provided hybrid delivery modules that include virtual delivery and in-person programming, when able to do so. Additionally, staff turnover was mentioned as an issue, with some programs reporting that they went months before being able to hire key staff.

One TRBHA reported that they are in the process of working with the schools and community partners to begin delivering services in

person again. They have developed a new opportunity for delivery of workshops and activities and have obtained a new mobile RV which allows for local travel to neighborhoods that might not have the resources to make it to local events.

Another TRBHA was challenged in how to deliver programming and services due to COVID-19. They continued to operate in a virtual environment for the health and safety of the community. This has also led to other barriers taking a toll on youth mental health and symptoms of "online fatigue".

Success Stories Shared

Prevention contractors were able to also identify a number of success stories.

GOYFF successfully onboarded 6 additional subrecipients during FY22 to provide Trauma-Informed prevention services in additional communities in Arizona. Additionally, they collected a total of 1,957 strategy reports detailing the prevention activities of the 28 sub-recipients across all six prevention strategies.

One TRBHA reported that a member from their Elder coffee talk group/event had shared information about a presentation they had attended about marijuana. By bringing this up naturally, the elders engaged in a meaningful discussion about how marijuana is impacting the community.

An emerging Drug Trends workshops with the FACE program was also offered and had a positive impact. Role playing took place with parents learning how to talk to kids about the hazards of substance use. The TRBHA received very positive feedback from this activity.

One TRBHA also implemented a drive-thru booth for family game night bags, which went very well (took place in March). Participants were happy to see faces again. It was a great opportunity to slowly begin the process of events and activities being in-person. Community members could not wait for the next drive-thru event.

Another TRBHA had a very successful Yo'olam (I am victorious) campaign. The highest number of Lutu'uria youth group participants graduated from high school in 2020, with 11 graduates. One of the youth group participants earned the City of Tempe's Youth Fest Changemaker Award. Additionally, the TRBHA is proud to report that two of their Lutu'uria youth group members have gone on to college at Arizona State University and Dartmouth.

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

There is no updated data for the second year target compared to the first year target, since the AYS that measures this indicator is only administered every 2 years and was last administered in 2022. However, the following strategies and progress toward the objective/goal is reported:

AHCCCS and its contracted partners have implemented evidence-based programs that impact underage alcohol, tobacco, and other drug (ATOD) use within their communities in a variety of ways. During the federal fiscal year 2023, 27 sub-recipients from Governor's Office of Youth, Faith, and Family (GOYFF) served 4,215,165 participants including the following IOM Categories:

Universal Direct: 55,384

Universal Indirect: 4,155,723

Selected: 2,651

Indicated: 1,398

The programs that subcontractors implemented are focused on working with the community and meeting the needs of the individuals being served making sure that the tools, and materials being presented are culturally appropriate, and in the language of the audience it is being presented to when applicable. A few of the programs that are being implemented are Botvins Life Skills, Too Good for Drugs, Keep a Clear Mind, Trauma Informed Care strategies, and Marijuana 360 presentations. Contractors also hold Tabling events with prevention education materials and messaging at local community events and school campuses.

GOYFF highlights Community Bridges, Inc. (CBI). CBI provided the community with an array of activities and services with resource tabling events providing information and resources on drug prevention and coping. Multiple students shared the fact that they had lost a friend or loved one due to drugs and wanted to share information with the people close to them. Drug Trends presentations were provided to Arizona Children's Association targeting case managers, who work directly with adolescents. At one community presentation, a student came in late, she quickly sat in the back, and staff could see how engaged she was from the moment she looked up. The facilitator finished the presentation, talked about the resources available locally and nationally, and shared the suicide hotline. At the bell, the student came over to talk to the faculty about the struggles she had been having and thanked him for speaking life back into her. The student shared with the facilitator, "I really needed to hear that talk today, and someone give me the hope to

keep going." The student has been dealing with suicidal ideation for the last two years and was able to get the support she needed that day.

In addition to the efforts of GOYFF and its subrecipients, AHCCCS contracts directly with 20 coalitions that implement community-based services inclusive of all SAMHSA, Center for Substance Abuse Prevention (CSAP) strategies. Programs include but are not limited to: Project Toward No Drugs, Thrive, Lion's Quest, Project Alert, Students Against Destructive Decisions, and Gathering of Native Americans (GONA).

In 2022, AHCCCS also began partnering with institutes of higher education to implement primary prevention services on college campuses. Arizona State University (ASU), Norther Arizona University (NAU), and University of Arizona (UA). Although these efforts will not impact this particular goal/objective indicator due to the data source used to measure impacts, these universities are contributing to the work of alcohol, tobacco and other drug prevention in Arizona during the reporting period. Programs and strategies include but are not limited to: Stress Busters, The Buzz, Alcohol e-CheckUp To Go, C3 training, fraternity and sorority AOD prevention, SHADE – Alcohol, SHADE – Marijuana, ScreenU, substance-free prosocial events for students, education on healthy coping strategies for stress, alternatives to substance use, and building community connections on campus.

AHCCCS contracted with PAXIS Institute to implement PAX Tools in community-based settings and Good Behavior Game in school-based settings as well as Prevent Child Abuse AZ to implement Positive Parenting Program (Triple P).

The Arizona Department of Liquor Licensing and Control (DLLC) implemented prevention education efforts on topics including anti-underage drinking efforts and the importance of not over-serving adult patrons. Additionally, 22 community tabling events where DLLC staff contacted 1,551 persons with fact sheets on adverse childhood experience, and underage drinking concerns. 117 teen alcohol awareness classes were taught across the state, reaching 5,787 teens.

The Gila River Tribal Regional Behavioral Health Authority (TRBHA) implements primary prevention services in the Gila River Indian Community and reported holding 109 Booths/Community events with 1,738 youth and 5,249 adults in attendance. They implemented drive through prevention strategies to allow community members to receive prevention information without leaving their car. This was an effective transition from the coronavirus disease 2019 (COVID-19) restrictions to in-person community activities with 490 youth and 1262 adults participating. They implemented 8 Red Ribbon events at the Gila Crossing Community School on October 25, 2022. Individual presentations took place in grades K-4. In addition, youth participated in a door decorating activity focused on prevention messages. 500 youth participated. Finally, they implemented a book club focused on self-care and provided alternative activities such as a neighborhood painting event with youth that incorporated prevention messaging. 21 youth participated in the activities.

107 educational presentations were provided with 214 youth and 754 adults as participants. Topics included;

Alcohol

Current Drug Trends

Fentanyl

Digital Wellness

Healthy Relationships

Marijuana

Meth

Parenting as Prevention

Self-Care

Tobacco/Vaping

Xylazine

Across all activities, a total of 15,982 information flyers and materials and 15,982 resource and referral materials were distributed throughout the Gila River Indian Community. A sample of the positive impacts include that 100% (n=15) of participants indicated that they learned how alcohol and drugs can be harmful and 93.33% of youth indicated that because of what they have learned they decided not to use alcohol until they turn 21.

Challenges

AHCCCS contractors have experienced some challenges and barriers while trying to implement prevention services. For GOYFF, one of the grant requirements of the TISAPP contract is that subrecipients agree to participate in the Arizona Youth Survey (AYS). However, AYS survey administration is not always supported by agencies or school administrations. In addition, only state and county level AYS survey data is available to the public, which does not provide data specific to the grantees' communities. This creates a significant barrier to measuring the goal of the priority area to reduce the amount of Arizona students with high risk (defined as the percentage of students who have more than a specified number of risk factors operating in their lives; 8th grade: 8 or more risk factors, 10th & 12th grades: 9 or more risk factors) from 32.0% in 2020 to 30.0%, as measured by the 2022 Arizona Youth Survey.

Another barrier for prevention in Arizona is HB2161, authorizing all school-based programs to now require active parental consent to administer youth surveys. This has created a significant barrier and delay to agencies trying to collect data on alcohol, tobacco, and other drug use. The exemptions for surveys that do not collect identifying information have been stricken from the law, which formerly allowed the statewide evaluation team to administer surveys because they are collected anonymously. Because of this additional requirement, many school-based programs have delayed or cancelled administration of youth participant surveys. In addition, because some providers have not been able to collect surveys, they have also not been permitted to collect demographic information on youth participants. Therefore, the direct service participant data shows more "unknown" age, gender, race, and ethnicity numbers than they have reported in previous years.

The COVID-19 pandemic has lasting impacts on prevention services primary for tribal communities. During this report period, some tribal partners continued reestablishing collaborations and partnerships in the community after the pandemic. This process has been slow but continues as activities transition back to in-person.

Proposed changes to future efforts

Arizona has identified challenges in using the AYS to measure the impacts of the SUBG prevention programming: 1) the AYS is only administered every two years, 2) the AYS only surveys 8th, 10th, and 12th graders willing to participate, 3) there is not a clear correlation between SUBG prevention program participants and those who take the AYS survey, and 4) data analysis is not stratified or weighted by various risk of confounding factors and indicators chosen may not be the best representation of the established goals and objectives. Arizona has updated these objectives and indicators in the FY24-24 plan/application not only to update according to Arizona trends and priorities, but also to try to set more appropriate and valid measures.

Six of the 27 subrecipient agencies under GOYFF did not administer any participant surveys during FFY23. Full grantee participation in the statewide evaluation will give GOYFF a better indication of the achievement of goals and objectives. In addition, new statewide outcome targets are being developed to expand the data collected on participant surveys to not only collect data on the perception of risk/harm, age of first use and attitudes toward underage alcohol, tobacco and other drugs, but also to collect data on risk and protective factors that contribute to or protect against youth and adult use and abuse of these substances.

DLLC is adding additional staff resources for FFY24. This will be impactful for the program's ability to reach a larger demographic. Additionally, DLLC has added a Spanish speaker of tribal descent to the program who can assist in strengthening ties with community members and underserved areas of the state, to include tribal land.

Tribal partners also continue to work on reestablishing connections with community partners. For example, Gila River is looking for new collaborative opportunities and outreach methods to better serve the community. Staff and community members have adapted and have learned how to provide virtual educational presentations and activities with a greater engagement rate than in previous years.

How second year target was achieved *(optional)*:

Priority #: 2

Priority Area: Youth Underage Alcohol (Prevention)

Priority Type: SAP

Population(s): PP, Other (LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Decrease the percentage of youth reporting past 30-day alcohol use (more than just a few sips) from the 2020 levels of 9.0% to 7.0% of those in the 8th grade, 17.6% to 15.6% of those in the 10th grade, and 27.3% to 25.3%% of those in the 12th grade, as measured by the 2022 Arizona Youth Survey.

Objective:

Increase awareness and use of educational messaging regarding the harms of underage alcohol use and increase use of evidence based prevention practices that address underage alcohol use.

Strategies to attain the goal:

Provide education on available evidence based practices related to addressing underage alcohol use, and provide training on how to choose EBPs based on community need. Increase the use of Evidence Based Programs (EBP) with activities to include:

Enhancing the ability of local community coalitions to more effectively provide prevention services for alcohol including organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building and networking.

Provide alternatives for underage drinking for youth including drug free dances and parties, Youth/adult leadership/mentor activities, community drop-in centers and community service activities.

Establish or change written and unwritten community standards and codes and attitudes that factor into underage alcohol use, including promoting the establishment or review of alcohol, tobacco and drug use policies in schools, technical assistance to communities to maximize local enforcement, procedures governing availability and distribution of alcohol, tobacco, and other drug use, modifying alcohol and tobacco advertising practices, and product pricing strategies.

Provide underage alcohol use education and educational opportunities that involve two-way communication and is distinguished from the Information Dissemination by the fact that interaction between the educator/facilitator and the participants is the basis of its activities, including education to affect critical life and social skills, decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.

Provide awareness and knowledge of the nature and extent of local and state underage alcohol use, abuse and addiction and their effects on individuals, families and communities, and increase awareness of available prevention programs and services through clearinghouse/information resource center(s), resource directories, media campaigns, brochures, radio/TV public service announcements, speaking engagements, and health fairs/health promotion.

Identify those who have indulged in illegal/age-inappropriate use of alcohol in order to assess if their behavior can be reversed through education, including student assistance programs, and driving while under the influence/driving while intoxicated education programs.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Annual Performance Indicators to measure success on a yearly basis
Baseline Measurement:	The percentage of Arizona students reporting past 30 day alcohol use (more than just a few sips) from the 2020 levels of 9.0% to 7.0% of those in the 8th grade, 17.6% to 15.6% of those in the 10th grade, and 27.3% to 25.3%% of those in the 12th grade, as measured by the 2022 Arizona Youth Survey.
First-year target/outcome measurement:	Reduce the amount of Arizona students reporting past 30 day alcohol use (more than just a few sips) from the 2020 levels of 9.0% to 8.0% of those in the 8th grade, 17.6% to 16.6% of those in the 10th grade, and 27.3% to 26.3%% of those in the 12th grade, as measured by the 2022 Arizona Youth Survey.
Second-year target/outcome measurement:	The percentage of Arizona students reporting past 30 day alcohol use (more than just a few sips) from the 2020 levels of 9.0% to 7.0% of those in the 8th grade, 17.6% to 15.6% of those in the 10th grade, and 27.3% to 25.3%% of those in the 12th grade, as measured by the 2022 Arizona Youth Survey.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Arizona Youth Survey (AYS)

New Data Source*(if needed)*:

Description of Data:

Data obtained from the Pre and Post Tests (Adolescent Core Measure) from the AYS

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

AYS is released every two years and has an impact on annual reporting.

https://www.azcjc.gov/Programs/Statistical-Analysis-Center/Arizona-Youth-Survey

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:
Two of the three indicators (30-day alcohol use by 3 grade levels) within the target were achieved. Eighth (8th) graders were reduced from 9% in 2020 to 8.6%, 2022 not meeting the 2022 target of 7%, but moving in the right direction. Tenth (10th) graders were reduced from 17.6% in 2020 to 13.9% in 2022 meeting and exceeding the second-year target off 15.6%. Finally, 12th graders were reduced from 2.7.3% in 2020 to 22.6% in 2022, meeting and exceeding the second-year target of 25.3%

Much of the information reported from contractors for underage alcohol (Goal 2) use was in alignment with the information presented for the goal (Goal 1) to reduce the percentage of AZ students at risk factors. This is likely due to the fact that outreach, collaboration, targeted interventions, outcomes, and barriers reported by contractors is often a comprehensive prevention approach, rather than risk-factor specific or substance-specific.

Outreach

A few alcohol-specific strategies were reported: The Arizona Department if Liquor Licensing and Control (DLLC) focuses on outreach and education specific to underage alcohol use through their SABG prevention-funded efforts. The DLLC dedicates detectives to do this work across Arizona. Coalitions also report outreach during community meetings such as council meetings. See more about DLLC and city council outreach/collaboration efforts below under collaboration.

Alcohol outreach was also conducted in the following ways: information dissemination of alcohol and drug facts shared via social media, family fun days and alternative activities and education to counter alcohol-focused adult community events, brochures such as "what to say about drugs and alcohol", drinking and driving, underage drinking, alcohol awareness, "more awkward talks, less likely to drink", how to talk to your child about alcohol and other drugs. Finally, health promotion events were reported as well as a movie night featuring alcohol effects on the teenage brain. These are the alcohol specific activities to report. However, general outreach described in goal 1 was also reported by contractors:

Outreach has been conducted in a variety of ways from prevention contractors. The following are examples of outreach efforts tailored to the populations served while implementing safety procedures to reduce the risk of COVID-19. Due to spikes in COVID-19 cases during the reporting period, outreach approaches across the state had to be shifted from in person events to virtual and social media outlets.

Overall, prevention contractors conducted outreach through community presentations, attending other community coalition meetings, council meetings, other prevention trainings such as suicide prevention trainings, naloxone trainings, use of resource centers, tabling events joining with other community events such as MLK day, Indigenous People's Day events, drug takeback days and Red Ribbon Week, other holidays such as 4th of July and Veteran's Day events, etc. Additionally, social media outreach and formal campaigns including flyers, radio and TV ads, billboards, public service announcements were implemented. Various promotional materials were distributed with the coalitions' names and/or prevention messaging.

Collaboration

Prevention contractors engaged in various collaborations that contributed to the goal related to reducing underage alcohol use. The DLLC worked tirelessly to build and maintain collaborations with organizations across the state with a focus on schools, businesses, and community prevention coalitions. DLLC educated on the Title IV liquor laws, ordinances and underage drinking trends, including fake identifications, to the general community, parents and caregivers, law enforcement officers,
DLLC also distributed reference guides to law enforcement officers to assist with enforcement of underage drinking laws. DLLC provides resources online at azliquor.gov. During the pandemic, DLLC was able to provide classes via Zoom.

Coalitions also report partnerships and collaboration with law enforcement, which can be and are leveraged to address the issue of underage drinking in Arizona communities.

Prevention work in high schools is a commonly reported collaboration that allows preventionists to offer substance use prevention specific to alcohol.

Other work that contractors reported under Goal 1 also apply here:

One TRBHA reports implementing cultural and traditional ways as prevention programming in order to reduce underage alcohol use. Specifically, one TRBHA facilitated a master gardener speaker, who presented on traditional and medicinal plants and trees for a Lutu'uria youth group event. This collaboration enhanced their prevention work to incorporate traditional ways and connection to culture as protective factors against substance use.

One TRBHA's development of a mobile app for prevention mentioned previously also contributes to these efforts, as well as the engagement with the community elders, Head Start Programs, Boys and Girls Club, District Services Center, Health and Behavioral Health programs, law enforcement, first responders, community social services, and other organizations to ensure outreach and program availability.

Targeted Interventions

The SABG program Trauma-Informed Substance Abuse Prevention Program (TISAPP) impacts underage alcohol use by focusing on some of the salient risk factors for substance use including alcohol.

Other trauma-focused interventions influence underage drinking over the lifespan. Interventions include ACEs Community of Practice, trauma-informed care trainings, Trauma 101, ACE, and the Trauma and Building Resilient Communities presentation.
Coalition events include alcohol-specific prevention workshops, health fairs, movie screenings, community engagement mural painting, and recreational activities, Underage drinking presentations in the community, mindfulness activities: stress management skills building, breathing techniques, and mindfulness rooms and training.

School-based activities: The Dicey Decisions activity, Red Ribbon Week, morning announcements, after school activities and clubs, mentoring, peer support groups, and tabling events were implemented into local schools.

One contractor reported they facilitated twelve workshops that focused on alcohol. The workshops included 50 participants
Some coalitions work with their local governments to establish and enforce social host ordinance laws.

One TRBHA also reported that their Lutu'uria youth group documented family and oral history with the assistance of their elder community members.

Outcomes Measured

Outcomes were measured in various ways across the various prevention contractors.

Although all prevention contractors had challenges in programming and measuring outcomes during the public health emergency, TRBHAs in particular were challenged to conduct activities in person. It was, can in places still is, common for tribal nations to be shut down and to continue social distances measures for extended periods of time. Although workshops took place virtually, this made survey administration difficult.
Not all participants had the proper and sufficient technology to access Survey Monkey or simply did not take the survey. The TRBHA is working on strategies to encourage survey response for those activities they continue to provide virtually as the public health emergency continues.

However, many prevention contractors were able to adjust their implementation and evaluation methods to gather outcomes. Some outcomes collected include:

96% of participants indicated that the information was useful.
87% of participants indicated they learned new information about youth alcohol and substance use.
93% of participants indicated that they intend to talk to their children or children they interact about consequences and dangers of alcohol and substance use.
90% of participants indicated that they have knowledge to connect to community resources related to youth alcohol and substance use prevention.
Specific to youth outcomes, the following were measured:
100% of participants indicated they learned how alcohol and drugs can be harmful
89% of participants indicated that they wanted to more about the dangers of drugs and alcohol.
90% of participants indicated that because of what they have learned they have decided not to use alcohol.
100% of participants indicated that because of what they have learned they have decided not to use drugs.

Additional measures include:
youth perception of risk/harm of cigarettes, e-cigarettes/vaping, marijuana, marijuana concentrates, underage drinking, binge drinking,

Rx drugs, other community trend drugs, and polysubstance use, youth attitude of cigarettes, e-cigarettes/vaping, marijuana, marijuana concentrates, underage drinking, binge drinking, Rx drugs, other community trend drugs, and polysubstance use, parent-child communication about alcohol and drug use, youth report of seeing, reading, watching, or listening to a prevention message, past 30-day use of alcohol, cigarettes, other tobacco products, e-cigarettes/vaping, marijuana, Rx drugs, Rx pain relievers, Rx stimulants, other illegal drugs, age of first use among youth for alcohol, cigarettes, e-cigarettes, marijuana, Rx drugs, other illegal drugs, youth attitude about employer workplace drug screening

Specific to adult outcomes, the following were measured:
adult perception of risk/harm of cigarettes, e-cigarettes/vaping, marijuana, marijuana concentrates, underage drinking, binge drinking, Rx drugs, other community trend drugs, and polysubstance use, adult disapproval of youth use of cigarettes, e-cigarettes/ vaping, marijuana, marijuana concentrates, underage drinking, binge drinking, Rx drugs, other community trend drugs, and polysubstance use, parent-child communication about alcohol and drug use, adult perception of family functioning, adult perception of family cohesion, adult/parent/caregiver report stress.
Additional contractors utilize a master pre-test and post-test developed by our evaluation contractor, which that can be customized to meet the need of the specific programming being implemented. It includes national outcome measures (NOMs) as well as optional measures for consideration.

Progress/Barriers Identified

Prevention contractors identified barriers and actions/progress toward addressing the identified barriers.

For GOYFF and its contractors, a primary challenge of the reporting period was connecting with individuals due to COVID-19. To address this barrier, the organizations funded under SABG program Trauma-Informed Substance Abuse Prevention Program (TISAPP) modified programming in an effort to be responsive to changes and restrictions. Organizations provided hybrid delivery modules that include virtual delivery and in-person programming, when able to do so. Additionally, staff turnover was mentioned as an issue, with some programs reporting that they went months before being able to hire key staff.

One TRBHA reported that they are in the process of working with the schools and community partners to begin delivering services in person again. They have developed a new opportunity for delivery of workshops and activities and have obtained a new mobile classroom RV which allows for local travel to neighborhoods that might not have the resources to make it to local events. They are in the process of scheduling activities.

Another TRBHA was challenged in how to deliver programming and services due to COVID-19. They continued to operate in a virtual environment for the health and safety of the community. This has also led to other barriers taking a toll on youth mental health and symptoms of “online fatigue”. This has remained a challenge, as in some areas, programming has still been limited to virtual facilitation.

Success Stories Shared

Prevention contractors were identified a number of success stories.

GOYFF successfully onboarded 6 additional subrecipients during FY22 to provide Trauma-Informed prevention services in additional communities in Arizona. Additionally, they collected a total of 1,957 strategy reports detailing the prevention activities of the 28 sub-recipients across all six prevention strategies.

In 2022, GOYFF ended their contract with the DLLC, but AHCCCS took on DLLC as a contractor through a direct Interagency Service Agreement (ISA). DLLCs efforts continue to be a major player in the state’s underage alcohol prevention efforts.

One TRBHA conducted a field trip to the Heard Museum, which is a Phoenix museum dedicated to the advancement of America Indian art. The purpose was to deliver education to youth about their history and provided a positive alternative activity opportunity as well as connection to culture and community, an important protective factor for tribal communities. Specifically, the boarding school exhibit had an intense and memorable impact on those that attended. The growth of the traditional garden initiative where individuals learned about traditional crops was also very rewarding for those involved.

Another TRBHA reported that many Lutu’uria youth group members have graduated from the previous year and an entirely new cohort of youth are actively being recruited.

TRBHA programs have slowly transitioned back to in-person services. The feedback from the community is that they missed the coalition efforts and activities during the height of the COVID-19 pandemic.

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

There is no updated data for the second year target compared to the first year target, since the AYS that measures this indicator is only

administered every 2 years and was last administered in 2022. However, the following strategies and progress toward the objective/goal is reported:

Arizona contracted partners implement a diverse array of prevention strategies to reduce youth alcohol use, inclusive of community-based process, pro-social events alternative to substance use, education to increase awareness regarding the harms of underage alcohol use through curriculum and presentations, environmental strategies such retail distributor, parent education, and social host ordinances, as well as information dissemination at the local and state level, with increased efforts with media campaigns.

The Arizona Department of Liquor Licenses and Control (DLLC) conducted presentations to 7th-12th grade students on life consequences of underage alcohol use. DLLC travels throughout the state to present at schools and also attend community events, implementing a statewide underage drinking campaign. The state agency also visited licensed liquor establishments to provide training to staff to ensure they are familiar with the latest trends occurring with underage youth attempting to purchase alcohol.

The Governor's Office of Youth, Faith and Family (GOYFF) is an Arizona subcontractor that oversees 27 community-based subrecipients that administer SUBG primary prevention funds. GOYFF has implemented a total of 2,109 primary prevention activities to reduce substance use and misuse. The contractor collects data on seven youth outcomes that focus on the impact of underage alcohol consumption programs. Several of their subrecipient grantees implement evidence-based education programs that target multiple substances, including underage alcohol use. A subcontractor of GOYFF implemented the DUI Module (life skills) to help individuals learn how their thinking affects behavior and interferes with their focus on driving when we are under the influence of substances. Another subcontractor facilitated the "dicey decisions" maze activity that utilizes impairment goggles to teach students about impaired driving.

The Substance Abuse Coalition Leaders of Arizona (SACLAZ) is also currently implementing underage drinking awareness to youth and parents/caregivers across Arizona. They developed a local media campaign that consisted of input from 29 community coalitions in Arizona. Their efforts educate parents/caregivers on strategies to monitor and secure alcohol that is kept in the home. They also work with the community to spread awareness of underage drinking and the risks associated with allowing youth to drink before the legal age limit.

Arizona State University, the University of Arizona, and Northern Arizona University implement alcohol prevention and early intervention programs among students such as The Buzz, Alcohol e-CheckUp To Go, C3 training, fraternity and sorority AOD prevention, SHADE – Alcohol, and ScreenU.

Additionally, they hold sober nights on campus to increase awareness about the harms of underage alcohol consumption. They also facilitate sober social activities that incorporate prevention education to keep students on campus from participating in underage drinking activities. The goal is to prevent underage drinking at events such as tailgating and Greek life events. They host night life events as a sober alternative that reaches the young adult age population. Although these efforts will not impact this particular goal/objective indicator due to the data source used to measure impacts, these universities contributed to the work of alcohol prevention during reporting period.

The Gila River TRBHA serving the Gila River Indian Community reports increasing awareness about underage alcohol use and implementing strategies to reduce it as a top priority. Most of these efforts have incorporated alcohol use prevention messaging, along with other substances. An example of their efforts is that they facilitated six youth alcohol use prevention presentations during the reporting period. A total of 45 parents and community members attended. These presentations primarily took place virtually due to continued concerns around COVID-19, though the TRBHA has reported slowly transitioning back to in-person efforts.

Challenges

Arizona prevention providers reported experiencing challenges when attempting to establish new relationships with schools to gain permission to speak with or survey their students. An added barrier to receiving permission from schools is due to the passage of Arizona HB2161. The bill requires all school-based programs to now require active parental consent to administer youth surveys in schools. The needed consent has created a significant barrier and has caused delays to agencies trying to collect data on underage alcohol use. The exemptions for surveys that do not collect personally identifying information have been stricken from the law, which formerly allowed the statewide evaluation teams to administer surveys because they are collected anonymously. Due to the additional requirement, many school-based programs have been delayed or cancelled administration of youth participant surveys. The barriers to administering and collecting survey data have resulted in the inability to collect demographic information on youth participants in these programs. The lack of demographic information has impacted the direct service participant data by reflecting more "unknown" age, gender, race and ethnicity numbers than they have reported in previous years.

One Arizona contractor reported experiencing challenges and barriers during recent years reestablishing collaborations and partnerships in the community after the COVID-19 pandemic. The rapport building process has been slow, but activities are beginning to transition back to in-person.

Proposed changes for future efforts:

Prevention providers report that continued advanced training opportunities for prevention personnel will be beneficial. Their ability to

fill vacant positions will assist in expanding the reach of service implementation across the state.

The development of new statewide outcomes targets that are developed to expand upon the data collected on participant surveys will positively impact future efforts to more effectively achieve the goal. To reach the goal, collecting data on the perception of risk and harm, age of first use, and attitudes toward underage alcohol use will be beneficial. Additionally, contractors report collecting data on risk and protective factors that contribute to or protect against youth alcohol use will positively impact future efforts.

The Gila River TRBHA prevention intends to continue to seek to reestablish connections for collaboration. They also plan to continue outreach efforts for new community partnership opportunities. Through collaboration, efforts to meet the priority goal and objective will improve. The delivery of Botvin Life Skills evidence-based curriculum, which includes alcohol focused modules, will be delivered in schools within the community and neighboring communities where many Gila River Indian Community tribal members live. These reestablished collaborations will provide opportunities for staff to work with schools on alcohol-free alternative activities such as prom and graduation. An unintended positive outcome of the COVID-19 pandemic is that both the staff and community members became more technologically advanced to provide and participate in virtual educational presentations and activities.

How second year target was achieved *(optional)*:

Priority #: 3

Priority Area: Tuberculosis

Priority Type: SAT

Population(s): TB

Goal of the priority area:

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

Objective:

Increase documentation around screenings for TB and related services.

Strategies to attain the goal:

Strategies that providers are and will continue to implement include integrating TB education, in addition to hepatitis C, HIV, and other infectious diseases into member orientations, educational material, referrals handouts for TB, hepatitis C, and HIV testing at specified locations, as well as including elements to capture TB screening documentation in contactor's audit tools.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Performance Indicators to measure success on a yearly basis

Baseline Measurement: FY 2020 data on the number of members receiving substance abuse treatment with documentation of TB services documented in their chart. Current baseline for SFY 2020 is 57%.

First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2021), 60%.

Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2022), 65%.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Independent Case Review (ICR)

New Data Source*(if needed)*:

Description of Data:

A random sample of charts will be pulled and scored based on pre-determined elements that include documented evidence of screenings and referrals for TB services.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None noted.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:
The number of members receiving substance use treatment with documentation of Tuberculosis (TB) services documented in their chart was 42% in SFY22, not meeting the second-year target of 65%.

Although AHCCCS, the AHCCCS Complete Care Plans with a Regional Behavioral Health Agreement (ACC-RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs) do focus efforts to increase TB screenings, documentation, and interventions of TB in the substance use population, results for this measure were likely impacted by the COVID-19 pandemic. During the pandemic, several barriers presented that changed the way that treatment services were offered. AHCCCS and its contractors report the following efforts for TB services to SUD members. See more information in the barriers section below.

Outreach

Statewide efforts to increase documentation around screenings for TB and related services include targeted outreach strategies to ensure providers across the state are knowledgeable and have the capacity to process TB services, intervention, and educational material (in both English and Spanish). The three Regional Behavioral Health Authorities (RBHAs) across Arizona are responsible for ensuring that their assigned provider networks in their region (North, Central, South) receive, understand, and implement TB and related services. All three RBHAs review provider TB documentation expectations in regular intervals and offer support during these meetings to clarify any questions or concerns about implementing services.

In central Arizona, the RBHA encourages their network of providers to have easily accessible information on the prevention and treatment of infectious diseases. The RBHA also conducts targeted outreach and testing for HIV/STIs within high-risk populations (e.g., those experiencing homelessness, chaotic substance use, etc.), and has established multiple partnerships with community outpatient substance use treatment providers, most of whom are SABG subrecipients. In southern Arizona, the RBHA conducts street-based outreach and engagement to high-risk communities (e.g., substance users, people living with HIV, etc.) through engagement specialists located in Pima, Pinal, Cochise, Yuma, Santa Cruz, and La Paz to ensure adequate coverage and access to services throughout the region. Additionally, all three RBHAs utilize the annual independent peer review to identify gaps in TB screening and assessment. AHCCCS reviews these results with the RBHAs each year to obtain feedback, barriers, successes, and next steps for improving their TB screening results.

Further, Tribal Regional Behavioral Health Authorities (TRBHAs) utilize internal and external marketing tactics (e.g., advertisements, brochures, signs) to increase screenings and related services. One TRBHA sends out an email newsletter offering information for TB screening and other infectious diseases, as well as referring individuals to behavioral health residential facilities (BHRF).

Collaboration

To increase access to TB screenings and related services, ACC-RBHAs support their provider networks through ongoing administrative oversight of the policies, procedures, and expectations, as well as providing opportunities for cross-provider collaboration and referrals to services to fill in gaps in care. In southern Arizona, the ACC-RBHA contracts with several providers that roll their TB screening into their intake process for ease to the client and provider. Since HIV and TB are commonly linked, the RBHA works with HIV-specialty providers to coordinate HIV outreach, testing, and linkage to care in the event of a positive diagnosis. These providers attend programs at residential treatment centers and provide HIV/STI 101 sessions. After each session, participants are offered an HIV test and follow-up support. Additionally, the RBHA partners with a provider that conducts Hepatitis C screening and treatment across five locations in the southern region. The provider also provides transportation services for ongoing care.

Arizona's TRBHAs collaborate with local hospitals serving indigenous communities to ensure all in-patient network providers require TB screening prior to admission. Additionally, some of the TRBHAs utilize their Indian Health Services (IHS) unit.
Arizona utilizes a similar approach for targeted interventions throughout the state to increase screenings for TB and related services (e.g., HIV/STI testing). For instance, RBHAs and TRBHAs roll their TB screening into their required intake process for residential, specialty, and medications for opioid use disorder (MOUD) programs. This ensures consistent screening for all clients within their networks. In the

northern region, if an individual tests positive for TB and qualifies for a specialized care or disease management program, they are then referred to the appropriate treatment program to target their unique healthcare needs.

Targeted Interventions

Arizona utilizes a similar approach for targeted interventions throughout the state to increase screenings for TB and related services (e.g., HIV/STI testing). For instance, RBHAs and TRBHAs roll their TB screening into their required intake process for residential, specialty, and medications for opioid use disorder (MOUD) programs. This ensures consistent screening for all clients within their networks. In the northern region, if an individual tests positive for TB and qualifies for a specialized care or disease management program, they are then referred to the appropriate treatment program to target their unique healthcare needs.

Other Efforts or Information

Other efforts across the state to increase TB screening and related services include monitoring and oversight through the RBHAs' SABG provider network. This includes monitoring the minimum provisions outlined in the code of federal regulations (CFR) as well as AHCCCS policy. RBHAs also utilize the independent peer review, also known as the Independent Case Review (ICR) in Arizona, to assess TB screenings and conduct ongoing provider education, support, and technical assistance to increase TB screening. TRBHAs, serving indigenous communities, partner with other organizations to provide ongoing dialysis clinic information and after-care treatment planning to ensure they meet the complete healthcare needs of their members.

Outcomes Measured

The main outcomes measured under this goal are the number and percent of members in SUD treatment screened for TB as documented in clinical records. Documentation of screening for TB requires that the member's file 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. AHCCCS contracts and policies outlined requirements regarding TB screening and related services. In central Arizona, the RBHA conducts site visits, during which TB screening and referrals are emphasized to ensure providers are considering all aspects of a client's care. This means the provider must provide evidence of educational material, policies, and processes to help members receive screening, treatment and resources for TB screening and related services. In all regions throughout the state, the RBHAs also complete annual audits of SABG providers through the independent peer review/ICR. The review includes a section of screening for TB, which reports results by the state aggregate as well as by RBHA. Results are provided to the RBHAs for review and to identify areas for improvement.

TRBHAs measure outcomes for TB screening and related services through their health records, as well as by monitoring the stability of their clients throughout the inpatient treatment process, completion of program(s), and attendance at necessary follow-up appointments with medical providers.

Progress/Barriers Identified

There has been considerable progress for increasing TB screening and related services. For instance, in central Arizona the RBHA reported that all providers in their network have educational material on TB and other infectious diseases available to ensure members understand and have an increased awareness. Additionally, a TRBHA reported that there has been increased communication and relationship-building with the local Indian Health Services (IHS) unit.

There were similar barriers reported by all regions of the state, namely the impact of COVID-19 on service delivery and the ability to conduct outreach within their respective regions, with clients more hesitant/reluctant to follow-up on intakes. The central (most populous) and northern ACC-RBHA (least populous) both reported a lack of providers with the capacity to screen for TB "in-house." This necessitates the need to increase referrals and sending clients elsewhere to meet this requirement. Additionally, TRBHAs reported barriers in collaborating with providers off-reservation, and a limited number of patients who are enrolled in treatment.

Success Stories

Numerous success stories were shared with AHCCCS. Of note, the central ACC-RBHA reported a 12% increase in TB screenings compared to the year prior, and increased utilization of the TB testing (CPT code 86580) across lines of business between FY19-FY22, with a 24% increase of claims and a 52% average increase of unduplicated clients receiving the testing intervention. Additionally, the ACC-RBHA reported that the Non-Title XIX/XXI business increased (CPT Code 86580) utilization by 11% while increasing the count of unduplicated clients served by 55% between FY19-FY22.

How first year target was achieved *(optional)*:

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

The second year target was met at 46%.

AHCCCS and its contracted partners implement several strategies that focus on the priority of Tuberculous (TB) services among SUD members, which include reviewing the block grant requirements regarding TB services, educating providers, screening for TB at intake for SUD treatment services, and referring members for additional TB services as appropriate.

The AHCCCS Complete Care Plans with Regional Behavioral Health Agreements (ACC-RHBA) in southern Arizona has focused on TB screening and testing for members in the opioid treatment program and for any member admitted to a residential treatment setting. Additionally, efforts have focused on increasing referrals to TB testing, adding prompts within their comprehensive assessments and service notes indicating referral status. There are currently 380 locations that offer TB skin tests to all members and require testing for members engaging in medications for Opioid Use Disorder (MOUD).

At two Opioid Treatment Programs (OTPs) clinics in southern Arizona, TB skin tests are completed at intake and annually. If the member has had a TB vaccine in the past and tests positive through a skin test, the treatment team coordinates with external sources to obtain a chest x-ray. To date, only one member has tested positive for TB, and received treatment for TB through an infection disease physician.

Furthermore, at behavioral health residential facility (BHRF) locations in Southern Arizona, a TB test is required for admission. The TB test is normally done while the patient is in the inpatient setting, with a nurse reviewing the findings. If the member did not come from an inpatient placement and does not have a TB test, the provider completes a skin test at the facility.

Arizona's Insiders Program provides TB education as part of the Sexually Transmitted Infections (STIs) and infectious disease education curriculum.

The ACC-RHBA serving central Arizona completes annual site visits with all providers and assesses providers ability to screen and complete TB tests with individuals regardless of if they are outpatient or residential providers. Providers also provide technical assistance to providers as needed. The ACC-RBHA also receives and reviews provider policies using a tool that assesses compliance with the AHCCCS Medical Policy Manual (AMPM) policy 320-T1 and 300-2B which provides an overview of TB services. Residential service providers conduct TB screenings for any members entering residential treatment, including referring positive screenings to appropriate medical providers. Over the last two years during the annual site visits, the importance of screening and testing for infectious diseases has been emphasized as a standard practice for all providers and as a result TB screenings have improved during the reporting year. The ACC-RBHA met individually with a specific provider to help provide technical assistance on their process for screening and referring members to TB services as they have historically scored lower during the site visit for those areas. The provider then updated policy and procedures to adhere to requirements for TB screenings and are projected to score higher in the next annual site visit.

For this ACC-RBHA/GSA there was an increase in screenings for TB according to Independent Case Review (ICR) for FY22 (46%) compared to FY21 (39%), which was also slightly above the state average.

Additional highlights of TB testing (CPT Code 86580) were noted across the system of care and lines of business for FY22-FY23.

In northern Arizona, ACC-RHBAs TB screening processes are applied across the network. Depending on the provider or the level of care, TB testing may be a part of the referral packet for anyone being considered for admission to a BHRF, requesting primary care providers to verify TB screening (within the past 12 months) as a part of the referral packet whereas sometimes the actual TB test may be required, or the provider may offer the TB screens directly as needed at intake or admission. Providers may also have standing orders for chest x-rays for anyone with a positive screen, or they may be indicated due to a positive skin test. In certain settings, if members do not remember receiving a TB testing the residential Register Nurses (RNs) will implant PPD skin test and read it in two days and include it in the member record. In the case that a member is coming from a jail, the jail paperwork includes TB screening information, which includes test and results within the past year. TB testing may be required for all clients who have disengaged and/or it has been over a year since the initial TB test.

Other providers may have relationships with a local health care providers or harm reduction agencies who provide education and testing regarding TB. Historically, they have provided onsite education and rapid testing services.

The efforts reported by the ACC-RBHA in northern Arizona for TB screening have varied depending on the resources available at separate locations. In northeastern Arizona, TB screening and testing is only involved in inpatient processes.

TRBHAs also report that all clients entering residential treatment centers are required to obtain a TB screening prior to admission. The TRBHA can offer a chest x-ray to assist in streamlining this process in the instances where admittance to program needs to occur quickly.

Finally, AHCCCS efforts also include oversight and monitoring efforts which include an annual deliverable from the ACC-RBHAs: the TB Services Treatment Procedure and Protocol Report. The report identifies how oversight of TB services throughout the Substance Use Block Grant (SUBG) network includes annual site visits and technical assistance. Therefore, encouraging providers to offer psychoeducational material on infectious diseases on their website and in their lobby. AHCCCS also has an agreement with ADHS that outlines collaboration and data sharing on a need-to-know basis for TB oversight and monitoring among the SUD population.

Priority #: 4

Priority Area: Suicide

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Reduce the Arizona Suicide Rate to 18.0% per 100,000 by the end of calendar year (CY) 2021. The rate is currently 18.7%.

Objective:

Promote suicide prevention awareness through advocacy, education and easy access to best practice, evidence-based training.

Strategies to attain the goal:

HCCCS will continue to work collaboratively with other state agencies and stakeholders to implement suicide prevention strategies for all Arizonans, but specifically to address priority populations including: American Indians, those age 65 and older, the LGBTQI community, veterans, and teens. . Strategies will include but are not limited to community and conference presentations, social media messaging, social marketing/public awareness campaigns, youth leadership programs, gatekeeper trainings, improved data surveillance, and ongoing collaboration with stakeholders for systemic improvement.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Performance Indicators to measure success on a yearly basis

Baseline Measurement: The suicide rate in Arizona for CY2020 was 18.7 per 100,000 population 1419 suicide deaths/population.

First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of CY 2021), 18.0 per 100,000.

Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of CY 2022), 17.8 per 100,000.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

The Centers for Disease Control and Prevention (CDC): https://www.cdc.gov/nchs/pressroom/states/arizona/az.htm

New Data Source*(if needed)*:

Description of Data:

Each Fall, the Arizona Department of Health Services, Division of Public Health and Statistics (ADHS/PHS) calculates the State's suicide rate by determining the number of death certificates of Arizona residents where "Suicide" was indicated by a medical examiner as the cause of death during the second most recent complete calendar year (i.e. CY 2021 data will be made available in Fall 2022). Aggregated across the general population, this number establishes a suicide rate per 100,000 persons.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

AHCCCS and ADHS do not have a current data sharing agreement. AHCCCS suicide prevention team members have to wait for ADHS to publish their annual suicide data to understand what is happening statewide.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

The suicide rate for CYE21 is 21.2 per 100,000. AZ did not meet the target of 18 per 100,000.

Outreach

AHCCCS, the AHCCCS Complete Care Plans with Regional Behavioral Health Agreements (ACC-RHBAs), Tribal Regional Behavioral Health Authorities (TRBHAs) and contracted providers engaged in a variety of suicide prevention/intervention outreach strategies reaching both the general and targeted populations of Arizona. Examples of these efforts include: Suicide Intervention Gatekeeper program, Question, Persuade, and Refer (QPR) attended by community members, peer/families, partners, faith-based groups, first responders, tribal communities, school districts, community colleges, youth/provider agencies, and law enforcement; community-specific educational and resource information distribution in the form of flyers/brochures, door-to-door information, professional and member newsletters, websites, social media platforms, community boards, and digital media boards; increased number of Mental Health First Aid (MHFA) and Applied Suicide Intervention Skills Training (ASIST) trainings including train-the-trainer sessions. ACC-RBHAs and TRBHAs also supported and attended conferences as well as a variety of suicide education and awareness activities including support walks, community fairs, candlelight vigils, webinars and presentations.

Collaborations

AHCCCS, the ACC-RBHAs and TRBHAs and contractors work collaboratively with their communities including peers/families, stakeholders, faith-based organizations, adult and youth provider agencies and residential facilities, school districts/educational centers, first responders, hospitals/emergency departments/inpatient facilities, crisis response teams, law enforcement, adult and juvenile detention centers, and substance use/abuse treatment entities. Collaboration also occurs regularly with the Arizona Department of Health Services (ADHS) and the individual county public health departments of, Arizona Department of Veterans' Services, Arizona Coalition of Military Families, Arizona Foundation for Suicide Prevention, Arizona Department of Education (ADE), Arizona Suicide Prevention Coalition, and Indian Health and Behavioral Health Services including Native Americans for Community Action (NACC). One TRBHA collaborates with Tucson Senior Pride and Tucson Indian Center to support tribal members identifying as LGBTQI and their allies. Additionally, they collaborated with the fire department to conduct on-scene crisis stabilization and report training to 182 individuals in suicide prevention (QPR, ASIST, and general suicide prevention). Another ACC-RBHA became involved in a suicide prevention workgroup targeting the age 65+ population and their caregivers in addition to partnership with Project AWARE at the ADE to provide 4 school districts with cost-free Youth Mental Health First Aid Training, allowing each school in the district to have access to master trainers. Another TRBHA identified collaboration with their onsite women's clinic to provide mental health education and resources to pregnant and parenting women. A RHBA in our southern region facilitates three Suicide Prevention Task Forces in their region to discuss prevention, treatment, and postvention issues specific to their communities.

Targeted Interventions

Evidence-based suicide intervention and prevention initiatives implemented in Arizona include: increasing Applied Suicide Intervention Skills Training (ASIST) train-the-trainers and trainings across the state; safeTALK (Suicide Alertness for Everyone), Mental Health First Aid (MHFA)/Youth MHFA, Suicide to Hope, Teen Lifeline, Mobilize AZ, Project AWARE (Advancing Wellness & Resiliency in Education), SHOUT protocol, Pyx Health platform, and Healthy Relationship Workshops. National Alliance on Mental Illness (NAMI) Arizona's Ending the Silence (ETS) initiative (to be substantially expanding within the next 1-3 years), implementation of the 988 Crisis Call Centers (text/chat coming soon), and dissemination of gun locks to firearm owners via providers, crisis mobile teams, and community partners as part of the statewide means reduction campaign. One TRBHA reported groups focused on substance abuse/mental health, self-harm and trauma for both young adults and youth in addition to serious emotional disturbance (SED) and serious mental illness (SMI) day program options utilizing evidence-based practices: DBT, MATRIX, 7 Challenges and MBCT. They conducted 4 Healthy Relationship Workshops that were attended by 48 youth and 14 adults; 15 Self-Care Workshops with 35 youth and 159 adults participating; 2 Youth MHFA trainings attended by 17 adults; and 168 adults participated in the 27 QPR sessions. An ACC-RBHA in Arizona's northern region identified implementing the Pyx Health 24/7 mobile platform assisting individuals with SMI with Social Determinants of Health needs. Another ACC-RBHA in our Central region has prioritized commitment to building and sustaining a competent, confident, and well-trained workforce and bolstered their number of contractor provider staff training to increase staff members' preparedness to ask directly about suicide and confidence in their ability to intervene. Southern Arizona's ACC-RBHA reports that a total of 576 community members, peers/family members, stakeholders, faith-based groups and provider agencies participated in QPR trainings both virtually and live in-person.

Outcomes Measured

Annual deaths by suicide are tracked by the ADHS in collaboration with AHCCCS. ADHS tracks total annual and monthly number of deaths in addition to resident death by suicide by gender, race/ethnicity, age group, place of occurrence, and age adjusted mortality rates (number of deaths per 100,000 people) by county of residence. TRBHAs evaluate/measure by post-test and/or reviews distributed after QPR and ETS sessions; of those measured, the majority of participants identified that they learned new information and increased

their skills/knowledge about suicide prevention and mental illness. The number of persons trained, number of trainings held, number of schools/organizations and organizations participating in trainings, suicide prevention referrals, risk assessments, acute psychiatric stabilization facility placement/rehospitalization, and member self-success reporting are tracked to varying degrees by the ACC-RBHAs and TRBHAs.

Progress/Barriers

Barriers identified continue to be the inability to conduct activities/services in person, including client interventions and trainings in addition to social isolation related to the COVID-19 pandemic. In spite of these ongoing barriers, ACC-RBHAs and TRBHAs are successfully implementing techniques including virtual programming (and skill support for staff in providing virtual programs), virtual training events, and drive-through activities. A TRBHA reported success in increased awareness among community members and an increase in referrals/assessments with a correlated decrease in attempts in their community. Programs have identified a steady increase in the amount of people attending in-person services, appointments, and groups decreasing social isolation.

Success Stories:

QPR has been identified by school staff as a "great and brief way to assess a student's intent for suicide and how to quickly pass them on to support." One TRBHA reported that out of 57 QPR attendee responses, 100% of participants indicated the presentations were useful, 100% indicated that they have a better understanding of suicide risk factors and warning signs, 93% indicated that they felt more prepared to help someone displaying suicidal warning signs and 95% indicated that they have understanding about how to connect persons with community resources. Other ACC-RBHAs also report positive responses to this training. Based on the Governor's 2021 Summary of Accomplishments in Suicide Prevention by AHCCCS's report, successes include increasing utilization of population-based suicide prevention science including "Secure Your Weapon," development of a comprehensive list of evidence-based programming for Arizona's American Indian and Alaska Native communities which has been shared through tribal consultation; increasing access to the full continuum of mental health services, including crisis, with a particular focus on remote options when appropriate; increasing the number of public-facing and frontline staff trained in evidence-based suicide prevention including Project AWARE workforce development efforts impacting 13,435 school staff and 1,761 community members, individuals trained in safeTalk and ASIST, and the use of the 988 implementation to establish a singular statewide crisis call center leveraging existing ACC-RBHAs and the National Suicide Prevention Hotline.

How first year target was achieved *(optional)*:

Priority #: 5

Priority Area: Engaging youth with substance use disorder in treatment

Priority Type: SAT

Population(s): Other (Criminal/Juvenile Justice)

Goal of the priority area:

To increase the participation of youth with substance use disorder in appropriate intervention, treatment, and recovery services.

Objective:

Increase the percentage of those who are (1) under the age of 18 and (2) in the behavioral health system and (3) are diagnosed as having a substance use disorder and (4) receive treatment services.

Strategies to attain the goal:

1. Pilot a pre-peer support program for youth in recovery.
2. Arizona Health Care Cost Containment System (AHCCCS) Managed Care Organizations (MCOs) lines of business will continue to collaborate and meet regularly with child/adolescent providers to share information on substance abuse screening, trends, and best practices.
3. Require contractors to provide and promote access to substance abuse training initiatives among child/adolescent providers including those employed though other agencies such as the OJJDP Detention Centers.
4. Pursue a standardized, parent-friendly, screening tool to identify substance use/abuse in the children and adolescents.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	In the last 12 months, the percentage of minors in the behavioral health system with a diagnosis of substance use disorder who received a substance use-related treatment service.
Baseline Measurement:	SFY21 (7/1/20-6/30/21): 41.44%
First-year target/outcome measurement:	By the end of SFY2022, at least 44% of the minors diagnosed with SUD will receive a SUD-related treatment.
Second-year target/outcome measurement:	By the end of SFY2023, at least 47% of the minors diagnosed with SUD will receive a SUD-related treatment.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

AHCCCS recipient data

New Data Source*(if needed)*:

Description of Data:

Denominator is the number of youth under the age of 18 diagnosed with any substance use disorder (need not be primary diagnosis) in the past 12 months.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:
The first-year target was "By the end of SFY2022, at least 44% of the minors diagnosed with SUD will receive a SUD-related treatment." We met this target, as 46.3% of minors diagnosed with SUD received a SUD-related treatment.

The following efforts are reported by ACC-RBHAs and TRBHAs

Outreach:

To increase the participation of youth across Arizona with substance use disorder (SUD) in appropriate intervention, treatment, and recovery services, AHCCCS utilizes a multi-pronged approached such as piloting a pre-peer support program for youth in recovery, leveraging the AHCCCS Complete Care (ACC) Plans, ACC plans with a Regional Behavioral Health authorities (ACC-RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs), contract requirements, and pursuing standardized, parent-friendly screening tools to identify SUD among children and adolescents. RBHAs utilized a variety of approaches to meet this goal. In the central region, the ACC-RBHA contracted with the Juvenile Probation Department to connect youth to services and prevent/decrease involvement in the juvenile justice system. This included implementing a process to connect youth that touch the justice system, are Non-Title XIX/XXI and eligible for SABG funding, to a behavioral health service provider. The central ACC-RBHA has also partnered with new providers that will provide services to youth who are justice-involved. In the southern region, the ACC-RBHA funds outreach positions with local providers to coordinate re-entry planning and community services and support for youth who have an identified SUD. This ACC-RBHA also partners with a provider to assist in outreach and treatment services for youth in detention in need of reach-in and wrap-around services (ages 7 through 17). Some of the evidence-based practices used include: Multisystemic Therapy (MST); Functional Family Therapy (FFT); Multisystemic Therapy for Problem Sexual Behaviors (MST-PSB) and Project Hope Family Trauma Therapy.

TRBHAs also implemented strategies to increase participation of youth with a SUD in appropriate intervention. One TRBHA has an ongoing expansion of adolescent school-based services with a focus on substance use and outreach to juvenile court judges.

Collaboration

There are extensive efforts to collaborate throughout Arizona to increase the participation of youth with SUD in appropriate intervention, treatment, and recovery supports. In the central region, the ACC-RBHA engages with child/adolescent providers and community stakeholders at a variety of formal and informal settings. The ACC-RBHA through contracted providers provides training/education to the 44-school districts that have a formal partnership with the ACC-RBHA to increase knowledge of mental health awareness, substance use, and suicide prevention. Through a local partnership with a provider and school district, the ACC-RBHA provides services to youth who are at risk of using substances. In this partnership, the ACC-RBHA is working to expand service offering to the 80+ schools within the district.

In the southern region, the ACC-RBHA collaborates with four (4) juvenile detention centers in four counties. Once county offers individual therapy sessions as needed, and weekly Teen Addition Anonymous groups (following the Teen AA 12-Step program). This county also contracts with a medical provider offering individual and group therapy (focusing on treatment readiness and stages of change). One county in the southern region implements a detention screening instrument capturing substance use (past/current). If appropriate, juveniles are provided a weekly individual therapy session with a counselor and support. If it is determined the juvenile requires a higher level of care, the medical staff will notify probation, who will coordinate with community providers for services. Additionally, within this region is a youth and family centered program, Life in Full Throttle (LIFT) that provides comprehensive, evidence-based treatment services for youth 13 and older with SUD. LIFT enhances treatment by offering family focused services, such as parent education groups, information, support, and skills that will assist youth in recovery. Additional services through LIFT include Medication Assisted Treatment (MAT) for youth 16 and 17 years of age who have an opioid addiction; relapse prevention groups; individual and family therapy; early recovery adolescent groups and pro-social activities. As of summer 2022, this specific provider in the southern region has absorbed services previously provided by a former provider including individual and group counseling; recovery support groups and peer led activities; trauma-informed care tools for educational success; family support services; healthy relationship building and life skills. In addition, the provider has also expanded their services to include the Evidence Based Practice (EBP), Adolescent Community Reinforcement Approach (A-CRA) as well as an Intensive Outpatient Program (IOP), to their array of services.

TRBHAs also utilize an array of services to serve youth with SUD. One TRBHA collaborates with a local organization to address youth prevention and suicide prevention, offering it at their flagship location in central Arizona. The Tribal Tortuga ranch also provides equine-assisted psychotherapy for individuals and groups and addresses youth substance use issues and prevention, including the boy's youth group home, which attends every Saturday. Other collaborations for TRBHAs include partnering with local schools and juvenile courts.

Targeted Interventions

Arizona utilized an array of targeted interventions to increase participation of youth with SUD in appropriate intervention, treatment, and recovery supports. In the central region, the RBHAs' interventions were mostly centered around non-encounterable outreach efforts and education for at-risk youth. The ACC-RBHA leveraged representatives from their First Episode Psychosis (FEP) programs and partnered them with six (6) partners delivering non-encounterable outreach through MHBG-SED funding. Together, FEP representatives and outreach workers were able to provide education and training on SUD services and resources across Maricopa County. Over 3,800 participants from over 62 school districts attended these outreach efforts which resulted in 2,900 referrals for child and adolescent services and a 31.7% increase in enrollments for NTXIX/XXI children.

In the southern region, the ACC-RBHA utilizes a multi-pronged approach to serve youth with SUD. In Pinal County, staff complete a full mental health assessment within 72 hours (about 3 days) on each youth, asking comprehensive questions about substance use. When identified, licensed counselors provide counseling on SUD for youth while detained. They also administer a health assessment upon entry to detention that collects information about substance use. Yuma County completes a health assessment within 24 hours of entry into detention. They do not currently utilize a substance use assessment tool consistently across the detained population. In addition to the Comprehensive Intake Assessment and the American Society of Addiction Medicine (ASAM), the CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) tool is utilized by providers as a substance use screening and tool. Providers also utilize the SOCRATES (The Stages of Change Readiness and Treatment Eagerness Scale) and URICA (University of Rhode Island Change Assessment) as readiness for change screening tools. Assessment information can and is shared through the Child and Family Team process to support re-entry planning and Individual Service Plan (ISP) development with all parties involved with the treatment team. The ACC-RBHA continues to support the communication of assessment scores and healthcare services performed by the medical staff to the appropriate community provider(s).

TRBHA efforts to engage with youth with SUD includes standardized treatment and interventions for those diagnosed with SUD and who are eligible for SABG funding. One TRBHA works with a trauma specialty provider and an early childhood and attachment specialty provider.

Other Efforts or Information

Across the state, RBHAs and TRBHAs utilized their network providers and partnerships within their region to strengthen the system of care for youth with SUD. In central Arizona, the ACC-RBHA undertook outreach efforts to raise awareness for mental health concerns, lower stigma, and increase awareness of Non-Title XIX/XXI programming and treatment. In southern Arizona, the ACC-RBHA partners with a local university to offer education specific to youth with SUD. This ACC-RBHA also monitors its provider network to ensure evidence-based practices are available to youth with SUD consisting of: ACRA, Seven Challenges, Matrix, Contingency Management, Living in Balance, Motivational Interviewing, Seeking Safety, etc. An additional partnership with a local provider organization ensures youth

Opioid Use Disorder (OUD) have access to medications for OUD if medically necessary. In addition, the ACC-RBHA in the southern region collaborates with another provider organization who expanded services to include Supportive Outpatient Program (SOP).

TRBHAs utilize outreach to better engage with people in their service areas. One TRBHA is aiming to establish several group offerings to youth.

Outcomes Measured

Across the state, RBHAs and TRBHAs measured numerous outcome measures to measure the participation of youth with SUD in appropriate intervention, treatment, and recovery supports. In central Arizona, the ACC-RBHA utilized the following measures: number of school-based partnerships, number of unique impressions of education/TA, number of NTXIX/XXI enrollments, and percent increase of NTXIX/XXI enrollments. Of note, one ACC-RBHA reported a clinical school liaison enrolled 429 students 2021-2022 (compared to 85 in the previous year). Another provider also had 792 referrals (compared to 261 the school year prior). That amounts to a 203% increase in referrals from 2020-2021 school year to 2021-2022 school year. In the southern region, the ACC-RBHA monitors outcomes related to outreach, engagement, enrollment, and discharge outcomes.

TRBHAs measure outcomes such as the stability and progress of clients through the inpatient treatment process, completion of program, and attendance at necessary follow-up appointments with medical providers.

Progress/Barriers Identified

Across the state, RBHAs and TRBHAs cited progress and barriers in increasing participation of youth with SUD in appropriate intervention, treatment, and recovery supports. Notably, progress across the state included the following:

In Central Arizona, the ACC-RBHA continues to hold consistent meetings with providers offering school-based services. To date, this ACC-RBHA has 44 school districts participating in some form of service delivery.

One TRBHA reported increased engagement in services, ongoing positive relationship building with area schools, and a formal relationship established with the juvenile court.

Barriers experienced by providers throughout the state included the following:

In Central Arizona, capacity for the increased demand for treatment services has created challenges for new members attempting to establish care, and staffing concerns (workforce development) were reported as the number one issue impacting the RBHAs provider network.

In Southern Arizona, the ACC-RBHA reported ongoing barriers that are reported by providers such as hiring staff, staff burnout, and staff retention. A juvenile justice provider continues to see a decrease in SUD referrals as well as the number of youths on probation. Juvenile detention also saw a decrease occur and noted the following as possibilities: youth are not as unsupervised as they used to be and not out in the community as much.

One TRBHA cited workforce development issues with hiring and retaining staff, as well as nothing barriers with parental engagement, and the COVID-19 pandemic.

Success Stories Shared

ACC-RBHAs and TRBHAs reported to AHCCCS numerous success stories across the state. For instance, in Central Arizona, the ACC-RBHA noted how the telehealth school-based-services (SBS) format worked in the last quarter of the school year. Teens seem more open and did not mind telehealth services. In addition, one clinician stated they had a young teenager who was against engaging in services and only completed their intake to be polite to the Intake Coordinator. After their first scheduled session, they told their guardian that they weren't going to participate. As a result, the guardian and the counselor met for a few minutes and discussed how counseling could be focused on anything the student wanted to talk about, and that the focus would be to get them engaged in something positive and of support to the student. The counselor had asked the student if they would give the counselor 10 minutes to talk, and to see if they could "make a plan" for what they could do in counseling to make sure it was going to be interesting and relevant to the student. When they closed the session, the student told the counselor it was a lot better than they thought it would be, and that they were willing to try again next time. Since then, they have met every week, and their guardian even wrote to the school saying their teen is attending school more often and putting in more effort than the last few years and that their teachers are noticing the changes, too. In southern Arizona, a provider reported that a youth who achieved seven (7) months of sobriety, was receiving straight as at school.

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

The second year target "By the end of SFY2023, at least 47% of the minors diagnosed with SUD will receive a SUD-related treatment." was not achieved. In SFY2023, 45.32% of minors with SUD having received an SUD-related treatment service. The following details Arizona's progress, challenges, and proposals for future changes:

Across the state of Arizona, ACC-RBHAs are approaching youth treatment from many different approaches and showing great success. ACC-RBHAs fund outreach positions to coordinate re-entry planning and community services for adolescents who have a SUD treatment need. Programs offer several levels of substance abuse treatment designed to meet the specific needs of each client including Intensive outpatient services, Substance abuse recovery, Relapse prevention, Seeking Safety, and SMART Recovery.

ACC-RBHA providers also assist in outreach and treatment for youth in detention in need of reach in and wrap around services. Providers are in place to provide outpatient services to youth ages 7 through 17 and their families, utilizing a family-centered and family -focused approach to assist youth in their natural environment.

ACC-RBHAs have dedicated teams of Juvenile Justice liaisons who assist with connection to care for youth who are in detention. ACC-RBHAs used CRRSAA SUBG funding to bring on new providers/agencies to help improve connection to treatment for youth as well as expand services for youth through contracted agencies. Contracts are in place with providers that offer medication for opioid use disorder (MOUD) for youth. ACC-RBHAs collaborate with child/ adolescent providers and community stakeholders at a variety of formal and informal settings. These settings may include but are not limited to Member Advocacy Committee (MAC), School-based services collaborative, JOC Meetings with Providers, Quarterly Grants meeting, and Behavior Health in Schools Quarterly Meeting.

ACC-RBHAs continue to require adolescent treatment providers to utilize evidence-based screening tools and interventions to meet their needs including Multisystemic Therapy, Adolescent and Community Reinforcement Approach (A-CRA), Matric Model, Seven Challenges, Dialectical Behavioral Therapy, Multisystemic Therapy for Problem Sexual Behaviors (MST-PSB), Project Hope Family Trauma Therapy, and Functional Analysis of Substance Use Behavior (screening tool).

In FY23 in the Central GSA there were 56 unique individuals under the age of 18 that received treatment services through SUBG funding which is a significant increase from FY22. In FY22 there were 8 unique individuals under the age of 18 who received treatment through SUBG funding. Through CRRSAA SUBG funding a provider in the Central GSA was able to train 332 volunteers/mentors throughout Maricopa County with an emphasis of south Phoenix to connect with youth. The provider also established a collaboration with Maricopa County Juvenile Probation Department to connect youth to mentors. Additionally, providers assisted 174 families with resource navigation and 42 youth enrolled in peer support services. This data shows that efforts in the State of Arizona to treat youth are being met with great progress.

Challenges:

Providers reported ongoing barriers include hiring staff, staff burnout, and staff retention. Juvenile Centers reported seeing decreases in SUD referrals as well as the number of youth on probation. Many youths who receive SUD services are covered under Medicaid benefits thus making it more of a unique population to serve under SUBG. Another challenge is SABG restricts funds to be used to support youth who are housed in non-OJJDP facilities. Many OJJDP facilities already have robust programming for youth and the biggest need we see in the northern GSA for justice-related programs are for facilities that do not fall into that category. Staffing barriers have created some capacity issues with providers who serve youth.

Proposed Changes to Future Efforts:

The ACC-RBHA/providers have recommended AHCCCS consider amendments to AMPM 320-FF which more formally establish larger system expectations when youths receive Narcan intervention within ED/urgent care, EMS-EMT, first responder or other medical environments. System considerations include:

Expanding co-located Substance Use Navigators (SUNs) within Hospitals to support discharge planning/coordination to on-going treatment. (SUNs have been funded under state-opioid response grant and have demonstrated considerable success in converting members from ED settings into on-going treatment. These roles could be augmented to include familial support throughout the discharge and on-going treatment pursuit.)

One step further may include evaluating the state's feasibility of implementing the CA Bridge Model. This model is proven to work effectively in any hospital setting, and has been launched in 85% of California's Emergency Departments. The bridge model lowers the barrier to addiction treatment medications and creates 24/7 access to care. ER staff provide patients with immediate relief from withdrawal symptoms. Once patients are stabilized, they engage with a navigator—often a peer with lived experience—to discuss harm reduction and ongoing treatment. Bridge navigators triple the likelihood that a patient will be in treatment 30 days after they leave the Emergency Department.

Consider braided funding opportunities for agencies that offer prevention and treatment for youth to allow for a more comprehensive spectrum of treatment options for youth and families.

Identify more opportunities for family treatment for youth who have a substance use disorder, as it often takes the whole family system to shift to help improve outcomes for youth with substance use disorder.

How second year target was achieved *(optional)*:

Priority #: 6

Priority Area: Social determinants of health for individuals with substance use disorders

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Address the social determinants of health for individuals with substance use disorders to support stable, long term recovery.

Objective:

Increase the number of individuals with substance use disorders who have access to ongoing stable housing and childcare.

Strategies to attain the goal:

1. Increase the funding invested in Oxford Houses.
2. Educate and encourage the participation of service providers in the Closed Loop Referral System.
3. Leverage supported housing opportunities provided through the Statewide Housing Administrator.
4. Alleviate barriers to accessing childcare.
5. Expand capacity for supported independent living programs.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of Oxford Houses operating in the state of Arizona.

Baseline Measurement: For SFY2021, there were 41 houses.

First-year target/outcome measurement: By the end of SFY2022, there will be 44 houses.

Second-year target/outcome measurement: By the end of SFY2023, there will be 47 houses.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Contract deliverable to AHCCCS

New Data Source*(if needed)*:

Description of Data:

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

The first-year target was: "By the end of SFY2022, there will be 44 houses." This target was met, since as of 12/1/2022 there were 86 Oxford Houses in Arizona.

Outreach:

To increase the number of individuals with substance use disorders who have access to ongoing stable housing and childcare our strategies were to increase the funding invested in Oxford Houses, educate and encourage the participation of services providers in the closed loop referral system, leveraging supported housing opportunities provided through the Statewide Housing Administrator, alleviate barriers to accessing childcare and expand capacity to supported independent living programs.

The AHCCCS Complete Care Plans with Regional Behavioral Health Agreements (ACC-RBHAs) stated they allocated Non-Title XIX/XXI funding across the provider network and provided ongoing training and technical assistance to ensure proper utilization of available funding for eligible populations, along with the utilization of CRRSAA SABG funding to expand service utilization.

The three RBHAs (Northern, Central, Southern) had the opportunity to help Oxford House Inc (OHI) expand outreach with CRRSAA SABG funding to cover additional outreach personnel in FY22 and will continue efforts in FY23. Oxford continues to outreach by providing 5 reoccurring treatment presentations per month at various Crossroads' provider locations, Oxford house began planning the first ever Arizona event, Arizona Walk for Recovery, and Mercy Care agreed to table the event. Although the event is set to take place in September 2022, much of the planning occurred in FY22. Oxford house is invited and encouraged to attend the Central RBHAs quarterly grants meeting. This ACC-RBHA reached out in April 2022 to providers who often work with Pregnant & Post-Partum Women (PPW) to solicit feedback surrounding the limited use of the T1009 code with a goal of addressing the barriers over the next year. They've also had collaboration with Oxford House Recovery Housing programs outreach across southern AZ including renting suitable homes, recruiting residents, and teaching them the standard operating procedures, developing community resources and development and implementation of strategies for relapse prevention.

In the Northern Region, Health Choice funded four (4) Oxford House outreach workers. OHI team members are a regular part of leadership committees, such as the Northern RBHAs Adult and Children's Services Committee, and present updates on a regular basis. All SABG funded providers were made aware of the AHCCCS memo regarding billing to SABG for childcare when a memo was released in 2018. The Northern ACC-RBHA created and maintained a policy on childcare which was available to providers on the website.

One Tribal Regional Behavioral Health Authority (TRBHA), implements a supportive housing program and a behavioral health residential facility (BHRF), men's path residential facility, 10 bed, and a boy's group home 8 bed. They also have a transitional housing program to serve families working for reunification when involved in the Department of Child Safety (DCS) or Tribal Child Support (CSP) cases.

Collaboration

In Southern Arizona, the ACC-RBHA continues to partner with Oxford House recovery housing, allocating grant funds for the expansion of recovery homes to include homes specific to pregnant individuals in recovery and their children. Oxford House will continue to sustain these homes in Pima and expand these recovery homes in rural areas including Yuma, Pinal, and Cochise. Oxford House will coordinate with treatment providers and other state agencies to make them aware of the locations and availability of beds in an Oxford House.

The Southern ACC-RBHA, in collaboration with OHI, puts together workshops for the local and state levels. These are planned to inform new residents and keep current residents aware of the Oxford House system of operation. Presentations are provided to local and state treatment providers, correctional facilities, and other agencies that may have a need for Oxford Houses. Additionally, in August 2022, in collaboration with the Housing Authority City of Yuma (HACY), the Southern ACC-RBHA applied for a new Housing Trust Fund project (SB1616) for new construction of a triplex (2BD units). This project will provide permanent affordable housing opportunities to three individuals or families with serious mental illness. The Housing Authority City of Yuma will make two Section 8 vouchers available for every unit of newly constructed affordable housing. This leverages a total of six new housing subsidies. The Southern ACC-RBHA continues to collaborate with community stakeholders and affordable housing developers with proven track records to develop affordable housing under the State's Low-Income Housing Tax Credit (LIHTC) program. This ACC-RBHA also continues to collaborate with Community Based Organizations (CBO) and providers to encourage utilization of the Closed Loop Referral System (CLRS). These partnerships develop innovative layered funding sources, such as combining housing trust funds with HOME funding, project-based housing choice vouchers, the Housing Matters to Arizona Fund created by the Arizona Health Plan's reinvestment dollars, and the Arizona Housing Fund. The ACC-RBHA continues to collaborate with the Statewide Housing Administrator to ensure that our most vulnerable members are prioritized for housing as it becomes available. Additionally, the Northern ACC-RBHA collaborated with OHI to disseminate information to clinical and executive leadership.

In Northern Arizona, the ACC-RBHA works with OHI to incorporate the results of the annual survey into reporting measures. The Central ACC-RBHA provides quarterly technical assistance with Oxford House several times throughout the year to discuss progress and barriers. The ACC-RBHA provides an annual training/overview on grant and other community resources to the Oxford House outreach staff. Additional guidance is offered to OHI staff around reporting critical incidences – like, relapses, arrests, overdoses, evictions etc. – to the RBHA so that we can coordinate with affiliated treatment stakeholders or providers. This includes education to OHI staff on the Critical Incident Reporting form and ROIs. During FY22, OHI successfully obtained a monthly average of 18 new ROIs per month and reported a total number of critical incidents to the ACC-RBHA of 15 incidents during the fiscal year period. The ACC-RBHA then notified the affiliated provider of the incident for care coordination. This expanded OHI's reach with CRRSAA funding to cover additional outreach personnel in

Maricopa County.

One TRBHA stated they collaborated with the Social Services department, DCS, Department of Housing and Tribal Housing. They have discussed the Oxford House modality but have not started any additional projects in this time frame due to the pandemic.

Targeted Interventions

Oxford House is a concept in recovery from drug and alcohol addiction. In its simplest form, an Oxford House describes a democratically run, self-supporting and drug free home. The number of residents in a house may range from six to fifteen and there are houses for men, houses for women, and houses which accept women with children. Each House represents a remarkably effective and low-cost method of preventing relapse.

In Southern Arizona, the ACC-RBHA integrates member social determinants of health (SDOH) data with CLRS. Development of provider incentive strategies for EMR integration with the Closed Loop Referral System (CLRS). By the end of SFY2022, 27 Oxford Houses were established in Northern Arizona, accounting for 249 beds. Increased funding to Oxford house through adding additional outreach workers and additional funding for oxford expansion. Through CRRSAA funding Oxford House was able to open two women and children's homes and 1 LBGTQIA+ to serve individuals with unique needs. Increase the utilization of T1009 through ensuring rate was added to fee schedule and providing education on the service code. Mercy delivered a targeted release to current SABG subrecipients (IC, 77 provider types) notifying partners this service had been added to the Mercy Care Fee schedule.

Other Efforts or Information:

The ACC-RBHAs provided information regarding other efforts such as the Southern ACC-RBHA attending all collaborative forums, coalitions, crisis systems meetings, and other forums to ensure education and resources are readily available in all service areas for Oxford House. Additionally, increasing access to SSI/SSDI Outreach, Access, and Recovery, (SOAR) services to assist members in applying for and receiving SSI/SSDI benefits. According to the AHCCCS rules and regulations regarding SABG and billing for childcare, the provider types allowed to bill for this service are FQHCs and RHCs. None of the providers in the Northern ACC-RBHA region who received SABG funding are Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC.) CRRSAA funding helped to provide housing assistance for women at Center for Hope. 35 women and 17 children were served, 5 healthy babies were born, and 3 families were reunified. Arizona Women's Recovery Center assisted 8 children to professional childcare assistance through a childcare agency called Tiny Treasures, 22 women obtained stable housing through Her House and Legacy and 42 women and children received stable housing at Sally's Place, Weldon House, Terri's Place and Thelma's House.

One of the TRBHAs aims to open a transitional housing program for youth 26 and under and it is being discussed in management meetings and is on the future horizon plan list.

Outcomes Measured

Currently, the Southern ACC-RBHA monitors outcomes through internal data reports, deliverables, and monthly performance measures. Additionally, The ACC-RBHAs Phase II Housing Trust Fund project (SB1616) was completed as of August 8, 2022 and yielded nine additional housing authority vouchers with three new three-bedroom single family homes. AzCH-CCP assisted La Frontera with the Center of Hope apartment project through a Housing Trust Fund application. The project was completed in May of 2022 and has yielded twelve additional one-bedroom units for members with a diagnosis of serious mental illness. Furthermore, utilization of diagnosis codes (ICD-10 Z codes) related to SDOH (% of claims that contain an SDOH diagnosis). Services utilized by members in Permanent Supportive Housing. Provider utilization of CLRS. CLRS onboarding paused due to acquisition by Unite Us, however onboarding has resumed at this time.

A TRBHA reported that they yielded several positive outcomes and community member testimonials, but none are available currently.

By the end of SFY2022, 27 Oxford Houses were established in Northern Arizona, accounting for 249 beds. Additionally, the following outcomes occured:

Increase in new Oxford Homes for people with unique needs (two women and children's home and an LBGTQIA home
Operationalizing the T1009 code
Educating providers and the community about childcare as a covered service

Progress/Barriers Identified

By the end of SFY2022 – July 1, 2021 – June 30, 2022; Oxford House had 15 homes in the Southern region. Ten of the houses were for men only, three for women and children, and two for women only. No qualified providers for childcare services. The barriers found were, Oxford house has slowed down with purchasing new homes because of the Market's competitiveness. Oxford reported difficulty sourcing properties and competing with the influx of cash-buyers prevalent in Maricopa County's top-5 real-estate market. Previously this code was not in the Mercy Care fee schedule, however it has since been added in FY22 and there has been an increased demand for technical assistance. Providers have also historically stated it has been difficult to operationalize the service due to the low rate. The progress is some Outpatient providers are slowly starting to utilize the T1009 code for services they have been providing that have been uncompensated. Providers that are new to this type of service are beginning to identify their procedures and processes for implementing

this service.

Currently, the impacts of the COVID-19 pandemic have been an identified stressor making it difficult to take on additional projects. The Central ACC-RBHA has a program from within to train staff from peer support through BHT IIs, so they continue to offer and train and for advancement opportunities.

Success Stories Shared

Some examples from the Southern ACC-RBHA include having 25 residents attend in one of the meetings with Oxford House where they stated they had their first state retreat at Prescott Pines Christian camp in May 2022. One hundred and fifty residents of Oxford Houses of Arizona attended from all corners of the state. The retreat focused on fellowship, unity, and sessions about being a good Oxford House member and citizen of the community. The retreat provided a men and women empowerment lodge and Peer Support education. The retreat was self-supporting. Residents fundraised to pay for registration.

Another success story was reported from a member:

"After being released from prison, I was living with my sister, grateful to be back with her but sleeping on a mattress in the middle of the living room. I had a year and a half sober and was desperately trying to put my life back together. I moved into Oxford House Meseto on April 8, 2021. I count my first day in Oxford House as one of the best days of my life. Oxford House has been a home to me first and foremost. I have found peace in knowing that I get to go home to my bed in a bedroom in my house. I'm so grateful for it! I have learned so much here, I feel like it's preparing me for when my time comes to take my next step in this journey. Down to the way we pay our bills, do our chores, communicate and hold each other accountable, Oxford House helps us become responsible again. After all the traumatic hardships of drug addiction, I needed a refresher course. Oxford House gave me that."

A TRBHA reported a success of community members who have completed residential treatment, have obtained employment, moved into community living, and have successfully reunified with their families and children.

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

The second year target "By the end of SFY2023, there will be 47 houses" has been achieved, at 79 Oxford Houses.

The ACC-RBHAs allocate SUBG funds to Oxford House to provide recovery housing for members with SUD: 21 in southern Arizona, 5 in northern Arizona, and 53 in central Arizona. Each ACC-RBHA continuously works towards expansion of homes specific to priority populations such as pregnant and parenting women in recovery and their children. The ACC-RBHA in northern Arizona appears to only have included the number of Oxford Houses serving women with children. However, As of the end of SFY2023, they supported 31 Oxford Houses in the northern region. Using this number, the total number of Oxford Houses would increase to 105. A full directory of Oxford Houses in Arizona can be found at the following link https://www.oxfordhouse.org/directory_listing.php.

Oxford House utilizes outreach workers to identify areas of need when determining a location to establish additional housing. Outreach workers strategically meet with community stakeholders, government officials, and consumers to share availability and opening of new housing opportunities for women with children. Outreach workers' efforts include attending community coalitions, meetings with the public and professionals, presentations, identifying and renting suitable homes, recruiting residents, and teaching them the standard operating procedures. In addition, outreach workers provide coordinators for treatment providers to communicate availabilities of beds in homes. ACC-RBHA Care1st has collaborated with organizations in Mohave and Yavapai counties, Royal Life Centers and Mohave Substance Treatment Education & Prevention Partnership (MSTEPP). These outreach efforts assist Oxford House in creating community partnerships and recruiting new residents by spreading awareness of available housing and services.

Each quarter, the ACC-RBHAs work to open new houses to offer services to a wide range of individuals. The ACC-RBHAs provide quarterly technical assistance with Oxford House several times throughout the year to discuss progress, success, challenges and barriers. To ensure quality of services and compliance of the Oxford House outreach staff, the ACC-RBHAs provide annual training on the scope of the grant and other community resources. Some ACC-RBHAs like Mercy Care offer additional guidance to staff around reporting critical incidences such as relapses, arrests, overdoses, evictions etc., to coordinate with affiliated treatment stakeholders or providers.

The ACC-RBHAs work to continuously develop and progress their efforts by innovative developments such as reentry programs to allow for new members to enter Oxford House directly after incarceration. Another effort the ACC-RBHAs continually work towards is to collaborate with local organizations within their GSAs to improve treatment and recovery opportunities and events for members. Each ACC-RBHA also work towards creating housing for specific populations such as women and children and LGBTQIA+ friendly housing.

Similar to the work of ACC-RBHAs, the Pascua Yaqui Tribe (PYT) TRBHA currently supports members by referring them to resources offered by social services or halfway housing. PYT recently learned about a not-for-profit called Casa Maria which offered affordable

housing in south Tucson. PYT TRBHA plans to conduct site visits to determine if Casa Maria would be of benefit to members in need of housing.

Indicator #:	2
Indicator:	The number of non Title XIX childcare claims coded T1009 and/or funded alternatively through SABG.
Baseline Measurement:	For SFY2021, there were 0 documented requests for reimbursable childcare services.
First-year target/outcome measurement:	By the end of SFY2022, there will be 25 documented requests for reimbursable childcare services.
Second-year target/outcome measurement:	By the end of SFY2023, there will be 100 documented requests for reimbursable childcare services.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

AHCCCS claims and encounter data, and contract deliverable to AHCCCS

New Data Source*(if needed)*:

Description of Data:

Requests for reimbursable childcare services maybe documented in claims data or other contract deliverables.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:
The first-year target for this indicator was "By the end of SFY2022, there will be 25 documented requests for reimbursable childcare services." This target was not met, as there were 0 documented requests for reimbursable childcare services, as measured by the Non-Title XIX childcare claims coded T1009 and/or funded alternatively through SABG. However, other non-encounterable childcare services may have been offered as described below.

The following efforts are reported:

To increase the number of individuals with substance use disorders who have access to ongoing stable housing and childcare our strategies were to increase the funding invested in Oxford Houses, educate and encourage the participation of services providers in the closed loop referral system, leveraging supported housing opportunities provided through the Statewide Housing Administrator, alleviate barriers to accessing childcare and expand capacity to supported independent living programs.

Outreach

Arizona leverages the State Pilot Grant Program for Pregnant and Postpartum Women (PPW-PLT) to support family-based services for pregnant and postpartum women with a primary diagnosis of a SUD, including opioid use disorders (OUD). The outreach portion includes addressing the continuum of care for women such as promoting a coordinated, effective and efficient state system by encouraging new approaches and models of service delivery.

Collaborations

As Arizona leverages the PPW-PLT program, there is ongoing collaboration across the state to promote a coordinated, effective, and efficient state system for women with SUD and their children. In collaboration with the PPW-PLT, Arizona State University implemented a Project ECHO (Extension for Community Healthcare Outcomes). This ECHO is called the Substance Use Disorder Treatment for Women

ECHO linking expert specialist teams with primary care physicians in local communities. The PPW-PLT also connects with the RBHAs throughout the State to promote the use of the code T1009 in order to best integrate child sitting services into their practices and utilize the code to best support the needs of women and children.

Targeted Interventions

One TRBHA recently opened a women's behavioral health residential facility consisting of 10 beds. They offer groups and classes for supportive employment and provide childcare when needed.

Other efforts for the PPW-PLT program include utilizing and re-working AHCCCS' Standard of Care (SOC) for PPW across the state, this includes requiring universal screening using one of the tools recommended by the American College of Obstetricians and Gynecologists (ACOM). AHCCCS has also finalized a contract with Arizona State University to conduct an environmental scan of providers (including peers) trained to address perinatal and postpartum depression among women with SUD and develop an online resource guide.

Outcomes

One TRBHA reported they utilized CRRSSAA funding source to provider other means of childcare, and housing assistance for Center for Hope and Arizona Women's Recovery Center.

How first year target was achieved *(optional)*:

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

The second year target "By the end of SFY2023, there will be 100 documented requests for reimbursable childcare services." was not achieved. There was 0 documented requests for reimbursable childcare services through the AHCCCS claims and encounters system. Although there has not been any documented progress using this indicator, there have been many efforts, particularly with supplemental funding, to address the barrier of childcare for parents, particularly mothers, to particulate in treatment. The following details Arizona's progress, challenges, and proposals for future changes:

The ACC-RBHAs collaborate with community stakeholders and affordable housing developers under the state's Low Income Housing Tax Credit program to encourage utilization of the Closed Loop Referral System. These partnerships develop innovative layered funding sources, such as combining housing trust funds with HOME funding, project-based housing choice vouchers, the Housing Matters to Arizona Fund created by the Arizona Health Plan's reinvestment dollars, and the Arizona Housing Fund. The ACC-RBHAs work to prioritize the most vulnerable members as it becomes available. In addition, the ACC-RBHAs allocate Non-Title XIX/XXI funding across the provider network and offer ongoing training and technical assistance to ensure proper utilization of available funding for eligible populations.

Providing childcare to members receiving SUD services has been a pertinent need and social determinant of health. The ACC-RBHA providers continually look for opportunities and programs to offer childcare to members receiving treatment. A large component that deters ACC-RBHAs to offer this service is infrastructure costs; lack of space or staff to offer a dedicated childcare program. To bolster efforts to offer childcare, ACC-RBHAs work to provide community and provider education about the advantages associated with covering the costs of childcare for families receiving SUD treatment.

In FY2023, more providers submitted claim activity for T1009 than in previous years. Furthermore, some providers have allocated funds to hire childcare specialists to assist families in supportive housing to be able to engage in treatment. In addition, more houses are allowing mothers who are receiving treatment to bring up to two children under the age of 12.

Additional efforts for providing childcare so that parents can enter treatment were implemented and include the promotion of education and training that will seek to improve the billing of T1009 code for childcare services, residential treatment facilities offering childcare directly, paying for childcare staff salary rather than billing services as a claim to the health plan.

Challenges

There are many challenges the ACC-RBHAs face including securing childcare for parenting individuals who seek treatment and services for substance use disorder. This challenge presents barriers to care due to costs and availability of childcare services outside of the provider office in order for parenting individuals to receive the care they need for recovery. The cost of childcare is not only a barrier that ACC-RBHAs face, but providers within the health plans are also faced with infrastructure challenges that disallow childcare friendly spaces or staff dedicated to offer the service. Providers have cited these issues as some of the leading challenges in treating adult clients who are also parenting individuals. Another factor that ACC-RBHAs face is the lack of trust members may have leaving their child in the care of provider staff. Staff who are available to provide child-watching services may not have the training, education, or time to provide age-appropriate engagement with the children they are watching. This was apparent in the ACC-RBHA AzCH PPW-PLT program where parenting individuals were not comfortable leaving their children in the care of ACC-RBHA provider staff to receive treatment services. Childcare continues to be a deterrent for accessing SUD treatment for members in all ACC-RBHAs.

In addition, the T1009 code does not have a high reimbursement rate making it less likely for a provider to complete billing for that service. The T1009 code has also been difficult to get processed through our claims system for select provider types. Lastly, the lack of knowledge regarding the availability of the T1009 Childcare Services code presents a challenge to reaching the identified goal.

Additional challenges are related to child care licensing, staffing and space costs, as well as child care program administrative requirements that are not possible within the structure and purpose of substance use disorder treatment programs.

Proposed Changes to Future Efforts:

To better meet the goal in the future, the ACC-RBHAs are committed to providing technical assistance to providers to better understand the utilization of the T1009 Childcare Services code and monitor utilization through claims data. The ACC-RBHAs will use various resources such as the Non-Title XIX/XXI Services Exhibit 19-1 from the Fee for Service Provider Billing Manual. With more knowledge about the billing code, the ACC-RBHAs anticipate an increase in the utilization of T1009 Childcare Services.

ACC-RBHAs have also proposed creating pilot programs to fund gender-specific treatment providers to better support the infrastructure for childcare and hiring qualified sitters to improve trust in patients. Incentivizing childcare providers via scholarship funding to provide services while parenting individuals are engaged in treatment may also be a viable option to improve the quality, trust, and ultimately, usage of childcare.

Overall, the ACC-RBHAs' and TRBHAs' long-term goals are to offer an option for childcare, part- or full-time, to allow parenting individuals to fully engage in treatment and improve the quality of their recovery.

How second year target was achieved *(optional)*:

Priority #: 7

Priority Area: Integration of family care and substance use treatment

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Coordinate prenatal care, postpartum care, and substance use treatment.

Objective:

Increase the number of women receiving substance use treatment who access prenatal and/or postpartum care.

Strategies to attain the goal:

1. Leverage the PPW-PLT Learning Collaborative to identify opportunities for cross sector collaboration, education, and referrals.
2. Identify a SUD screening tool or tools for providers of prenatal and postpartum treatment services that considers gender and cultural specific needs of pregnant and postpartum women.
3. Provide gender specific substance use disorder training to provider networks of both substance use disorder treatment, prenatal care, and postpartum treatment.
4. Conduct an environmental scan of providers (including peers) trained to address perinatal and postpartum depression among women with substance use disorder and develop an online resource guide.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In last 12 months, percent of pregnant women enrolled in a SUD treatment program who accessed outpatient primary medical care within 3 months prior to the delivery of a baby.

Baseline Measurement: SFY21 (7/1/20 - 6/30/21): 11.58%

First-year target/outcome measurement: By the end of SFY2022, 15% of the pregnant women with SUD will access outpatient care within 3 months prior to delivery.

Second-year target/outcome measurement: By the end of SFY2023, 25% of the pregnant women with SUD will access outpatient care within 3 months prior to delivery.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

AHCCCS recipient, claims and encounter data

New Data Source*(if needed)*:

Description of Data:

Denominator is the number of pregnant women enrolled to a SUD treatment service in the last 12 months.

New Description of Data:*(if needed)*

12/1/2023: AHCCCS is reporting this data as a preliminary report, consistent with the usual methodology. However, the data query logic is currently under review.

Data issues/caveats that affect outcome measures:

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:
The first-year target was "By the end of SFY2022, 15% of the pregnant women with SUD will access outpatient care within 3 months prior to delivery." This target was not met, as only 6.19% of the pregnant women with SUD accessed outpatient care within 3 months prior to delivery.

The following efforts were reported:

Outreach

To Increase the number of women receiving substance use treatment who access prenatal and/or postpartum care, our ACC-RBHA's, such as, AzCH-CCP continues to fund outreach positions through CODAC, both in jail and hospitals, to ensure that pregnant and parenting individuals receive priority access to behavioral health and substance use services. Additionally, the outreach positions assist pregnant and parenting individuals in receiving developmental and behavioral health services for their children, and ensure they receive treatment as a family unit.

The AzCH-CCP Maternal Child Health Team (MCH) uses a daily Notification of Pregnancy (NOP) report to identify pregnant members. The report also identifies if substance use is a risk factor. Every pregnant member identified with an SUD is assigned to a high-risk (HR) OB Care Manager and outreach is completed as soon as possible from the receipt of notification. The report also captures claims data to identify providers may be receiving services from. Members are screened for identification of high-risk factors, using a comprehensive assessment tool that covers cultural/linguistic preferences, psychosocial, nutritional, medical, and educational factors, to prevent problems that could affect birth outcomes, such as premature birth and low birth weight. Health Choice partners with providers and the PPW-PLT learning collaborative.

Mercy Care attends the PPW/PLT collaborative and publicizes the collaborative at various provider meetings (SOR Collaborative, MAT Collaborative, GMHSU Provider Meeting and the Grants Quarterly Meeting). Mercy Care sought out opportunities to present on accessing care through grant funding in FY22 for both the PPW/PLT collaborative and the Arizona Maternal Mortality Summit, solidifying formal presentation opportunities in July 2022. Both opportunities targeted community substance use providers that work with PPW and maternal physical health care providers. In FY22 Mercy Care's clinical operations department began working on the structure and purpose of newly formed Outreach, Education, and Engagement (OEE) committee. The OEE committee's mission includes reaching the PPW population to ensure access to quality care is available.

One of the TRBHAs along with their partners conduct outreach to promote prenatal care.

Another TRBHA reported that they conduct outreach to raise community awareness as well.

Collaboration

In the Southern Region, AzCH-CCP collaborates with various agencies and system partners to ensure Pregnant, and Parenting Individuals (PPI) receive appropriate SUD treatment which is inclusive of the family unit. Those collaboration efforts include partnering with direct treatment providers, law enforcement, Department of Child Safety (DCS), and the justice system. Specific collaborations include, participating in the monthly PPW-PLT learning collaborative that is designed to connect resources to support PPI, Tucson Medical Center (TMC) and CODAC collaboration ensures outreach and enrollment for PPI with SUD who have dependent children. CODAC has dedicated space at TMC to ensure PPI and babies are outreached for service while in the hospital and prior to discharge. TMC has also dedicated space for the Department of Child Services (DCS) so that TMC, CODAC, and DCS can work together to prevent removals whenever possible. AzCH-CCP collaborates with Banner University Medical Center which has implemented a Family Centered Neonatal Abstinence Syndrome (NAS) Care Program. AzCH-CCP participates in a monthly PAPN (Pregnancy, Addiction, and Parenting Newborns) Task Force meeting. The PAPN Task Force of Southern Arizona is a gathering of hospitals, law enforcement, treatment programs and community providers who offer services to those impacted by a substance use disorder. This collaboration provides monthly training to educate participants on treatment options and how to meet the needs of the PPI and their families. The PAPN collaboration has created a website with a resource guide for PPI as well and can be reviewed here: https://papnarizona.wixsite.com/resource-guide,.

AzCH-CCP collaborates with HOPE Inc. to provide outreach and engagement support to PPI in Yuma and Pima County. HOPE Inc. has standing Memorandums of Understanding (MOUs) and partnerships with the hospitals in these regions to further ensure access to care. AzCH-CCP collaborates with CODAC to offer transitional living programs for PPI and their children through the Connie Hillman House and the PPW-PLT casitas where PPI can continue their road to recovery while living in a safe and supportive environment. AzCH-CCP collaborates with Community Bridges, Inc. (CBI) to provide outreach to Pregnant and Parenting Individuals in Pinal, Pima and Yuma Counties. They provide recovery housing through CBI's Renaissance House–Women's Transition Program located in Bisbee, Cochise County provides gender-specific Substance Use Disorder Residential Treatment services to pregnant women and their children. They also received allocations to develop Rapid Recovery Housing for the opioid use and stimulant use populations in Pima and Pinal County with availability for Pregnant Individuals and babies. AzCH-CCP collaborates with Hushabye Nursery in Maricopa County for PPI active in their program. AzCH-CCP collaborates with the Maricopa County Safe, Healthy Infants and Families Thrive (SHIFT) program to support pregnant individuals with substance use disorder during their recovery. SHIFT is a collaboration of community providers dedicated to providing compassionate, family-centered substance abuse treatment services that may include but are not limited to Medication for Opioid Use Disorder (MOUD), maternal and infant care, prenatal care, home visitation, and early childhood development education.

In the Central Region, Mercy Care's GMHSU team completes an environmental scan of evidence-based practices and services for specialty populations. In the environmental scan the following agencies provide gender specific treatment and have staff that are trained to address perinatal and post-partum women's health needs; Women's Health Innovations, Southwest Behavioral Health Services, Open Hearts, New Hope Behavioral Health Center, Hushabye, Lifewell, ITS, Hopess, CleanSlate, Arizona Women's Recovery Center, and Center for Hope. Mercy Care continues to attend the ASU ECHO Substance Use Disorder Treatment for Women every other Friday to collaborate with medical providers, and community stakeholders on evidence-based practices and collaborative efforts to reach PPW populations. Mercy Care's Medical Management Department continues to provide education to OBGYN offices about the importance of screening for SUD and other risk factors through care plans. Mercy Care also provides the Edinburgh depression tool when sharing care plans with the providers.

In the Northern Region, HCA collaborates with HushaBye Nursery to provide specialized services for HCA members with babies experiencing withdrawal symptoms. HCA staff attend the PPW-PLT learning collaborative and have staff who sit on the advisory council for this collaborative.

One TRBHA reported that they work directly with Pediatrics and the Women's Health Clinic to identify and provide services to patients seeking prenatal and/or postpartum care.

Other TRBHAs report collaborating with Indian Health Services (HIS) and Hushabye Nursery, other tribal departments and WIC.

Targeted Interventions

Through the above collaborations, AzCH-CCP is able to ensure that pregnant individuals (pre- and post-partum) and their babies receive services while in the hospital, while they transition back to the community, and throughout their recovery. AzCH-CCP Maternal Child Health (MCH) team facilitates provider outreach regarding the expectation to develop an individualized plan of care, that includes completion of appropriate screenings, using American College of Obstetricians and Gynecologists (ACOG) guidelines for each Pregnant and parenting individuals identified with a history of SUD, including medication adjustment needs, evidence-based breastfeeding recommendations and precautions, and providing Narcan prescription.

AzCH-CCP MCH Team has held OB provider forums during which information regarding substance use; STI's; breastfeeding; family planning; importance of timely prenatal and postpartum care, etc. was delivered. AzCH-CCP ensures that all contracted Opioid Treatment Programs (OTPs) provide services to Pregnant and Parenting Individuals and receive SABG Funding for their OTPs to ensure there are no treatment gaps. Smart Start for Baby (SSFB®) Perinatal Management program information is mailed to all newly identified pregnant individuals within one week of notification of pregnancy as well as a Life After Delivery booklet. The information provided in the booklet educates and targets specific ways to manage a healthy pregnancy, which in turn creates a healthy baby. Topics include tobacco cessation (ASHLine, etc.); avoidance of alcohol and other harmful substances, including illegal drugs (e.g., opioids); low birth/very low birth weight; breastfeeding; deliveries; pregnancy spacing/family planning; safe sleep; etc.

HCA has added providers to the network who serve pregnant and parenting women and provide specialized programs or services to meet the unique needs of this population. These providers include sober living providers and residential treatment providers. Parenting skills training and support are offered at all Health Homes for any member identified as parenting and/or pregnant. Multiple specialized service providers accept pregnant or parenting women, with or without their dependent children, into residential treatment exist within the HCA network. These providers are utilized as necessary to meet the needs of this specialized population.

Mercy Care provided targeted education to subrecipients around SAMHSA's Treatment Improvement Protocol (TIP) 51 – Substance Abuse Treatment: Addressing the specific needs of women. This Treatment Improvement Protocol (TIP) includes practical content and strategies for subrecipient programs to incorporate into their service offerings. Mercy Care meets with SABG providers for an annual site visit which using a scoring tool to assess adherence to SABG requirements and provides guidance and recommendations on connection to physical healthcare, interim services, and educational material on infectious diseases, treatment, pregnancy and MAT, posted in lobby and website if possible. One of Mercy Cares providers, Arizona Women's Recovery Center (AWRC), identified that pregnant and post-partum clients meet with a health coach, case manager and benefits staff within the first two days of treatment to set up OBGYN care. All AWRC's groups and treatment are gender specific, including group and individual counseling, DBT group, trauma group and some ancillary groups such as parenting, yoga, art, hiking).

One TRBHA reports a program called Baby Smarts, which provides on-site assessment and referral.

Meanwhile, another TRBHA's New Beginnings MAT program reports four females that were pregnant last year receiving SUD services. They expanded outreach services for PPW populations through SABG Supplemental funding for several providers including; Community Bridges, Alium, Hushabye, Ebony House, Native American Connections, Arizona Women's Recovery Center, Southwest Behavioral Health, Valle Del Sol, and Oxford House.

Other Efforts or Information

One provider, CODAC, implements a 24/7 Medications for Opioid Use Disorder (MOUD) clinic, offering OB/GYN and wellness services in addition to SUD treatment to ensure they are meeting the needs of PPI. AzCH-CCP contracts with The Haven to provide Behavioral Health Residential, Intensive Outpatient and Outpatient services to PPI. The residential program provides a registered nurse on duty seven (7) days a week to provide nursing assessments, linkages to pre-natal and postpartum care, and assistance with adherence to any treatments. The intensive outpatient treatment program provides recovery coaches who assist with linking PPIs to pre-natal and postpartum care and with helping them access services for their children. Additionally, they can ensure that the PPIs are connected to parenting classes. CBI increased outreach workers in Pinal County to assist with bridging our Pregnant Individuals with the hospitals. AzCH-CCP partners with Oxford House recovery housing by allocating grant funds for the expansion of recovery homes to include homes specific to PPIs in recovery and their children. Currently, Oxford House has houses available to PPIs in Pima and Pinal counties. In accordance with the Governor's Taskforce on Preventing Prenatal Exposure to Substances and/or prescribed controlled medications, the AzCH-CCP MCH Team closely monitors high-risk members. Members follow up is completed by the MCH Team to ensure that members are being offered education and appropriate services to address any presenting concerns to ensure a healthy pregnancy and decrease Neonatal Abstinence Syndrome (NAS). All pregnant and parenting individuals who have been enrolled in the Smart Start for Baby (SSFB®) Perinatal Management program due to a high-risk pregnancy receive a follow up phone contact by their High-Risk OB CM within 3 days after discharge and as needed throughout the postpartum period. Staff complete a postpartum assessment to obtain information about the member's delivery and identify any potential risk factors and/or concerns. If SUD has been identified, the CM provides non-judgmental support and connect members with resources/referral which may include medically supervised detox, residential treatment, or IOP where moms and babies can stay together. Care Management can assist members in coordinating referral/transportation for MOUD and other services.

HCA maintains a maternal care management where nurses provide condition-specific education and assist pregnant women in obtain the medical, behavioral, social, and community resources they need during the pregnant and post-partum period. Mercy Care also provides education on women's health needs on the following websites:

https://www.mercycareaz.org/wellness/womenshealth
https://www.mercycareaz.org/wellness/opioids.

One TRBHA reports increased recruiting for qualified staff have been other efforts and another TRBHA reported that their nursing staff also promotes overall health among SUD members including PPI.

Outcomes Measured:

ACC-RBHAs report outcome measures in various ways.

AzCH-CCP monitors on a quarterly basis. They have several measures for timeliness of prenatal and postpartum care, members with SUD who are enrolled in CM, infants born with low/very low birth weight, NAS deliveries and NICU admits/readmits. They also have annual monitoring as well for the effectiveness of Maternity Child Health (MCH) Program strategies, interventions and activities designed to improve health outcomes for pregnant and postpartum members. Identified opportunities for improvement are considered for inclusion in next year's Maternity Care Program work plan. AzCH-CCP monitors outcomes for the Pregnant and Parenting Individual transitional

living programs, Connie Hillman House and PPW-PLT that include number of individuals served, successful/unsuccessful discharges, DCS removal likely avoided, individual currently in program, and children living on site. AzCH-CCP also implements monthly outcome measures for outreach positions dedication through SABG funds for Pregnant and Parenting Individuals in Detention and Hospital facilities to monitor engagement, enrollments, barriers, and successes. HCA has examined the number of pregnant members receiving SABG-funded treatment services. This population continues to be one of the smallest categories of SABG members, remaining consistent with prior years. Mercy Care Increased utilization of services for PPW population, provider process/policies for PPW coordination and access to medical care, increased stable housing placement options for PPW, identified additional outreach/collaboration opportunities.

TRBHAs report additional outcome measures are tracked such as report measures such as number of referrals for BHS services and number of enrollment by important demographics such as sex/gender. One TRBHA reported that there were 91 females enrolled in services with a SUD diagnosis.

Progress/Barriers Identified

AzCH reports progress such as improved network of resources through collaborations, increase in outreach positions specific to the PPI population to ensure engagement and support for treatment services, increase in knowledge that improved outcomes for PPI occur when treatment is family focused as opposed to individual as evidenced by the trainings provided through the various collaborations. Barriers were, PPI with SUD can be a difficult population to outreach and engage, often our Non-title pregnant and parenting population will meet criteria for AHCCCS and due to 42 CFR guidelines, it can be difficult to obtain a Release of Information to work with other providers directly.

HCA reported that there are a limited number of residential providers who specialize in serving PPW in the Northern GSA. HCA continues to monitor population health and needs of PPW to determine if or when a specialized provider needs to open a facility to exclusively serve PPW.

Mercy Care reported that funding through CRRSAA initiatives has allowed providers to fill some of the gaps of care including outreach and provided opportunity for them to expand services to meet the demand. Barriers were women who are ineligible for Medicaid and cannot afford medical insurance or don't qualify for it often need medical and prenatal care that can be difficult to find even when they have high risk pregnancies. SABG funding does not cover these types of services, which often fragments or prevents care all together. It would be incredibly helpful to allocate some funding for medical care to certain priority populations (Pregnant and IV drug users) to increase integrated and whole health care that is needed for these populations. There is a need to identify new ways to collaborate and meet with women's physical health providers, trying to schedule time with them can be difficult. However, collaboration efforts with the Arizona State University (ASU) ECHO project for PPW/PPI have been promising since many providers attend and receive CME credit.

One TRBHA reported progress such as having a BHS staff member embedded in the Pediatrics department. They found barriers were that it was challenging to find a qualified LCSW for the Behavioral Health Clinical Consultant position and second case manager.

Another TRBHA reported that the COVID-19 pandemic slowed things down, but this population of women received prenatal care.

Another TRBHA reported progress of development of relationships across community stakeholders; awareness in the community. Barriers were social determinants of health and community awareness of resources.

Success Stories Shared

ACC-RBHAs and TRBHA reported success stories as well.

A transitional living program participant stated when the member entered the program and in early recovery, pregnant and working with DCS to get her older daughter back. Members showed strong motivation and dedication to the program and support and utilized what PPW had to offer. This member has maintained her sobriety, graduated IOP and continues to attend support groups voluntarily. The member gave birth to a baby boy while in the program and was able to bring the baby home with her after his stay in the hospital, soon after her daughter was placed with her. Her DCS case is about to be successfully closed. The member has found daycare for her children, and signed up for services including a job training program, which she started in November 2020. The member's next goal is to find employment and start saving money to move into independent living.

Another success story was when entering the program, a member had just given birth to her son and became a first-time mom (getting to bring baby home with her). In the beginning she struggled with being a mom and with the responsibility it entailed. She avoided staff and other residents, kept to herself, avoided the DCS investigator, and showed very little interest in wanting to engage in the support and services offered to her. She also relapsed shortly after joining the program. Things changed after her relapse. She followed through with recommendation from staff and treatment interventions put in place to address relapse and support her recovery. Since her relapse she has shown that motivation to pursue and continue her recovery journey and that she wants to be a "good mom." She has maintained sobriety, built a relationship with her Peer Support Specialist (PSS), and took a chance to trust the childcare worker and that showed growth. The member contacted her DCS case worker and ultimately the case was closed, after they investigated the PPW program and members living arrangements and noted that despite member having a relapse after entering the program, she had all the support and services in place for her and her son and there was no need for an ongoing case. The member has graduated IOP programming. She is now seeking daycare for her son, so she can focus on gaining employment. She has been able to keep a clean apartment, establish a

schedule with PSS and childcare worker for support with childcare and 1:1 follow up check ins. As of November 2020, she has been trying to quit smoking, has gone 2 days so far without a cigarette, and will be working with a PSS 1:1 to continue along her smoking cessation path.

AzCH-CCP reports that a pregnant member who had achieved sobriety with the use of Medications for Opioid Use Disorder (MOUD), shortly thereafter found out she was pregnant. AzCH-CCP HR OB engaged her in Care Management services. She faced several hurdles during her pregnancy and her journey to maintain sobriety. Not long after finding sobriety, member's brother died from a substance overdose. AzCH-CCP CM assisted members in connecting with behavioral health services which included individual therapy services in addition to MOUD services. Member lives in a very rural area and consistently faces barriers with transportation to her daily MOUD dosing. AzCH-CCP CM collaborated with the MOUD and transportation providers to ensure members did not miss any doses. Another identified solution was a family member began providing her with transportation for which they utilized the family reimbursement program. Despite all the barriers and complications with her pregnancy, she was able to maintain sobriety and carry the baby to full term. The baby did show mild signs of NAS, so the member was able to provide breastmilk while baby was in the NICU. AzCH-CCP CM continued to work with the mother and providers to develop an individualized plan of care including medication adjustment needs, evidence-based breastfeeding recommendations and precautions, and providing Narcan prescription.

Another success story is reported by the Arizona Women's Recovery Center:

"At Sally's Place through AWRC a client came to our Agency directly from jail on MAT services. The client was helped by staff in contacting Dr. Maria Manriquez at Banner Health to obtain OB/GYN services as well as her expertise with pregnancy and opiates. The client was quiet and withdrawn for her first few months of treatment but persisted. After the birth of her baby the client utilized Hushaby Nursery to monitor her days old daughter for withdrawal. It was at this time that the client began participating fully in treatment and became a leader in the Sally's Place community. The client regained the trust of her family and was able to begin co-parenting her 3-year-old. The client moved into Thelma's House upon its opening in August of 2022. The client is currently working as a Certified Peer Support in a treatment facility and cares for her 2 young daughters."

How first year target was achieved *(optional)*:

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

The second year target "By the end of SFY2023, 25% of the pregnant women with SUD will access outpatient care within 3 months prior to delivery" was not met. Although there was an increase from last fiscal year, only 23.08% of pregnant women with SUD accessed outpatient care within 3 months prior to delivery. The following details Arizona's progress, challenges, and proposals for future changes:

n the ACC-RBHAs' efforts to focus on pregnant and parenting individuals (PPIs) and ensuring this population receives priority access to behavioral health and substance use services, the ACC-RBHAs continue to fund outreach positions through gender specific treatment providers. The outreach positions assist PPIs in receiving developmental and behavioral health services for their children, and ensure they receive treatment as a family unit.

The ACC-RBHAs work collaboratively with other teams to identify pregnant members who use substances. Every pregnant member identified is assigned to a high-risk obstetric Care Manager and outreach is completed as soon as possible from the receipt of notification. The report also captures claims data to identify providers that members may already be receiving services from. Members are screened for identification of high-risk factors, using a comprehensive assessment tool that covers cultural/linguistic preferences, psychosocial, nutritional, medical, and educational factors, to prevent problems that could affect birth outcomes, such as premature birth and low birth weight. After delivery, individuals are outreached within three business days to discuss the importance of postpartum follow-up and the baby's one month well child visit appointment. Community resources are provided as needed to ensure PPIs remain connected with support and services.

The ACC-RBHAs collaborate with various agencies and system partners to ensure PPIs receive appropriate SUD treatment inclusive of the family unit. Those efforts include partnering with direct treatment providers, law enforcement, DCS, and the Justice system. Hushabye Nursery is an example of a partnership in the community geared towards PPIs. The program provides pre- and post-natal education and support to families impacted by substance use and trauma. The work primarily surrounds ensuring that infants are discharged to empowered and loving caregivers. In addition, PPIs work with peer mentors and team to support their newborn(s) throughout the withdrawal process and if necessary, create a child services plan to avoid removal or work toward reunification.

Another effort towards engaging this population is offering 24/7 Medications for Opioid Use Disorder (MOUD) clinic that provides both OB/GYN and wellness services in addition to SUD treatment to meet the needs of PPIs. To provide a holistic approach, the ACC-RBHAs work with various subcontractors to provide Behavioral Health Residential, Intensive Outpatient and Outpatient services to PPIs. The residential program staffs a registered nurse to provide assessments, linkages to pre-natal and postpartum care, and assistance with adherence to treatment.

ACC-RBHAs also work to collaborate and connect with PPIs on tribal reservations by subcontracting providers with designated Peer Navigators for the PPI population. Through SAMHSA supplemental funding, the ACC-RBHAs hope to expand outreach and access to

care with providers for members in tribal reservations, justice involved population, and PPIs. Utilizing a braided funding system, the outreach will impact and increase the utilization of SUBG treatment services for these populations. The ACC-RBHAs continue working to allocate supplemental funding for gender specific treatment, outreach, and housing.

In 2023, the ACC-RBHAs implemented and achieved some successes including referring PPIs to enter the PPW-PLT program to encourage family reunification. ACC-RBHAs have also been able to outreach more PPIs to engage them in treatment services through the use of cultural and linguistically appropriate materials that encourage patients to receive care. Through collaborations, the ACC-RBHAs work to ensure our pregnant individuals (pre- and post-partum) and their babies receive services while in the hospital, while they transition back to the community, and throughout their recovery before and after delivery of their babies.

Additionally, the TRBHAs work to identify PPIs in need of not only behavioral health services, but also medical services. The TRBHAs implement integrated health services to tribal members. These integrated teams work to identify and engage patients seeking prenatal and/or postpartum care.

Challenges

A main challenge for ACC-RBHAs to provide services is outreaching, identifying, and engaging PPIs with SUD. Since this population is often covered under Medicaid; many PPIs do not seek out or need to utilize SUBG funding. Women who are ineligible for Medicaid and cannot afford medical insurance or do not qualify for it often need medical and prenatal care that can be difficult to find even when they have high risk pregnancies. SUBG funding does not cover these types of services, which often fragments or prevents care. The ACC -RBHAs also only have limited insight on prenatal or postpartum claim activity for individuals covered by commercial payors or alternative titled plans, making effective tracking of this objective difficult to comprehensively validate. Another challenge is follow-up as staying in contact with the members throughout their pregnancy and postpartum is difficult. Care managers consistently reach out and make contact to provide on-going education to the members, however, there continues to be perceived fear of mothers losing their children due to mandated reporting or substance use. The TRBHAs face similar challenges such as individuals who refuse comprehensive medical and counseling MAT services as they seek out more preferred quicker solutions instead. Overall, patient engagement and lack of trust with healthcare providers on and off the tribal lands result in on-going challenges for these communities.

Proposed Changes to Future Efforts:

The ACC-RBHAs provide a holistic approach and work with providers through monthly non-title XIX/XXI Provider meetings, quarterly SUD Provider meeting, and individual technical assistance meeting to identify new barriers and challenges in providing services to this population. ACC-RBHAs will monitor their funding allocations to provide care for certain priority populations (pregnancy, IV drug users) to increase integrated and whole health care. In addition, ACC-RBHAs work collaboratively in their communities with various organizations to improve care and connect PPIs to care if needed. These partnerships may help reinforce the importance of stigma-reduction and treatment advocacy. As an agency-wide change, AHCCCS may consider establishing a dashboard which comprehensively identifies AHCCCS-covered activity for members who fall into these populations (i.e., prenatal care & postpartum care). Creating and implementing trainings geared towards the Department of Child Safety (DCS) staff on perinatal harm reduction, resources, collaboration, and partnership may also be helpful in keeping families together and establishing trust for PPIs with SUD.

One TRBHA reports that there are future efforts to re-evaluate MAT and Health Psychology services and referrals. Since the need to increase health literacy, engagement, and rapport building between providers and members on tribal reservations is at the forefront, the TRBHA hopes to launch a health education campaign in the future.

How second year target was achieved *(optional)*:

Indicator #:	2
Indicator:	In last 12 months, percent of pregnant women admitted to SUD treatment service who accessed outpatient care within 3 months after the delivery of a baby.
Baseline Measurement:	SFY21 (7/1/20 - 6/30/21): 92.75%
First-year target/outcome measurement:	By the end of SFY2022, 94% of the women in SUD treatment who gave birth will receive outpatient care within 3 months following delivery.
Second-year target/outcome measurement:	By the end of SFY2023, 95% of the women in SUD treatment who gave birth will receive outpatient care within 3 months following delivery.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

AHCCCS recipient, claims and encounter data

New Data Source*(if needed)*:

Description of Data:

Denominator is the number of pregnant women admitted to a SUD treatment service who gave birth in the last 12 months.

New Description of Data:*(if needed)*

SFY22 AHCCCS data team reports that the baseline data and first-year outcome data likely had different parameters, which likely contributes to the discrepancy between baseline and first-year outcome.

12/1/2023: AHCCCS is reporting this data as a preliminary report, consistent with the usual methodology. However, the data query logic is currently under review.

Data issues/caveats that affect outcome measures:

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:
The first-year indicator was "By the end of SFY2022, 94% of the women in SUD treatment who gave birth will receive outpatient care within 3 months following delivery." This target was not met, as only 15% of women in SUD treatment who gave birth received outpatient care within 3 months following delivery.

The following efforts were reported:

Outreach

To Increase the number of women receiving substance use treatment who access prenatal and/or postpartum care, our ACC-RBHA's, such as, AzCH-CCP continues to fund outreach positions through CODAC, both in jail and hospitals, to ensure that pregnant and parenting individuals receive priority access to behavioral health and substance use services. Additionally, the outreach positions assist pregnant and parenting individuals in receiving developmental and behavioral health services for their children, and ensure they receive treatment as a family unit.

The AzCH-CCP Maternal Child Health Team (MCH) uses a daily Notification of Pregnancy (NOP) report to identify pregnant members. The report also identifies if substance use is a risk factor. Every pregnant member identified with an SUD is assigned to a high-risk (HR) OB Care Manager and outreach is completed as soon as possible from the receipt of notification. The report also captures claims data to identify providers may be receiving services from. Members are screened for identification of high-risk factors, using a comprehensive assessment tool that covers cultural/linguistic preferences, psychosocial, nutritional, medical, and educational factors, to prevent problems that could affect birth outcomes, such as premature birth and low birth weight. Health Choice partners with providers and the PPW-PLT learning collaborative.

Mercy Care attends the PPW/PLT collaborative and publicizes the collaborative at various provider meetings (SOR Collaborative, MAT Collaborative, GMHSU Provider Meeting and the Grants Quarterly Meeting). Mercy Care sought out opportunities to present on accessing care through grant funding in FY22 for both the PPW/PLT collaborative and the Arizona Maternal Mortality Summit, solidifying formal presentation opportunities in July 2022. Both opportunities targeted community substance use providers that work with PPW and maternal physical health care providers. In FY22 Mercy Care's clinical operations department began working on the structure and purpose of newly formed Outreach, Education, and Engagement (OEE) committee. The OEE committee's mission includes reaching the PPW population to ensure access to quality care is available.

One of the TRBHAs along with their partners conduct outreach to promote prenatal care.

Another TRBHA reported that they conduct outreach to raise community awareness as well.

Collaboration

In the Southern Region, AzCH-CCP collaborates with various agencies and system partners to ensure Pregnant, and Parenting Individuals (PPI) receive appropriate SUD treatment which is inclusive of the family unit. Those collaboration efforts include partnering with direct treatment providers, law enforcement, Department of Child Safety (DCS), and the justice system. Specific collaborations include,

participating in the monthly PPW-PLT learning collaborative that is designed to connect resources to support PPI, Tucson Medical Center (TMC) and CODAC collaboration ensures outreach and enrollment for PPI with SUD who have dependent children. CODAC has dedicated space at TMC to ensure PPI and babies are outreached for service while in the hospital and prior to discharge. TMC has also dedicated space for the Department of Child Services (DCS) so that TMC, CODAC, and DCS can work together to prevent removals whenever possible. AzCH-CCP collaborates with Banner University Medical Center which has implemented a Family Centered Neonatal Abstinence Syndrome (NAS) Care Program. AzCH-CCP participates in a monthly PAPN (Pregnancy, Addiction, and Parenting Newborns) Task Force meeting. The PAPN Task Force of Southern Arizona is a gathering of hospitals, law enforcement, treatment programs and community providers who offer services to those impacted by a substance use disorder. This collaboration provides monthly training to educate participants on treatment options and how to meet the needs of the PPI and their families. The PAPN collaboration has created a website with a resource guide for PPI as well and can be reviewed here: https://papnarizona.wixsite.com/resource-guide,.

AzCH-CCP collaborates with HOPE Inc. to provide outreach and engagement support to PPI in Yuma and Pima County. HOPE Inc. has standing Memorandums of Understanding (MOUs) and partnerships with the hospitals in these regions to further ensure access to care. AzCH-CCP collaborates with CODAC to offer transitional living programs for PPI and their children through the Connie Hillman House and the PPW-PLT casitas where PPI can continue their road to recovery while living in a safe and supportive environment. AzCH-CCP collaborates with Community Bridges, Inc. (CBI) to provide outreach to Pregnant and Parenting Individuals in Pinal, Pima and Yuma Counties. They provide recovery housing through CBI's Renaissance House–Women's Transition Program located in Bisbee, Cochise County provides gender-specific Substance Use Disorder Residential Treatment services to pregnant women and their children. They also received allocations to develop Rapid Recovery Housing for the opioid use and stimulant use populations in Pima and Pinal County with availability for Pregnant Individuals and babies. AzCH-CCP collaborates with Hushabye Nursery in Maricopa County for PPI active in their program. AzCH-CCP collaborates with the Maricopa County Safe, Healthy Infants and Families Thrive (SHIFT) program to support pregnant individuals with substance use disorder during their recovery. SHIFT is a collaboration of community providers dedicated to providing compassionate, family-centered substance abuse treatment services that may include but are not limited to Medication for Opioid Use Disorder (MOUD), maternal and infant care, prenatal care, home visitation, and early childhood development education.

In the Central Region, Mercy Care's GMHSU team completes an environmental scan of evidence-based practices and services for specialty populations. In the environmental scan the following agencies provide gender specific treatment and have staff that are trained to address perinatal and post-partum women's health needs; Women's Health Innovations, Southwest Behavioral Health Services, Open Hearts, New Hope Behavioral Health Center, Hushabye, Lifewell, ITS, Hopess, CleanSlate, Arizona Women's Recovery Center, and Center for Hope. Mercy Care continues to attend the ASU ECHO Substance Use Disorder Treatment for Women every other Friday to collaborate with medical providers, and community stakeholders on evidence-based practices and collaborative efforts to reach PPW populations. Mercy Care's Medical Management Department continues to provide education to OBGYN offices about the importance of screening for SUD and other risk factors through care plans. Mercy Care also provides the Edinburgh depression tool when sharing care plans with the providers.

In the Northern Region, HCA collaborates with HushaBye Nursery to provide specialized services for HCA members with babies experiencing withdrawal symptoms. HCA staff attend the PPW-PLT learning collaborative and have staff who sit on the advisory council for this collaborative.

One TRBHA reported that they work directly with Pediatrics and the Women's Health Clinic to identify and provide services to patients seeking prenatal and/or postpartum care.

Other TRBHAs report collaborating with Indian Health Services (HIS) and Hushabye Nursery, other tribal departments and WIC.

Targeted Interventions

Through the above collaborations, AzCH-CCP is able to ensure that pregnant individuals (pre- and post-partum) and their babies receive services while in the hospital, while they transition back to the community, and throughout their recovery. AzCH-CCP Maternal Child Health (MCH) team facilitates provider outreach regarding the expectation to develop an individualized plan of care, that includes completion of appropriate screenings, using American College of Obstetricians and Gynecologists (ACOG) guidelines for each Pregnant and parenting individuals identified with a history of SUD, including medication adjustment needs, evidence-based breastfeeding recommendations and precautions, and providing Narcan prescription.

AzCH-CCP MCH Team has held OB provider forums during which information regarding substance use; STI's; breastfeeding; family planning; importance of timely prenatal and postpartum care, etc. was delivered. AzCH-CCP ensures that all contracted Opioid Treatment Programs (OTPs) provide services to Pregnant and Parenting Individuals and receive SABG Funding for their OTPs to ensure there are no treatment gaps. Smart Start for Baby (SSFB®) Perinatal Management program information is mailed to all newly identified pregnant individuals within one week of notification of pregnancy as well as a Life After Delivery booklet. The information provided in the booklet educates and targets specific ways to manage a healthy pregnancy, which in turn creates a healthy baby. Topics include tobacco cessation (ASHLine, etc.); avoidance of alcohol and other harmful substances, including illegal drugs (e.g., opioids); low birth/very low birth weight; breastfeeding; deliveries; pregnancy spacing/family planning; safe sleep; etc.

HCA has added providers to the network who serve pregnant and parenting women and provide specialized programs or services to meet the unique needs of this population. These providers include sober living providers and residential treatment providers. Parenting skills training and support are offered at all Health Homes for any member identified as parenting and/or pregnant. Multiple specialized service

providers accept pregnant or parenting women, with or without their dependent children, into residential treatment exist within the HCA network. These providers are utilized as necessary to meet the needs of this specialized population.

Mercy Care provided targeted education to subrecipients around SAMHSA's Treatment Improvement Protocol (TIP) 51 – Substance Abuse Treatment: Addressing the specific needs of women. This Treatment Improvement Protocol (TIP) includes practical content and strategies for subrecipient programs to incorporate into their service offerings. Mercy Care meets with SABG providers for an annual site visit which using a scoring tool to assess adherence to SABG requirements and provides guidance and recommendations on connection to physical healthcare, interim services, and educational material on infectious diseases, treatment, pregnancy and MAT, posted in lobby and website if possible. One of Mercy Cares providers, Arizona Women's Recovery Center (AWRC), identified that pregnant and post-partum clients meet with a health coach, case manager and benefits staff within the first two days of treatment to set up OBGYN care. All AWRC's groups and treatment are gender specific, including group and individual counseling, DBT group, trauma group and some ancillary groups such as parenting, yoga, art, hiking).

One TRBHA reports a program called Baby Smarts, which provides on-site assessment and referral.

Meanwhile, another TRBHA's New Beginnings MAT program reports four females that were pregnant last year receiving SUD services. They expanded outreach services for PPW populations through SABG Supplemental funding for several providers including; Community Bridges, Alium, Hushabye, Ebony House, Native American Connections, Arizona Women's Recovery Center, Southwest Behavioral Health, Valle Del Sol, and Oxford House.

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treatment services. This population continues to be one of the smallest categories of SABG members, remaining consistent with prior years. Mercy Care Increased utilization of services for PPW population, provider process/policies for PPW coordination and access to medical care, increased stable housing placement options for PPW, identified additional outreach/collaboration opportunities.

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AzCH reports progress such as improved network of resources through collaborations, increase in outreach positions specific to the PPI population to ensure engagement and support for treatment services, increase in knowledge that improved outcomes for PPI occur when treatment is family focused as opposed to individual as evidenced by the trainings provided through the various collaborations. Barriers were, PPI with SUD can be a difficult population to outreach and engage, often our Non-title pregnant and parenting population will meet criteria for AHCCCS and due to 42 CFR guidelines, it can be difficult to obtain a Release of Information to work with other providers directly.

HCA reported that there are a limited number of residential providers who specialize in serving PPW in the Northern GSA. HCA continues to monitor population health and needs of PPW to determine if or when a specialized provider needs to open a facility to exclusively serve PPW.

Mercy Care reported that funding through CRRSAA initiatives has allowed providers to fill some of the gaps of care including outreach and provided opportunity for them to expand services to meet the demand. Barriers were women who are ineligible for Medicaid and cannot afford medical insurance or don't qualify for it often need medical and prenatal care that can be difficult to find even when they have high risk pregnancies. SABG funding does not cover these types of services, which often fragments or prevents care all together. It would be incredibly helpful to allocate some funding for medical care to certain priority populations (Pregnant and IV drug users) to increase integrated and whole health care that is needed for these populations. There is a need to identify new ways to collaborate and meet with women's physical health providers, trying to schedule time with them can be difficult. However, collaboration efforts with the Arizona State University (ASU) ECHO project for PPW/PPI have been promising since many providers attend and receive CME credit.

One TRBHA reported progress such as having a BHS staff member embedded in the Pediatrics department. They found barriers were that it was challenging to find a qualified LCSW for the Behavioral Health Clinical Consultant position and second case manager.

Another TRBHA reported that the COVID-19 pandemic slowed things down, but this population of women received prenatal care.

Another TRBHA reported progress of development of relationships across community stakeholders; awareness in the community. Barriers were social determinants of health and community awareness of resources.

Success Stories Shared

ACC-RBHAs and TRBHA reported success stories as well.

A transitional living program participant stated when the member entered the program and in early recovery, pregnant and working with DCS to get her older daughter back. Members showed strong motivation and dedication to the program and support and utilized what PPW had to offer. This member has maintained her sobriety, graduated IOP and continues to attend support groups voluntarily. The member gave birth to a baby boy while in the program and was able to bring the baby home with her after his stay in the hospital, soon after her daughter was placed with her. Her DCS case is about to be successfully closed. The member has found daycare for her children, and signed up for services including a job training program, which she started in November 2020. The member's next goal is to find employment and start saving money to move into independent living.

Another success story was when entering the program, a member had just given birth to her son and became a first-time mom (getting to bring baby home with her). In the beginning she struggled with being a mom and with the responsibility it entailed. She avoided staff and other residents, kept to herself, avoided the DCS investigator, and showed very little interest in wanting to engage in the support and services offered to her. She also relapsed shortly after joining the program. Things changed after her relapse. She followed through with recommendation from staff and treatment interventions put in place to address relapse and support her recovery. Since her relapse she has shown that motivation to pursue and continue her recovery journey and that she wants to be a "good mom." She has maintained sobriety, built a relationship with her Peer Support Specialist (PSS), and took a chance to trust the childcare worker and that showed growth. The member contacted her DCS case worker and ultimately the case was closed, after they investigated the PPW program and members living arrangements and noted that despite member having a relapse after entering the program, she had all the support and services in place for her and her son and there was no need for an ongoing case. The member has graduated IOP programming. She is now seeking daycare for her son, so she can focus on gaining employment. She has been able to keep a clean apartment, establish a schedule with PSS and childcare worker for support with childcare and 1:1 follow up check ins. As of November 2020, she has been trying to quit smoking, has gone 2 days so far without a cigarette, and will be working with a PSS 1:1 to continue along her smoking cessation path.

AzCH-CCP reports that a pregnant member who had achieved sobriety with the use of Medications for Opioid Use Disorder (MOUD), shortly thereafter found out she was pregnant. AzCH-CCP HR OB engaged her in Care Management services. She faced several hurdles during her pregnancy and her journey to maintain sobriety. Not long after finding sobriety, member's brother died from a substance overdose. AzCH-CCP CM assisted members in connecting with behavioral health services which included individual therapy services in addition to MOUD services. Member lives in a very rural area and consistently faces barriers with transportation to her daily MOUD dosing. AzCH-CCP CM collaborated with the MOUD and transportation providers to ensure members did not miss any doses. Another identified solution was a family member began providing her with transportation for which they utilized the family reimbursement program. Despite all the barriers and complications with her pregnancy, she was able to maintain sobriety and carry the baby to full term. The baby did show mild signs of NAS, so the member was able to provide breastmilk while baby was in the NICU. AzCH-CCP CM continued to work with the mother and providers to develop an individualized plan of care including medication adjustment needs, evidence-based breastfeeding recommendations and precautions, and providing Narcan prescription.

Another success story is reported by the Arizona Women's Recovery Center:

"At Sally's Place through AWRC a client came to our Agency directly from jail on MAT services. The client was helped by staff in contacting Dr. Maria Manriquez at Banner Health to obtain OB/GYN services as well as her expertise with pregnancy and opiates. The client was quiet and withdrawn for her first few months of treatment but persisted. After the birth of her baby the client utilized Hushaby Nursery to monitor her days old daughter for withdrawal. It was at this time that the client began participating fully in treatment and became a leader in the Sally's Place community. The client regained the trust of her family and was able to begin co-parenting her 3-year-old. The client moved into Thelma's House upon its opening in August of 2022. The client is currently working as a Certified Peer Support in a treatment facility and cares for her 2 young daughters."

How first year target was achieved *(optional)*:

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

The second year target "By the end of SFY2023, 95% of the women in SUD treatment who gave birth will receive outpatient care within 3 months following delivery." was not met. Although there was an increase from last fiscal year, only 38.46% of pregnant women with SUD accessed outpatient care within 3 months following delivery. The same progress, challenges, and proposals for future changes are reported for this indicator as the 7-1 regarding care prior to delivery.

n the ACC-RBHAs' efforts to focus on pregnant and parenting individuals (PPIs) and ensuring this population receives priority access to behavioral health and substance use services, the ACC-RBHAs continue to fund outreach positions through gender specific treatment providers. The outreach positions assist PPIs in receiving developmental and behavioral health services for their children, and ensure they receive treatment as a family unit.

The ACC-RBHAs work collaboratively with other teams to identify pregnant members who use substances. Every pregnant member identified is assigned to a high-risk obstetric Care Manager and outreach is completed as soon as possible from the receipt of notification. The report also captures claims data to identify providers that members may already be receiving services from. Members are screened for identification of high-risk factors, using a comprehensive assessment tool that covers cultural/linguistic preferences, psychosocial, nutritional, medical, and educational factors, to prevent problems that could affect birth outcomes, such as premature birth and low birth weight. After delivery, individuals are outreached within three business days to discuss the importance of postpartum follow-up and the baby's one month well child visit appointment. Community resources are provided as needed to ensure PPIs remain connected with support and services.

The ACC-RBHAs collaborate with various agencies and system partners to ensure PPIs receive appropriate SUD treatment inclusive of the family unit. Those efforts include partnering with direct treatment providers, law enforcement, DCS, and the Justice system. Hushabye Nursery is an example of a partnership in the community geared towards PPIs. The program provides pre- and post-natal education and support to families impacted by substance use and trauma. The work primarily surrounds ensuring that infants are discharged to empowered and loving caregivers. In addition, PPIs work with peer mentors and team to support their newborn(s) throughout the withdrawal process and if necessary, create a child services plan to avoid removal or work toward reunification.

Another effort towards engaging this population is offering 24/7 Medications for Opioid Use Disorder (MOUD) clinic that provides both OB/GYN and wellness services in addition to SUD treatment to meet the needs of PPIs. To provide a holistic approach, the ACC-RBHAs work with various subcontractors to provide Behavioral Health Residential, Intensive Outpatient and Outpatient services to PPIs. The residential program staffs a registered nurse to provide assessments, linkages to pre-natal and postpartum care, and assistance with adherence to treatment.

ACC-RBHAs also work to collaborate and connect with PPIs on tribal reservations by subcontracting providers with designated Peer Navigators for the PPI population. Through SAMHSA supplemental funding, the ACC-RBHAs hope to expand outreach and access to care with providers for members in tribal reservations, justice involved population, and PPIs. Utilizing a braided funding system, the outreach will impact and increase the utilization of SUBG treatment services for these populations. The ACC-RBHAs continue working to allocate supplemental funding for gender specific treatment, outreach, and housing.

In 2023, the ACC-RBHAs implemented and achieved some successes including referring PPIs to enter the PPW-PLT program to encourage family reunification. ACC-RBHAs have also been able to outreach more PPIs to engage them in treatment services through the use of cultural and linguistically appropriate materials that encourage patients to receive care. Through collaborations, the ACC-RBHAs work to ensure our pregnant individuals (pre- and post-partum) and their babies receive services while in the hospital, while they transition back to the community, and throughout their recovery before and after delivery of their babies.

Additionally, the TRBHAs work to identify PPIs in need of not only behavioral health services, but also medical services. The TRBHAs implement integrated health services to tribal members. These integrated teams work to identify and engage patients seeking prenatal and/or postpartum care.

Challenges

A main challenge for ACC-RBHAs to provide services is outreaching, identifying, and engaging PPIs with SUD. Since this population is often covered under Medicaid; many PPIs do not seek out or need to utilize SUBG funding. Women who are ineligible for Medicaid and cannot afford medical insurance or do not qualify for it often need medical and prenatal care that can be difficult to find even when they have high risk pregnancies. SUBG funding does not cover these types of services, which often fragments or prevents care. The ACC -RBHAs also only have limited insight on prenatal or postpartum claim activity for individuals covered by commercial payors or alternative titled plans, making effective tracking of this objective difficult to comprehensively validate. Another challenge is follow-up as staying in contact with the members throughout their pregnancy and postpartum is difficult. Care managers consistently reach out and make contact to provide on-going education to the members, however, there continues to be perceived fear of mothers losing their children due to mandated reporting or substance use. The TRBHAs face similar challenges such as individuals who refuse comprehensive medical and counseling MAT services as they seek out more preferred quicker solutions instead. Overall, patient engagement and lack of trust with healthcare providers on and off the tribal lands result in on-going challenges for these communities.

Proposed Changes to Future Efforts:

The ACC-RBHAs provide a holistic approach and work with providers through monthly non-title XIX/XXI Provider meetings, quarterly SUD Provider meeting, and individual technical assistance meeting to identify new barriers and challenges in providing services to this population. ACC-RBHAs will monitor their funding allocations to provide care for certain priority populations (pregnancy, IV drug users) to increase integrated and whole health care. In addition, ACC-RBHAs work collaboratively in their communities with various organizations to improve care and connect PPIs to care if needed. These partnerships may help reinforce the importance of stigma-reduction and treatment advocacy. As an agency-wide change, AHCCCS may consider establishing a dashboard which comprehensively identifies AHCCCS-covered activity for members who fall into these populations (i.e., prenatal care & postpartum care). Creating and implementing trainings geared towards the Department of Child Safety (DCS) staff on perinatal harm reduction, resources, collaboration, and partnership may also be helpful in keeping families together and establishing trust for PPIs with SUD.

One TRBHA reports that there are future efforts to re-evaluate MAT and Health Psychology services and referrals. Since the need to increase health literacy, engagement, and rapport building between providers and members on tribal reservations is at the forefront, the TRBHA hopes to launch a health education campaign in the future.

How second year target was achieved *(optional)*:

Priority #: 8

Priority Area: Retention in SUD treatment services

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Provide support to individuals receiving community SUD treatment services early in the treatment process that is gender specific and culturally responsive to improve completion rates of treatment programs.

Objective:

Increase the number of individuals receiving community SUD treatment services who complete their treatment program.

Strategies to attain the goal:

1. Require contractors to plan to document in each individual service plan the individual's natural supports.
2. Require contractors to plan to increase the use of peer support services throughout the treatment and recovery processes.
3. Require contractors to document in the individual service plan when an individual declines peer support services and the reasons for declining.

4. Revise the Independent Case Review evaluation tool to reflect changes in requirements.
5. Require contractors to provide training and support to providers on evidence-based engagement strategies by providing training.
6. Identify providers to engage in developing a range of Practice-Based Evidence engagement strategies as defined by SAMHSA to support the positive culture and traditions of local communities.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In last 12 months, percent of individuals receiving an SUD treatment service who continue to receive a SUD service every month for at least 3 consecutive months after enrollment in a SUD treatment program.

Baseline Measurement: SFY21 (7/1/20 - 6/30/21): 10.38%

First-year target/outcome measurement: By the end of SFY2022, 12% of the individuals receiving SUD services will sustain them for at least 3 consecutive months.

Second-year target/outcome measurement: By the end of SFY2023, 15% of the individuals receiving SUD services will sustain them for at least 3 consecutive months.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

AHCCCS recipient data

New Data Source*(if needed)*:

Description of Data:

Denominator is all (unduplicated) individuals admitted to SUD treatment in the previous 12 months receiving a SUD service the month following admission.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:
The first-year target, "By the end of SFY2022, 12% of the individuals receiving SUD services will sustain them for at least 3 consecutive months." This target was met, as 52% of the individuals receiving SUD services sustained them for at least 3 consecutive months.

The following efforts are reported by the ACC-RBHAs and TRBHAs:

Outreach

The Arizona statewide goals to improve and retain members in SUD treatment services include increasing the length of time that an individual is receiving treatment services for at least three months after enrollment in an SUD treatment program, increasing the use of natural supports, peer support, and family support while enrolled in treatment services. To reach these goals Arizona providers, focus on increasing outreach services to expand the number of individuals that are aware of and offered SUD treatment services.

To increase outreach efforts, Mercy Care (MC) Clinical Operations team began the process for creating an Outreach, Education, and Engagement (OEE) committee to address the need of targeted outreach and education to members in the community who are unfamiliar and not yet connected to care. MC shared and encouraged participation in learning opportunities including several different Project Extension for Community Healthcare Outcomes (ECHOs) through Arizona State University (ASU) that target unique populations at MC forums including the General Mental Health/Substance Use (GMHSU) quarterly meeting, and the MAT and State Opioid Response (SOR) collaborative.

In Southern Arizona, Arizona Complete Health (AzCH) continued to fund outreach positions to engage and increase effective and timely access to care for substance use population. AzCH conducted an annual and an internal semi-annual Independent Chart Review (ICR) Peer Review audits on SABG-funded providers to ensure providers are utilizing SABG funds appropriately and serving SABG-eligible members.

AzCH participated in community substance use coalition meetings and crisis system meetings within each county to ensure any gaps and barriers to treatments or follow up are addressed. AzCH partnered with first responders, hospitals, detox facilities, residential facilities, and recovery housing agencies to ensure outreach and peer support services are offered to members with SUD.

Health Choice Arizona (HCA) providers were made aware of the SABG ICR results and were requested to maintain proper documentation about all aspects of treatment beyond the direct improvement suggestion regarding TB testing.

TRBHAs have aimed to increase outreach by using internal and external advertisement through email, and mailing flyers in and out of the county, to appropriate organizations including government agencies.

One TRBHA promoted its behavioral health and other programs, including outreach efforts such as calling members, completing home visits, and delivering food boxes to connect with participants during the COVID-19 pandemic.

Another TRBHA conducted ongoing outreach through community events and education.

Collaboration

To increase collaboration, MC was able to bring on a new provider to the Non-Title XIX/XXI network (Axiom) to provide care to individuals with SUD creating more opportunities and member choice for treatment. MC also collaborated with 14 additional providers to increase their outreach and engagement efforts. MC planned to bring on several other providers to the network that work with specialized populations by providing treatment and MAT services in FY23. Additionally, MC hosted several different forums for providers to meet and discuss engagement strategies including a GMHSU Collaborative, a MAT collaborative and quarterly grant meetings.

In Southern Arizona, AzCH continued to partner and met with each contracted providers' site directors, to ensure their understanding of SABG funds and ICR Peer Review needs, and to better serve the Non-Title XIX/XXI eligible community.

HCA collaborated with providers and AHCCCS to participate in the ICR and Secret Shopper programs and reviewed the results of the prior year, and relayed improvement suggestions to providers at the SUD Forum. The HCA Office of Individual and Family Affairs (OIFA) department has collaborated with other Peer Run & Family Run organizations (PFROs) and delivered training on peer support to help increase availability and utilization for all HCA members.

TRHBAs have worked with Case Management staff, Clinicians and Medical Providers, and identified when support is needed to help with retention of residents in SUD treatment programs. Gila River collaborated with the New Beginnings program, Crisis Response Center (CRC) and other hospitals. They have also collaborated with Women Infants and Children (WIC) program, Department of Child Safety (DCS) and social services department.

One TRBHA reported a collaboration with the Indian Health Services (IHS) unit.

Targeted Interventions

ACC-RBHAs have generated targeted interventions to ensure that SUD treatment goals are met. To do this, MC has built infrastructure through outreach initiatives to increase access to care and engagement. They have provided specialized peer training such as forensic peer support, opioid use crisis training, and motivational leadership training through Peer and Family Career Academy (PFCA) to better equip peer support employees and their managers with tools to work with unique populations. In addition, MC's GMHSU department completes a yearly environmental scan of provider's use of evidence-based practices (EBPs). MC required providers attempt to re-engage members in an episode of care that have withdrawn from treatment process prior to the successful completion of treatment, refused services or failed to appear for a scheduled appointment. MC revamped their reengagement policy 7100.17D and delivered technical assistance (TA) highlighting that behavioral health providers must engage in at least three (3) separate attempts.

AzCH provided updates and feedback to providers in individual TA meetings, substance use provider meetings, Non-Title XIX/XXI provider meetings and integrated provider calls to ensure these standards are being adhered to. HCA employed a Cultural Competency Administrator who conducts ongoing survey, education, and interventions to ensure that providers understand appropriate cultural competency practices and continue to improve cultural competency and access to services for all members across the network.

One TRBHA reported offering peer supports services when appropriate and document when services are declined. They worked to identify how peer support can work within the framework of an SUD treatment program and provide additional support for those receiving services, as needed.

Another TRBHA offers Medical Assisted Treatment (MAT) services, Intensive Outpatient Program (IOP), supportive employment, and supportive housing. PYT provided groups, classes and prevention activities, and psychiatric care and health services.

Another TRBHA increased staff awareness and education throughout their agency.

Other Efforts or Information

MC has trained 42 staff on effective engagement techniques for natural supports. Additionally, they have presented to 108 community members on family support at the 2022 Connections Conference with an additional 24 views on YouTube and posted welcome orientations outlining family support services to MC YouTube page with 71 views. They attended provider meetings to discuss the importance of family support, including the Division of Developmental Disabilities (DDD), ACC-RBHA Health Homes, GMH/SU, Department of Child Safety Child Health Plan (DCS-CHP) lines of business and attended individual provider joint operating meetings to discuss barriers to family support. MC reports that 146 participants within Peer and Family Trainings facilitated by MC Workforce Development Plan (WFD) Team during spring of 2022.

AzCH attended all collaborative forums, coalitions, crisis systems meetings, and other forums to ensure education and resources are readily available in all our service areas.

One TRBHA reported that they have ensured that peer support staff receive adequate training and understand the dynamics of the population they will be assisting.

Outcomes Measured

During FY22 there were 495 unique SABG members who received peer support services through MC. Regrettably, this figure represented a 23.3% drop in the number of unique SABG members who received a unit of H0038 from FY21. On a more positive note, 182 unique individuals were credentialed as Recovery Support Specialists (Peer Support Specialists) within MC's Geographic Service Area (GSA) during FY22. Of those credentialed during the fiscal year, 136 (74.5%) were employed with a network-contracted provider. Additionally, 4 unique individuals were credentialed as Parent/Family Support Provider (CPFSP) within MC's GSA during FY22. Through the environmental scan of EBP's, providers identified the following models; Seeking Safety, Matric Model, Dialectical behavior therapy (DBT), MAT, Mindfulness Based Cognitive Therapy, Cognitive behavioral therapy (CBT), Assertive Community Treatment (ACT), Motivational Interviewing, Prolonged Exposure Therapy, Eye Movement Desensitization and Reprocessing (EMDR), Peer Support, Somatic Therapy, Internal Family Systems, supported employment and permanent supportive housing models as some of the models that are used to treat individuals with SUD.

AzCH gave each provider annual and semi-annual TA sessions to review results of the previous year's ICR Peer Reviews and the internal semi- annual audit results. Additionally, AzCH worked with the contracted providers to discuss, develop, and implement protocols to improve service delivery and EBP to our SABG funded members. Additionally, AzCH conducted an annual site visit with all sites receiving SABG funding and conducted site visits/reviews to ensure that SABG funded providers are appropriately utilizing and expending SABG funds. Lastly, AzCH met with site directors to review the programmatic needs of each provider. Site visits included discussions regarding: SABG posters required in lobby of each provider with education on eligible populations, capacity and staff-to-member ratio, EBPs, individualization of services to fit members' needs, cultural competency and special population needs.

SABG services were measured on a quarterly basis through claims/utilization reports to ensure that appropriate services are being provided to the SABG population for HCA members.

One TRBHA identified areas of improvement for the individual receiving services, developing goals that will enhance the treatment process, and develop a plan to meet or exceed the goals put in place.

Another TRBHA had a cultural competency staff group that addresses issues, and they held community health trainings every Tuesday virtually.

Progress/Barriers Identified

MC had several providers utilize new methods of outreach (web-based applications, new intake protocols to help improve engagement and retention of members in SUD treatment. MC's barriers included that members may be receiving other services from a peer support specialist that is would not be reflected through the H0038 code, but is still recovery centered where the member is benefiting from a peer support lens while receiving services such as living skills, case management, personal care etc.

AzCH implemented increased oversight and TA to providers resulting in increased adherence to several of the measures within the ICR peer review. However, their contracted providers continue to struggle with documentation of providing resources for members for TB screening and testing.

One TRBHA reported restrictions and safety protocols related to providing in-person service, and technology used/required to maintain consistent contact with patients enrolled in services. WMAT struggled with metal health stigma and language obstacles that have contributed to a barrier in treatment.

Success Stories Shared

MC reported that one provider designed an intervention called I.N.T.A.K.E (Inspiring Newcomers Toward Acceptance, Knowledge and Excellence) which focuses on providing the member with mentorship at time of admission through certified peer support staff, senior clients, and Adult Recovery Team (ART) team members. This intervention has improved the length of stay in the brief residential care with an overall length of stay around 45 days. The intervention was also to reduce ASA discharge rate within the first 72 hours to under 10% with 5 out of their 7 facilities meeting the benchmark. This provider also identified a median of 86 days members stayed in treatment including residential and the step-down options. They have added a community day treatment with a strong peer support component as a level of care option for those meeting medical necessity. This level of care has been helpful for the members in transitioning to independent living while still utilizing their peers to help navigate the system of care.

Another provider utilized a free web/phone-based application called Recovery Path to engage with clients to help increase retention which not only increased engagement by clients, but also increased engagement by counselors without adding extra work. The provider recognizes that the first month of treatment is crucial for long term engagement and has used this platform to encourage it. The provider will continue to gather data on outcomes in treatment retention over the next year. Some data that is available now includes:

Sixteen (16) counselors worked with 110 clients, recorded 3,695 therapeutic in-application entries, on average 38 entries per patient of 1.9 per day. An in-application entry can include a check-in with the counselor, logging their feelings of cravings, mood, or how they are doing that day, and completing short assignments.

On the counselor side they saw 1,455 counselor check-ins on client progress and 1,166 in-application feedback notes. Feedback from counselors included:

“I get a lot of messages after hours when the client remembers at that time, they can send me a quick message and then we can check in which has improved our rapport and my ability to support them!”

“It allowed me to see who was thinking about their treatment, tracking their triggers, and what was keeping them up at night”

“This was great for those clients who were reluctant to engage in treatment in clinic, but now we can support them outside of the clinic until they are ready to engage more in-person.”

AzCh’s Semi-Annual ICR Audit TA meeting with a providers Chief Executive Officer; stated that from now on, they will document the IPS either as a note or scan.

One TRBHA reported that individuals were engaged in telehealth services, using smartphones and computer technology.

Another TRBHA reported a community member who had utilized services later became a peer support, and then had a baby while in recovery and while employed. She obtained General Educational Development Test (GED) and now is a Behavioral Health Technician (BHT).

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

The second year target "By the end of SFY2023, 15% of the individuals receiving SUD services will sustain them for at least 3 consecutive months" was met at 30.77%

ACC-RBHAs are committed to increasing the number of individuals receiving an SUD treatment service. ACC-RBHAs continue to fund outreach positions to engage and increase effective and timely access to care for the substance use population. ACC-RBHAs have developed peer-based programs that engage members who present at an ED or ER, as well as at inpatient settings and BHRFs. These programs deploy to engage members as quickly as possible to ensure that they are supported as they transition back to outpatient care, providing nonjudgmental support for clinical services, SDOH needs, and even legal involvement navigation and support.

ACC-RBHAs attend all collaborative forums, coalitions, crisis systems meetings, and other forums to ensure education and resources are readily available in each service area and participates in Community Substance Use Coalitions and Crisis system meetings within each county to ensure any gaps and barriers to treatments or follow up are being addressed.

ACC-RBHAs also partner with first responders, hospitals, detox facilities, residential facilities and recovery housing agencies as well to ensure outreach and peer supports are offered to the substance use population.

ACC-RBHAs reinforce AHCCCS Medical Policy Manual (AMPM) 1040 throughout subrecipient award year. ACC-RBHA monitors provider compliance with AMPM 1040 through oversight and monitoring functions affiliated with ACC-RBHA policy 7100.17D Outreach, Engagement & Re-engagement. Specific guidance on outreach activities is also provided in AMPM Policy 1040 and distributed to providers through the Outreach, Engagement, Reengagement and Closure section of the RBHA (Chapter 400) and Complete Care/Mercy DD/Mercy DCS CHP (Chapter 200) Provider Manuals.

As it relates to critical incidents, ACC-RBHA expects that contracted behavioral health providers engage with their members following a significant or critical event and all activities are documented to maintain engagement within the following timeframes:

Discharged from inpatient services in accordance with the discharge plan and clinical team should be present at discharge and complete clinically appropriate home visits and discharge follow-up,

Involved in a behavioral health crisis within timeframes based upon the member's clinical needs, with minimum contact within 24 hours regarding specific BHMP required timeframes for appointments),

Refusing prescribed psychotropic medications within timeframes based upon the member's clinical needs and history, and

Released from local and county jails and detention facilities within 72 hours Member who are not engaged with a behavioral health provider will have an outreach attempt from a health plan care manager.

One ACC-RBHs reports maintaining Medications for Opioid Use Disorder (MOUD) retention data for individuals with either an Opioid Use Disorder or Stimulant Use Disorder. During the program fiscal year, the percentage of members retained in MAT/MOUD treatment services month-over-month increased from 86% to 98% for Titled Membership and 77% to 89% for Non-Title XIX/XXI Members.

In addition to the state level ICR, ACC-RBHAs conduct annual and an internal semi-annual Independent Chart Review (ICR) Peer Review audits on SUBG funded providers to ensure providers are utilizing SUBG funds appropriately and serving SUBG eligible members. These ICR Peer Reviews consist of a thorough review of member charts including demographics, assessments and screenings, progress notes, and Treatment/Safety/Relapse Prevention Plans. ACC-RBHA gives each provider annual and semi-annual Technical Assistance (TA) sessions to review results of previous year's ICR Peer Reviews as well as the results from the internal semi-annual audit. ACC-RBHA works with the contracted providers to discuss, develop, and implement protocols to improve service delivery and evidence-based programs to our SUBG funded members. The year-end review, which happens with each provider in September, ensures providers are prepared to meet SUBG goals for the following contract year.

Additionally, an ACC-RBHA reports that they conduct annual site visits to all sites with SUBG funding. ACC-RBHA site visits and reviews ensure that SUBG funded providers are appropriately utilizing SUBG funds. ACC-RBHA meets with site directors to review the programmatic needs of each provider. Site visits include discussion regarding: SUBG Posters required in lobby of each provider with education on eligible populations, capacity and staff to member ratio, Evidence Based Practices, individualization of services to fit member's needs, cultural competency and special population needs. The ACC-RBHA provides updates and feedback to providers in individual technical assistance meetings, Substance Use Provider Meetings, Non-Title Provider meetings and integrated provider calls to ensure these standards are being adhered to.

Indicator #:	2
Indicator:	In last 12 months, percent of files including documentation of natural supports.
Baseline Measurement:	In the FY20 ICR, 14% of the files documented the inclusion of family or other supports in treatment planning.
First-year target/outcome measurement:	By the end of SFY2022, 18% of the files reviewed will document the inclusion of family or other supports in treatment planning.
Second-year target/outcome measurement:	By the end of SFY2023, 20% of the files reviewed will document the inclusion of family or other supports in treatment planning.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Independent Case Review

New Data Source*(if needed)*:

Description of Data:

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:
The first-year target "By the end of SFY2022, 18% of the files reviewed will document the inclusion of family or other supports in treatment planning." was not met. Using the SFY21 Independent Case Review (ICR) report, which occurs during SFY 22, only 8% of the files reviewed documented family or other supports in treatment planning.

The following efforts are reported by the RBHAs and TRBHAs:

Outreach

The Arizona statewide goals to improve and retain members in SUD treatment services include increasing the length of time that an individual is receiving treatment services for at least three months after enrollment in an SUD treatment program, increasing the use of natural supports, peer support, and family support while enrolled in treatment services. To reach these goals Arizona providers, focus on increasing outreach services to expand the number of individuals that are aware of and offered SUD treatment services.

To increase outreach efforts, Mercy Care (MC) Clinical Operations team began the process for creating an Outreach, Education, and Engagement (OEE) committee to address the need of targeted outreach and education to members in the community who are unfamiliar and not yet connected to care. MC shared and encouraged participation in learning opportunities including several different Project Extension for Community Healthcare Outcomes (ECHOs) through Arizona State University (ASU) that target unique populations at MC forums including the General Mental Health/Substance Use (GMHSU) quarterly meeting, and the MAT and State Opioid Response (SOR) collaborative.

In Southern Arizona, Arizona Complete Health (AzCH) continued to fund outreach positions to engage and increase effective and timely access to care for substance use population. AzCH conducted an annual and an internal semi-annual Independent Chart Review (ICR) Peer Review audits on SABG-funded providers to ensure providers are utilizing SABG funds appropriately and serving SABG-eligible members.

AzCH participated in community substance use coalition meetings and crisis system meetings within each county to ensure any gaps and barriers to treatments or follow up are addressed. AzCH partnered with first responders, hospitals, detox facilities, residential facilities, and recovery housing agencies to ensure outreach and peer support services are offered to members with SUD.

Health Choice Arizona (HCA) providers were made aware of the SABG ICR results and were requested to maintain proper documentation about all aspects of treatment beyond the direct improvement suggestion regarding TB testing.

TRBHAs have aimed to increase outreach by using internal and external advertisement through email, and mailing flyers in and out of the county, to appropriate organizations including government agencies.

One TRBHA promoted its behavioral health and other programs, including outreach efforts such as calling members, completing home visits, and delivering food boxes to connect with participants during the COVID-19 pandemic.

Another TRBHA conducted ongoing outreach through community events and education.

Collaboration

To increase collaboration, MC was able to bring on a new provider to the Non-Title XIX/XXI network (Axiom) to provide care to individuals with SUD creating more opportunities and member choice for treatment. MC also collaborated with 14 additional providers to increase their outreach and engagement efforts. MC planned to bring on several other providers to the network that work with specialized populations by providing treatment and MAT services in FY23. Additionally, MC hosted several different forums for providers to meet and discuss engagement strategies including a GMHSU Collaborative, a MAT collaborative and quarterly grant meetings.

In Southern Arizona, AzCH continued to partner and met with each contracted providers' site directors, to ensure their understanding of SABG funds and ICR Peer Review needs, and to better serve the Non-Title XIX/XXI eligible community.

HCA collaborated with providers and AHCCCS to participate in the ICR and Secret Shopper programs and reviewed the results of the prior

year, and relayed improvement suggestions to providers at the SUD Forum. The HCA Office of Individual and Family Affairs (OIFA) department has collaborated with other Peer Run & Family Run organizations (PFROs) and delivered training on peer support to help increase availability and utilization for all HCA members.

TRHBAs have worked with Case Management staff, Clinicians and Medical Providers, and identified when support is needed to help with retention of residents in SUD treatment programs. Gila River collaborated with the New Beginnings program, Crisis Response Center (CRC) and other hospitals. They have also collaborated with Women Infants and Children (WIC) program, Department of Child Safety (DCS) and social services department.

One TRBHA reported a collaboration with the Indian Health Services (IHS) unit.

Targeted Interventions

ACC-RBHAs have generated targeted interventions to ensure that SUD treatment goals are met. To do this, MC has built infrastructure through outreach initiatives to increase access to care and engagement. They have provided specialized peer training such as forensic peer support, opioid use crisis training, and motivational leadership training through Peer and Family Career Academy (PFCA) to better equip peer support employees and their managers with tools to work with unique populations. In addition, MC's GMHSU department completes a yearly environmental scan of provider's use of evidence-based practices (EBPs). MC required providers attempt to re-engage members in an episode of care that have withdrawn from treatment process prior to the successful completion of treatment, refused services or failed to appear for a scheduled appointment. MC revamped their reengagement policy 7100.17D and delivered technical assistance (TA) highlighting that behavioral health providers must engage in at least three (3) separate attempts.
AzCH provided updates and feedback to providers in individual TA meetings, substance use provider meetings, Non-Title XIX/XXI provider meetings and integrated provider calls to ensure these standards are being adhered to. HCA employed a Cultural Competency Administrator who conducts ongoing survey, education, and interventions to ensure that providers understand appropriate cultural competency practices and continue to improve cultural competency and access to services for all members across the network.

One TRBHA reported offering peer supports services when appropriate and document when services are declined. They worked to identify how peer support can work within the framework of an SUD treatment program and provide additional support for those receiving services, as needed.

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AzCH attended all collaborative forums, coalitions, crisis systems meetings, and other forums to ensure education and resources are readily available in all our service areas.

One TRBHA reported that they have ensured that peer support staff receive adequate training and understand the dynamics of the population they will be assisting.

Outcomes Measured

During FY22 there were 495 unique SABG members who received peer support services through MC. Regrettably, this figure represented a 23.3% drop in the number of unique SABG members who received a unit of H0038 from FY21. On a more positive note, 182 unique individuals were credentialed as Recovery Support Specialists (Peer Support Specialists) within MC's Geographic Service Area (GSA) during FY22. Of those credentialed during the fiscal year, 136 (74.5%) were employed with a network-contracted provider. Additionally, 4 unique individuals were credentialed as Parent/Family Support Provider (CPFSP) within MC's GSA during FY22. Through the environmental scan of EBP's, providers identified the following models; Seeking Safety, Matric Model, Dialectical behavior therapy (DBT), MAT, Mindfulness Based Cognitive Therapy, Cognitive behavioral therapy (CBT), Assertive Community Treatment (ACT), Motivational Interviewing, Prolonged Exposure Therapy, Eye Movement Desensitization and Reprocessing (EMDR), Peer Support, Somatic Therapy, Internal Family Systems, supported employment and permanent supportive housing models as some of the models that are used to treat individuals with SUD. AzCH gave each provider annual and semi-annual TA sessions to review results of the previous year's ICR Peer Reviews and the internal semi- annual audit results. Additionally, AzCH worked with the contracted providers to discuss, develop, and implement protocols to improve service delivery and EBP to our SABG funded members. Additionally, AzCH conducted an annual site visit with all sites receiving SABG funding and conducted site visits/reviews to ensure that SABG funded providers are appropriately utilizing and expending SABG funds. Lastly, AzCH met with site directors to review the programmatic needs of each provider. Site visits included discussions regarding:

SABG posters required in lobby of each provider with education on eligible populations, capacity and staff-to-member ratio, EBPs, individualization of services to fit members' needs, cultural competency and special population needs.

SABG services were measured on a quarterly basis through claims/utilization reports to ensure that appropriate services are being provided to the SABG population for HCA members.

One TRBHA identified areas of improvement for the individual receiving services, developing goals that will enhance the treatment process, and develop a plan to meet or exceed the goals put in place.

Another TRBHA had a cultural competency staff group that addresses issues, and they held community health trainings every Tuesday virtually.

Progress/Barriers Identified

MC had several providers utilize new methods of outreach (web-based applications, new intake protocols to help improve engagement and retention of members in SUD treatment. MC's barriers included that members may be receiving other services from a peer support specialist that is would not be reflected through the H0038 code, but is still recovery centered where the member is benefiting from a peer support lens while receiving services such as living skills, case management, personal care etc.

AzCH implemented increased oversight and TA to providers resulting in increased adherence to several of the measures within the ICR peer review. However, their contracted providers continue to struggle with documentation of providing resources for members for TB screening and testing.

One TRBHA reported restrictions and safety protocols related to providing in-person service, and technology used/required to maintain consistent contact with patients enrolled in services. WMAT struggled with metal health stigma and language obstacles that have contributed to a barrier in treatment.

Success Stories Shared

MC reported that one provider designed an intervention called I.N.T.A.K.E (Inspiring Newcomers Toward Acceptance, Knowledge and Excellence) which focuses on providing the member with mentorship at time of admission through certified peer support staff, senior clients, and Adult Recovery Team (ART) team members. This intervention has improved the length of stay in the brief residential care with an overall length of stay around 45 days. The intervention was also to reduce ASA discharge rate within the first 72 hours to under 10% with 5 out of their 7 facilities meeting the benchmark. This provider also identified a median of 86 days members stayed in treatment including residential and the step-down options. They have added a community day treatment with a strong peer support component as a level of care option for those meeting medical necessity. This level of care has been helpful for the members in transitioning to independent living while still utilizing their peers to help navigate the system of care.

Another provider utilized a free web/phone-based application called Recovery Path to engage with clients to help increase retention which not only increased engagement by clients, but also increased engagement by counselors without adding extra work. The provider recognizes that the first month of treatment is crucial for long term engagement and has used this platform to encourage it. The provider will continue to gather data on outcomes in treatment retention over the next year. Some data that is available now includes:

Sixteen (16) counselors worked with 110 clients, recorded 3,695 therapeutic in-application entries, on average 38 entries per patient of 1.9 per day. An in-application entry can include a check-in with the counselor, logging their feelings of cravings, mood, or how they are doing that day, and completing short assignments.

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"I get a lot of messages after hours when the client remembers at that time, they can send me a quick message and then we can check in which has improved our rapport and my ability to support them!"

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AzCh's Semi-Annual ICR Audit TA meeting with a providers Chief Executive Officer; stated that from now on, they will document the IPS either as a note or scan.

One TRBHA reported that individuals were engaged in telehealth services, using smartphones and computer technology.
Another TRBHA reported a community member who had utilized services later became a peer support, and then had a baby while in recovery and while employed. She obtained General Educational Development Test (GED) and now is a Behavioral Health Technician (BHT).

How first year target was achieved *(optional)*:

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

The second year target "By the end of SFY2023, 20% of the files reviewed will document the inclusion of family or other supports in treatment planning" was not met. The SFY2022 ICR conducted in SFY2023 reported that 13% of member case files reviewed documented family or other supports in treatment planning. The following details Arizona's progress, challenges, and proposals for future changes:

ACC-RBHAs seek to increase the utilization of natural supports. One ACC-RBHA reports that their Office of Individual and Family Affairs (OIFA) team is working with the OIFA Alliance to ensure that natural supports are utilized within a member's plan. The OIFA team is continuing to work with providers on education around what natural support is and encourages the use of natural support throughout the treatment process. According to the most recent ACC-RBHA SUBG audit in FY23 32.6% of treatment plans were completed with participation of family/natural support system.

During the annual site visits, another ACC-RBHA asks for providers to offer evidence of how they involve family in the treatment of the members. Many providers talked about offering to include in the assessment and treatment plan as well as some providers offering family psychoeducation groups. ACC-RBHA have championed Pat Deegan's Personal Medicine Coaching for members and practitioners within the ACC-RBHA line of business. During the program fiscal year, the ACC-RBHA has offered 16 sessions across the Central GSA (Gila, Maricopa, & Pinal Counties).

Another ACC-RBHA conducted their own SUBG audit in FY23 and found that 97.4% of total charts reviewed had the use of peer support as part of treatment. Eighty-five individuals trained on the value of personal medicine coaching, which may include natural supports. These figures include 8 ACC-RBHA staff who completed the training and 27 individuals who participated in the Train-the-Trainer session (s).

Many providers note they ask about natural supports and inclusion during assessment and treatment planning, however, many individuals decline their involvement in that process. Perhaps there are more opportunities to include natural supports during the treatment process such as family days at the clinic, family psychoeducation groups, ART team meetings being offered and scheduled at beginning of treatment, the use of technology to include natural support and follow up.

AHCCCS added qualitative data collection and analysis to the SFY2023 ICR and found that barriers to involvement of family supports includes the following: lack of the ability to bill for services provided to family members, staff capacity to provide for this without the ability to bill, particularly with the workforce shortage and the high volume of intense needs. Members reported not being comfortable to include others in their treatment plan, and members not wanting to be a burden to others.

The full Arizona ICR report for SFY2022 can be found at this link
https://www.azahcccs.gov/Resources/Downloads/Grants/SABG/FY2022_SABG_ICR_Report.pdf

How second year target was achieved *(optional)*:

Indicator #:	3
Indicator:	In last 12 months, percent of files including documentation that peer or family support was offered as part of the treatment plan.
Baseline Measurement:	In the FY20 ICR, 36% of the files documented that peer support services were offered as part of the treatment plan.
First-year target/outcome measurement:	By the end of SFY2022, 45% of the files reviewed will document that peer support services were offered as part of the treatment plan.
Second-year target/outcome measurement:	By the end of SFY2023, 55% of the files reviewed will document that peer support services were offered as part of the treatment plan.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Independent Case Review

New Data Source*(if needed)*:

Description of Data:

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:
The first-year target "By the end of SFY2022, 45% of the files reviewed will document that peer support services were offered as part of the treatment plan." was not met. Using the SFY21 Independent Case Review (ICR) report, which occurs during SFY 22, only 18% of the files reviewed documented family or other supports in treatment planning.

The following efforts are reported by the RBHAs and TRBHAs:

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How first year target was achieved *(optional)*:

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

The second year target "By the end of SFY2023, 55% of the files reviewed will document that peer support services were offered as part of the treatment plan." was not achieved. According to the SFY2022 ICR, conducted in SFY2023, 57% of case files reviewed included documentation that peer or family support was offered as part of the treatment plan. The following details Arizona's progress, challenges, and proposals for future changes:

The ACC-RBHAs strive to increase the utilization of peer and family supports. One ACC-RBHA reports that their OIFA team has educated Health Homes regarding peer and family support services availability. OIFA intends to define the peer and family support role with support from the OIFA Alliance to provide guidance and education around the peer support and family support roles to the community. ACC-RBHA completes an annual member survey to ask for feedback from members about their experience accessing treatment and if the provider offered them a peer support specialist.

One ACC-RBHA reports that they continue to improve and expand the network of certified peers in the community. In 2022 this network included 4,635 peer support specialists and in 2023, 5,187 peers providing services (11.9% increase in the peer workforce year-over-year). In the FY23, the Member Survey showed that out of 268 member surveys, 83% of members indicated that the provider offered to connect them with a peer support specialist. Additional progress includes expansion of Peer Curricula through Peer and Family Career Academy via CRRSAA SUBG (COVID-19 Supplemental) to enhance the didactic skills of the provider workforce.

Another ACC-RBHA reports that for their region served, the SFY2022 ICR showed that there was an increase of peer support offered as part of treatment (36% of records reviewed, compared to 23% in the previous year). Through the training with the Peer and Family Career Academy, 643 individuals were trained on Hope and Healing for the Opioid Use Crisis, Breaking Down the Barriers of Forensic Peer Support Specialists and Motivational Leadership, providing another resource for peer and family staff to access quality training that they can utilize within their roles.

AHCCCS and its partners continue to recognize the importance of, and promote peer support and family support services and many providers have intentionally increased their peer support specialist workforce and provide trainings to support them as well as their supervisors around best practices.

Challenges

Working with congregate care settings and convincing those settings to allow peers to engage with members while in treatment has posed a challenge.

Another barrier is when peer support specialists promote into other clinical roles, it can be challenging to both maintain the peer identify and to document their work as peer support while also providing other specific services (counseling, case management, etc.). It can be difficult to track the impact of Peer and Family support services as individuals credentialed to deliver these services can deliver other covered services within their scope.

Proposed Changes for Future Efforts

Although AHCCCS and its partners will continue to promote the increase of the utilization of peer support services, there are some additional ways that this effort may be enhanced. At least one ACC-RBHA/provider reports that AHCCCS could consider alternative and complementary indicators of peer and family support, beyond claim activity or participation with ISPs/Treatment planning. AHCCCS is exploring the most effective way to measure this activity, whether from the ICR or through claims data. an ACC-RBHA/provider also recommends that AHCCCS could identify incentives for providers to increase utilization of the peer service code within claims. These recommendations have been received and are under review by the agency.

How second year target was achieved *(optional)*:

Priority #: 9

Priority Area: Substance use treatment that addresses the specific needs of women

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

To improve treatment engagement, retention, and outcomes for women with substance use disorder

Objective:

Increase access and availability of substance use treatment tailored to the unique needs of women with substance use disorder.

Strategies to attain the goal:

1. Implement a training collaborative for service providers focused on the unique needs of women with substance use disorder.
2. Formalize processes for monitoring gender specific treatment among contractors, including the use of the annual Independent Case Review, Operational Review, and Secret Shopper program.
3. Provide ongoing training through a learning management system on gender specific treatment for women with substance use disorder.
4. Leverage the PPW-PLT Learning Collaborative to identify emerging needs and address them.
5. Leverage opportunities in new contracts to require evidence-based and practice-based gender-specific treatment.
6. Revise Measure V of the Independent Case Review to collect more specific information on gender-specific treatment.
7. Define gender-specific treatment in contract and policy.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of clinical files for women which include evidence that gender specific treatment (GST) was offered.

Baseline Measurement: For SFY2021, 28% of the files reviewed documented access to GST.

First-year target/outcome measurement: By the end of SFY2022, 35% of the files reviewed documented access to GST.

Second-year target/outcome measurement: By the end of SFY2023, 40% of the files reviewed documented access to GST.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Independent Case Review

New Data Source*(if needed)*:

Description of Data:

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:
The first-year target was "By the end of SFY2022, 35% of the files reviewed documented access to GST." Using the SFY21 Independent Case Review (ICR) report, which occurs during SFY 22, only %18 of the files reviewed documented access to GST."

Although the target was not met, the following efforts and progress are reported:

Outreach

Mercy Care (MC) utilized marketing materials including a poster that targets pregnant women/women with dependent children along with the Substance Abuse Block Grant (SABG) brochure at community events to provide information on services including, Project Connect, Arizona Department of Health Services (AZDHS) Maternal Mortality Summit, and the AZ Recovery Walk. In FY22, MC developed a platform where providers can independently request grant marketing material. Additionally, MC continued to attend the r Pregnant and Postpartum Women (PPW) collaborative and publicizes the collaborative at various provider meetings State Opioid Response (SOR) Collaborative, Medical Assisted Treatment (MAT) Collaborative, General Mental Health/Substance Use (GMHSU) Provider Meeting and the Grants Quarterly Meeting). Lastly, MC Clinical Operations Department created an Outreach, Education and Engagement (OEE) committee that is focused on expanding outreach to the public by targeting specific populations including PPW and women who use substances.

MC also completed annual site visits in Q3 with providers where they inquired how providers target their own outreach activities and MC provides technical assistance (TA) as needed.

Arizona Complete Health (AzCH) funded outreach specialist positions at various behavioral health agencies to ensure that women with substance use disorder (SUD) are outreached and enrolled into treatment as appropriate.

One TRBHA reported that they implemented internal and external advertisements through email, and mailing flyers in and out of county, to appropriate organizations and government agencies.

Another TRBHA reported that their staff contacts clients monthly and held a wellness conference.

Another TRBHA promoted outreach by community awareness through Pediatric Integrated Care Collaborative (PICC).

Collaboration

MC secured an opportunity to present at the PPW collaborative in July 22 and the Arizona Department of Health Maternal Mortality Summit to give an overview of accessing care through grant resources for Gender Specific and PPW populations. MC attended bi-weekly ASU Project Extension for Community Healthcare Outcomes (ECHOs) on evidence-based practices (EBPs) for gender specific substance use treatment services. Additionally, MC's Ombudsmen completed annual secret shopper calls with providers who receive block grant funding to assess access to care, provider staff knowledge of grants and customer service experience. This tool is then reviewed with each provider during the annual site visit. Lastly, during the site visit MC requested evidence from providers who serve women about their gender specific treatment practices and provides TA as needed.

AzCH's Health Homes and medications for opioid use disorder (MOUD) outpatient providers work directly with hospitals to coordinate care and ensure timely access to care for women who are identified as having an Opioid Use Disorder, which may include MOUD assistance in addition to other services. Additionally, AzCH participated in the monthly PPW-PLT learning collaborative.

Health Choice Arizona (HCA) staff attend the PPW-PLT learning collaborative and have staff who sit on the advisory council for this collaborative.

Furthermore, HCA collaborated with providers and AHCCCS to participate in the Independent Case Review (ICR) and Secret Shopper programs and reviews the results of the prior years' annually, and relays improvement suggestions to providers at the SUD Forum.

A TRBHA reported that they worked with Tribal Social Services and Tribal Family Court to assist with the re-unification process for mothers, fathers, and children. They collaborated with clinicians, providers and organizations that focus on appropriate gender specific treatment modalities and incorporate certain practices in our SUD treatment process.

Another TRBHA reported that they collaborated with all Health Department Programs.

Targeted Interventions

MC provided targeted education to subrecipients around SAMHSA's Treatment Improvement Protocol (TIP) 51 – Substance Abuse Treatment: Addressing the specific needs of women. This TIP includes practical content and strategies for subrecipient programs to incorporate into their service offerings for women with SUD. Other targeted training initiatives included delivery of Online Relias Module, Women & Substance Abuse (1.5 hours). In this course, participants learned the effects of age and life transitions on alcohol and drug use in women and how these are reflected in treatment methodologies. . MC provided Relias training to teach employees of stressors and life transitions that can be accompanied by significant changes in substance use and can be implicated in women's development of a substance use disorder and approaches to delivering gender-sensitive treatment to women struggling with substance use or at risk of developing a substance use disorder. The goal of the module, Women & Substance Abuse (1.5 hours) is to provide marriage and family counseling, nursing, professional counseling, social work, and psychology professionals in health and human services settings with information about substance use treatment for women at various stages of development. 48 unique staff completed Women & Substance Abuse Training (1.5 hours) on Relias Learning Portal in SFY2022 with an average score of 93%. 100% of the individuals completing the training were employed by SABG Provider Subrecipients. Mercy Care's Ombudsmen does complete secret shopper calls every year, in FY22 the Ombudsmen called identifying as a priority population (pregnant woman or woman with children) for 12 out of the 21 provider calls with a goal of identifying process of accessing services, quality of customer service and assessing provider awareness of grant eligibility and increase/ expanded provider network and outreach services for gender specific care through CRRSAA grant funding.

AzCH created an annual member newsletter, which educates on the topic of substance abuse as well as available covered services/resources, which could include childcare for women with a SUD. https://www.azcompletehealth.com/content/dam/centene/az-complete-health/pdf/member/newsletters/508_AzCH_Medicaid-Newsletter_Q3%202022.pdf

The Women's Transition Project (WTP) in Bisbee, AZ operated by Community Bridges (CBI), serves pregnant and parenting individuals with substance use and behavioral health issues. HCA contracted with several providers who serve women only or have women-only residential programs and outpatient groups or services.

One TRBHA reported revised programming and their review processes to identify areas where gender specific programming can enhance the overall treatment experience (at the inpatient SUD treatment center).

Another TRBHA reported MAT programming, group counseling, individual counseling, psychiatric care, and medication box management. They now have a women's Behavioral Health Residential Facilities (BRHF) but not during this period we have other network in-patient providers that we do aftercare planning with.

Other Efforts or Information:

AzCH implemented Crisis Bed Connect, a website used by internal staff and providers to identify bed availability in behavioral health and substance use residential facilities. The in-network providers were responsible for regularly updating their bed availability. This tool filtered residential settings specifically for women with SUD to ensure that support staff can find applicable resource when needed. Additionally, AzCH staff are required to complete an annual training regarding SABG and Mental Health Block Grant (MHBG) to ensure they are aware of programs and can connect individuals to the most appropriate resources. Lastly, AzCH implemented a secret shopper program to monitor agency awareness of programming and grants supporting Non-XIX/XXI members. AzCH completed calls quarterly to providers and relays a scenario that will lead agency staff to refer members of a special and/or underserved population to a specific program. An excel spreadsheet will record responses. AzCH provided immediate feedback to the agency staff regarding the responses given. HCA provided information about training hosted by AHCCCS, SAMSHA TIPs, and other online or outside training regarding gender-specific services. This information continued to be shared at all SUD Tx Forums hosted this year.

One TRBHA reported that they identified training opportunities that staff can attend that will help improve their knowledge and skill set. The TRBHA developed a class/group that will focused on the unique needs of women in treatment and provide a standardized curriculum for the group.

Another TRBHA provided an employment program that offered women's employment and life skills group weekly in person with COVID-19 testing during this period.

Outcomes Measured

MC had 8,781 unique staff who completed SABG training in the Relias Learning Portal in FY22. Course material outlines grant eligibility, covered services, contracted providers and priority populations, including gender-specific treatment for women with SUD. Average passing score was 85%. Additionally, 48 unique staff completed Women & Substance Abuse Training (1.5 hours) on Relias Learning Portal in SFY2022 with an average score of 93%. Out of the 21 providers that were called for the secret shopper 100% of providers stated that they could help the person calling, however, only 16% of the provider calls stated they could help the person same day. 14 out of 21 providers had information easily accessible on the website

AzCH reported 482 women's program involvement during that timeframe (including all subprograms)., 68 unique members. 41 at CHH and 7 at "PPW Transitional" and 144 admissions to Las Amigas during that time through their provider CODAC. During FY 2022, Dorothy Kret, and Associates (DKA) had female residents working on Alcohol, Meth, and Marijuana addiction. At the Haven for FY 2022, 140 residential women and 130 IOP women were discharged. AzCH gave each provider annual and semi-annual TA sessions to review results of previous year's ICR Peer Reviews and the internal semi- Annual audit results. AzCH worked with the contracted providers to discuss, develop, and implement protocols to improve service delivery and EBPs to our SABG funded members. The year-end review, which happens with each provider in September, ensures providers are prepared to meet SABG goals for the following contract year.

One TRBHA reported that through self-report of women post-treatment, they evaluated the effectiveness of the program and assessed feedback/survey. They evaluated what needs are being met and what needs are not (based on gender-specific services).

Another TRBHA provided that satisfaction surveys were conducted, and the results were reviewed by the management team.

Progress/Barriers Identified

Numerous providers have adopted gender-specific groups that focus on unique needs of women and peer facilitated groups through MC. On the other hand, some providers stated in the environmental scan of EBPs that they would love to have a resource or list of recommended EBPs along with additional free or low cost EBP training. AzCH contributed COVID-19 as barrier for women to engage in treatment both residential and outpatient. Clients have shared how they appreciate the women-only approach to treatment. Women continue to be the minority gender of the SABG population with HCA.

One TRBHA reported that mothers can have children live with them while they participate in SUD treatment services, but mothers are limited to 2 children, under the age of 12, living with them while in treatment.

Another TRBHA also reported barriers to the COVID-19 pandemic but reported that the most vulnerable populations were served.

Another TRBHA developed relationships across community stakeholders and provided awareness in the community.

Success Stories Shared

MC's Center for Hope graduated a client to Starfish housing. This client excelled in the Center for Hope program. She was able to welcome a healthy baby boy and reunify with her older son. She could work and accommodate her own schedule to her older son who struggles with down syndrome to provide him with all the appropriate care to ensure he had everything he needed. She completed the Center for Hope's Program and moved out to independent living.

AzCH member aged 32, completed residential treatment at The Haven on 2/24/22, IOP on 5/25/22 and continues to participate in outpatient treatment. She works full-time at a re-entry house. She is currently in transitional housing but has been approved for a Pinsor Grant and is looking for an apartment. She has been intoxicant free since 8/28/2022. At CODAC, a member agreed to go to Las Amigas for treatment and was there for 3 months and stepped down to PPW-PLT back in May. The member has completed IOP, attends Trauma Recovery and Empowerment Model (TREM) and all other required groups. She receives methadone and is medication complaint. She sees her Primary Care Physican (PCP) and Behavioral Health Medical Professional (BHMP) regularly and can verbalize what she needs. She is complying with all DCS requirements and now has unsupervised visits with her healthy infant boy. She is also abiding by all probation requirements and is hopeful and excited for what the future has in store for her. A client at DKA, accepted employment with CBI. Client enrolled into the Working with Women's program with her certification as Recovery Support Specialist certificate and needed assistance in finding employment. The client was grateful for the assistance and will continue with the WWW program with DKA.

Testimonial from resident of Women's Transition Project (WTP):
"I want to thank everyone at the WTP for helping me to find myself. I came into the WTP feeling unsure of who I was, unloved, unaccepted, and hopeless. I realized early in my life that I was different and although I am female, I always identified as male. My family could not accept this and continually tried to change me. Eventually I turned to drugs to help deal with my pain. WTP not only helped me to find my self-worth, but you were able to make my family realize that I am who I am and would always identify as male. Today I help run a non-profit for the LGBT community, am not needing to use drugs, and have a close relationship with my family. My stay at the WTP transformed my life and was filled with love and acceptance. Thank you all for your love, support, and direction."

Three mothers enrolled with one of the TRBHAs are currently working with government agencies that will assist them with reunification of their family.

Another TRBHA received the following feedback from members, "Centered Spirit has been a great help to my family in trying to deal with trauma and learning to live a functional day to day life" and "Centered Spirit is a very wonderful place and staff".

How first year target was achieved *(optional)*:

Second Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved *(optional)*:

The second year target "By the end of SFY2023, 40% of the files reviewed documented access to GST. " was achieved with 57% of files documenting that gender-specific treatment services were offered.

AHCCCS and its contracted partners implement several strategies that focus on the priority area of substance use disorder (SUD) treatment that addresses the specific needs of women.

Southern Arizona SUBG funds outreach specialist positions at various behavioral health agencies to ensure that women with substance use disorder are being outreached and enrolled into treatment as appropriate.

Health Homes and Medications for Opioid Use Disorder (MOUD) outpatient providers work directly with hospitals to coordinate care and ensure timely access to care for women who are identified as having a substance use disorder, which may include MOUD assistance in addition to other services.

Southern Arizona has participated in several monthly collaboration meetings that as stated above in Goal 7 to include the monthly State Pilot Grant Program for Treatment for Pregnant and Postpartum Women (PPW-PLT) learning collaborative, the Polysubstance Abuse in Pregnancy & Newborns (PAPN) meeting, and the statewide (Safe, Healthy Infants and Families Thrive) SHIFT collaborative.

Additionally, southern Arizona attends county-specific substance use coalition and crisis system meetings to assess any unmet needs and ensure that providers and system partners are aware of the services specific to substance use treatment for women.

The southern Arizona ACC-RBHA continues to utilize Crisis Bed Connect, a website which is used by internal staff and providers to identify bed availability in behavioral health and substance use residential facilities. Southern Arizona in-network providers are responsible for regularly updating their bed availability. This tool can filter residential settings specifically for women with SUD to ensure that support staff can find applicable resources for when needed.

Southern Arizona Care Management staff are required to complete an annual training regarding SUBG to ensure they are aware of programs and can connect individuals to the most appropriate resources.

Additionally, southern Arizona creates member newsletters to provide education on the topic of substance abuse as well as available covered services/resources specific to women. Examples of a general newsletter and one specific to women can be found at the following links:

https://www.azcompletehealth.com/content/dam/centene/az-complete-health/pdf/member/newsletters/508_2023Q1-AzCH-CCP%20MemberNewsletter.pdf

https://www.azcompletehealth.com/content/dam/centene/az-complete-health/pdf/member/newsletters/AzCH-CCP_Maternal_Child_Health_Newsletter_2023.pdf

This year, southern Arizona's provider outreach team was able to build a strong, collaborative relationship with a local charity in Tucson. This charity is a center where unhoused women can access shelter, hot meals, clothes, showers, and connections to resources and services. This has been a remarkable success for the provider and is now scheduled to be onsite weekly and will respond to any referrals or inquiries received when they are not onsite.

Additionally, another southern Arizona provider was able to add 14 beds to their women's residential treatment center through grant funds allocated which increased their capacity to support women in recovery.

The central Arizona ACC-RBHA Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA) funds have allowed for six SUBG subrecipients to build infrastructure for outreach and expansion of treatment for this priority population.

Central Arizona continues to assess network needs and identify gender specific treatment providers to join the network annually.

Additionally, central Arizona provides SUBG funding to five providers to offer residential treatment or supported housing and treatment where children can come with the mother.

In FY23, 33.36% of the SUBG population were female with a total of 1,612 distinct female members services with SUBG funding.

A central Arizona provider receiving SUBG funds has created a program to provide supportive housing for women and children along with treatment for the women. The provider utilizes evidence-informed research protocols to assess depression, self-image, and Post Traumatic Stress Disorder (PTSD) along with the Consumer Health Inventory and client satisfaction with treatment. These forms were developed over the last 10 years in conjunction with Arizona State University (ASU), School of Social Work to ensure that they are providing effective treatment interventions that help retain women in treatment along with keeping families together.

The program result has shown that 51.3% of clients reported their Department of Child Safety (DCS) cases were closed while 20.5% reported they still had a DCS open but were moving toward reunification.

Furthermore, 95% of the women reported the children were living with them while in the program. This is significant because the program is designed for pregnant and parenting women, noting that no or extremely limited bond disruptions occurred due to placement of their children.

Additionally, 64% of the women have reported that they feel extremely bonded with their children, while 16% identified "somewhat." This is also a good indicator that the women feel safe enough to share bonding challenges.

Lastly, 100% of the women in the program reported they had not used any alcohol or substances that were not prescribed within the past 30 days. The program utilizes several different evidence-based practices in their treatment model including Maslow's Hierarchy of Needs.

The program started their first alumni picnic with over 300 attendees spanning just one day of sobriety all the way to 25 years.

ACC-RBHAs and providers have offered the following success stories related to this objective:

"We have witnessed families being restored as the Department of Child Safety has permitted mothers in treatment to be reconciled to their children because they are living in supportive environments with onsite observation and assistance to ensure safe parenting while

addressing the SUD patterns that directly interfere with safe parenting. We have seen resilience at its most critical moments as we navigate through relapses with our members determined to engage in varying levels of care while gaining footage for long-term recovery. We have witnessed women deliver substance-free and healthy babies thereby creating change in the generational patterns of addiction that deeply and negatively impact families. In April 2023, we hosted our first Alumni picnic where 300 people registered to attend, and many alumni members returned to share their experiences with us. Some achieving 20 years of sobriety and some returning to us after a recent relapse but feeling confident recovery is within their reach. In a survey of those attending, we were told that we participated in changing their lives in 100 percent of the respondents."

"At [a women's supportive housing program] a client came to the Agency directly from jail on Medicated Assisted Treatment (MAT) services. The client was helped by staff contacting Banner Health to obtain OB/GYN services and her expertise with pregnancy and opiates. The client was quiet and withdrawn for her first few months of treatment but persisted. After her baby's birth, the client used [an additional women's supportive program]

to monitor her daughter for withdrawal. It was then that the client turned it around and started to get it. She began participating fully in treatment and became a leader in [the women's supportive housing program]. The client regained the trust of her family and began co-parenting her [other child]. ...The client is currently working as a Certified Peer Support in a treatment facility and cares for her 2 young daughters."

"[A client] had been staying at one of the health-supported housing facilities. Like many on the path to recovery, she faced setbacks and relapsed. However, it was the supportive environment and the comprehensive programs and services offered by the provider that made all the difference. During her relapse, [the client's] primary concern was the safety and well-being of her infant. Thanks to the resources and guidance provided by a Central Arizona Treatment Provider, she could take immediate action. She arranged for her child to stay with a DCS approved safety monitor. This ensured her child's safety and allowed [the client] to focus on her own recovery. With determination and the support of a treatment program, [the client] successfully secured a place in a residential facility that allowed her to take her child with her. [The client] said that thanks to the continuous support and commitment of provider, she could ask for help knowing that she was welcomed back to one of their housing facilities, where she could continue her recovery journey following her residential stay."

"One client successfully completed 90-day residential program. She was able to obtain employment ... and enrolled in supportive sobriety housing. She eventually found permanent housing and has stayed in contact with her sponsor. The client is enrolled in an ongoing outpatient program."

Success stories highlight the fact that some of the members served may need to utilize several systems and services on a journey of wellness, from connecting to MOUD services, utilizing supportive housing and treatment, prenatal and postnatal services, as well as supported employment and education, finding meaningful work to gain income. It also highlights that relapse is a part of recovery and with diligent support and follow up with the member, they can overcome the relapse to move to sobriety and recovery. The result can be not only member success in treatment and recovery but also family reunification and child safety, and unlimited other positive impacts of their work in treatment and recovery services.

Central Arizona has expanded the network for gender specific services. In FY23, central Arizona utilized SUBG funding to support some expansion of supportive housing for pregnant and parenting women with substance use disorder along with supporting a pilot childcare project to reduce barriers to treatment.

According to the most recent SUBG audit by the ACC-RBHA in FY23, female members showed evidence of gender specific treatment being offered and/or attended.

There is ongoing work to implement peer support programs and outreach to pregnant and parenting individually in the northern region, including efforts to utilize peer support for outreach and assistance in reducing barriers to care.

Northern Arizona has been able to connect with the Yavapai SHIFT community of practice workgroup and joins their meetings. Northern Arizona has been invited to join the statewide SHIFT workgroup. This will allow the ACC-RBHA to support Pregnant and Parenting Individuals (PPI) struggling with substance use and identify any gaps that may be present.

Additionally, Crisis Teams have been implemented in each county to assist and offer education to providers, serving as liaisons and collaborating with stakeholders in each county to ensure effectiveness of outreach, as well as continued access to care by the populations served.

The Guidance Center in the northern region offers a program to pregnant women that starts during their pregnancy and continues through the second year after the baby's birth. This program began in 2023 and has been extraordinarily successful with over 20 moms and babies served.

The northern ACC-RBHA has joined [PPW program] in Navajo County to collaborate and connect services that may be available for pregnant mothers and women with children who are experiencing substance use disorder.

An additional peer support program was implemented in March 2023, and has had over 200 referrals to date. The program reported

that they met with a pregnant mother that presented to the Emergency Department (ED) with a SUD. The mother had lost custody of two other children previously. Since having peer support involvement, the individual has remained substance free and continues with treatment.

The previous northern ACC-RBHA informed providers about the ACC-RBHAs plan transition and worked closely with the incoming northern ACC-RBHA to ensure smooth transition of members receiving care from providers funded through SUBG.

One TRBHA reports that they continue internal and external advertisement through email, and mailing flyers in and out of county, to appropriate organizations and government agencies, as well as continued work with Tribal Social Services and Tribal Family Court to assist with the re-unification process for mothers, fathers and children, and collaborates with clinicians, providers and organizations that focus on appropriate gender specific treatment modalities and incorporate certain practices in our SUD treatment process. The TRBHA's integrated team works closely with the women's clinic to identify and offer services for women with a SUD diagnosis. The provider continues to admit women who have children or are pregnant at time of admission. One mother gave birth in treatment this past year.

One TRBHA service provider opened a 10 bed women's residential behavioral health facility, Women's Path, in 2023. There have been various groups for SUD and mental health provided to participants in Women's Path. Their Centered Spirit program continues to provide outpatient counseling and psychiatric services to women.

Priority #: 10

Priority Area: Persons Who Inject Drugs

Priority Type: SAT

Population(s):

Goal of the priority area:

Increase the engagement of persons who inject drugs in harm reduction program services.

Objective:

The number of persons receiving services from the harm reduction program services annuals who report injecting drugs

Strategies to attain the goal:

Expand harm reduction services by implementing programs through the state. Monitor the self-reported number of persons who inject drugs with harm reduction service providers.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of persons receiving services from the harm reduction program services annuals who report injecting drugs.

Baseline Measurement: This baseline will be zero as this is not currently being monitored.

First-year target/outcome measurement: The number of individuals utilizing harm reduction program services in Calendar Year 2022.

Second-year target/outcome measurement: Increase the number of individuals utilizing harm reduction program services by 2% in Calendar Year 2023.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Harm Reduction RFP provider. Deliverables SABG Numbers Served Report quarterly report.

New Data Source*(if needed)*:

Description of Data:

Harm Reduction RFP provider. Deliverables SABG Numbers Served Report quarterly report.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

The Indicator measure covers calendar years because the Harm Reduction RFP programming contract is on a calendar year basis. The deliverables are quarterly based on a calendar year.

New Data issues/caveats that affect outcome measures:

While the statewide contract began January 1, 2022, the Syringe Service Program (SSP) elements were not approved and subsequently implemented and reported on until June 8, 2022.

The data related to the statewide syringe service program (using non-federal funds) such as used syringes collected for disposal, number of engaged individuals via disposal, number of sterile syringes distributed, number of individuals to whom syringes were distributed, and referrals, are reported from June 8, 2022 – September 30, 2022.

The data related to naloxone distribution, fentanyl test strip distribution, and community harm reduction training (overdose education), are reported from January 1, 2022 – September 30, 2022.

SPW does not collect client level data regarding type of drug use (e.g., does the client smoke, inject, etc.), However, data for this objective is provided using proxy data: used the Syringe Distribution and Syringe Disposal data from the SPW Individuals Served Report. This proxy data may have duplication.

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:
The first-year target is "the number of individuals utilizing harm reduction program services in Calendar Year 2022." This target establishes the baseline for the outcome measures proposed by the contractor which will be used by AHCCCS to evaluate the program year after year. According to the SPW Individuals Served Report, 21,403 individuals were served through Syringe Distribution and Disposal (may have duplication).

Between January 1, 2022 – September 30, 2022, the Statewide Harm Reduction Program achieved the following outputs:
1) Naloxone Distribution (3 doses/kit): 125,737 doses
2) Fentanyl Test Strip Distribution (1/kit): 9,188
3) Community & Provider Training Sessions: 24
3A) Total Attendees Trained (unduplicated): 4,388
4) Used Syringes Collected for Disposal: 103,180
5) # of Engaged Individuals via Disposal: 3,723
6) # of Sterile Syringes Distributed: 334,935
7) # of Individuals to whom Syringes Distributed: 12,500
8) Referrals to HIV/HCV Screening: 13
9) Referrals to HIV/STI Treatment: 0
10) Referrals to Viral Hepatitis Treatment: 8
11) Referrals to SUD/MH Treatment: 19
12) Referrals to Treatment (other): 46
13) Women Engaged: 1,925

Overall, the major success of the program to date is the rollout of the Syringe Service Program (SSP) elements approved on June 8, 2022. The rollout included ensuring the statewide subcontractors understood their roles and responsibilities as it relates to the SSP, as well as securing contractual agreements between all parties to ensure appropriate management and oversight. Another success of the program was the increase in service provision quarter to quarter. For instance, during quarter one of 2022 (January-March) 980 fentanyl test strips (FTS) were distributed. By the end of quarter three (July-September), there were 6,537 FTS distributed throughout the state, an astounding increase of over 500%. Similarly, in quarter two (April-June) there were 103,365 sterile syringes distributed. This increased to 231,570 sterile syringes distributed by the end of the third quarter, a 124% increase.

Challenges included the approval to implement elements of the SSP into the overall program. AHCCCS received formal approval from SAMHSA to utilize SABG funding to implement elements of SSPs on March 16, 2022. Due to staffing changes and related delays, AHCCCS formally amended and approved the use of SABG funds for elements of SSPs for the statewide contractor on June 8, 2022. While the

contractor waited for formal approval from AHCCCS, they began hiring, training, and establishing key partnerships to ensure once approval was received, they would be ready to implement the program.

Second Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

At the time this goal/objective was written (September 2021), AHCCCS was not yet funding the statewide harm reduction program and its syringe service program. Therefore, baseline data for the number of persons receiving services from the harm reduction program who reported injecting drugs was 0. At the time of the 2023 SUBG Report 12/1/2022, AHCCCS was able to report on the progress toward this goal/objective, but because the program did not specifically collect information on the route by which members used drugs, AHCCCS reported using proxy data. The proxy was established as the sum or two measures reported by the program: "Numbers of Individuals Engaged via Disposal" + "Number of Individuals to whom Syringes Distributed". On 12/1/2022, AHCCCS reported that 21,403 individuals were served between 6/8/2022 (the date of approval to utilize funds for this service) and 9/30/2022. As an update, 31,417 individuals were served in contract year 2022, between 6/8/2022 and 12/31/22. The second-year target of a 2% increase would equate to 32,045. Using this method, this target was not met yet in CY2023. Between 1/1/2023 - 9/30/2023, the program reports 7,959 were served with syringe disposal and syringe distribution, though this number is impacted by SPW's work to reduce duplication in their data collection and reporting. Progress, challenges, and proposed changes for future efforts are reported as follows:

AHCCCS is contracted with Sonoran Prevention Works (SPW) to implement a state-wide harm reduction program inclusive of a syringe services program (SSP). While SPW is the main driver of this goal/objective, the agency works with many partners, including all three ACC-RBHAs and some TRBHAs as well as others throughout the state to ensure statewide reach as well as a referral network both to and from SPW.

SPW and ACC-RBHA Mercy Care collaboratively and strategically engage persons who inject drugs in harm reduction program services through community-based outreach and partnerships with various organizations. There are several methods used to deliver services; fixed outreach sites, mail-based services, deliveries, mobile/street-based services, active outreach through presentations and meetings, and participating in meetings with stakeholders.

Currently, SPW has staff working in seven of fifteen counties in Arizona and has a headquarters office within the state. With only one central office, SPW relies heavily on the support of community partners to ensure participants are able to access services in satellite locations consistently. At satellite sites for outreach, SPW aims to provide as many aspects of comprehensive syringe services programming as possible. These services may include any or all of the following: Safer use supplies; Safe disposal of nonsterile supplies; Naloxone; Abscess and wound care supplies; Referrals to multiple types of substance use treatment (e.g., MOUD, MAUD, IOP, EOP, Detox, Residential/Sober Living, and/or General Mental Health Care); Screenings & linkage to treatments for HIV & HCV; Navigation to HIV prevention services (e.g., PrEP & PEP); Systems navigation support (i.e., legal, DCS, immigration); Supplies addressing the social determinants of health; Referrals to services addressing the social determinants of health (e.g., housing, food, general medical care, dental care, and transportation); Education pertaining to harm reduction, overdose prevention, and safer substance use approaches; and Support groups & opportunities for community-building amongst participants. Throughout the years, SPW has consistently developed and strengthened relationships with other harm reduction providers who provide similar services and operate within the same geographical service area (GSA). As a result, SPW currently subcontracts three organizations to provide expert services tailored to communities of persons who inject drugs.

ACC-RBHA Mercy Care participates on the board of Hep Free AZ committee and works with the co-chair of the Gila County Criminal Justice Collaborative to share about grant resources, harm reduction approaches and stigma-reduction, development and feedback solicitation from medical and clinical professionals regarding the boards' Overdose Prevention Guide. Mercy Care attends the Drug Policy Research and Advocacy Board (DPRAB) meeting monthly to learn and contribute to harm reduction efforts and access to quality treatment across Arizona. The DPRAB is a group of people with lived or living experience with accessing Medications for Opioid Use Disorder (MOUD) treatment, AZ MOUD treatment providers, AZ based harm reduction organizations, and university-based researchers. The goal of the DPRAB is to improve access to care for those on MOUD medication and ensure staff that provide the service also have the education and support they need. To date, Mercy Care has successfully distributed over 8,053 units of Narcan and contributed to 83 overdose reversals in the central GSA (Gila, Maricopa, and Pinal counties).

Together, Mercy Care and SPW work collaboratively as the state's primary provider of Harm Reduction Services and Narcan supplies, training and education.

Challenges

Until recently, the SPW harm reduction program data collection methods related to this goal/objective were limited due to duplication. While implementing the new system to identify unique persons served has been a great success, it may result in an overall decrease in the number of individuals SPW engages due to removals of duplicative persons served. Despite the dip in numbers served, the new data will offer a richer evaluation in regard to the volume, effectiveness, and quality of harm reduction program services offered.

In efforts to navigate infrastructure-related barriers, SPW has had to move one or more outreach site locations. The barriers include lack of understanding of harm reduction services, stigma towards persons who inject drugs and/or persons experiencing homelessness, and/or unnecessarily frequent interference from law enforcement professionals. Another barrier as a result of relocating sites is the loss

of participants and subsequently making it more difficult for consistent follow-ups with individuals who typically frequent those sites for services. While the harm reduction scope of work remains relatively controversial for some, SPW works to continue building trust within communities most in need of services.

With AHCCCS support and continued funding, SPW has collected evidence of an overall decrease in injection drug use among harm reduction program participants, deeming the efforts a huge success as injection is the riskiest route of substance use administration. As a result, many persons served have shifted to smoking substances instead due to the most prominent type of substance used in Arizona (i.e., fentanyl in pressed pills) and education materials that SPW has distributed for years about the lowered risk for overdose among non-injection substance consumption routes as compared to injection of substances. Although this certainly is evidence of a positive impact of the program on participants and overdose risk, it also presents an additional challenge for SPW as a harm reduction service provider because safer smoking supplies are not considered allowable program expenses.

Other challenges include: stigma regarding SSP and other harm reduction measures; a lack of understanding about its efficacy in reducing overdose deaths, communicable diseases; purchasing other harm reduction supplies as they are unallowable costs; limited funding; access to treatment; costs of Narcan/naloxone; and lack of education for providers treating persons with SUD.

Proposed Changes to Future Efforts

Working towards the goal of increasing reach among persons who inject drugs, SPW has partnered with a MOUD provider to implement a harm reduction vending machine intervention at ten clinics across Arizona. Initial implementation of this new harm reduction service offering is anticipated during the 4th quarter of CY2023 or the 1st quarter of CY2024. Another effort to improve the program and meet goals is SPW's harm reduction by mail program. This program has been tremendously successful since its inception during the early days of the COVID-19 pandemic as it allowed outreach to persons who inject drugs in rural areas in efforts to continue reaching this specific population, SPW offers this option for communities that do not have on-ground-efforts. To overcome this, SPW has begun initial planning to engage participants who have consistently used and benefitted from service to serve as secondary distributors in their communities. This could be done on a voluntary or contracted basis.

ACC-RBHA Mercy Care continues to expand co-located Substance Use Navigators (SUNs) to support discharge planning/coordination to on-going treatment. Mercy Care aims to lower the barrier to addiction treatment medications and 24/7 access to care by implementing the CA Bridge Model that allows navigators to engage with patients in the ER. Other opportunities that the ACC-RBHA has consider is mandating that all OTPs have OPCs (overdose prevention centers or safe consumption sites) once legal in Arizona, hybrid funding approaches to Narcan/naloxone or lobby for cost-reduction, making Oxygen available to those who are pre-overdose, PRIOR to administering Narcan/naloxone, "clubhouse" model of treatment options for substance use disorder treatment providers, more inclusive and empowering options for people who use drugs to engage in treatment and activities that are of their choosing. Other proposed changes include identifying opportunities to include people who use drugs in decision making, utilize harm reduction vending machines, incentives or strategies for providers to expand clinic hours and/or offer internal transportation options for patients who may need that support, identify ways to be flexible about dispensing or picking up prescriptions including home delivery of medication when possible, expand the spectrum of recovery housing to include subsidized or scholarship housing for people who are not fully abstinent from drugs but still need housing assistance.

How second year target was achieved *(optional)*:

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

Center for Substance Abuse Treatment

Division of State and Community Systems

State Systems Partnership Branch

FY 21 SABG ARP COVID Testing and Mitigation Supplemental Funding: FY 23 Annual Report

Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)

Report Expenditure Period: October 1, 2022 - September 30, 2023

Report Submission Due Date: Tuesday, January 2, 2024

Name of SUBG Grantee: Arizona
Name of State, DC, Territory, Associated State, or Tribe

Submitted By: Emma Hefton, SUBG Grant Administrator
Name and Title of Individual Submitting Report

Date Submitted: 1/2/2024

Total FY 21 SABG Supplemental Funding Amount Awarded in August, 2021:

$1,392,949

Instructions: For the FFY 2023, ending on 9/30/23, please complete this FY 23 Annual Report form for the FY 23 expenditures from the FY 21 SABG ARP COVID Testing and Mitigation Supplemental Funding. Please upload as a Word or PDF document in Table 1 of the 2024 SUBG Report that was submitted on 12/1/23. Please report on the FY 21 SUBG ARP COVID Testing and Mitigation Supplemental Funding activities and expenditures by January 2, 2024. The period of performance for this report is October 1, 2022 through September 30, 2023.

#	FY 23 Date of Expenditure	FY 23 Item/Activity Description*	FY 23 Amount of Expenditure*
1	10/2022	Personnel (salary for 10 staff members), ERE (fringe for 10 staff members), travel (hotel and meals for 4 days), other (medical supplies, car lease, cell phone, iPad service plans, laptop, and iPad purchase), indirect	$8700.66
2	11/2022	Personnel (salary for 9 staff members), ERE, other (cell phone, iPad service plans), indirect	$7437.27

#	FY 23 Date of Expenditure	FY 23 Item/Activity Description*	FY 23 Amount of Expenditure*
3	12/2022	Personnel (salary for 9 staff members), ERE, travel (hotel, meals), other (medical supplies, car lease, cell phone, iPad service plans), indirect	$8417.21
4	1/2023	Personnel (salary for 9 staff members), ERE, travel (lodging, meals), other (medical supplies, car lease, cell phone, iPad service plans), indirect	$9704.28
5	2/2023	Personnel (salary for 10 staff members), ERE, other (cell phone, iPad service plans), indirect	$8303.90
6	3/2023	Personnel (salary for 10 staff members), ERE, other (laptop, car lease, cell phone, iPad service plans), indirect	$4438.12
7	4/2023	Personnel (salary for 9 staff members), ERE, other (medical supplies, supplies, cell phone, iPad service plans, car lease) indirect	$13,521.85
8	5/2023	Personnel (salary for 10 staff members), ERE, other (medical supplies, cell phone, iPad service plans), indirect	$10,121.67
9	6/2023	Personnel (salary for 5 staff members), ERE, other (cell phone, iPad service plans), indirect	$5752.78
10	7/2023	Personnel (salary for 3 staff members), ERE, other (cell phone), indirect	$1007.06
11	8/2023	Personnel (salary for 3 staff members), ERE, other (cell phone), indirect	$452.57
12	9/2023	Personnel (salary for 3 staff members), ERE, other (cell phone), indirect	$481.56
		Total	**$78,338.93**

**All activities and expenditures were supported approximately 50% by the SUBG Testing and Mitigation funds and approximately 50% by the MHBG Testing and Mitigation funds. The dollar amounts reported here are the SUBG portion of the cost for the project activities under Spectrum Health Group. See narrative section for additional detail on activities related to these expenditures.*

Narrative

To fulfill the objectives of the Coronavirus Disease 2019 (COVID-19) Testing and Mitigation Supplemental Funding, Arizona Health Care Cost Containment System (AHCCCS) sought a contractor to increase access to COVID-19 testing and enhance spread mitigation strategies for individuals with substance use disorder (SUD), Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) in congregate settings, including behavioral health residential facilities (BHRFs), crisis stabilization units, day treatment programs, shelters, and other settings where large groups of individuals gather to receive behavioral health services.

Combining the Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG) awards, AHCCCS contracted with Spectrum Healthcare Group to implement the COVID-19 Testing and Mitigation of Spread activities. Spectrum Healthcare Group provides a multi-pronged approach that takes into

consideration the COVID-19 related finite resources (i.e., testing supply and PPE availability), staff capacity to conduct testing (i.e., workforce availability, training), and other resource limitations such as transportation in geographical rural and tribal regions of our State.

During the reporting period, Spectrum Healthcare Group leveraged a team of Anywhere Care Specialists to outreach congregate care settings to offer free personal protective equipment (PPE) and assistance in developing and implementing COVID-19 mitigation strategies. A brief needs assessment and telephone script was developed to facilitate outreach and service provision. Dependent upon assessed needs, examples of potential activities Spectrum offers include: coordination and partnership with state and local health departments/agencies on how to align provider mental health and substance use COVID-19 mitigation efforts and activities; develop guidance for partnership; develop strategies and/or support existing community partnerships to prevent infectious disease transmissions; develop onsite testing confidentiality policies and implementation of program practices; policy and procedure development relevant to the individualized needs of the setting; maintain healthy environments (clean and disinfect, ensure ventilation systems operate properly, install physical barriers and guides to support social distancing if appropriate); increase access to testing supplies and PPE for staff and consumers; procure COVID-19 tests and other mitigation supplies such as handwashing stations, hand sanitizer and masks; provide training and technical assistance to implement rapid onsite COVID-19 testing; mobilize COVID-19 testing units to geographic locations, such as rural and tribal regions with high need, limited resources, and/or other identified barriers to care for SMI, SED and/or SUD populations; facilitate access to behavioral health services for people with SMI, SUD, and SED who are at high risk for COVID-19; engage in activities within the CDC Community Mitigation Framework to address COVID-19 in rural communities; conduct contact tracing - the process of notifying people (contacts) of their potential exposure to SARS-CoV-2, the virus that causes COVID-19 that includes, but is not limited to: providing information about the virus, discussing symptom history and other relevant health information, and provide instructions for self-quarantine and self-monitoring for symptoms; expand local or tribal programs workforce to implement COVID-response services for those connected to the behavioral health system, education, rehabilitation, prevention, treatment, and support services for symptoms occurring after recovery from acute COVID-19 infection, including, but not limited to, support for activities of daily living; promote behaviors that prevent the spread of COVID-19 and other infectious diseases (healthy hygiene practices, stay at home when sick, practice physical distancing to lower the risk of disease spread, cloth face coverings, getting vaccinated); behavioral health services to staff working as contact tracers and other members of the COVID-related workforce; and maintain health operations for staff, including building measures to cope with employee stress and burnout.

Spectrum's Anywhere Care Specialists outreached over 1300 congregate care settings serving individuals with SMI, SED, ESMI/FEP, and/or SUD throughout Arizona to offer free testing supplies and PPE, increased access to testing services, and technical assistance and training regarding mitigation strategies. They additionally created processes to manage supply orders and prepared COVID Mitigation policy and procedure documents that could be adapted to meet the needs of facilities. Spectrum reported barriers connecting directly with provider personnel with the knowledge or authority to engage in the needs assessments, assess agency need for testing supplies, PPE, and sanitation supplies , or make decisions regarding receiving training, technical support, and/or procurement of said supplies. The discontinuation of the Public Health Emergency and overall public's reduced urgency related to COVID has resulted in utilization trending downward throughout this fiscal year. Spectrum and AHCCCS are collaborating to overcome these challenges and have created a plan to improve statewide agency utilization of these available resources, especially as we have entered another infectious disease season and positive COVID cases increase.

The Community Mental Health Block Grant (MHBG) team at AHCCCS outreached our network of Arizona Complete Care with Regional Behavioral Health Agreements (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs) personally in meetings and via email with information regarding the services Spectrum offers in addition to the availability of testing and mitigation supplies all at no cost to their provider agencies. The RBHAs and TRBHAs in turn outreached leadership within their provider networks and received a multitude of interest. Spectrum is developing a letter explaining the free resources they have to offer through the grant; this letter will be signed by Spectrum leaders and distributed to the identified RBHA/TRBHA network and other statewide organizations that provide behavioral health services for our targeted populations. The collaborative messages between AHCCCS, our RBHAs/TRBHAs Administration, and Spectrum leadership increases confidence in the legitimate availability of no cost resources and, more importantly, ensures that personnel with the knowledge and authority at each organization receive the information, are aware of what is available, can assess their needs, coordinate with a specific contact person at Spectrum to meet these needs.

Personnel and Employee Related Expenditures(ERE) include Anywhere Care Specialists conducting the grant related activities outlined above in addition to coordination, planning, and oversight by leadership. Travel expenses incurred are for personnel to visit sites and deliver supplies. Other expenditures include technology required to carry out the activities related to the grant including laptops and tablets for mobility of necessary information and documentation, a percentage of cellular service/WiFi plans for mobile connectivity. Indirect costs include administrative overhead including, but not limited to, administration, finance, human resources, and data team operations allocated as a percentage of expenses.

Details for SUBG Grantees: After completing the table above, grantees are requested to upload this report document through a regular WebBGAS Revision Request that will be created by your CSAT SPO, as an Attachment to Table 1 Priority Area and Annual Performance Indicators – Progress Report, of the 2024 SUBG Report Submitted, as a Word or PDF document. Please submit no later than 11:59 pm EST, on Tuesday, January 2, 2024. For the expenditure period of October 1, 2022 through September 30, 2023, please include a complete listing of the expenditure of FY 21 SABG ARP COVID Testing and Mitigation Supplemental Funding, by expenditure dates, items and activities of expenditure, and amounts of expenditures. If no funds were expended during this period, please complete and upload this report document indicating "Not Applicable". Please feel free to address any questions or concerns to your CSAT SPO. Thank you.

Background and Description of Funding: On August 19, 2021 SAMHSA released guidance on one-time funding for awards authorized under the American Rescue Plan (ARP) Act of 2021 (P.L. 117-2) and Section 711 of the Social Security Act (42 U.S.C. 711(c)) for the targeted support necessary for mental health and substance use disorder treatment providers to overcome barriers towards achieving and maintaining high COVID-19 testing rates (commonly referred to as COVID Testing and Mitigation funds). The total overall expenditure period performance period for this funding is September 1, 2021 – September 30, 2025, though the expenditure period for the report above is for FY 23 only, from 10/1/22 through 9/30/23.

As indicated in your SABG Notice of Award of August 10, 2021, States, DC, Territories, Associated States, and the Red Lake Band of Chippewa Indians are required to submit an Annual Report by December 31 of each year, until the funds expire. Grantees must upload a report including activities and expenditures to Table 1 of the 2024 Substance Use Block Grant Report filed on 12/1/23. A Revision Request will be sent to grantees by the CSAT SPO to upload the report.

12/4/2023: SUBG Grantee WebBGAS Revision Request will be created by the CSAT SPO for the grantee upload of the FY 23 SABG ARP COVID Testing and Mitigation Supplemental Funding Annual Report, for the FY 23 expenditure period of October 1, 2022 through September 30, 2023. Using the FY 23 Annual Report form provided to grantees by the CSAT SPO, grantees are requested to upload an Attachment to **Table 1 Priority Area and Annual Performance Indicators – Progress Report**, 2024 SUBG Report Submitted, as a Word or PDF document by 11:59 pm EST, on Tuesday, January 2, 2024. Please provide a complete list of the expenditure dates, items and activities of expenditure, and amounts of expenditures, between October 1, 2022 and September 30, 2023. If no activities were completed, please complete and upload the report document indicating "Not Applicable".

Excerpts from the August 10, 2021 guidance letter to Single State Authority Directors and State Mental Health Authority Commissioners from Miriam E. Delphin-Rittmon, Ph.D., Assistant Secretary for Mental Health and Substance Use, regarding the use of this funding in as follows:

"People with mental illness and substance use disorder are more likely to have co-morbid physical health issues like diabetes, cardiovascular disease, and obesity. Such chronic illnesses are associated with higher instances of contracting coronavirus disease (COVID-19) as well as higher risk of death or a poor outcome from an episode of COVID-19. To address this concern, the U.S. Department of Health and Human Services (HHS), through the Substance Abuse and Mental Health Services

Administration (SAMHSA), will invest $100 million dollars to expand dedicated testing and mitigation resources for people with mental health and substance use disorders.

As COVID-19 cases rise among unvaccinated people and where the more transmissible Delta virus variant is surging, this funding will expand activities to detect, diagnose, trace, and monitor infections and mitigate the spread of COVID-19 in homeless shelters, treatment and recovery facilities, domestic violence shelters and federal, state and local correctional facilities–some of the most impacted and highest risk communities across the country. These funds will provide resources and flexibility for states to prevent, prepare for, and respond to the COVID-19 public health emergency and ensure the continuity of services to support individuals connected to the behavioral health system.

This one-time funding for awards was authorized under the American Rescue Plan (ARP) Act of 2021 (P.L. 117-2) and Section 711 of the Social Security Act (42 U.S.C. 711(c)). SAMHSA will supplement the ARP funding for state grantees. The performance period for this funding is September 1, 2021 – September 30, 2025.

Targeted support is necessary for mental health and substance use treatment providers to overcome barriers towards achieving and maintaining high COVID-19 testing rates. From the provider perspective, these barriers include limited financial and personnel resources to support ongoing testing efforts. Providers have limited staff and physical resources and COVID-19 testing activities must be balanced against COVID-19 vaccinations and other health care services. From the consumer perspective, these barriers include hesitancy in accepting vaccines and challenges with health care access. Recipients may allocate reasonable funds for the administrative management of these grants. SAMHSA envisions the maximum support possible for COVID-19 testing and mitigation; toward that goal, recipients are encouraged to expend a minimum of 85 percent of funding for allowable COVID-19 testing and mitigation activities.

The list below includes examples of allowable activities. While this list is not exhaustive, any activity not included on this list must be directly related to COVID-19 testing and mitigation. All recipients are strongly encouraged to work with state or local health departments to coordinate activities. The state must demonstrate that the related expense is directly and reasonably related to the provision of COVID-19 testing or COVID-19 mitigation activities. The related expense must be consistent with relevant clinical and public health guidance. For additional examples, you can visit the CDC Community Mitigation Framework website. Funding may not be used for any activity related to vaccine purchase or distribution.

SAMHSA, through this supplemental funding, allocates $50 million each for Mental Health Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block grants (SABG) to the states. States have until September 30, 2025, to expend these funds. SAMHSA asks that states consider the following in developing a COVID-19 Mitigation Funding Plan:

• Coordinate and partner with state and local health departments/agencies on how to better align the state/provider mental health and substance use COVID-19 mitigation efforts and activities; develop guidance for partnering with state/local health departments; disseminating sample training curriculums.

• Testing education, establishment of alternate testing sites, test result processing, arranging for the processing of test results, and engaging in other activities within the CDC Community Mitigation Framework to address COVID-19 in rural communities.

• Rapid onsite COVID-19 testing and for facilitating access to testing services. Training and technical assistance on implementing rapid onsite COVID-19 testing and facilitating access to behavioral health services, including the development of onsite testing confidentiality policies; and implementing model program practices.

• Behavioral health services for those in short-term housing for people who are at high risk for COVID-19.

• Testing for staff and consumers in shelters, group homes, residential treatment facilities, day programs, and room and board programs. Purchase of resources for testing-related operating and administrative costs otherwise borne by these housing programs. Hire workers to coordinate resources, develop strategies and support existing community partners to prevent infectious disease transmission in these settings. States may use this funding to procure COVID-19 tests and other mitigation supplies such as handwashing stations, hand sanitizer and masks for people experiencing homelessness and for those living in congregate settings.

• Funds may be used to relieve the burden of financial costs for the administration of tests and the purchasing of supplies necessary for administration such as personal protective equipment (PPE); supporting mobile health units, particularly in medically underserved areas; and expanding local or tribal programs workforce to implement COVID-response services for those connected to the behavioral health system.

• Utilize networks and partners to promote awareness of the availability of funds, assist providers/programs with accessing funding, and assist with operationalizing the intent of said funding to ensure resources to mitigate the COVID-19 health impacts and reach the most under-served, under-resourced, and marginalized communities in need.

• Expanding local or tribal programs workforce to implement COVID-response services for those connected to the behavioral health system.

• Provide subawards to eligible entities for programs within the state that are designed to reduce the impact of substance abuse and mental illness; funding could be used for operating and administrative expenses of the facilities to provide onsite testing and mobile health services; and may be used to provide prevention services to prevent the spread of COVID-19.

• Develop and implement strategies to address consumer hesitancy around testing. Ensure access for specific community populations to address long-standing systemic health and social inequities that have put some consumers at increased risk of getting COVID-19 or having severe illness.

• Installing temporary structures, leasing of properties, and retrofitting facilities as necessary to support COVID-19 testing and COVID-19 mitigation.

• Education, rehabilitation, prevention, treatment, and support services for symptoms occurring after recovery from acute COVID-19 infection, including, but not limited to, support for activities of daily living.

• Other activities to support COVID-19 testing including planning for implementation of a COVID-19 testing program, hiring staff, procuring supplies to provide testing, training providers and staff on COVID-19 testing procedures, and reporting data to HHS on COVID-19 testing activities.

• Promote behaviors that prevent the spread of COVID-19 and other infectious diseases (healthy hygiene practices, stay at home when sick, practice physical distancing to lower the risk of disease spread, cloth face coverings, getting vaccinated).

• Maintain healthy environments (clean and disinfect, ensure ventilation systems operate properly, install physical barriers and guides to support social distancing if appropriate).

• Behavioral health services to staff working as contact tracers and other members of the COVID-related workforce. Maintain health operations for staff, including building measures to cope with employee stress and burnout.

• Investigate COVID-19 cases; the process of working with a consumer who has been diagnosed with COVID-19 and includes, but is not limited to:

- Discuss test result or diagnosis with consumers;
- Assess patient symptom history and health status;
- Provide instructions and support for self-isolation and symptom monitoring; and
- Identify people (contacts) who may have been exposed to COVID-19.

• Conduct contact tracing: the process of notifying people (contacts) of their potential exposure to SARS-CoV-2, the virus that causes COVID-19 and includes, but is not limited to:

- Provide information about the virus;
- Discuss their symptom history and other relevant health information; and
- Provide instructions for self-quarantine and monitoring for symptoms.

The following are ineligible costs for the purposes of this funding:

• Costs already paid for by other federal or state programs, other federal or state COVID-19 funds, or prior COVID-19 supplemental funding.
• Any activity related to purchasing, disseminating, or administering COVID-19 vaccines.
• Construction projects.
• Support of lobbying/advocacy efforts.
• Facility or land purchases.
• COVID-19 mitigation activities conducted prior to 9/1/2021.
• Financial assistance to an entity other than a public or nonprofit private entity.

III: Expenditure Reports

Table 2 - State Agency Expenditure Report

This table provides a report of SUPTRS BG and state expenditures by the SSA during the SFY immediately preceding the FFY for which the state is applying for funds for authorized activities to prevent and treat SUDs. For detailed instructions, refer to those in the WebBGAS. Please note that this expenditure period is different from that on SUPTRS BG Table 4.

Expenditure Period Start Date: 7/1/2022 Expenditure Period End Date: 6/30/2023

Activity (See instructions for entering expenses in Row 1)	A. SUPTRS BG	B. MHBG	C. Medicaid (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19[1]	I. ARP[2]
1. Substance Use Prevention (Other than Primary Prevention), Treatment, and Recovery[3]	$33,230,460.79		$260,227,478.28	$34,176,468.80	$11,735,886.98	$73,575.00	$0.00	$14,334,544.16	$457,164.00
a. Pregnant Women and Women with Dependent Children	$3,500,776.70		$0.00	$0.00	$0.00	$0.00	$0.00	$3,219,081.58	$39,268.19
b. Recovery Support Services	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
c. All Other	$29,729,684.09		$260,227,478.28	$34,176,468.80	$11,735,886.98	$73,575.00	$0.00	$11,115,462.58	$417,895.81
2. Substance Use Disorder Primary Prevention	$7,614,383.82		$0.00	$0.00	$0.00	$0.00	$0.00	$3,950,339.19	$402,343.10
3. Tuberculosis Services	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4. Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV)[4]	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
5. State Hospital									
6. Other 24 Hour Care									
7. Ambulatory/Community Non-24 Hour Care									
8. Mental Health Primary Prevention									
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)									
10. Administration (Excluding Program and Provider Level)	$2,140,192.00		$0.00	$614,669.29	$0.00	$0.00	$0.00	$244,012.17	$25,071.46
11. Total	**$42,985,036.61**	**$0.00**	**$260,227,478.28**	**$34,791,138.09**	**$11,735,886.98**	**$73,575.00**	**$0.00**	**$18,528,895.52**	**$884,578.56**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SUPTRS BG and MHBG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current Notice of Award Terms and Conditions (NoA). Per the instructions, the standard SUPTRS BG expenditures are for the state planned expenditure period of July 1, 2023 – June 30, 2025 for most states.

[2]The expenditure period for ARP supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025.

[3]Prevention other than primary prevention

[4]Only designated states as defined in 42 U.S.C. § 300x-24(b)(2) and 45 CFR § 96.128(b) for the applicable federal fiscal year should enter information in this row. This may include a state or states that were previously considered "designated states" during any of the three prior FFYs for which a state was applying for a grant. See EIS/HIV policy change in SUPTRS BG Annual Report instructions.

Please indicate the expenditures are actual or estimated.

(●) Actual ( ) Estimated

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

Column A represents all SUBG expenditures incurred during SFY23. Column Other Federal represent all SFY23 for SOR II and SOR III and PPW. Local funds represent Liquor service fees expended during SFY23. Column H and I represent expenditures from beginning of grant through 06/30/23.

AHCCCS is aware of suspected fraudulent billing activities associated with the American Indian Health Program. During 2023, the Agency suspended a large number of providers for credible allegations of fraud. Currently, AHCCCS and the appropriate law enforcement agencies are still investigating the impact. Ultimately, this may require a restatement of the 2023 expenditures reported here.

III: Expenditure Reports

Table 3a – Syringe Services Program (SSP)

Expenditure Start Date: 07/01/2022 Expenditure End Date: 06/30/2023

				SSP Expenditures			
SSP Agency Name	**SSP Main Address**	**SUD Treatment Provider (Yes or No)**	**# Of locations (Include any mobile locations)**	**SUPTRS BG Funds**	**COVID-19[1] Funds**	**ARP[2] Funds**	**Actions**
No Data Available							

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SUPTRS BG and MHBG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current Notice of Award Terms and Conditions.

[2] The expenditure period for The ARP supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025.

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Footnotes:

AZ did not complete the table as it is not required.

III: Expenditure Reports

Table 3b - Syringe Services Program

Expenditure Start Date: 07/01/2022 Expenditure End Date: 06/30/2023

SUPTRS

Syringe Services Program Name	# of Unique Individuals Served		HIV Testing *(Please enter total number of individuals served)*	Treatment for Substance Use Conditions *(Please enter total number of individuals served)*	Treatment for Physical Health *(Please enter total number of individuals served)*	STD Testing *(Please enter total number of individuals served)*	Hep C *(Please enter total number of individuals served)*
	0	ONSITE Testing	0	0	0	0	0
		REFERRAL to testing	0	0	0	0	0

COVID-19[1]

Syringe Services Program Name	# of Unique Individuals Served		HIV Testing *(Please enter total number of individuals served)*	Treatment for Substance Use Conditions *(Please enter total number of individuals served)*	Treatment for Physical Health *(Please enter total number of individuals served)*	STD Testing *(Please enter total number of individuals served)*	Hep C *(Please enter total number of individuals served)*
	0	ONSITE Testing	0	0	0	0	0
		REFERRAL to testing	0	0	0	0	0

ARP[2]

Syringe Services Program Name	# of Unique Individuals Served		HIV Testing *(Please enter total number of individuals served)*	Treatment for Substance Use Conditions *(Please enter total number of individuals served)*	Treatment for Physical Health *(Please enter total number of individuals served)*	STD Testing *(Please enter total number of individuals served)*	Hep C *(Please enter total number of individuals served)*
	0	ONSITE Testing	0	0	0	0	0
		REFERRAL to testing	0	0	0	0	0

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 – March 14, 2023, which is different from the expenditure period for the "standard" SUPTRS BG and MHBG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SUPTRS BG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current Notice of Award Terms and Conditions.

[2] The expenditure period for ARP supplemental funding is September 1, 2021 – September 30, 2025, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025.

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Footnotes:
AZ did not complete the table as it is not required.

III: Expenditure Reports

Table 3c – Harm Reduction Activities

Expenditure Period Start Date: 07/01/2022 Expenditure Period End Date: 06/30/2023

Harm Reduction Activities								Expenditures		
Provider/Program Name	Main Address	SSP (Yes/No)	Number of Naloxone Kits Purchased	Number of Naloxone Kits Distributed	Number of Overdoese Reversals	Number of Fentanyl Test Strips Purchased	Number of Fentanyl Test Strips Distributed	SUPTRS BG Funds	COVID-19[1] Funds	ARP[2] Funds
No Data Available										

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 - March 14, 2023, which is different from the expenditure period for the "standard" SUPTRS BG and MHBG. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current Notice of Award Terms and Conditions.

[2]The expenditure period for ARP supplemental funding is September 1, 2021 - September 30, 2025, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 - June 30, 2025.

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Footnotes:

AZ did not complete the table as it is not required.

III: Expenditure Reports

Table 4 - State Agency SUPTRS BG Expenditure Compliance Report

This table provides a description of SUPTRS BG expenditures for authorized activities to prevent and treat SUDs. For detailed instructions, refer to those in WebBGAS. Only one column is to be filled in each year.

Expenditure Period Start Date: 10/1/2020 Expenditure Period End Date: 9/30/2022

Expenditure Category	FY 2021 SA Block Grant Award
1. Substance Use Prevention[1], Treatment, and Recovery	$30,831,482.82
2. Substance Use Primary Prevention	$8,118,329.00
3. Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV)[2]	$0.00
4. Tuberculosis Services	$0.00
5. Administration (excluding program/provider level)	$1,641,518.10
Total	**$40,591,329.92**

[1]Prevention other than Primary Prevention

[2]Only designated states as defined in 42 U.S.C. § 300x-24(b)(2) and 45 CFR § 96.128(b) for the applicable federal fiscal year should enter information in this row. This may include a state or states that were previously considered "designated states" during any of the three prior FFYs for which a state was applying for a grant. See EIS/HIV policy change in SUPTRS BG Annual Report instructions.

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Footnotes:

AHCCCS expended a total of $40,644,228.44 of which AHCCCS expended $52,898.52 for Technical Assistance.

III: Expenditure Reports

SUPTRS BG Table 5a - Primary Prevention Expenditures

The state or jurisdiction must complete SUPTRS BG Table 5a. There are six primary prevention strategies typically funded by principal agencies administering the SUPTRS BG. Expenditures within each of the six strategies or Institute of Medicine Model (IOM) should be directly associated with the cost of completing the activity or task. For example, information dissemination may include the cost of developing pamphlets, the time of participating staff and/or the cost of public service announcements, etc. If a state plans to use strategies not covered by these six categories or the state is unable to calculate expenditures by strategy, please report them under "Other" in Table 5a.

Expenditure Period Start Date: 10/1/2020 Expenditure Period End Date: 9/30/2022

Strategy	IOM Target	Substance Use Block Grant	Other Federal	State	Local	Other
Information Dissemination	Selective	$100,573.79				
Information Dissemination	Indicated	$0.00				
Information Dissemination	Universal	$1,324,999.36				
Information Dissemination	Unspecified	$0.00				
Information Dissemination	**Total**	**$1,425,573.15**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Education	Selective	$470,252.92				
Education	Indicated	$108,744.02				
Education	Universal	$2,383,483.11				
Education	Unspecified	$0.00				
Education	**Total**	**$2,962,480.05**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Alternatives	Selective	$50,577.17				
Alternatives	Indicated	$0.00				
Alternatives	Universal	$301,636.52				
Alternatives	Unspecified	$0.00				
Alternatives	**Total**	**$352,213.69**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Problem Identification and Referral	Selective	$5,287.29				
Problem Identification and Referral	Indicated	$201.12				
Problem Identification and Referral	Universal	$85,727.33				
Problem Identification and Referral	Unspecified	$0.00				
Problem Identification and Referral	**Total**	**$91,215.74**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Community-Based Process	Selective	$281,089.86				
Community-Based Process	Indicated	$6,301.12				
Community-Based Process	Universal	$1,901,895.46				
Community-Based Process	Unspecified	$0.00				
Community-Based Process	**Total**	**$2,189,286.44**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Environmental	Selective	$0.00				
Environmental	Indicated	$0.00				
Environmental	Universal	$164,345.34				
Environmental	Unspecified	$0.00				
Environmental	**Total**	**$164,345.34**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Section 1926 (Synar)-Tobacco	Selective	$0.00				
Section 1926 (Synar)-Tobacco	Indicated	$0.00				
Section 1926 (Synar)-Tobacco	Universal	$0.00				
Section 1926 (Synar)-Tobacco	**Total**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Other	Universal Direct	$0.00				
Other	Universal Indirect	$0.00				
Other	Selective	$0.00				
Other	Indicated	$0.00				
Other	**Total**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
	Grand Total	**$7,185,114.41**				

Section 1926 (Synar)-Tobacco: Costs associated with the Synar Program Pursuant to the January 19, 1996 federal regulation "Tobacco Regulation for Substance Abuse Prevention and Treatment Block Grants, Final Rule" (45 CFR § 96.130), a state may not use the SABG to fund the enforcement of its statute, except that it may expend funds from its primary prevention set aside of its Block Grant allotment under 45 CFR §96.124(b)(1) for carrying out the administrative aspects of the requirements, such as the development of the sample design and the conducting of the inspections. States should include any non-SABG funds* that were allotted for Synar activities in the appropriate columns under 7 below.

*Please list all sources, if possible (e.g.., Centers for Disease Control and Prevention, Block Grant, foundations, etc.)

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

*Many coalition subrecipients that are directly contracted with AHCCCS reported their expenditures in table 5a inclusive of their indirect costs. SUBG Administrator adjusted the 5a totals proportionally to remove the duplication of the non-direct service costs.

III: Expenditure Reports

Table 5b - SUPTRS BG Primary Prevention Targeted Priorities (Required)

The purpose of the first table is for the state or jurisdiction to identify the substance and/or categories of substances it identified through its needs assessment and then addressed with primary prevention set-aside dollars from the FY 2021 SUPTRS BG NoA. The purpose of the second table is to identify each special population the state or jurisdiction selected as a priority for primary prevention set-aside expenditures.

Expenditure Period Start Date: 10/1/2020 Expenditure Period End Date: 9/30/2022

	SUPTRS BG Award
Prioritized Substances	
Alcohol	☑
Tobacco	☑
Marijuana	☑
Prescription Drugs	☑
Cocaine	☑
Heroin	☑
Inhalants	☑
Methamphetamine	☑
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☑
Fentanyl	☑
Prioritized Populations	
Students in College	☑
Military Families	☑
LGBTQ+	☑
American Indians/Alaska Natives	☑
African American	☑
Hispanic	☑
Homeless	☑
Native Hawaiian/Other Pacific Islanders	☑
Asian	☑

Rural	☑
Other Underserved Racial and Ethnic Minorities	☑

Footnotes:

III: Expenditure Reports

Table 6 - Non Direct Services/System Development

Expenditure Period Start Date: 10/1/2020 Expenditure Period End Date: 9/30/2022

Activity	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]
1. Information Systems	$318,175.23	$194,944.43	$0.00
2. Infrastructure Support	$226,169.54	$47,200.00	$0.00
3. Partnerships, community outreach, and needs assessment	$617,526.71	$154,839.84	$0.00
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	$0.00	$75,837.30	$0.00
5. Quality Assurance and Improvement	$437,921.78	$110,325.72	$0.00
6. Research and Evaluation	$346,704.11	$113,085.68	$0.00
7. Training and Education	$611,274.34	$236,981.72	$0.00
8. Total	**$2,557,771.71**	**$933,214.69**	**$0.00**

[1]Integrated refers to funds both treatment and prevention portions of the SUPTRS BG for overarching activities.

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

III: Expenditure Reports

Table 7 - Statewide Entity Inventory

This table provides a report of the sub-recipients of SUPTRS BG funds including community and faith-based organizations which provided SUD prevention activities and treatment services, as well as intermediaries/administrative service organizations. Table 7 excludes system development/non-direct service expenditures.

Expenditure Period Start Date: 10/01/2020 Expenditure Period End Date: 9/30/2022

										Source of Funds Substance Use Block Grant							
	Entity Number	I-BHS ID (formerly I-SATS)		Area Served (Statewide or SubState Planning Area)	Provider / Program Name	Street Address	City	State	Zip	A. All SUPTRS BG Funds	B. Prevention (other than primary prevention) and Treatment Services	C. Pregnant Women and Women with Dependent Children	D. Primary Prevention	E. Early Intervention Services for HIV	F. Syringe Services Program	G[1]. Opioid Treatment Programs (OTPs)	H. Office-based opioid treatment (OBOTs)
*	408874	AZ100577	X	Pima	CODAC Health, Recovery & Wellness, Inc.	502 N Silverbell Rd	Tucson	AZ	85745	$17,336.00	$0.00	$17,336.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	213286	AZ104216	X	Maricopa	Community Bridges, Inc.	2770 E. Van Buren St.	Phoenix	AZ	85008	$171,604.00	$15,021.00	$156,583.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	296965	AZ103426	X	Pima	Community Medical Services	2001 W Orange Grove Rd Ste 202	Tucson	AZ	85704	$9,112.00	$2,984.00	$3,355.00	$0.00	$0.00	$0.00	$2,773.00	$0.00
*	231924	AZ102728	X	Cochise	Community Partners Integrated Healthcare	2039 E. Wilcox Dr. Suites A & B	Sierra Vista	AZ	85635	$21,371.00	$8,501.00	$12,870.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	845604	AZ100878	X	Pinal	Ebony House, Inc	8646 S. 14th St.	Phoenix	AZ	85042	$228,065.00	$21,336.00	$206,729.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	517724	AZ901971	X	Pinal	Horizon Health and Wellness	2271 S Peart Road (Peart 4)	Casa Grande	AZ	85222	$22,113.00	$10,616.00	$11,497.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	617183	AZ102825	X	Maricopa	LIFEWELL BEHAVIORAL WELLNESS LWC Bery	2505 W. Beryl Ave.	Phoenix	AZ	85021	$71,000.00	$18,602.00	$52,398.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	617175	AZ101866	X	Maricopa	LIFEWELL BEHAVIORAL WELLNESS LWC Mitchell	40 E. Mitchell Dr.	Phoenix	AZ	85012	$359,998.00	$94,321.00	$265,678.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	762746	AZ100232	X	Maricopa.Pinal.Gila	LIFEWELL BEHAVIORAL WELLNESS LWC Power	6915 E. Main St.	Mesa	AZ	85201	$340,706.00	$89,266.00	$251,440.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	617167	AZ100239	X	Maricopa County	LIFEWELL BEHAVIORAL WELLNESS LWC University	262 E. University Dr.	Mesa	AZ	85201	$202,084.00	$52,946.00	$149,138.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	56962	AZ102764	X	Maricopa County	LIFEWELL BEHAVIORAL WELLNESS Site 1	3301 E. Pinchot Ave	Phoenix	AZ	85018	$402,270.00	$105,396.00	$296,874.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	424472	AZ750162	X	Maricopa County	Native American Connections	4520 N . Central Ave , Suite 120	Phoenix	AZ	85012	$70,400.00	$16,754.00	$53,646.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	223657	AZ101384	X	Maricopa County	Terros, Inc Priest Dr	1642 S. Priest Dr.	Phoenix	AZ	85281	$913,956.00	$4,589.00	$14,779.00	$0.00	$894,588.00	$0.00	$0.00	$0.00
*	592867	AZ750311	X	Pima	The Haven	1107 E Adelaide Dr	Tucson	AZ	85719	$310,491.00	$0.00	$310,491.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	77397	AZ103170	X	Pima	The Haven	2601 N Campbell Ave #105	Tucson	AZ	85719	$22,924.00	$0.00	$22,924.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	366918	AZ901153	X	Maricopa	Center for Behavioral Health Phoenix, Inc.	1501 East Washington Stree	Phoenix	AZ	85034	$58,325.00	$54,583.00	$3,742.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	339855	AZ100871	X	Maricopa	Center for Behavioral Health, Inc.	2123 East Southern Avene	Tempe	AZ	85282	$202,538.00	$177,627.00	$24,910.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	393718	AZ104591	X	Holbrook	Change Point Integrated Health	103 N 1st Ave	Holbrook	AZ	86025	$1,729.00	$1,532.00	$197.00	$0.00	$0.00	$0.00	$0.00	$0.00

*	426191	AZ300158		Winslow	Change Point Integrated Health	1015 East 2nd Street	Winslow	AZ	86047	$1,092.00	$967.00	$124.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	318067	AZ105631		Show Low	Change Point Integrated Health	2500 Show Low Lake Rd	Show Low	AZ	85901	$10,165.00	$9,235.00	$930.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	514765	AZ100960		Snowflake	Change Point Integrated Health	423 S Main St.	Snowflake	AZ	85937	$5,461.00	$4,839.00	$622.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	991977	AZ105631		Lakeside	Change Point Integrated Health	1920 W Commerce	Lakeside	AZ	85929	$695.00	$615.00	$79.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	185821	AZ101114		Pima	CODAC Health, Recovery & Wellness, Inc.	1075 E Fort Lowell Rd	Tucson	AZ	85719	$8,515.00	$4,388.00	$4,127.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	331673	AZ103152		Pima	CODAC Health, Recovery & Wellness, Inc.	380 E Fort Lowell Rd	Tucson	AZ	85705	$102,118.00	$60,301.00	$7,986.00	$0.00	$0.00	$0.00	$33,831.00	$0.00
*	434281	AZ104206		Pima	Community Bridges, Inc.	250 S. Toole Avenue, Ste 110	Tucson	AZ	85701	$132,852.00	$123,707.00	$9,145.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	235872	AZ103200		Pima	Community Bridges, Inc.	250 S. Toole Avenue, Ste B	Tucson	AZ	85701	$525,835.00	$470,785.00	$55,050.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	419223	AZ104199		Pinal	Community Bridges, Inc.	675 E. Cottonwood, Suite 140	Casa Grande	AZ	85122	$152,748.00	$109,757.00	$12,612.00	$0.00	$0.00	$0.00	$30,379.00	$0.00
*	533574	AZ104285		Pinal	Community Intervention Associates	1667 N Trekell Rd Suite 101-102	Casa Grande	AZ	85122	$112,325.00	$110,129.00	$2,196.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	423879	AZ103649		Pima	Community Medical Services	6802 E Broadway Blvd (closed)	Tucson	AZ	85710	$72,579.00	$28,294.00	$19,200.00	$0.00	$0.00	$0.00	$25,085.00	$0.00
*	590019	AZ101028		Maricopa County	Community Medical Services	2301 W. Northern Ave.	Phoenix	AZ	85021	$2,142,516.00	$2,079,109.00	$63,407.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	231825	AZ102870		Pima	Community Partners Integrated Healthcare	3939 S. Park Ave. Suite 150	Tucson	AZ	85714	$11,985.00	$8,444.00	$3,541.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	31601	AZ105524		Pima	Cope Community Services	5401 E. 5th Street	Tucson	AZ	85711	$122,351.00	$65,031.00	$13,511.00	$0.00	$0.00	$0.00	$43,809.00	$0.00
*	556649	AZ104662		Pima	Cope Community Services	3332 N. Los Altos	Tucson	AZ	85705	$77,738.00	$53,169.00	$24,569.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	408949	AZ104660		Pima	Cope Community Services	535 E. Drachman	Tucson	AZ	85705	$35,618.00	$31,377.00	$4,241.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	927130	AZ100912		Pima	Cope Community Services	620 N. Craycroft Rd	Tucson	AZ	85711	$17,956.00	$13,036.00	$4,920.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	112684	AZ103243		Pima	Cope Community Services	5840 N. La Cholla	Tucson	AZ	85741	$34,840.00	$15,533.00	$4,249.00	$0.00	$0.00	$0.00	$15,058.00	$0.00
*	612433	AZ103151		Yuma	Crossroads Mission	944 S Arizona Ave Bld 100	Yuma	AZ	85364	$109,434.00	$84,742.00	$24,692.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	704719	AZ103164		Yuma	Crossroads Mission	944 S Arizona Ave Bld. 200	Yuma	AZ	85364	$113,767.00	$105,974.00	$7,793.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	186858	AZ102875		Maricopa County	EMPACT Suicide Prevention Center	914 S 52nd St, Suite 100	Tempe	AZ	85281	$11,783.00	$11,212.00	$571.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	128821	AZ102753		Page	Encompass Health Services	463 S. Lake Powell Blvd.	Page	AZ	86040	$427,963.00	$422,751.00	$5,212.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	737330	AZ102754		Page	Encompass Health Services	32 N. 10th Ave Ste 5	Page	AZ	86040	$16,029.00	$15,829.00	$201.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	433954	AZ102754		Fredonia	Encompass Health Services	170 N Main	Fredonia	AZ	86022	$15,282.00	$15,090.00	$191.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	675748	AZ101869		Littlefield	Encompass Health Services	4103 E Fleet	Littlefield	AZ	86432	$25,418.00	$25,100.00	$318.00	$0.00	$0.00	$0.00	$0.00	$0.00

*	346214	AZ101722	X	Pinal County	Gila River Health Care BHS	483 W Seed Farm Rd	Sacaton	AZ	85147	$302,295.00	$132,484.00	$971.00	$168,839.00	$0.00	$0.00	$0.00	$0.00
*	683287	AZ101868	X	Pinal County	Gila River Health Care OASIS	291 W. Casa Blanca Rd.	Sacaton	AZ	85147	$27,913.00	$26,915.00	$998.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	467033	x	X	Maricopa County	Gila River Health Care RTH	3042 W Queen Creek Road	Chandler	AZ	85286	$26,005.00	$22,966.00	$3,039.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	589093	AZ101809	X	Maricopa County	Gila River Health Care Thwajik Ki RTC	3850 N. 16th Street	Laveen	AZ	85339	$47,408.00	$47,272.00	$136.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	6579	AZ101080	X	Flagstaff	Health Choice Arizona	1300 South Yale St	Flagstaff	AZ	86001	$451,911.00	$435,304.00	$16,606.00	$0.00	$9,277.00	$0.00	$0.00	$0.00
*	395648	AZ103345	X	Pinal	Horizon Health and Wellness	450 W Adamsville Rd	Florence	AZ	85132	$23,846.00	$17,840.00	$2,988.00	$0.00	$0.00	$0.00	$3,018.00	$0.00
*	492195	AZ103352	X	Yuma	Horizon Health and Wellness	3180 E 40th Street	Yuma	AZ	85365	$93,727.00	$73,343.00	$20,384.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	1508942723	AZ101044	X	Maricopa County	Intensive Treatment Systems Main	651 W Coolidge Street Phoenix AZ 85013	Phoenix	AZ	85013	$189,095.00	$186,927.00	$2,168.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	1811073059	AZ101490	X	Maricopa County	Intensive Treatment Systems North	19401 N Cave Creek Rd #18 Phoenix AZ 85024	Phoenix	AZ	85024	$376,890.00	$373,854.00	$3,036.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	1184701906	AZ101030	X	Maricopa	Intensive Treatment Systems West	4136 N 75th Ave Ste 116, Phoenix, AZ 85033	Phoenix	AZ	85033	$377,324.00	$373,854.00	$3,470.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	57837	AZ103099	X	Pima	La Frontera Center	1900 W. Speedway	Tucson	AZ	85745	$313,287.00	$277,738.00	$35,549.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	68233	AZ100921	X	Pima	La Frontera Center	4891 E. Grant Road	Tucson	AZ	85712	$116,029.00	$88,611.00	$27,418.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	7519	AZ100665	X	Springerville	Little Colorado Behavioral Health Center	50 N. Hopi	Springerville	AZ	85938	$4,645.00	$3,618.00	$1,027.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	3442	AZ300133	X	Saint Johns	Little Colorado Behavioral Health Center	470 West Cleveland Street	Saint Johns	AZ	85936	$15,238.00	$11,870.00	$3,368.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	515719	AZ100619	X	Bullhead City	Mohave Mental Health Clinic	2580 Hwy 95 Ste. 208, 209, 210	Bullhead City	AZ	86442	$3,051.00	$2,760.00	$291.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	116667	AZ101040	X	Bullhead City	Mohave Mental Health Clinic	1145 Marina Boulevard	Bullhead City	AZ	86442	$54,607.00	$49,398.00	$5,209.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	117136	AZ300174	X	Kingman	Mohave Mental Health Clinic	3505 Western Ave.	Kingman	AZ	86409	$90,030.00	$81,442.00	$8,588.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	589848	AZ102112	X	Kingman	Mohave Mental Health Clinic	1741 Sycamore Avenue	Kingman	AZ	86409	$60,514.00	$54,741.00	$5,772.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	690405	AZ100945	X	Kingman	Mohave Mental Health Clinic	915 Airway Ave	Kingman	AZ	86409	$2,614.00	$2,365.00	$249.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	147125	AZ100491	X	Lake Havasu City	Mohave Mental Health Clinic	2187 Swanson Avenue	Lake Havasu City	AZ	86403	$78,332.00	$70,860.00	$7,472.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	213385	AZ101295	X	Lake Havasu City	Mohave Mental Health Clinic	151 Riviera Ste B	Lake Havasu City	AZ	86403	$7,111.00	$6,433.00	$678.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	895659	AZ901070	X	Graham	Southeastern Arizona Behavioral Health Services	1615 S 1st Avenue	Safford	AZ	85546	$24,464.00	$24,203.00	$261.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	559042	AZ100848	X	Cochise	Southeastern Arizona Behavioral Health Services	611 W Union St	Benson	AZ	85602	$17,977.00	$15,431.00	$2,546.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	253753	AZ100679	X	Lake Havasu City	Southwest Behavioral Health Services	1845 McColloch Blvd Ste B1	Lake Havasu City	AZ	86403	$74,966.00	$73,460.00	$1,506.00	$0.00	$0.00	$0.00	$0.00	$0.00

*	348874	AZ102777	X	Prescott Valley	Southwest Behavioral Health Services	7600 E. Florentine Ave Ste. 101	Prescott Valley	AZ	86314	$138,653.00	$135,868.00	$2,785.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	435457	AZ100994	X	Bullhead City	Southwest Behavioral Health Services	2580 HWY 95 Ste 119-125	Bullhead City	AZ	86442	$31,213.00	$30,586.00	$627.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	172632	AZ100678	X	Bullhead City	Southwest Behavioral Health Services	809 Hancock Rd Ste 1	Bullhead City	AZ	86442	$71,931.00	$70,487.00	$1,445.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	950683	AZ104698	X	Bullhead City	Southwest Behavioral Health Services	401 Emery St	Bullhead City	AZ	86442	$69,873.00	$68,469.00	$1,403.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	237443	AZ100668	X	Kingman	Southwest Behavioral Health Services	2215 Hualapai Mountain Rd. Ste. H&I	Kingman	AZ	86401	$50,017.00	$49,012.00	$1,005.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	263067	AZ104697	X	Kingman	Southwest Behavioral Health Services	1301 W Beal St	Kingman	AZ	86401	$26,430.00	$25,899.00	$531.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	560020	AZ101979	X	Payson	Southwest Behavioral Health Services	8985 W Stageline Rd	Payson	AZ	85541	$326.00	$320.00	$7.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	83489	AZ102777	X	Prescott Valley	Southwest Behavioral Health Services	7600 E Florentine Rd	Prescott Valley	AZ	86314	$51,401.00	$50,369.00	$1,032.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	216898	AZ100993	X	Flagstaff	Southwest Behavioral Health Services	1515 E. Cedar Ave. Ste B2	Flagstaff	AZ	86004	$84,805.00	$83,101.00	$1,703.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	389892	AZ104584	X	Maricopa County	Southwest Behavioral Health Services, Inc	1424 S. 7th Ave	Phoenix	AZ	85007	$274,459.00	$272,356.00	$2,103.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	438745	AZ100886	X	Cottonwood	Spectrum Healthcare Group	8 E. Cottonwood St. Bldg C	Cottonwood	AZ	86326	$23,834.00	$22,135.00	$1,699.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	153499	AZ101170	X	Cottonwood	Spectrum Healthcare Group	651 West Mingus Ace	Cottonwood	AZ	86326	$2,656.00	$2,467.00	$189.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	184460	AZ100931	X	Cottonwood	Spectrum Healthcare Group	8 E. Cottonwood St.	Cottonwood	AZ	86326	$35,573.00	$33,482.00	$2,091.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	57952	AZ100384	X	Cottonwood	Spectrum Healthcare Group	8 E. Cottonwood St.	Cottonwood	AZ	86326	$242,137.00	$230,613.00	$11,525.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	144577	AZ104857	X	Sedona	Spectrum Healthcare Group	2880 Hopi Dr	Sedona	AZ	86336	$50.00	$47.00	$4.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	290679	AZ101170	X	Camp Verde	Spectrum Healthcare Group	452 Finnie Flats Rd	Camp Verde	AZ	86322	$9,406.00	$8,735.00	$671.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	116807	AZ101006	X	Williams	The Guidance Center	220 W. Grant Street	Williams	AZ	86046	$4,288.00	$4,041.00	$247.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	106944	AZ100434	X	Flagstaff	The Guidance Center	2188 N. Vickey Street	Flagstaff	AZ	86004	$248,734.00	$234,401.00	$14,332.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	154902	AZ100434	X	Flagstaff	The Guidance Center	2187 N. Vickey Street	Flagstaff	AZ	86004	$35,118.00	$33,095.00	$2,024.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	158133	AZ101007	X	Flagstaff	The Guidance Center	2695 E. Industrial Dr	Flagstaff	AZ	86004	$37,722.00	$35,549.00	$2,174.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	969884	AZ101008	X	Flagstaff	The Guidance Center	2697 E. Industrial Dr	Flagstaff	AZ	86004	$65,499.00	$61,725.00	$3,774.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	90458	AZ102793	X	Yuma	Transitional Living Center Recovery	1340 S. 4th Avenue	Yuma	AZ	85364	$34,046.00	$30,955.00	$3,091.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	90406	AZ100684	X	Pinal	Transitional Living Center Recovery	117 E. 2nd Street	Casa Grande	AZ	85122	$55,535.00	$41,265.00	$14,270.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	53059	AZ100095	X	Maricopa County	Valle del Sol	1209 S 1st Avenue	Phoenix	AZ	85003	$330,703.00	$314,179.00	$16,525.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	388606	AZ100504	X	Maricopa County	Valle del Sol	3807 N 7th Street	Phoenix	AZ	85014	$29,245.00	$29,084.00	$161.00	$0.00	$0.00	$0.00	$0.00	$0.00
*	580100	AZ101704	X	Maricopa County	Valle del Sol	4135 S Power Road Ste. 108	Mesa	AZ	85212	$7,990.00	$7,889.00	$101.00	$0.00	$0.00	$0.00	$0.00	$0.00

*	*347204*	*AZ100686*		*Maricopa County*	*Valle del Sol*	*509 S Rockford Drive*	*Tempe*	*AZ*	*85251*	*$166,851.00*	*$154,389.00*	*$12,462.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*
*	*801237*	*AZ104715*		*Maricopa County*	*Valle del Sol*	*8410 W Thomas Road Suite 116*	*Phoenix*	*AZ*	*85037*	*$25,628.00*	*$25,614.00*	*$14.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*
*	*159727*	*AZ000221*		*Prescott Valley*	*West Yavapai Guidance Center*	*3345 N. Windsong Drive*	*Prescott Valley*	*AZ*	*86314*	*$34,595.00*	*$33,478.00*	*$1,117.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*
*	*290802*	*AZ103176*		*Prescott Valley*	*West Yavapai Guidance Center*	*8655 E. Eastridge Rd*	*Prescott Valley*	*AZ*	*86314*	*$15,641.00*	*$15,136.00*	*$505.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*
*	*347207*	*AZ103176*		*Prescott Valley*	*West Yavapai Guidance Center*	*8655 E. Eastridge Rd*	*Prescott Valley*	*AZ*	*86314*	*$92,144.00*	*$89,168.00*	*$2,976.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*
*	*366233*	*AZ101842*		*Prescott Valley*	*West Yavapai Guidance Center*	*3345 N. Windsong Drive*	*Prescott Valley*	*AZ*	*86314*	*$165,594.00*	*$160,245.00*	*$5,349.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*
*	*3434*	*AZ300117*		*Prescott*	*West Yavapai Guidance Center*	*505 S Cortez*	*Prescott*	*AZ*	*86303*	*$14,293.00*	*$13,831.00*	*$462.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*
*	*116790*	*AZ101309*		*Prescott*	*West Yavapai Guidance Center*	*642 Dameron Drive*	*Prescott*	*AZ*	*86301*	*$175,872.00*	*$170,191.00*	*$5,680.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*
*	*591562*	*AZ100689*		*Prescott*	*West Yavapai Guidance Center*	*642 Dameron Dr*	*Prescott*	*AZ*	*86301*	*$331,629.00*	*$320,918.00*	*$10,711.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*
*	*904511*	*AZ101278*		*Chino Valley*	*West Yavapai Guidance Center*	*555 W Road 3 North*	*Chino Valley*	*AZ*	*86323*	*$25,992.00*	*$25,152.00*	*$840.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*
	419898	X		Pima	Adam Case	380 E Ft Lowell Rd	Tucson	AZ	85705	$22,456.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$22,456.00
	502289	X		Pinal	Allison C. Scott, PMHNP	675 E. Cottonwood Ave.	Casa Grande	AZ	85122	$175.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$175.00
	89255	X		Pima	Amy Vanden Heuvel	8050 E. Lakeside Parkway	Tucson	AZ	85730	$1,118.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,118.00
	45394	X		Pinal	Angela Webb, NP	625 N Plaza	Apache Junction	AZ	85120	$108.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$108.00
	10422	AZ103012		So.AZ Counties	Arizona Complete Health Complete Care Plan	333 E Wetmore	Tucson	AZ	85705	$258,867.00	$258,867.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	7689949	AZ103571		Phoenix	Ascend Bevhaioral Health	33508 N 24th Ln	Phoenix	AZ	85085	$10,457.00	$10,457.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	319460	AZ101530		Maricopa	BAART Behavioral Health Services	908 A West Chandler Blvd.	Chandler	AZ	85225	$77,300.00	$77,300.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	620864	X		Pinal	Bryan M. Davis, DO	675 E. Cottonwood Ave.	Casa Grande	AZ	85122	$37.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$37.00
	925422	AZ102144		Guadalupe	Centered Spirit Maricopa	9405 S. Avenida Del Yaqui	Guadalupe	AZ	85283	$236,000.00	$0.00	$0.00	$236,000.00	$0.00	$0.00	$0.00	$0.00
	530296	X		Pinal	Charlene Diaz NP	625 N Plaza	Apache Junction	AZ	85120	$2,809.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2,809.00
	445266	AZ104700		Flagstaff	Children & Family Support Services	3100 N West St.	Flagstaff	AZ	86004	$1,318.00	$1,318.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	136923	X		Pima	Christa Cuellar, FNP C	2001 W Orange Grove, Suite 202	Tucson	AZ	85704 -113	$12,520.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$12,520.00
	34061	X		Pima	Christopher Neal	6802 E. Broadway Blvd.	Tucson	AZ	85710	$2,832.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2,832.00
	345961	AZ103167		Pima	CODAC Health, Recovery & Wellness, Inc.	630 N Alvernon Way	Tucson	AZ	85711	$34,704.00	$34,704.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	35468	AZ103168		Pima	CODAC Health, Recovery & Wellness, Inc.	1600 N Country Club Rd	Tucson	AZ	85716	$281.00	$281.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

	164588	AZ102120		Pima	Community Bridges, Inc.	2950 N Dodge Blvd	Tucson	AZ	85716	$420,730.00	$420,730.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	242445	AZ103202		Pima	Community Bridges, Inc.	250 S. Toole Avenue, Ste A	Tucson	AZ	85701	$138,802.00	$138,802.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	221736	AZ104217		Maricopa	Community Bridges, Inc.	358 E. Javelina Ave.	Mesa	AZ	85210	$185,984.00	$185,984.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	382935	AZ100796		Phoenix	Community Bridges, Inc.	2770 E Van Buren	Phoenix	AZ	85008	$236.00	$236.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	238225	AZ103204		Pima	Community Bridges, Inc.	250 S. Toole Avenue, Ste C	Tucson	AZ	85701	$217,528.00	$217,528.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	341724	AZ101825		Pinal	Community Bridges, Inc.	675 E. Cottonwood, Suite 101	Casa Grande	AZ	85122	$24,257.00	$15,461.00	$0.00	$0.00	$0.00	$0.00	$8,796.00	$0.00
	407986	AZ103687		Maricopa County	Community Bridges, Inc.	1520 E. Pima St.	Phoenix	AZ	85034	$82,853.00	$82,853.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	237236	AZ104210		Cochise	Community Bridges, Inc.	240 O'Hara Avenue, PO Box 943	Bisbee	AZ	85603	$1,753.00	$1,753.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	657478	AZ100512		Cochise	Community Bridges, Inc.	470 S Ocotillo Avenue	Benson	AZ	85602	$74,683.00	$74,683.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	453702	AZ105417		Maricopa	Community Bridges, Inc.	560 S. Bellview	Mesa	AZ	85204	$156,849.00	$156,849.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	210945	AZ104229		Maricopa	Community Bridges, Inc.	824 N. 99th Ave.	Avondale	AZ	85323	$303,334.00	$303,334.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	382935	AZ100796		Maricopa	Community Bridges, Inc.	2770 E. Van Buren St.	Phoenix	AZ	85008	$35,664.00	$35,664.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	385867	AZ105409		Maricopa	Community Bridges, Inc.	560 S. Bellview	Mesa	AZ	85204	$36,725.00	$36,725.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	210846	AZ100513		Maricopa	Community Bridges, Inc.	1012 S. Stapley Dr. Bldg. 5	Mesa	AZ	85204	$38,928.00	$38,928.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	210909	AZ100973		Maricopa	Community Bridges, Inc.	554 S. Bellview	Mesa	AZ	85204	$130,356.00	$130,356.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	451901	AZ100519		Maricopa	Community Bridges, Inc.	1125 W. Jackson St.	Phoenix	AZ	85007	$50,245.00	$50,245.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	325351	AZ101831		Maricopa	Community Bridges, Inc.	824 N. 99th Ave.	Avondale	AZ	85323	$2,458.00	$2,458.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	333246	AZ101832		Winslow	Community Bridges, Inc.	110 E. 2nd St	Winslow	AZ	86047	$87,967.00	$87,967.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	210945	AZ101831		Avondale	Community Bridges, Inc.	824 N. 99th Ave	Avondale	AZ	85323	$466.00	$466.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	252714	AZ101829		Payson	Community Bridges, Inc.	803C W. Main St	Payson	AZ	85541	$38,517.00	$38,517.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	422788	AZ101833		Winslow	Community Bridges, Inc.	105 N Cottonwood Ave	Winslow	AZ	86047	$24,920.00	$24,920.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	438223	AZ101828		Globe	Community Bridges, Inc.	5734 E Hope Lane	Globe	AZ	85501	$37,577.00	$37,577.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	378626	AZ101827		Globe	Community Bridges, Inc.	5737 E Hope Lane	Globe	AZ	85501	$20,412.00	$20,412.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	206501	AZ101834		Yuma	Community Bridges, Inc.	3250 East 40th St., Suite C	Yuma	AZ	85365	$133,405.60	$85,794.60	$0.00	$0.00	$0.00	$0.00	$47,611.00	$0.00
	488183	AZ101695		Yuma	Community Bridges, Inc.	3250 E 40th Street	Yuma	AZ	85365	$195,396.00	$163,323.00	$0.00	$0.00	$0.00	$0.00	$32,073.00	$0.00
	488183	AZ101834		Yuma	Community Bridges, Inc.	3250 B East 40th St.	Yuma	AZ	85365	$693.00	$693.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	23659	AZ100518		Holbrook	Community Bridges, Inc.	993 Hermosa Dr, Area B	Holbrook	AZ	86025	$140,357.00	$140,357.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	389308	AZ104283		Yuma	Community Intervention Associates	410 S Maiden Lane	Yuma	AZ	85364	$55,001.00	$55,001.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	160138	AZ101097		Pima	Community Intervention Associates	1773 West St Mary Road Suite 105	Tucson	AZ	85745	$2,403,447.00	$2,403,447.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	156147	AZ103071		Pima	Community Intervention Associates	1773 West St Mary Road Suite 102	Tucson	AZ	85745	$822.00	$822.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	373651	AZ103477		Graham	Community Medical Services	102 E Main St	Safford	AZ	85546	$1,704.00	$865.00	$0.00	$0.00	$0.00	$0.00	$839.00	$0.00

	478012	AZ103683	X	Cochise	Community Medical Services	302 El Camino Real Bldg 10, Suites C & D	Sierra Vista	AZ	85635	$4,545.00	$2,308.00	$0.00	$0.00	$0.00	$0.00	$2,237.00	$0.00
	560277	AZ104255	X	Yuma	Community Medical Services	501 W 8TH ST	Yuma	AZ	85364	$12,317.00	$6,254.00	$0.00	$0.00	$0.00	$0.00	$6,063.00	$0.00
	507294	AZ103876	X	Santa Cruz	Community Medical Services	274 W Viewpoint Dr	Nogales	AZ	85621	$3,555.00	$1,805.00	$0.00	$0.00	$0.00	$0.00	$1,750.00	$0.00
	366686	AZ103434	X	Pinal	Community Medical Services	440 N Camino Mercado Ste 2	Casa Grande	AZ	85122	$2,586.00	$1,313.00	$0.00	$0.00	$0.00	$0.00	$1,273.00	$0.00
	231843	AZ101843	X	Yuma	Community Partners Integrated Healthcare	2545 S. Arizona Ave. Bldg A-D	Yuma	AZ	85364	$8,725.00	$8,725.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	232022	AZ102733	X	Cochise	Community Partners Integrated Healthcare	500 S. Highway 80 Suite A	Benson	AZ	85602	$4,928.00	$4,928.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	232459	AZ102730	X	Graham	Community Partners Integrated Healthcare	301 E. 4th St. Suites A & B	Safford	AZ	85546	$5,218.00	$5,218.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	232617	AZ103265	X	La Paz	Community Partners Integrated Healthcare	1021 Kofa Ave.	Parker	AZ	85344	$1,572.00	$1,572.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	554498	AZ103273	X	Pima	Community Partners Integrated Healthcare	1021 E Palmdale, Ste. 130	Tucson	AZ	85714	$39,898.00	$20,557.00	$0.00	$0.00	$0.00	$0.00	$19,341.00	$0.00
	178248	AZ102871	X	Pima	Community Partners Integrated Healthcare	2502 N. Dodge Blvd. Suite 190	Tucson	AZ	85716	$10,277.00	$10,277.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	347216	AZ101836	X	Pima	Cope Community Services	1501 W. Commerce Court	Tucson	AZ	85746	$375,602.00	$46,591.00	$0.00	$0.00	$329,011.00	$0.00	$0.00	$0.00
	918854	AZ100740	X	Pima	Cope Community Services	8050 E. Lakeside Pkwy	Tucson	AZ	85730	$8,987.00	$8,987.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	108742	AZ101837	X	Pima	Cope Community Services	1660 W. Commerce Court Place	Green Valley	AZ	85614	$14,629.00	$14,629.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	921819	AZ103239	X	Pima	Cope Community Services	2435 N. Castro Avenue	Tucson	AZ	85705	$30,977.00	$30,977.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	298346	AZ103241	X	Pima	Cope Community Services	924 N. Alvernon	Tucson	AZ	85712	$27,589.00	$27,589.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	716251	AZ102108	X	Pinal	Corazon	900 E Florence Blvd Suite G	Casa Grande	AZ	85122	$9,139.00	$9,139.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	112219	AZ103000	X	Maricopa County	CPLC: CENTRO DE LA FAMILIA	6850 W. Indian School RD	Phoenix	AZ	85033	$166,891.00	$166,891.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	1255851994	AZ103906	X	Maricopa County	Crossroads, Inc.	1700 E. Thomas Rd	Phoenix	AZ	85016	$3,934,743.00	$3,934,743.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	513925	X	X	Pima	Daniel Maduma, DNP, FNP	250 S. Toole Avenue	Tucson	AZ	85701	$234.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$234.00
	288923	X	X	Pima	Daniela Losey	380 E Ft Lowell Rd	Tucson	AZ	85705	$27,009.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$27,009.00
	506361	X	X	Pima	Denise Patterson	620 N. Craycroft	Tucson	AZ	85711	$1,016.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,016.00
	439095	AZ100600	X	Maricopa County	Destiny Sober Living	5306 N 17th Ave	Phoenix	AZ	85015	$1,622.00	$1,622.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	439095	AZ100171	X	Maricopa	Destiny Sober Living	5306 N 17th Ave	Phoenix	AZ	85015	$2,434.00	$2,434.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	274629	AZ103994	X	Maricopa	Ebony House, Inc	6218 S. 13th St.	Phoenix	AZ	85042	$34,811.00	$34,811.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	319790	AZ750154	X	Maricopa	Ebony House, Inc	6222 S. 13th St.	Phx	AZ	85042	$21,336.00	$21,336.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	274629	AZ103994	X	Pinal	Ebony House, Inc	6222 S. 13th St. Building Y	Phoenix	AZ	85042	$34,811.00	$34,811.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

	614534	X	X	Pima	Elizabeth Moran	924 N. Alvernon Way	Tucson	AZ	85711	$21,587.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$21,587.00
	084711	AZ102873	X	Pinal County	EMPACT Suicide Prevention Center	2474 E Hunt Highway, Suite A100	San Tan Valley	AZ	85143	$35,307.00	$35,307.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	756486	AZ100540	X	Maricopa County	EMPACT Suicide Prevention Center	618 S Madison Dr	Tempe	AZ	85281	$41,865.00	$41,865.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	622987	AZ101844	X	Maricopa County	EMPACT Suicide Prevention Center	4425 W Olive Ave, Suite 194	Glendale	AZ	85302	$38,150.00	$38,150.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	183711	AZ102874	X	Maricopa County	EMPACT Suicide Prevention Center	11518 E Apache Trail, Ste 129	Apache Junction	AZ	85120	$18,908.00	$18,908.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	127021	X	X	Pinal	Ethel O. Winfunke, FNP	675 E Cottonwood Lane	Casa Grande	AZ	85122	$4,843.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4,843.00
	231251	X	X	Pima	Frederick Mittleman	3939 S Park Avenue Ste 150-190	Tucson	AZ	85714	$51.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$51.00
	334582	AZ100964	X	Pinal County	Gila River Health Care Family Planning	PO BOX 2175	Sacaton	AZ	85147	$18,686.00	$0.00	$0.00	$0.00	$18,686.00	$0.00	$0.00	$0.00
	266554	X	X	Cochise	Helen T. Ferrer Irwin, GNP	470 S Ocotillo Avenue	Benson	AZ	85602	$2,753.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2,753.00
	49454	AZ101861	X	Pinal	Helping Associates	1901 N. Trekell Rd. Ste A	Casa Grande	AZ	85122	$27,908.00	$27,908.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	363298	X	X	Pima	Herald Surya	380 E Ft Lowell Rd	Tucson	AZ	85705	$1,464.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,464.00
	756638	AZ100839	X	Pima	HOPE, Inc.	1200 N.Country Club Rd	Tucson	AZ	85716	$4,504.00	$4,504.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	6758	AZ103086	X	Yuma	HOPE, Inc.	201 S. 1st Ave	Yuma	AZ	85364	$12,257.00	$12,257.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	401711	AZ103350	X	Globe	Horizon Health & Wellness	478 Hagen Road	Globe	AZ	85501	$1,745.00	$1,745.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	772758	AZ103357	X	Pinal	Horizon Health and Wellness	2269 S Peart RoadD (Peart 3)	Casa Grande	AZ	85222	$19,774.00	$19,774.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	431556	AZ103344	X	Yuma	Horizon Health and Wellness	791 S 4th Avenue, Ste A	Yuma	AZ	85364	$19,966.00	$19,966.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	34269	AZ103351	X	Yuma	Horizon Health and Wellness	3180 E 40th Street	Yuma	AZ	85365	$778.00	$778.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	898413	AZ104665	X	Pinal	Horizon Health and Wellness	210 E Cottonwood Lane	Casa Grande	AZ	85222	$17,912.00	$12,826.00	$0.00	$0.00	$0.00	$0.00	$5,086.00	$0.00
	593908	AZ102128	X	Pinal	Horizon Health and Wellness	625 N Plaza Drive	Apache Junction	AZ	85120	$9,914.00	$7,785.00	$0.00	$0.00	$0.00	$0.00	$2,129.00	$0.00
	48648	AZ103360	X	Pinal	Horizon Health and Wellness	115/117 W 2nd Street	Casa Grande	AZ	85122	$1,215.00	$1,215.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	346363	AZ103358	X	Pinal	Horizon Health and Wellness	222 E Cottonwood Lane	Casa Grande	AZ	85122	$14.00	$14.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	451145	AZ100880	X	Pima	Intermountain Centers for Human Development	994 S. Harrison Road	Tucson	AZ	85748	$6,856.00	$6,856.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	198509	AZ103129	X	Pima	Intermountain Health Centers Inc	5055 E. Broadway Blvd, Suite C-104	Tucson	AZ	85711	$390.00	$390.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	223743	X	X	Pima	James McGlamery	260 S Scott Ave	Tucson	AZ	85713	$5,053.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5,053.00
	71049	X	X	Pima	Jennifer Budd	2435 N. Castro St.	Tucson	AZ	85705	$506.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$506.00
	810459	AZ101534	X	Maricopa	Jewish Family & Children's Service	3001 N. 33rd Ave.	Phoenix	AZ	85017	$3,361.00	$3,361.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

	584965	AZ100507	X	Maricopa	Jewish Family & Children's Service	1840 N. 99th Ave. Ste 146	Phoenix	AZ	85037	$1,875.00	$1,875.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	007486	AZ100726	X	Maricopa	Jewish Family & Children's Service	5701 W. Talavi Blvd. Ste. 180	Glendale	AZ	85306	$3,996.00	$3,996.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	810095	AZ100374	X	Maricopa	Jewish Family & Children's Service	1255 W. Baseline Rd. Ste B258	Mesa	AZ	85202	$2,630.00	$2,630.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	356648	X	X	Pima	John Mark Rogers, FNP	250 S. Toole Avenue	Tucson	AZ	85701	$4,040.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4,040.00
	485046	X	X	Pima	John Schmaling	6802 E Broadway Boulevard	Tucson	AZ	85710	$19,287.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$19,287.00
	869990	X	X	Pima	Judith M. Ochieng, FNP	250 S. Toole Avenue	Tucson	AZ	85701	$165.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$165.00
	353497	X	X	Pima	Kelsey E. Brisbin, PMHNP	250 S. Toole Avenue	Tucson	AZ	85701	$2,745.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2,745.00
	603898	AZ100152	X	Pima	La Frontera Center	260 S. Scott Avenue	Tucson	AZ	85701	$158,302.00	$81,043.00	$0.00	$0.00	$0.00	$0.00	$77,259.00	$0.00
	57464	AZ102194	X	Pima	La Frontera Center	10841 N. Thornydale Rd.	Tucson	AZ	85742	$27,061.00	$27,061.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	603843	AZ750550	X	Pima	La Frontera Center	502 W. 29th Street	Tucson	AZ	85713	$156,220.00	$156,220.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	277449	AZ103253	X	Douglas, AZ	La Frontera SEABHS Douglas Coalition	936 F. Ave	Douglas	AZ	85607	$96,679.00	$0.00	$0.00	$96,679.00	$0.00	$0.00	$0.00	$0.00
	158677	X	X	Pima	Larry Onate	380 E Ft Lowell Rd	Tucson	AZ	85705	$50,083.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$50,083.00
	276234	X	X	Pima	Lisa Robertson	3620 N. Mountain	Tucson	AZ	85719	$8,803.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$8,803.00
	369445	X	X	Pima	Monica Leverette	380 E Ft Lowell Rd	Tucson	AZ	85705	$22,971.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$22,971.00
	151346	AZ750162	X	Maricopa County	Native American Connections	4520 N . Central Ave - Suite 100	Phoenix	AZ	85012	$108,658.00	$108,658.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	347143	AZ102050	X	Prescott	NAZCARE	599 White Spar Rd	Prescott	AZ	86303	$11,327.00	$11,327.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	893554	AZ101283	X	Maricopa County	New Hope Behavioral Health Centers	215 S Power Rd Suite 114	Mesa	AZ	85208	$234,105.00	$234,105.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	539184	AZ101041	X	Flagstaff	North Country Health Care	2920 N. 4th Street	Flagstaff	AZ	86004	$70,151.00	$0.00	$0.00	$0.00	$70,151.00	$0.00	$0.00	$0.00
	349127	AZ101835	X	Maricopa County	Open Hearts	4414 N. 19th Ave	Phoenix	AZ	85015	$87,072.00	$87,072.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	218075	AZ101774	X	Tucson	Pascua Yaqui Tribe Pima	7490 S. Camino de Oeste	Tucson	AZ	85746	$123,750.00	$123,750.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	274453	AZ102093	X	Pima	Pima Prevention Partnership	924 N. Alvernon Way Suite 150	Tucson	AZ	85711	$44,620.00	$44,620.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	688903	X	X	Eloy	Pinal Hispanic Council Eloy Governor's Alliance Against Drug Coalition	107 E 4TH ST	ELOY	AZ	85131	$82,816.00	$0.00	$0.00	$82,816.00	$0.00	$0.00	$0.00	$0.00
	519324	AZ100658	X	Santa Cruz	Pinal Hispanic Council, Inc.	275 N Grand Court Plaza	Nogales	AZ	85621	$3,079.00	$3,079.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	991830	X	X	Pima	Scott A. Kristie, PMHNP	2950 N Dodge Blvd.	Tucson	AZ	85716	$3,848.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3,848.00
	407398	AZ103544	X	99	Sonoran Prevention Works	2211 S. 48th St	Tempe	AZ	85282	$806,697.00	$806,697.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	336159	AZ104881	X	Cochise	Southeastern Arizona Behavioral Health Services	4755 Campus Dr	Sierra Vista	AZ	85635	$24,245.00	$24,245.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	277449	AZ103249	X	Cochise	Southeastern Arizona Behavioral Health Services	936 F Ave, Ste B	Douglas	AZ	85607	$4,733.00	$4,733.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

	AZ100992	AZ100992	X	Pima County	Southern Arizona AIDS Foundation	375 S. Euclid Ave	Tucson	AZ	85719	$23,217.00	$0.00	$0.00	$0.00	$0.00	$23,217.00	$0.00	$0.00
	AZ100992	AZ100992	X	Pima	Southern Arizona Aids Foundation	375 Euclid Avenue	Tucson	AZ	85719	$31,489.00	$0.00	$0.00	$0.00	$31,489.00	$0.00	$0.00	$0.00
	AZ100992	AZ100992	X	Pima County	Southern Arizona AIDS Foundation Youth Empowerment and LGBTQ Leadership	526 N. 4th Ave.	Tucson	AZ	85705	$120,283.00	$0.00	$0.00	$120,283.00	$0.00	$0.00	$0.00	$0.00
	215898	X	X	Yuma	Tammi Bancroft	3250 E. 40th St.	Yuma	AZ	85365	$25,561.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$25,561.00
	980961	AZ100003	X	Maricopa County	Terros, Inc	1111 S. Stapley Dr.	Mesa	AZ	85204	$100,115.00	$100,115.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	810053	AZ104113	X	Maricopa County	Terros, Inc	3864 N. 27th Avenue	Phoenix	AZ	85017-470	$79,082.00	$79,082.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	907972	AZ100766	X	Maricopa County	Terros, Inc	4425 W. Olive Ave #200 & #140	Glendale	AZ	85302-384	$57,670.00	$57,670.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	056996	AZ301404	X	Maricopa County	Terros, Inc	4909 E. McDowell Rd	Phoenix	AZ	85008-773	$105,074.00	$105,074.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	906404	Az103582	X	Maricopa County	Terros, Inc	5801 N. 51st Avenue	Glendale	AZ	85301	$87,898.87	$87,898.87	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	011432	AZ100001	X	Maricopa County	Terros, Inc	6153 W. Olive Ave	Glendale	AZ	85302-456	$55,588.00	$55,588.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	950925	AZ101378	X	Maricopa County	Terros, Inc	2400 W Dunlap Ave. Ste 300	Phoenix	AZ	85021	$12,380.00	$12,380.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	037862	AZ100968	X	Maricopa County	Terros, Inc 23rd Ave	8836 N 23rd Ave. Ste B1	Phoenix	AZ	85021	$6,134.00	$6,134.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	232932	AZ101383	X	Maricopa County	Terros, Inc 51st Ave	4616 N 51st Ave	Phoenix	AZ	85031	$4,437.00	$4,437.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	151359	AZ100463	X	Pima	Touchstone Behavioral Health	1430 E Fort Lowell Road Ste 100	Tucson	AZ	85719	$47,212.00	$47,212.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	357279	AZ101943	X	Maricopa County	Touchstone Behavioral Health, Inc	15648 North 35th Avenue	Phoenix	AZ	85053	$6,332.00	$6,332.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	378853	AZ100737	X	Maricopa County	Touchstone Behavioral Health, Inc	3602 East Greenway, Suite 102	Phoenix	AZ	85032	$9,498.00	$9,498.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	7667	AZ103627	X	Maricopa County	Unhooked	215 S Power Rd STE 1251	Mesa	AZ	85206	$116,144.00	$116,144.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	258528	AZ103631	X	Maricopa County	Unhooked	5801 E Main St.	Mesa	AZ	85205	$309,716.00	$309,716.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	493467	AZ102756	X	Maricopa County	Valle del Sol	10320 W McDowell Road Ste. G	Avondale	AZ	85392	$5,510.00	$5,510.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	349475	X	X	Pima	Wenhui Cai	502 W 29th St	Tucson	AZ	85713	$1,086.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,086.00
	289886	X	X	Pima	William Johnson	2800 E. Ajo Way	Tucson	AZ	85713	$8,487.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$8,487.00
Total										$27,679,390.47	$22,592,133.47	$2,403,439.00	$704,617.00	$1,353,202.00	$23,217.00	$358,410.00	$253,647.00

*** Indicates the imported record has an error.**

Note: [1]42 CFR 8.12: Federal Opioid Treatment Standards (OTP) providers only
0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:
12/1/23 AHCCCS is submitted the updated Table 7 Statewide Entity Inventory via the WebBGAS help desk.

III: Expenditure Reports

Table 8a - Maintenance of Effort for State Expenditures for SUD Prevention, Treatment, and Recovery

This Maintenance of Effort table provides a description of non-federal state expenditures for authorized activities to prevent and treat substance use and provide recovery services flowing through the Single State Agency (SSA) during the state fiscal year immediately preceding the federal fiscal year for which the state is applying for funds. Dates given are for the FFY 2024 SUPTRS BG Report. For the FFY 2025 SUPTRS BG report, please increase each year by one. For detailed instructions, see those in BGAS.

Expenditure Period Start Date: 07/01/2022 Expenditure Period End Date: 06/30/2023

Total Single State Agency (SSA) Expenditures for Substance Abuse Prevention and Treatment		
Period **(A)**	**Expenditures** **(B)**	**B1(2021) + B2(2022)** **2** **(C)**
SFY 2021 (1)	$84,158,809.65	
SFY 2022 (2)	$124,889,711.96	$104,524,260.81
SFY 2023 (3)	$271,963,365.26	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

SFY 2021	Yes	X	No
SFY 2022	Yes	X	No
SFY 2023	Yes	X	No

Did the state or jurisdiction have any non-recurring expenditures as described in 42 U.S.C. § 300x-30(b) for a specific purpose which were not included in the MOE calculation?

Yes No X

If yes, specify the amount and the State fiscal year:

If yes, SFY:

Did the state or jurisdiction include these funds in previous year MOE calculations?

Yes No

When did the State or Jurisdiction submit an official request to SAMHSA to exclude these funds from the MOE calculations?

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA:

Please provide a description of the amounts and methods used to calculate the total Single State Agency (SSA) expenditures for substance use disorder prevention and treatment 42 U.S.C. §300x-30.
See attachment for Methodology Description

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

AHCCCS is aware of suspected fraudulent billing activities associated with the American Indian Health Program. During 2023, the Agency suspended a large number of providers for credible allegations of fraud. Currently, AHCCCS and the appropriate law enforcement agencies are still investigating the impact. Ultimately, this may require a restatement of the 2023 expenditures reported here.

2023 Maintenance of Effort (MOE) SABG & MHBG Block Grant Instructions

Report Submitted to SAMHSA in WebBGAS Reporting System by December 1 of each year
Report Approved by DBF Assistant Director, Budget Administrator, & Finance Administrator

Part I: Medicaid Behavioral Health Expenditures

1. AHCCCS has established clinical criteria to define distinct categories of services
    a. Based on primary diagnosis code (ICD-9 or ICD-10) for non-pharmacy costs
    b. Based on Generic Product Identifier (GPI) code for pharmacy costs
    c. Physical Health (PH) is differentiated from Behavioral Health (BH)
    d. BH is grouped into subcategories for Mental Health (MH) or Substance Abuse (SA)
    e. PH and BH are mutually exclusive; MH and SA are mutually exclusive

2. AHCCCS Division of Business and Finance (DBF) Healthcare Finance reports fee-for-service (FFS) expenditures in these categories
    a. For SFY 2023 paid claims, the clinical criteria are applied to all expenditures
    b. Resulting classification of expenses is provided to Division of Business and Finance (DBF)

3. AHCCCS DBF actuaries report managed care organization (MCO) rate components in these categories
    a. Review encounter data for CYE 2021 dates of service (DOS) and apply clinical criteria
        i. Compute relative PH%, MH%, and SA% of each MCO capitation rate
        ii. Separately report BH inpatient (IP) expenditures in own category to be excluded
    b. Utilize encounter data from two years prior to effective rate – CYE 2021 used to develop CYE 2023 rate break-out
        i. Most complete encounter data available
        ii. Same underlying encounter data used to develop the new rate
    c. Resulting classification of rate components provided to DBF Budget for all lines of business (LOB) and risk groups
    d. Rate components are expressed as percentages (%s) of a total paid rate

4. AHCCCS DBF Budget receives FFS and MCO expenditure data by category from DBF Healthcare Finance and computes corresponding state match amounts
    a. Applies DBF Healthcare Finance and Actuary data to paid financial data from actuals as reported in the most recent budget submission to capture all expenses
    b. Applies effective Federal Medical Assistance Percentage (FMAP) rate to all expenditures to calculate state match component
    c. Summarizes state match expenditures by BH subcategories for MH and SA

Part II: Non-Medicaid Behavioral Health Expenditures

1. AHCCCS DBF queries Arizona Financial Information System (AFIS) expenditures from the IBM Cognos data warehouse. Data is reviewed and reconciled.
2. Pivot Tables separate the data by major program to determine which expenditures are applicable to the MOE calculation. Expenditures are separated between MH & SA, as applicable.

All expenditures for both Medicaid & Non-Medicaid Behavioral are entered into the MOE Calculation Worksheet.

III: Expenditure Reports

Table 8b - Expenditures for Services to Pregnant Women and Women with Dependent Children

This MOE table provides a report of state and SUBG funds expended on specialized SUD treatment services for pregnant women and women with dependent children for the state fiscal year immediately preceding the FFY for which the state is applying for funds.

Expenditure Period Start Date: 10/01/2020 Expenditure Period End Date: 09/30/2022

Base

Period	Total Women's Base (A)
SFY 1994	$ 2,796,016.00

Maintenance

Period	Total Women's Base (A)	Total Expenditures (B)	Expense Type
SFY 2021		$ 3,500,777.00	
SFY 2022		$ 3,501,567.00	
SFY 2023		$ 3,500,777.00	(•) Actual ( ) Estimated
Enter the amount the State plans to expend in SFY 2024 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Section III: Table 8b – Expenditures for Services to Pregnant Women and Women with Dependent Children, Base, Total Women's Base (A) for Period of (SFY 1994)): $ 3,500,777.00;			

Please provide a description of the amounts and methods used to calculate the base and, for 1994 and subsequent fiscal years, report the Federal and State expenditures for such services for services to pregnant women and women with dependent children as required by 42 U.S.C. §300x-22(b)(1).
Please see uploaded attachment for the SABG Description
of Calculations for Table 8b, Expenditures for Services to
Pregnant Women and
Women with Dependent Children.

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

SABG Description of Calculations for SFY2023, Reporting Due 12/1/2023

Table 8b: Women's base for services to pregnant women and women with dependent children as required by 42 U.S.C §300x-22(b)(1); and for 1994 and subsequent fiscal years;

Calculations for the Women's Base are grounded in a survey done in FY92 attempting to capture all specialty women's treatment programs operating during that year. The total value of services to pregnant women, and women with dependent children who received primarily residential treatment services in FY92 at state supported treatment programs equaled $1,225,977, which consisted of $1,164,678 of Federal funds and $61,299 of State Appropriations. This became the FY92 Women's Base (**Table II**).

For FY93, States must spend not less than 5% of grant to increase, relative to FY92, the availability of treatment services designed for pregnant women and women with dependent children. In FY93, 5% of the block grant award equated to $768,307. For FY94, States must spend not less than 5%, relative to FY93, for these services. In FY94, 5% of the block grant award equated to $801,732 **(Table III). T**he state will expend for such services for women not less than an amount equal to the amount expended for FY94 with equates to $2,796,016.

Table II: Expenditures for Services to Pregnant Women & Women with Dependent Children (Base)

Period	(1992) Amount from ADMS Block Grant Spent for Pregnant Women and Women with Dependent Children	(1992) State Expenditures for Pregnant Women and Women with Dependent Children	(1992) Women's Base
1992	$1,164,678	$61,299	$1,225,977

Table III: Expenditures for Services to Pregnant Women & Women with Dependent Children (MOE)

Period	Total Women's Base From Previous Year (A)	Total SAPT Block Grant Award (B)	5 % of SAPT Block Grant Award (C)	State Expenditures (D)	Total Women's Base (A+B+C+D)
1993	$1,225,977	$15,366,146	$768,307	$0	$1,994,284
1994	$1,994,284	$16,034,641	$801,732	$0	$2,796,016
1995					$2,796,016
1996					$2,796,016

The State's Chart of Accounts has a Major Program Structure set up in the Accounting System that tracks all disbursements for Pregnant Women and Women with Dependent Children from the SABG Block Grant. The amount reported in the 2019 reporting period reflects the total amount of federal block grant expenditures from the FFY2017 SABG Block Grant to ensure consistency in reporting with prior years.

Table 8b: Expenditures for Services to Pregnant Women & Women with Dependent Children

Period (State Fiscal Year)	Total Women's Base (A)	Total Expenditures (B)	Reflects Grant Award
1994	$2,796,016		
2008		$3,500,777	FFY2006

2009		$3,500,777	FFY2007
2010		$3,500,777	FFY2008
2011		$3,500,777	FFY2009
2012		$3,515,680	FFY2010
2013		$3,860,921	FFY2011
2014		$3,500,777	FFY2012
2015		$3,496,101	FFY2013
2016		$4,274,549	FFY2014
2017		$3,500,777	FFY2015
2018		$3,500,777	FFY2016
2019		$3,500,777	FFY2017
2020		$3,500,778	FFY2018
2021		$3,500,777	FFY2019
2022		$3,501,567	FFY2020
2023		35000777	FFY2021

Footnote: Expenses reported in Column B reflect the Federal Fiscal Year Grant Award to maintain consistency in reporting.

IV: Population and Services Reports

Table 9 - Prevention Strategy Report

This table requires additional information (pursuant to Section 1929 of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C.§ 300x-29) about the primary prevention activities conducted by the entities listed on SUPTRS BG Table 7.

Expenditure Period Start Date: 10/1/2020 Expenditure Period End Date: 9/30/2022

Column A (Risks)	Column B (Strategies)	Column C (Providers)
not specified	**1. Information Dissemination**	
	1. Clearinghouse/information resources centers	5
	2. Resources directories	9
	3. Media campaigns	31
	4. Brochures	35
	5. Radio and TV public service announcements	11
	6. Speaking engagements	14
	7. Health fairs and other health promotion, e.g., conferences, meetings, seminars	36
	8. Information lines/Hot lines	3
	2. Education	
	1. Parenting and family management	22
	2. Ongoing classroom and/or small group sessions	37
	3. Peer leader/helper programs	8
	4. Education programs for youth groups	33
	5. Mentors	10
	6. Preschool ATOD prevention programs	3
	3. Alternatives	
	1. Drug free dances and parties	9
	2. Youth/adult leadership activities	14
	3. Community drop-in centers	9
	4. Community service activities	2
	6. Recreation activities	23
	4. Problem Identification and Referral	
	1. Employee Assistance Programs	2
	2. Student Assistance Programs	18
	3. Driving while under the influence/driving while intoxicated education programs	1

4. referrals for older adults for medication misuse and referrals for mental health	
5. Community-Based Process	
1. Community and volunteer training, e.g., neighborhood action training, impactor-training, staff/officials training	19
2. Systematic planning	15
3. Multi-agency coordination and collaboration/coalition	34
4. Community team-building	11
5. Accessing services and funding	2
6. Environmental	
1. Promoting the establishment or review of alcohol, tobacco, and drug use policies in schools	5
2. Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drugs	6
5. safe storage and disposal of medication	2

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

IV: Population and Services Reports

Table 10a – Treatment Utilization Matrix

This table is intended to capture the count of persons with initial admissions and subsequent admission(s) to an episode of care.

Expenditure Period Start Date: 7/1/2022 Expenditure Period End Date: 6/30/2023

Level of Care	SUPTRS BG Number of Admissions > Number of Persons Served		COVID-19 Number of Admissions > Number of Persons Served[1]		ARP Number of Admissions > Number of Persons Served[2]		SUPTRS BG Service Costs			COVID-19 Costs[1]			ARP Costs[2]		
	Number of Admissions (A)	Number of Persons Served (B)	Number of Admissions (C)	Number of Persons Served (D)	Number of Admissions (E)	Number of Persons Served (F)	Mean (G)	Median (H)	Standard Deviation (I)	Mean Cost (J)	Median Cost (K)	Standard Deviation (L)	Mean Cost (M)	Median Cost (N)	Standard Deviation (O)
DETOXIFICATION (24-HOUR CARE)															
1. Hospital Inpatient	1,895	4,404					4,144.28	3,962.45	2,169.59						
2. Free-Standing Residential	10,554	11,212					2,364.84	1,965.63	2,681.49						
REHABILITATION/RESIDENTIAL															
3. Hospital Inpatient	15,703	21,663					5,727.76	4,914.88	5,788.65						
4. Short-term (up to 30 days)	24,080	22,204					1,005.40	262.43	1,836.35						
5. Long-term (over 30 days)	1,301	1,177					20.62	19.93	4.41						
AMBULATORY (OUTPATIENT)															
6. Outpatient	617,384	260,724					236.28	53.88	1,010.22						
7. Intensive Outpatient	5,260	5,287					95.56	96.97	113.58						
8. Detoxification	0	0	0	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
OUD MEDICATION ASSISTED TREATMENT															
9. MOUD Medication-Assisted Detoxification	30,938	26,095					10.89	12.29	12.65						
10. MOUD Medication-Assisted Treatment Outpatient	159,170	94,716					173.19	73.91	667.91						

Please explain why Column A (SUPTRS BG and COVID-19 Number of Admissions) are less than Column B (SUPTRS BG and COVID-19 Number of Persons Served)

*Members all identified with SUD Diagnoses during State Fiscal Year 2023
** Mean, Median, and Standard Deviation of Cost are calculated per unique claim number.
***AZ does not provide for Outpatient Detoxification (8) services.
****

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 – March 14, 2023, which is different from the expenditure period for the "standard" SUPTRS BG and MHBG. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current NoA Terms and Conditions.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025.

[3] In FY 2020 SAMHSA modified the "Level of Care" (LOC)" and "Type of Treatment Service/Setting" to "Medication-Assisted Treatment" and "Medication- Assisted Treatment," respectively. In prior SUPTRS BG Reports, the LOC was entitled "Opioid Replacement Therapy" and the Type of Treatment Service/Setting included "Opioid Replacement Therapy," Row 9 and "ORT Outpatient," Row 10. The changes inadvertently created a barrier for data analysis as one-to-one mapping of the data submitted in the FY 2020 Table 10 to the data submitted in prior Reports is not possible. In the current and future SUPTRS BG Reports, the LOC is "MOUD & Medication Assisted Treatment" and the Types of Treatment Service/Setting will include "MOUD Medication-Assisted Treatment Detoxification," Row 9 and "MOUD & Medication Assisted Treatment Outpatient," Row 10. MOUD & Medication-Assisted Treatment Withdrawal Management includes hospital detoxification, residential detoxification, or ambulatory detoxification services/settings AND Opioid Medication-Assisted Treatment. MOUD & Medication Assisted Treatment Outpatient includes outpatient services/settings AND Opioid Medication-Assisted Treatment.

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

12/1/2023 AHCCCS is reporting this data as a preliminary report, consistent with the usual methodology. However, the data query logic is currently under review. SFY2023 data as well as year over year comparisons may be impacted by the unwinding of the flexibilities from the COVID-19 public health emergency as well as a current and ongoing investigation of credible allegations of fraud within the AHCCCS behavioral health system.

IV: Population and Services Reports

Table 10b – Number of Persons Served (Unduplicated Count) Who Received Recovery Supports

This table provides an aggregate profile of the unduplicated persons that received recovery support services funded through the SUPTRS BG by age and gender identity.

Expenditure Period Start Date: 07/01/2022 Expenditure Period End Date: 06/30/2023

	Age 0-5[1]							Age 6-12						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available
Peer-to-Peer Support Individual	0	0	0	0	0	0	0	11	4	0	0	0	0	0
Peer-Led Support Group	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Peer-Led Training or Peer Certification Activity	0	0	0	0	0	0	0	11	5	0	0	0	0	0
Recovery Housing	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Social Support or Social Inclusion Activity	0	0	0	0	0	0	0	14	5	0	0	0	0	0
Other SAMHSA Approved Recovery Support Event or Activity	0	0	0	0	0	0	0	6	11	0	0	0	0	0

[1]Age category 0-5 years is not applicable.

	Age 13-17							Age 18-20						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available
Peer-to-Peer Support Individual	24	41	0	0	0	0	0	45	125	0	0	0	0	0
Peer-Led Support Group	7	14	0	0	0	0	0	27	34	0	0	0	0	0
Peer-Led Training or Peer Certification Activity	53	80	0	0	0	0	0	68	117	0	0	0	0	0
Recovery Housing	1	0	0	0	0	0	0	5	7	0	0	0	0	0
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Transportation	7	12	0	0	0	0	0	10	31	0	0	0	0	0
Secondary School, High School, or Collegiate Recovery Program Service or Activity	23	21	0	0	0	0	0	1	7	0	0	0	0	0
Recovery Social Support or Social Inclusion Activity	170	217	0	0	0	0	0	170	331	0	0	0	0	0
Other SAMHSA Approved Recovery Support Event or Activity	310	374	0	0	0	0	0	237	405	0	0	0	0	0

	Age 21-24							Age 25-44						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available
Peer-to-Peer Support Individual	165	317	0	0	0	0	0	1,711	3,012	0	0	0	0	0
Peer-Led Support Group	55	99	0	0	0	0	0	503	851	0	0	0	0	0
Peer-Led Training or Peer Certification Activity	162	327	0	0	0	0	0	1,625	2,886	0	0	0	0	0
Recovery Housing	14	11	0	0	0	0	0	116	49	0	0	0	0	0
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Transportation	32	80	0	0	0	0	0	362	756	0	0	0	0	0

Secondary School, High School, or Collegiate Recovery Program Service or Activity	2	5	0	0	0	0	0	19	30	0	0	0	0	0
Recovery Social Support or Social Inclusion Activity	505	916	0	0	0	0	0	4,880	8,625	0	0	0	0	0
Other SAMHSA Approved Recovery Support Event or Activity	672	1,125	0	0	0	0	0	6,342	10,864	0	0	0	0	0

	Age 45-64							Age 65-74						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available
Peer-to-Peer Support Individual	729	1,381	0	0	0	0	0	87	147	0	0	0	0	0
Peer-Led Support Group	161	409	0	0	0	0	0	27	55	0	0	0	0	0
Peer-Led Training or Peer Certification Activity	726	1,400	0	0	0	0	0	87	142	0	0	0	0	0
Recovery Housing	50	26	0	0	0	0	0	1	0	0	0	0	0	0
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Transportation	201	442	0	0	0	0	0	48	62	0	0	0	0	0
Secondary School, High School, or Collegiate Recovery Program Service or Activity	4	21	0	0	0	0	0	0	4	0	0	0	0	0
Recovery Social Support or Social Inclusion Activity	2,336	3,978	0	0	0	0	0	271	450	0	0	0	0	0
Other SAMHSA Approved Recovery Support Event or Activity	3,266	5,025	0	0	0	0	0	429	628	0	0	0	0	0

	Age 75+							Age Not Available						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non - Conforming	Other	Not Available
Peer-to-Peer Support Individual	5	9	0	0	0	0	0	0	0	0	0	0	0	0
Peer-Led Support Group	4	4	0	0	0	0	0	0	0	0	0	0	0	0
Peer-Led Training or Peer Certification Activity	7	13	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Housing	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Childcare Fee or Family Caregiver Fee	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Support Service Transportation	6	8	0	0	0	0	0	0	0	0	0	0	0	0
Secondary School, High School, or Collegiate Recovery Program Service or Activity	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Recovery Social Support or Social Inclusion Activity	16	33	0	0	0	0	0	0	0	0	0	0	0	0
Other SAMHSA Approved Recovery Support Event or Activity	27	48	0	0	0	0	0	0	0	0	0	0	0	0

	Total						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
Peer-to-Peer Support Individual	**2,777**	**5,036**	**0**	**0**	**0**	**0**	**0**
Peer-Led Support Group	**784**	**1,467**	**0**	**0**	**0**	**0**	**0**
Peer-Led Training or Peer Certification Activity	**2,739**	**4,970**	**0**	**0**	**0**	**0**	**0**
Recovery Housing	**187**	**93**	**0**	**0**	**0**	**0**	**0**
Recovery Support Service Childcare Fee or Family Caregiver Fee	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Recovery Support Service Transportation	**666**	**1,391**	**0**	**0**	**0**	**0**	**0**
Secondary School, High School, or Collegiate Recovery Program Service or Activity	**49**	**88**	**0**	**0**	**0**	**0**	**0**

Recovery Social Support or Social Inclusion Activity	**8,362**	**14,555**	**0**	**0**	**0**	**0**	**0**
Other SAMHSA Approved Recovery Support Event or Activity	**11,289**	**18,480**	**0**	**0**	**0**	**0**	**0**
Comments on Data (Age):							
Comments on Data (Gender):	AHCCCS data system only captures male and female.						
Comments on Data (Overall):	This is the first year that AHCCCS and the ACC-RBHAs and TRBHAs have reported information in these categories. AHCCCS is in the process of reviewing and verifying data query logic used.						

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

IV: Population and Services Reports

Tables 11a, 11b and 11c - Unduplicated Count of Persons Served for Alcohol and Other Drug Use

This table provides an aggregate profile of the unduplicated number of admissions and persons for services funded through the SUPTRS BG. This table should not include persons served using COVID-19 Relief Supplemental Funding.

Expenditure Period Start Date: 07/01/2022 Expenditure Period End Date: 06/30/2023

SUPTRS BG Table 11a - Unduplicated Count of Persons Served For Alcohol and Other Drug Use

This table provides an aggregate profile of the unduplicated number of admissions and persons for services funded through SUPTRS BG. This table should not include persons served using COVID-19 Relief Supplemental Funding.

	Total								American Indian or Alaska Native						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Total	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years[1]	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0	0	0	0	0	0	0
6-12 years	**357**	**390**	**64**	**0**	**0**	**0**	**0**	**811**	0	66	64	0	0	0	0
13-17 years	**6,741**	**6,767**	**603**	**0**	**0**	**0**	**0**	**14,111**	0	565	603	0	0	0	0
18-20 years	**7,621**	**8,800**	**699**	**0**	**0**	**0**	**0**	**17,120**	0	644	699	0	0	0	0
21-24 years	**15,116**	**17,120**	**1,239**	**0**	**0**	**0**	**0**	**33,475**	0	1,262	1,239	0	0	0	0
25-44 years	**108,198**	**145,233**	**9,112**	**0**	**0**	**0**	**0**	**262,543**	0	10,983	9,112	0	0	0	0
45-64 years	**75,584**	**98,062**	**3,619**	**0**	**0**	**0**	**0**	**177,265**	0	5,378	3,619	0	0	0	0
65-74 years	**13,551**	**16,273**	**342**	**0**	**0**	**0**	**0**	**30,166**	0	529	342	0	0	0	0
75+ years	**3,283**	**2,865**	**81**	**0**	**0**	**0**	**0**	**6,229**	0	112	81	0	0	0	0
Not Available	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0	0	0	0	0	0	0
Total	**230,451**	**295,510**	**15,759**	**0**	**0**	**0**	**0**	**541,720**	**0**	**19,539**	**15,759**	**0**	**0**	**0**	**0**
Pregnant Women	**14,253**								1,119						

Number of Persons Served who were admitted in a Period Prior to the 12-month reporting Period	158422
Number of Persons Served outside of the levels of care described on SUPTRS BG Table 10	10989

Are the values reported in this table generated from a client-based system with unique identifiers?

(•) Yes ( ) No

Comments on Data (Race)	*AZ collects Race and Ethnicity in one category/field. "Hispanic or Latino Origin Not Available" and "Some Other Race" are not categories in the AZ system.
Comments on Data (Gender)	***AZ only collects Male/Female for Gender Identity
Comments on Data (Overall)	12/1/2023 Table 11a: AHCCCS is reporting this data as a preliminary report, consistent with the usual methodology. However, the data query logic is currently under review. SFY2023 data as well as year over year comparisons may be impacted by the unwinding of the flexibilities from the COVID-19 public health emergency as well as a current and ongoing investigation of credible allegations of fraud within the AHCCCS behavioral health system.

[1]Age category 0-5 years is not applicable.

SUPTRS BG Table 11a - Unduplicated Count of Persons Served For Alcohol and Other Drug Use (continued)

	Asian							Black or African American						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years[1]	0	0	0	0	0	0	0	0	0	0	0	0	0	0

6-12 years	1	2	0	0	0	0	0	15	18	0	0	0	0	0
13-17 years	28	22	0	0	0	0	0	250	207	0	0	0	0	0
18-20 years	31	28	0	0	0	0	0	353	387	0	0	0	0	0
21-24 years	72	63	0	0	0	0	0	820	778	0	0	0	0	0
25-44 years	482	553	0	0	0	0	0	5,215	6,121	0	0	0	0	0
45-64 years	241	516	0	0	0	0	0	2,528	3,552	0	0	0	0	0
65-74 years	45	90	0	0	0	0	0	415	518	0	0	0	0	0
75+ years	16	28	0	0	0	0	0	81	70	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**916**	**1,302**	**0**	**0**	**0**	**0**	**0**	**9,677**	**11,651**	**0**	**0**	**0**	**0**	**0**
Pregnant Women	49							824						

[1]Age category 0-5 years is not applicable.

SUPTRS BG Table 11a - Unduplicated Count of Persons Served For Alcohol and Other Drug Use (continued)

	Native Hawaiian or Other Pacific Islander							White						
	Female	**Male**	**Transgender (Trans Woman)**	**Transgender (Trans Man)**	**Gender Non-Conforming**	**Other**	**Not Available**	**Female**	**Male**	**Transgender (Trans Woman)**	**Transgender (Trans Man)**	**Gender Non-Conforming**	**Other**	**Not Available**
0-5 years[1]	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	63	56	0	0	0	0	0
13-17 years	9	2	0	0	0	0	0	1,431	1,263	0	0	0	0	0
18-20 years	12	7	0	0	0	0	0	1,765	1,742	0	0	0	0	0
21-24 years	24	17	0	0	0	0	0	3,762	3,429	0	0	0	0	0
25-44 years	149	161	0	0	0	0	0	31,047	33,706	0	0	0	0	0
45-64 years	61	95	0	0	0	0	0	22,964	24,996	0	0	0	0	0
65-74 years	5	13	0	0	0	0	0	3,960	4,252	0	0	0	0	0
75+ years	1	2	0	0	0	0	0	948	657	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**261**	**297**	**0**	**0**	**0**	**0**	**0**	**65,940**	**70,101**	**0**	**0**	**0**	**0**	**0**
Pregnant Women	24							3,603						

[1]Age category 0-5 years is not applicable.

SUPTRS BG Table 11a - Unduplicated Count of Persons Served For Alcohol and Other Drug Use (continued)

	Some Other Race							More than One Race Reported						
	Female	**Male**	**Transgender (Trans Woman)**	**Transgender (Trans Man)**	**Gender Non-Conforming**	**Other**	**Not Available**	**Female**	**Male**	**Transgender (Trans Woman)**	**Transgender (Trans Man)**	**Gender Non-Conforming**	**Other**	**Not Available**
0-5 years[1]	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	14	21	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	12	15	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	23	41	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	131	291	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	114	146	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	27	39	0	0	0	0	0

75+ years	0	0	0	0	0	0	0	9	3	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**330**	**556**	**0**	**0**	**0**	**0**	**0**
Pregnant Women	0							1						

[1]Age category 0-5 years is not applicable.

SUPTRS BG Table 11a - Unduplicated Count of Persons Served For Alcohol and Other Drug Use (continued)

	Race Not Available							Not Hispanic or Latino						
	Female	**Male**	**Transgender (Trans Woman)**	**Transgender (Trans Man)**	**Gender Non-Conforming**	**Other**	**Not Available**	**Female**	**Male**	**Transgender (Trans Woman)**	**Transgender (Trans Man)**	**Gender Non-Conforming**	**Other**	**Not Available**
0-5 years[1]	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	67	53	0	0	0	0	0	210	195	0	0	0	0	0
13-17 years	1,325	1,290	0	0	0	0	0	3,660	3,370	0	0	0	0	0
18-20 years	1,278	1,561	0	0	0	0	0	4,150	4,384	0	0	0	0	0
21-24 years	2,221	2,933	0	0	0	0	0	8,161	8,523	0	0	0	0	0
25-44 years	12,363	20,473	0	0	0	0	0	58,499	72,288	0	0	0	0	0
45-64 years	9,736	14,086	0	0	0	0	0	39,263	48,769	0	0	0	0	0
65-74 years	2,052	2,633	0	0	0	0	0	6,846	8,074	0	0	0	0	0
75+ years	524	541	0	0	0	0	0	1,660	1,413	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**29,566**	**43,570**	**0**	**0**	**0**	**0**	**0**	**122,449**	**147,016**	**0**	**0**	**0**	**0**	**0**
Pregnant Women	1,499							7,119						

[1]Age category 0-5 years is not applicable.

SUPTRS BG Table 11a - Unduplicated Count of Persons Served For Alcohol and Other Drug Use (continued)

	Hispanic or Latino							Hispanic or Latino Origin Not Available						
	Female	**Male**	**Transgender (Trans Woman)**	**Transgender (Trans Man)**	**Gender Non-Conforming**	**Other**	**Not Available**	**Female**	**Male**	**Transgender (Trans Woman)**	**Transgender (Trans Man)**	**Gender Non-Conforming**	**Other**	**Not Available**
0-5 years[1]	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	1	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	24	27	0	0	0	0	0	0	0	0	0	0	0	0
18-20 years	20	32	0	0	0	0	0	0	0	0	0	0	0	0
21-24 years	33	74	0	0	0	0	0	0	0	0	0	0	0	0
25-44 years	312	657	0	0	0	0	0	0	0	0	0	0	0	0
45-64 years	677	524	0	0	0	0	0	0	0	0	0	0	0	0
65-74 years	201	125	0	0	0	0	0	0	0	0	0	0	0	0
75+ years	44	39	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**1,312**	**1,478**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Pregnant Women	15							0						

[1]Age category 0-5 years is not applicable.

SUPTRS BG Table 11b - COVID-19 Number of Persons Served (Unduplicated Count) for Alcohol and Other Drug Use[1]

This table provides an aggregate profile of the unduplicated number of admissions and persons for services funded under COVID-19 Relief Supplemental Funding.

	Total							American Indian or Alaska Native						

	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Total	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years[2]	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0	0	0	0	0	0	0
6-12 years	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0	0	0	0	0	0	0
13-17 years	**0**	**4**	**0**	**0**	**0**	**0**	**0**	**4**	0	0	0	0	0	0	0
18-20 years	**5**	**12**	**0**	**0**	**0**	**0**	**0**	**17**	2	1	0	0	0	0	0
21-24 years	**15**	**103**	**0**	**0**	**0**	**0**	**0**	**118**	0	1	0	0	0	0	0
25-44 years	**60**	**158**	**0**	**0**	**0**	**0**	**0**	**218**	5	13	0	0	0	0	0
45-64 years	**17**	**45**	**0**	**0**	**0**	**0**	**0**	**62**	1	3	0	0	0	0	0
65-74 years	**0**	**3**	**0**	**0**	**0**	**0**	**0**	**3**	0	1	0	0	0	0	0
75+ years	**0**	**53**	**0**	**0**	**0**	**0**	**0**	**53**	0	0	0	0	0	0	0
Not Available	**28**	**52**	**0**	**0**	**0**	**0**	**0**	**80**	0	0	0	0	0	0	0
Total	**125**	**430**	**0**	**0**	**0**	**0**	**0**	**555**	**8**	**19**	**0**	**0**	**0**	**0**	**0**
Pregnant Women	**0**								0						

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 – March 14, 2023, which is different from the expenditure period for the "standard" SUPTRS BG and MHBG. However, grantees are requested to annually report SUPTRS BG COVID-19 Supplemental Funding expenditures in accordance with requirements included in their current NoA Terms and Conditions.

[2]Age category 0-5 years is not applicable.

Comments on Data (Race)	
Comments on Data (Gender)	11b Arizona's claims and encounters system does not capture genders other than Male and Female. Data is reported as 0s for this table.
Comments on Data (Overall)	11b Arizona's SUBG COVID-19 Supplemental Funds are generally not captured in the AHCCCS claims and encounters system. Data is reported from ACC-RBHAs and TRBHAs. One TRBHA data was not available at the time of this report. 11c Arizona's claims and encounters system does not capture sexual orientation. Data is reported as 0s for this table.

SUPTRS BG Table 11b - COVID-19 Number of Persons Served (Unduplicated Count) for Alcohol and Other Drug Use (continued)

	Asian							Black or African American						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years[1]	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	0	1	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	2	8	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	0	7	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**16**	**0**	**0**	**0**	**0**	**0**
Pregnant Women	0							0						

[1]Age category 0-5 years is not applicable.

SUPTRS BG Table 11b - COVID-19 Number of Persons Served (Unduplicated Count) for Alcohol and Other Drug Use (continued)

	Native Hawaiian or Other Pacific Islander							White						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years[1]	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	0	3	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	4	5	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	21	69	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	7	23	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	1	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**32**	**102**	**0**	**0**	**0**	**0**	**0**
Pregnant Women	0							0						

[1]Age category 0-5 years is not applicable.

SUPTRS BG Table 11b - COVID-19 Number of Persons Served (Unduplicated Count) for Alcohol and Other Drug Use (continued)

	Some Other Race							More than One Race Reported						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years[1]	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18-20 years	1	1	0	0	0	0	0	0	0	0	0	0	0	0
21-24 years	7	7	0	0	0	0	0	0	0	0	0	0	0	0
25-44 years	3	34	0	0	0	0	0	0	0	0	0	0	0	0
45-64 years	0	10	0	0	0	0	0	0	0	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**11**	**52**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Pregnant Women	0							0						

[1]Age category 0-5 years is not applicable.

SUPTRS BG Table 11b - COVID-19 Number of Persons Served (Unduplicated Count) for Alcohol and Other Drug Use (continued)

	Race Not Available							Not Hispanic or Latino						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years[1]	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	4	0	0	0	0	0

18-20 years	0	0	0	0	0	0	0	2	7	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	4	89	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	28	33	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	8	2	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	1	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	52	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	14	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**56**	**188**	**0**	**0**	**0**	**0**	**0**
Pregnant Women	0							0						

[1]Age category 0-5 years is not applicable.

SUPTRS BG Table 11b - COVID-19 Number of Persons Served (Unduplicated Count) for Alcohol and Other Drug Use (continued)

	Hispanic or Latino							Hispanic or Latino Origin Not Available						
	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available	Female	Male	Transgender (Trans Woman)	Transgender (Trans Man)	Gender Non-Conforming	Other	Not Available
0-5 years[1]	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25-44 years	1	1	0	0	0	0	0	0	0	0	0	0	0	0
45-64 years	1	0	0	0	0	0	0	0	0	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Available	14	52	0	0	0	0	0	0	0	0	0	0	0	0
Total	**16**	**53**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Pregnant Women	0							0						

[1]Age category 0-5 years is not applicable.

SUPTRS BG Table 11c - Sexual Orientation Unduplicated Count of Persons Served for Alcohol and Other Drugs

	Sexual Orientation								
A. Age	B. Straight or Heterosexual	C. Homosexual (Gay or Lesbian)	D. Bisexual	E. Queer	F. Pansexual	G. Questioning	H. Asexual	I. Other	J. Not Available
0-5 years[1]	0	0	0	0	0	0	0	0	0
6-12 years	0	0	0	0	0	0	0	0	0
13-17 years	0	0	0	0	0	0	0	0	0
18-20 years	0	0	0	0	0	0	0	0	0
21-24 years	0	0	0	0	0	0	0	0	0
25-44 years	0	0	0	0	0	0	0	0	0
45-64 years	0	0	0	0	0	0	0	0	0
65-74 years	0	0	0	0	0	0	0	0	0
75+ years	0	0	0	0	0	0	0	0	0
TOTAL	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

[1]Age category 0-5 years is not applicable.

Footnotes:

IV: Population and Services Reports

Table 12 - SUPTRS BG Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV) in Designated States

Expenditure Period Start Date: 7/1/2022 Expenditure Period End Date: 6/30/2023

Early Intervention Services for Human Immunodeficiency Virus (HIV)		
1. Number of EIS/HIV projects among SUPTRS BG sub-recipients in the state	Statewide: _____	Rural: _____
2. Total number of individuals tested through SUPTRS BG sub-recipient EIS/HIV projects:		
3. Total number of HIV tests conducted with SUPTRS BG EIS/HIV funds:		
4. Total number of tests that were positive for HIV		
5. Total number of individuals who prior to the 12-month reporting period were unaware of their HIV infection		
6. Total number of HIV-infected individuals who were diagnosed and referred into treatment and care during the 12-month reporting period		
7. Total number of persons at risk for HIV/AIDS referred for PrEP services?		
Identify barriers, including State laws and regulations, that exist in carrying out HIV testing services:		

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Footnotes:

10/19/23 Arizona is not a designated state and therefore did not provide the data for this table.

IV: Population and Services Reports

Table 13 - Charitable Choice – Required

Under Charitable Choice Provisions; Final Rule (42 CFR Part 54), states, local governments, and religious organizations, such as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide to all potential and actual program beneficiaries (services recipients) notice of their right to alternative services; (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the state to be accessible and comparable and provided within a reasonable period of time from another substance use disorder provider ("alternative provider") to which the program beneficiary (services recipient) has no religious objection. The purpose of this table is to document how the state is complying with these provisions.

Expenditure Period Start Date: 7/1/2022 Expenditure Period End Date: 6/30/2023

Notice to Program Beneficiaries - Check all that apply:

- [x] Used model notice provided in final regulation.
- [ ] Used notice developed by State (please attach a copy to the Report).
- [x] State has disseminated notice to religious organizations that are providers.
- [x] State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

- [ ] State has developed specific referral system for this requirement.
- [x] State has incorporated this requirement into existing referral system(s).
- [x] SAMHSA's Behavioral Health Treatment Locator is used to help identify providers.
- [x] Other networks and information systems are used to help identify providers.
- [ ] State maintains record of referrals made by religious organizations that are providers.

0 nter the total number of referrals to other substance use disorder providers ("alternative providers") necessitated by religious objection, as defined above, made during the state fiscal year immediately preceding the federal fiscal year for which the state is applying for funds. Provide the total only. No information on specific referrals is required. If no alternative referrals were made, enter zero.

Provide a brief description (one paragraph) of any training for local governments and/or faith-based and/or community organizations that are providers on these requirements.

AHCCCS provides technical assistance to ACC-RBHAs, TRBHAs, and other contractors as needed relating to charitable choice provisions. Members have freedom of choice among providers within their ACC-RBHA networks and are notified of this right when enrolling, and are provided information about freedom of choice via member handbooks.

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Footnotes:

V: Performance Data and Outcomes

Table 14 - Treatment Performance Measure: Employment/Education Status (From Admission to Discharge)

Short-term Residential(SR)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	52	30
Total number of clients with non-missing values on employment/student status [denominator]	193	193
Percent of clients employed or student (full-time and part-time)	26.9 %	15.5 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	5,829
Number of CY 2022 discharges submitted:	4,995
Number of CY 2022 discharges linked to an admission:	883
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	869
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	193

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Long-term Residential(LR)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	0	0
Total number of clients with non-missing values on employment/student status [denominator]	0	0
Percent of clients employed or student (full-time and part-time)	0.0 %	0.0 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	0
Number of CY 2022 discharges submitted:	0
Number of CY 2022 discharges linked to an admission:	0
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0

Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	0

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Outpatient (OP)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	2,582	2,306
Total number of clients with non-missing values on employment/student status [denominator]	6,297	6,297
Percent of clients employed or student (full-time and part-time)	41.0 %	36.6 %
Notes (for this level of care):		
Number of CY 2022 admissions submitted:		165,725
Number of CY 2022 discharges submitted:		162,221
Number of CY 2022 discharges linked to an admission:		48,165
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		46,355
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):		6,297

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Intensive Outpatient (IO)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	0	0
Total number of clients with non-missing values on employment/student status [denominator]	13	13
Percent of clients employed or student (full-time and part-time)	0.0 %	0.0 %
Notes (for this level of care):		
Number of CY 2022 admissions submitted:		185
Number of CY 2022 discharges submitted:		262
Number of CY 2022 discharges linked to an admission:		72
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		69

Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	13

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

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Footnotes:

V: Performance Data and Outcomes

Table 15 - Treatment Performance Measure: Stability of Housing (From Admission to Discharge)

Short-term Residential(SR)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	0	0
Total number of clients with non-missing values on living arrangements [denominator]	0	0
Percent of clients in stable living situation	0.0 %	0.0 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	5,829
Number of CY 2022 discharges submitted:	4,995
Number of CY 2022 discharges linked to an admission:	883
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	869
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	0

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Long-term Residential(LR)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	0	0
Total number of clients with non-missing values on living arrangements [denominator]	0	0
Percent of clients in stable living situation	0.0 %	0.0 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	0
Number of CY 2022 discharges submitted:	0
Number of CY 2022 discharges linked to an admission:	0
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	0

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Outpatient (OP)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	0	0
Total number of clients with non-missing values on living arrangements [denominator]	0	0
Percent of clients in stable living situation	0.0 %	0.0 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	165,725
Number of CY 2022 discharges submitted:	162,221
Number of CY 2022 discharges linked to an admission:	48,165
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	46,355
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	0

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Intensive Outpatient (IO)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	0	0
Total number of clients with non-missing values on living arrangements [denominator]	0	0
Percent of clients in stable living situation	0.0 %	0.0 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	185
Number of CY 2022 discharges submitted:	262
Number of CY 2022 discharges linked to an admission:	72
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	69
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	0

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Footnotes:

V: Performance Data and Outcomes

Table 16 - Treatment Performance Measure: Criminal Justice Involvement (From Admission to Discharge)

Short-term Residential(SR)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	135	132
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	194	194
Percent of clients without arrests	69.6 %	68.0 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	5,829
Number of CY 2022 discharges submitted:	4,995
Number of CY 2022 discharges linked to an admission:	883
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	870
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	194

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Long-term Residential(LR)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	0	0
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	0	0
Percent of clients without arrests	0.0 %	0.0 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	0
Number of CY 2022 discharges submitted:	0
Number of CY 2022 discharges linked to an admission:	0
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0

Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	0

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Outpatient (OP)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	4,967	4,992
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	6,404	6,404
Percent of clients without arrests	77.6 %	78.0 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	165,725
Number of CY 2022 discharges submitted:	162,221
Number of CY 2022 discharges linked to an admission:	48,165
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	46,768
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	6,404

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Intensive Outpatient (IO)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	11	11
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	13	13
Percent of clients without arrests	84.6 %	84.6 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	185
Number of CY 2022 discharges submitted:	262
Number of CY 2022 discharges linked to an admission:	72
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	69

Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	13

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

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Footnotes:

V: Performance Data and Outcomes

Table 17 - Treatment Performance Measure: Change in Abstinence - Alcohol Use (From Admission to Discharge)

Short-term Residential(SR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	144	145
All clients with non-missing values on at least one substance/frequency of use [denominator]	190	190
Percent of clients abstinent from alcohol	75.8 %	76.3 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		7
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	46	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		15.2 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		138
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	144	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		95.8 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	5,829
Number of CY 2022 discharges submitted:	4,995
Number of CY 2022 discharges linked to an admission:	883
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	870
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	190

Long-term Residential(LR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	0	0
All clients with non-missing values on at least one substance/frequency of use [denominator]	0	0
Percent of clients abstinent from alcohol	0.0 %	0.0 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		0
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	0	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		0.0 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		0
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	0	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		0.0 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	0
Number of CY 2022 discharges submitted:	0
Number of CY 2022 discharges linked to an admission:	0
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	0

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Outpatient (OP)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	5,471	5,319
All clients with non-missing values on at least one substance/frequency of use [denominator]	6,348	6,348
Percent of clients abstinent from alcohol	86.2 %	83.8 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		98
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	877	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		11.2 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		5,221
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	5,471	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		95.4 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	165,725
Number of CY 2022 discharges submitted:	162,221
Number of CY 2022 discharges linked to an admission:	48,165
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	46,768
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	6,348

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Intensive Outpatient (IO)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	11	10
All clients with non-missing values on at least one substance/frequency of use [denominator]	13	13
Percent of clients abstinent from alcohol	84.6 %	76.9 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		0
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		0.0 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		10
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	11	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		90.9 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	185
Number of CY 2022 discharges submitted:	262
Number of CY 2022 discharges linked to an admission:	72
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	69
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	13

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

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Footnotes:

V: Performance Data and Outcomes

Table 18 - Treatment Performance Measure: Change in Abstinence - Other Drug Use (From Admission to Discharge)

Short-term Residential(SR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	104	108
All clients with non-missing values on at least one substance/frequency of use [denominator]	190	190
Percent of clients abstinent from drugs	54.7 %	56.8 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		14
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	86	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		16.3 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		94
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	104	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		90.4 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	5,829
Number of CY 2022 discharges submitted:	4,995
Number of CY 2022 discharges linked to an admission:	883
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	870
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	190

Long-term Residential(LR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	0	0
All clients with non-missing values on at least one substance/frequency of use [denominator]	0	0
Percent of clients abstinent from drugs	0.0 %	0.0 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		0
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	0	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		0.0 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		0
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	0	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		0.0 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	0
Number of CY 2022 discharges submitted:	0
Number of CY 2022 discharges linked to an admission:	0
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	0

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Outpatient (OP)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	4,786	4,594
All clients with non-missing values on at least one substance/frequency of use [denominator]	6,348	6,348
Percent of clients abstinent from drugs	75.4 %	72.4 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		232
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,562	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		14.9 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		4,362
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	4,786	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		91.1 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	165,725
Number of CY 2022 discharges submitted:	162,221
Number of CY 2022 discharges linked to an admission:	48,165
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	46,768
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	6,348

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Intensive Outpatient (IO)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	10	7
All clients with non-missing values on at least one substance/frequency of use [denominator]	13	13
Percent of clients abstinent from drugs	76.9 %	53.8 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		0
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		0.0 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		7
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	10	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		70.0 %

Notes (for this level of care):	
Number of CY 2022 admissions submitted:	185
Number of CY 2022 discharges submitted:	262
Number of CY 2022 discharges linked to an admission:	72
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	69
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	13

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

Table 19 – State Description of Social Support of Recovery Data Collection

Short-term Residential(SR)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	32	30
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	120	120
Percent of clients participating in self-help groups	26.7 %	25.0 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	-1.7 %	
Notes (for this level of care):		
Number of CY 2022 admissions submitted:	5,829	
Number of CY 2022 discharges submitted:	4,995	
Number of CY 2022 discharges linked to an admission:	883	
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	870	
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	120	

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Long-term Residential(LR)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	0	0
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	0	0
Percent of clients participating in self-help groups	0.0 %	0.0 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	0.0 %	
Notes (for this level of care):		
Number of CY 2022 admissions submitted:	0	
Number of CY 2022 discharges submitted:	0	

Number of CY 2022 discharges linked to an admission:	0
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	0

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Outpatient (OP)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	864	950
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	4,733	4,733
Percent of clients participating in self-help groups	18.3 %	20.1 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	1.8 %	
Notes (for this level of care):		
Number of CY 2022 admissions submitted:	165,725	
Number of CY 2022 discharges submitted:	162,221	
Number of CY 2022 discharges linked to an admission:	48,165	
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	46,768	
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	4,733	

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

Intensive Outpatient (IO)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	4	3
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	12	12
Percent of clients participating in self-help groups	33.3 %	25.0 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	-8.3 %	
Notes (for this level of care):		
Number of CY 2022 admissions submitted:	185	

Number of CY 2022 discharges submitted:	262
Number of CY 2022 discharges linked to an admission:	72
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	69
Number of CY 2022 linked discharges eligible for this calculation (non-missing values):	12

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

Table 20 - Retention - Length of Stay (in Days) of Clients Completing Treatment

Level of Care	Average (Mean)	25th Percentile	50th Percentile (Median)	75th Percentile
DETOXIFICATION (24-HOUR CARE)				
1. Hospital Inpatient	48	6	30	69
2. Free-Standing Residential	32	3	7	38
REHABILITATION/RESIDENTIAL				
3. Hospital Inpatient	22	2	2	6
4. Short-term (up to 30 days)	48	9	29	59
5. Long-term (over 30 days)	0	0	0	0
AMBULATORY (OUTPATIENT)				
6. Outpatient	39	1	4	38
7. Intensive Outpatient	90	17	41	120
8. Detoxification	0	0	0	0
OUD MEDICATION ASSISTED TREATMENT				
9. OUD Medication-Assisted Detoxification[1]	173	63	98	222
10. OUD Medication-Assisted Treatment Outpatient[2]	164	17	87	232

Level of Care	2022 TEDS discharge record count	
	Discharges submitted	Discharges linked to an admission
DETOXIFICATION (24-HOUR CARE)		
1. Hospital Inpatient	1672	46
2. Free-Standing Residential	3776	172
REHABILITATION/RESIDENTIAL		
3. Hospital Inpatient	578	86
4. Short-term (up to 30 days)	4995	883

5. Long-term (over 30 days)	0	0
AMBULATORY (OUTPATIENT)		
6. Outpatient	162221	46784
7. Intensive Outpatient	262	72
8. Detoxification	0	0
OUD MEDICATION ASSISTED TREATMENT		
9. OUD Medication-Assisted Detoxification[1]		11
10. OUD Medication-Assisted Treatment Outpatient[2]		1381

Source: SAMHSA/CBHSQ TEDS CY 2022 admissions file and CY 2022 linked discharge file
[Records received through 2/1/2024]

[1] OUD Medication-Assisted Treatment Detoxification includes hospital detoxification, residential detoxification, or ambulatory detoxification services/settings AND Opioid Medication-Assisted Treatment.

[2] OUD Medication-Assisted Treatment Outpatient includes outpatient services/settings AND Opioid Medication-Assisted Treatment.

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

Table 21 – Substance Use Disorder Primary Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: 30-Day Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	**Source Survey Item:** NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from **[DATEFILL]** through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?[Response option: Write in a number between 0 and 30.]" **Outcome Reported:** Percent who reported having used alcohol during the past 30 days.		
	Age 12 - 20 - CY 2020 - 2021		
	Age 21+ - CY 2020 - 2021		
2. 30-day Cigarette Use	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you smoke part or all of a cigarette?[Response option: Write in a number between 0 and 30.]" **Outcome Reported:** Percent who reported having smoked a cigarette during the past 30 days.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
3. 30-day Use of Other Tobacco Products	**Survey Item: NSDUH Questionnaire:** "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you use [other tobacco products][1]?[Response option: Write in a number between 0 and 30.]" **Outcome Reported:** Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (cigars, smokeless tobacco, pipe tobacco).		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
4. 30-day Use of Marijuana	**Source Survey Item: NSDUH Questionnaire:** "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?[Response option: Write in a number between 0 and 30.]" **Outcome Reported:** Percent who reported having used marijuana or hashish during the past 30 days.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
5. 30-day Use of Illicit Drugs Other Than Marijuana	**Source Survey Item: NSDUH Questionnaire:** "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use [any other illicit drug]?[2]" **Outcome Reported:** Percent who reported having used illicit drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, hallucinogens, inhalants, methamphetamine, and misuse of prescription drugs).		
	Age 12 - 17 - CY 2020 - 2021		

	Age 18+ - CY 2020 - 2021		

[1]NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.
[2]NSDUH asks separate questions for each illicit drug. The number provided combines responses to all questions about illicit drugs other than marijuana or hashish.
0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

Table 22 – Substance Use Disorder Primary Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: Perception of Risk/Harm of Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. Perception of Risk From Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk]" **Outcome Reported:** Percent reporting moderate or great risk.		
	Age 12 - 20 - CY 2020 - 2021		
	Age 21+ - CY 2020 - 2021		
2. Perception of Risk From Cigarettes	**Source Survey Item: NSDUH Questionnaire:** "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?[Response options: No risk, slight risk, moderate risk, great risk]" **Outcome Reported:** Percent reporting moderate or great risk.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
3. Perception of Risk From Marijuana	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk]" **Outcome Reported:** Percent reporting moderate or great risk.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

Table 23 – Substance Use Disorder Primary Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: Age of First Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	**Source Survey Item: NSDUH Questionnaire:** "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink. [Response option: Write in age at first use.]" **Outcome Reported:** Average age at first use of alcohol.		
	Age 12 - 20 - CY 2020 - 2021		
	Age 21+ - CY 2020 - 2021		
2. Age at First Use of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?[Response option: Write in age at first use.]" **Outcome Reported:** Average age at first use of cigarettes.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
3. Age at First Use of Tobacco Products Other Than Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product][1]?[Response option: Write in age at first use.]" **Outcome Reported:** Average age at first use of tobacco products other than cigarettes.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
4. Age at First Use of Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?[Response option: Write in age at first use.]" **Outcome Reported:** Average age at first use of marijuana or hashish.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
5. Age at First Use Heroin	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used heroin? [Response option: Write in age at first use.]" **Outcome Reported:** Average age at first use of heroin.		
	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		
6. Age at First Misuse of Prescription Pain Relievers Among Past Year Initiates	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [specific pain reliever][2] in a way a doctor did not direct you to use it?"[Response option: Write in age at first use.]" **Outcome Reported:** Average age at first misuse of prescription pain relievers among those who first misused prescription pain relievers in the last 12 months.		

	Age 12 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		

[1]The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.
[2]The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

Table 24 – Substance Use Disorder Primary Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]" **Outcome Reported:** Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2020 - 2021		
2. Perception of Peer Disapproval of Cigarettes	**Source Survey Item: NSDUH Questionnaire:** "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]" **Outcome Reported:** Percent reporting that their friends would somewhat or strongly disapprove.		
	Age 12 - 17 - CY 2020 - 2021		
3. Disapproval of Using Marijuana Experimentally	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]" **Outcome Reported:** Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2020 - 2021		
4. Disapproval of Using Marijuana Regularly	**Source Survey Item: NSDUH Questionnaire:** "How do you feel about someone your age using marijuana once a month or more?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]" **Outcome Reported:** Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2020 - 2021		
5. Disapproval of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]" **Outcome Reported:** Percent somewhat or strongly disapproving.		
	Age 12 - 20 - CY 2020 - 2021		

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

Table 25 – Substance Use Disorder Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use
Measure: Perception of Workplace Policy

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Perception of Workplace Policy	**Source Survey Item:** NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?[Response options: More likely, less likely, would make no difference]" **Outcome Reported:** Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.		
	Age 15 - 17 - CY 2020 - 2021		
	Age 18+ - CY 2020 - 2021		

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

Table 26 – Substance Use Disorder Primary Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: Average Daily School Attendance Rate

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	**Source:** National Center for Education Statistics, Common Core of Data: *The National Public Education Finance Survey* available for download at **http://nces.ed.gov/ccd/stfis.asp**. **Measure calculation:** Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.		
	School Year 2020		

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

Table 27 – Substance Use Disorder Primary Prevention NOMs Domain: Crime and Criminal Justice Measure: Alcohol Related Fatalities

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Alcohol-Related Traffic Fatalities	**Source:** National Highway Traffic Safety Administration Fatality Analysis Reporting System **Measure calculation:** The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.		
	CY 2021		

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

Table 28 – Substance Use Disorder Primary Prevention NOMs Domain: Crime and Criminal Justice Measure: Alcohol and Drug-Related Arrests

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Alcohol- and Drug-Related Arrests	**Source:** Federal Bureau of Investigation Uniform Crime Reports **Measure calculation:** The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.		
	CY 2021		

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

Table 29 – Substance Use Disorder Primary Prevention NOMs Domain: Social Connectedness Measure: Family Communications Around Drug and Alcohol Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. Family Communications Around Drug and Alcohol Use (Youth)	**Source Survey Item:** NSDUH Questionnaire: "Now think about the past 12 months, that is, from [DATEFILL] through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No] **Outcome Reported:** Percent reporting having talked with a parent.		
	Age 12 - 17 - CY 2020 - 2021		
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12-17)	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?" [1][Response options: 0 times, 1 to 2 times, a few times, many times] **Outcome Reported:** Percent of parents reporting that they have talked to their child.		
	Age 18+ - CY 2020 - 2021		

[1]NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

Table 30 – Substance Use Disorder Primary Prevention NOMs Domain: Retention Measure: Percentage of Youth Seeing, or Listening to a Prevention Message

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Exposure to Prevention Messages	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use][1]?" **Outcome Reported:** Percent reporting having been exposed to prevention message.		
	Age 12 - 17 - CY 2020 - 2021		

[1]This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

V: Performance Data and Outcomes

Reporting Period Start and End Dates for Information Reported on SUPTRS BG Tables 31, 32, 33, 34 and 35

Reporting Period Start and End Dates for Information Reported on Tables 31, 32, 33, 34 and 35

Please indicate the reporting period for each of the following NOMS.

Tables	A. Reporting Period Start Date	B. Reporting Period End Date
1. Table 31 – Substance Use Disorder Primary Prevention Individual-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity	10/1/2020	9/30/2022
2. Table 32 – Substance Use Disorder Primary Prevention Population-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity	10/1/2020	9/30/2022
3. Table 33 (Optional) – Substance Use Disorder Primary Prevention Number of Persons Served by Type of Intervention	10/1/2020	9/30/2022
4. Table 34 – Substance Use Disorder Primary Prevention Number of Evidence-Based Programs and Strategies by Type of Intervention	10/1/2020	9/30/2022
5. Table 35 – Total Substance Use Disorder Primary Prevention Number of Evidence Based Programs/Strategies and Total SUPTRS BG Dollars Spent on Substance Use Disorder Primary Prevention Evidence-Based Programs/Strategies	10/1/2020	9/30/2022

General Questions Regarding Prevention NOMS Reporting

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

For the 2024 SUBG Report, AHCCCS accepted the pre-populated NOMs data from National Survey on Drug Use and Health (NSDUH). Additional strategy information, program participant data, and program evaluation data is collected in a variety of ways. Program data, including NOMs data, may be collected through print or electronic program surveys at the provider-level, and/or using the Arizona Youth Survey. Ultimately, SUBG program and survey data, including NOMs, is submitted to AHCCCS or GOYFF through web portals designed specifically for the SUBG funding.

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race.

Indicate whether the State added those participants to the number for each applicable racial category or whether the State added all those partipants to the More Than One Race subcategory.

Subrecipients report program data to AHCCCS or GOYFF into the SUBG web-based portal(s). During program implementation, program participants self-identify their demographic information either on surveys or on participant sign-in sheets. The options for other race and more than one race are among the options available for selection.

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

For the 2024 report, AHCCCS opted to align the reporting periods for these tables with the expenditure period in the expenditure reports. Previous reports utilized the most recent state fiscal year.

V: Performance Data and Outcomes

Table 31 – Substance Use Disorder Primary Prevention Individual-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Total
A. Age	**87,837**
0-5	335
6-12	10,378
13-17	35,386
18-20	1,732
21-24	2,072
25-44	8,823
45-64	3,304
65-74	789
75 and Over	385
Age Not Known	24,633
B. Gender	**87,837**
Male	26,057
Female	30,434
Trans man	0
Trans woman	0
Gender non-conforming	11
Other	31,335
C. Race	**87,837**
White	34,106
Black or African American	3,514
Native Hawaiian/Other Pacific Islander	192

Asian	766
American Indian/Alaska Native	4,236
More Than One Race (not OMB required)	2,117
Race Not Known or Other (not OMB required)	42,906
D. Ethnicity	**87,837**
Hispanic or Latino	24,921
Not Hispanic or Latino	19,605
Ethnicity Unknown	43,311

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

1) For the 2024 report, AHCCCS opted to align the Table 31 reporting period with the expenditure period in the expenditure report tables. Previous reports utilized the most recent state fiscal year

2) Gender demographics were not collected in all of the listed categories. Those reported in "Other" are inclusive of "gender not collected/reported"

V: Performance Data and Outcomes

Table 32 – Substance Use Disorder Primary Prevention Population-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Total
A. Age	**7107314**
0-5	4096
6-12	63612
13-17	130091
18-20	134352
21-24	112970
25-44	1664944
45-64	1348721
65-74	223959
75 and Over	155549
Age Not Known	3269020
B. Gender	**7107314**
Male	1866538
Female	1972708
Trans man	
Trans woman	
Gender non-conforming	
Other	3268068
C. Race	**7107314**
White	2204526
Black or African American	107407
Native Hawaiian/Other Pacific Islander	6705

Asian	31053
American Indian/Alaska Native	1074142
More Than One Race (not OMB required)	177094
Race Not Known or Other (not OMB required)	3506387
D. Ethnicity	**7107314**
Hispanic or Latino	596627
Not Hispanic or Latino	3050791
Ethnicity Unknown	3459896

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

1) For the 2024 report, AHCCCS opted to align the Table 32 reporting period with the expenditure period in the expenditure report tables. Previous reports utilized the most recent state fiscal year

2) Gender demographics were not collected in all of the listed categories. Those reported in "Other" are inclusive of "gender not collected/reported"

V: Performance Data and Outcomes

Table 33 (Optional) – Substance Use Disorder Primary Prevention Number of Persons Served by Type of Intervention

Number of Persons Served by Individual- or Population-Based Program or Strategy

Intervention Type	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct		N/A
2. Universal Indirect	N/A	
3. Selective		N/A
4. Indicated		N/A
5. Total	**0**	**$0.00**
Number of Persons Served[1]	**87,837**	**7,107,314**

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

AZ did not complete the table as it is not required.

V: Performance Data and Outcomes

Table 34 – Substance Use Disorder Primary Prevention Number of Evidence-Based Programs and Strategies by Type of Intervention

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, Identifying and Selecting Evidence-based Interventions, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
  - Guideline 1:
    The intervention is based on a theory of change that is documented in a clear logic or conceptual model; and
  - Guideline 2:
    The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and
  - Guideline 3:
    The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to Identifying and Selecting Evidence-Based Interventions scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; and
  - Guideline 4:
    The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.

AHCCCS requires the use of evidence-based programs and strategies. Specific details of the requirements vary by contract type. As of July 1, 2021, AHCCCS removed the administration of SUBG prevention funds from the ACC-RBHAs (SUBG prevention funding to the TRBHAs remained) and instead directly contracted with 19 coalitions. These contracts include a requirement to implement evidence-based program (EBP) or promising practices or program. Innovative practices/program are allowed at a ratio of 1 innovative practice/program per 1 evidence based or promising practice or program. These contracts delineate the definition of an evidence-based program, a promising program, and an innovative program. The definition of an evidence-based program is consistent with SAMHSA's Center for Substance Abuse Prevention (CSAP) and "Selecting Best-fit Programs and Practices" publication. In order to evaluate the allowability of the use of an innovative program, and to help identify if a program would be considered evidence-based (if not already clear) or promising, the contractor submits an Innovative Program Protocol for AHCCCS to review and deem the appropriate category, and the appropriate approval decision. The Governor's Office of Youth Faith and Family (GOYFF), which helps administer SUBG prevention funds, also sets requirements for its SUBG prevention subrecipients. GOYFF used guidance from both SAMHSA and AHCCCS to develop a list of pre-approved EBPs and strategies for sub-grantees to use when reporting service numbers and expenditures. If a program is not on the pre-approved list the funded entities require sub-grantees to receive approval from a Program Administrator well versed in the definition and criteria used in both the SUBG and the Strategic Prevention Framework State Incentive Grant before being able to report service numbers or expenditures categorized as evidence-based. Various EBP online registries are used to vet EBP as needed. Staff also attend trainings prior to providing any EBP curriculum. All community education presentations are developed using current data related to current drug trends. Staff are also trained in presentation techniques to adapt to multiple learning styles. AHCCCS funds a number of tribal entities under SUBG prevention, some of which are funded under the 7/1/21 direct contracts mentioned above while others – Tribal Regional Behavioral Health Authorities (TRBHAs) are funded through Intergovernmental Agreements (IGAs). IGAs also delineate that SUBG prevention programs must be evidence-based. AHCCCS provides technical assistance to TRBHA partners to ensure programming is in alignment with SAMHSA guidelines, and also recognizes the “Culture Is Prevention” model as an EBP. Some tribal entities implement EBPs such as Botvin's Life Skills and Active Parenting, while others may make special cultural adaptations to EBPs to best meet the needs of their community, while others may implement traditional tribal cultural-specific activities as a means of evidence-based programming.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?

AHCCCS requires data to be collected and reported anywhere from monthly to annually on SUBG prevention programs and strategies. The source of the data and other details vary by contract type. In 2021-2022, AHCCCS worked with a professional evaluation vendor to develop a web-based portal where most SUBG prevention subrecipients would be required to enter data for SUBG prevention activities. Data may be collected using physical forms or online forms but is ultimately reported in this web-based portal at https://azpreventionsabg.org/. The first training for subrecipients to learn how to enter and manage data in the portal occurred in June 2022. The data source for evidence-based program information is an online form called the Activity List, where they are required to enter the funding source, the CSAP strategy, the activity category, a description, and type of program (innovative, promising, EBP). As of November 2023, the 19 directly contracted prevention coalitions and the 3 institutes of higher education (Arizona State University, Northern Arizona University, and University of Arizona) use the portal to enter and manage their data. Additional contractors may be added to the portal as contracts allow. Similarly, the GOYFF has maintained an online web-based portal for their subrecipients to report data into. Among other data fields/measures, the subrecipients enter data regarding the type of program being implemented and indicate if the strategy being implemented is evidence-based. The Program Administrator at GOYFF reviews

strategy data reports for accuracy. Each strategy report entered by subrecipients is manually calculated to determine the total number of programs/strategies funded and the total number of evidence-based programs/strategies funded. Though currently not required to, TRBHAs are offered the opportunity to use the web-based portal but as of yet have not. They report annually on their programs and strategies to identify evidence-based categories. Additionally, the Gila River TRBHA Prevention Team documents their activities in a process documentation log. This log records the date of activity, type of activity, duration, location, number of participants, and notes about the activity. The Pascua Yaqui TRBHA program staff consolidates, tracks, and records metadata for all events. The data sources include program logs and reports from providers. Other contractors such as the Department of Liquor Licensing and Control (DLLC) also report on their prevention programs and strategies directly to AHCCCS on a regular basis. DLLC's data is collected in real time from the deployed prevention specialist who is providing the service and is entered into an in-house database called Speakeasy, and then reported up to AHCCCS.

Table 34 - SUBSTANCE USE DISORDER PRIMARY PREVENTION **Number of Evidence-Based Programs and Strategies by Type of Intervention**

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selective	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	197	75	272	39	80	391
2. Total number of Programs and Strategies Funded	1383	1152	2535	181	165	2881
3. Percent of Evidence-Based Programs and Strategies	14.24 %	6.51 %	10.73 %	21.55 %	48.48 %	13.57 %

0930-0168 Approved: 06/15/2023 Expires: 06/30/2025

Footnotes:

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V: Performance Data and Outcomes

Table 35 – Total Substance Use Disorder Primary Prevention Number of Evidence Based Programs/Strategies and Total SUPTRS BG Dollars Spent on Substance Use Disorder Primary Prevention Evidence-Based Programs/Strategies

	Total Number of Evidence-Based Programs/Strategies for IOM Category Below	Total Substance Use Block Grant Dollars Spent on evidence-based Programs/Strategies
Universal Direct	Total # 332	$1,882,593.00
Universal Indirect	Total # 74	$161,683.00
Selective	Total # 20	$332,064.00
Indicated	Total # 4	$60,698.00
Unspecified	Total #	
	Total EBPs: 430	Total Dollars Spent: $2,437,038.00

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Footnotes:

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V: Performance Data and Outcomes

Prevention Attachments

Submission Uploads

FFY 2024 Prevention Attachment Category A:

File	Version	Date Added

FFY 2024 Prevention Attachment Category B:

File	Version	Date Added

FFY 2024 Prevention Attachment Category C:

File	Version	Date Added

FFY 2024 Prevention Attachment Category D:

File	Version	Date Added

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Footnotes: