





COVID-19 Behavioral Health Task Force

July 23, 2021

AHCCCS
Arizona Health Care Cost Containment System

Welcome to today's Behavioral Health Task Force Meeting

We will begin shortly. All lines have been automatically muted.

While you are waiting TEST YOUR AUDIO.

LISTEN FOR MUSIC.

Please use the chat feature for questions or raise your hand.

Thank you.

Behavioral Health Task Force
Agenda

- Welcome: Dr. Sara Salek
- Suicide and Opioid Data Trends Update: Jacqueline Kurth
- Mental Well Being Section AZHIP: Kelli Donley Williams & Sheila Sjolander
- Child and Adolescent Psychiatry ED Holds: Dr. Sandy Stein
- Hushabye Nursery: Tara Sundem
- ADHS Update: Priscilla Lauro & Shane Brady
- Questions, Open Discussion & Wrap-Up: All

Suicide and Opioid Data Trends Update

Jacqueline Kurth
Office Chief Injury and Violence Prevention
Arizona Department of Health Services

AHCCCS
Arizona Health Care Cost Containment System

Suicide Mortality Review Program Update Behavioral Health Meeting

Jacqueline Kurth

Office Chief Injury and Violence Prevention

Bureau of Chronic Disease and Health Promotions

Suicide Mortality Review Program

- Authorized in March 2020 by SB1523
- ADHS will utilize Prop 207 funding to start and maintain program
- Allocating $675,000 per year for establishing local teams
- Completed to begin July 1, 2021

Suicide Deaths in Arizona

County	# of Suicides 2020	# of Suicides 2021*
Apache	24	10
Cochise	30	14
Coconino	58	18
Gila	21	12
Graham	6	
Greenlee	4	1
La Paz	4	7

*Preliminary as of 07/13/2021

County	# of Suicides 2020	# of Suicides 2021*
Maricopa	712	360
Mohave	76	40
Navajo	41	16
Pima	225	113
Pinal	73	35
Santa Cruz	4	
Yavapai	71	34
Yuma	23	21

Healthy People Healthy Communities (HPHC) IGA

- Less than 10 suicides per year = 5K:
  - La Paz County
  - Santa Cruz Counties
- 11-30 suicides = $25K:
  - Apache
  - Gila
  - Navajo
- 31-200 suicides = $50K:
  - Cochise
  - Coconino
  - Mohave
  - Pinal
  - Yavapai
  - Yuma
- 201-500 suicides = $100K:
  - Pima (Pima would also review Graham and Greenlee Counties)
- More than 500 suicides = $200K: Maricopa
  - More than 500 suicides = $200K: Maricopa

Next Steps

ADHS Suicide Mortality Review Program Staff

- Health Program Manager – Jessica Bell
- Epidemiologist – Mercedeh Reamer
- CDC Assignee/Epidemiologist – Michael Gallaway

ADHS Responsibilities

Data Collection Tool
Case Narrative Example
Records Request Example
Example Timelines
Create Program Manual
Quarterly report template
Training Dates
Provide Death Data

Create Program Guide
Case Tracking Sheet
Confidentiality Form
Recommendation Form
Create Contracts
Training Materials
Annual Report

State Suicide Mortality Review Team

- A.R.S. § 36-199. Suicide mortality review team; members; duties; review team termination

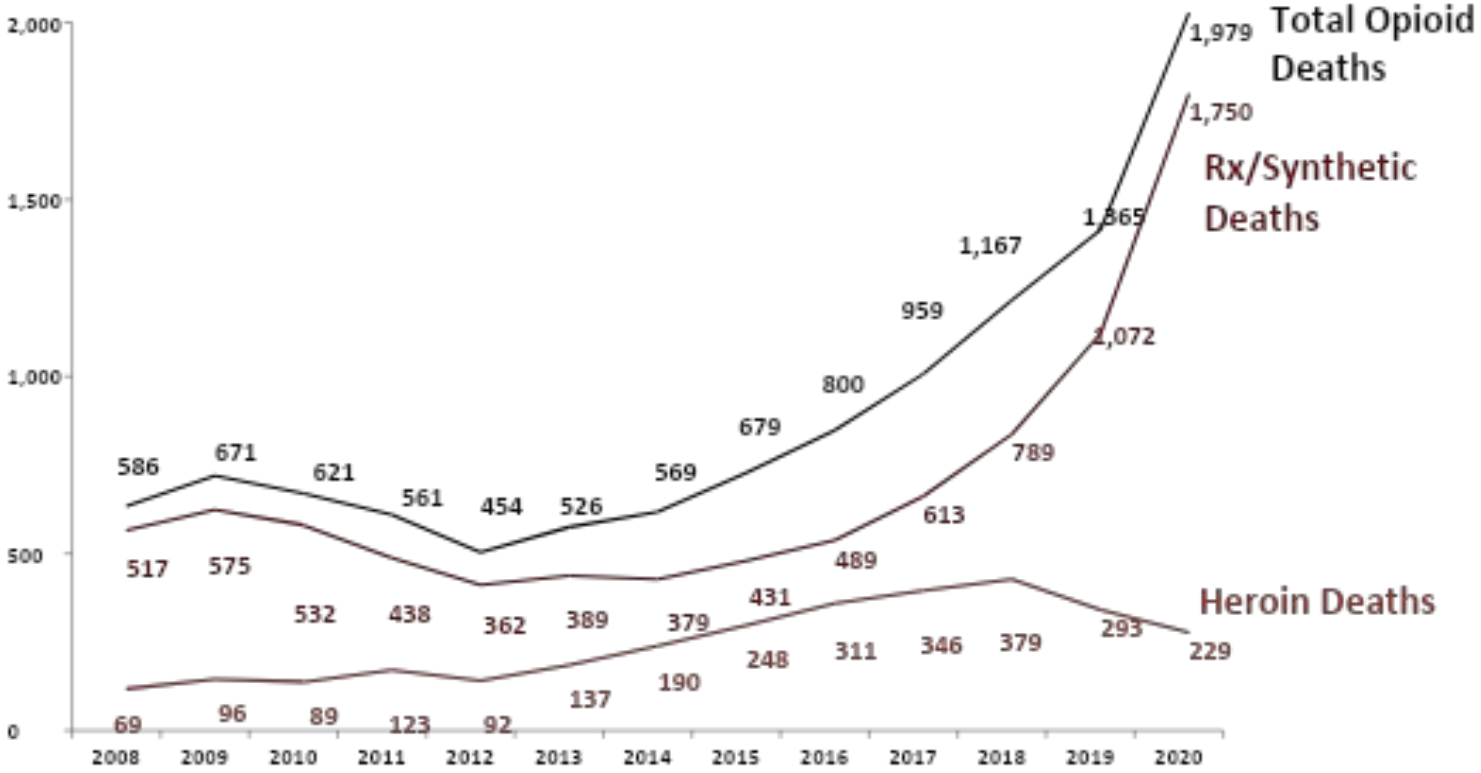
- The statute states the requirements for the state team roster

- ADHS will work with local county suicide mortality review programs to develop team rosters

Timelines

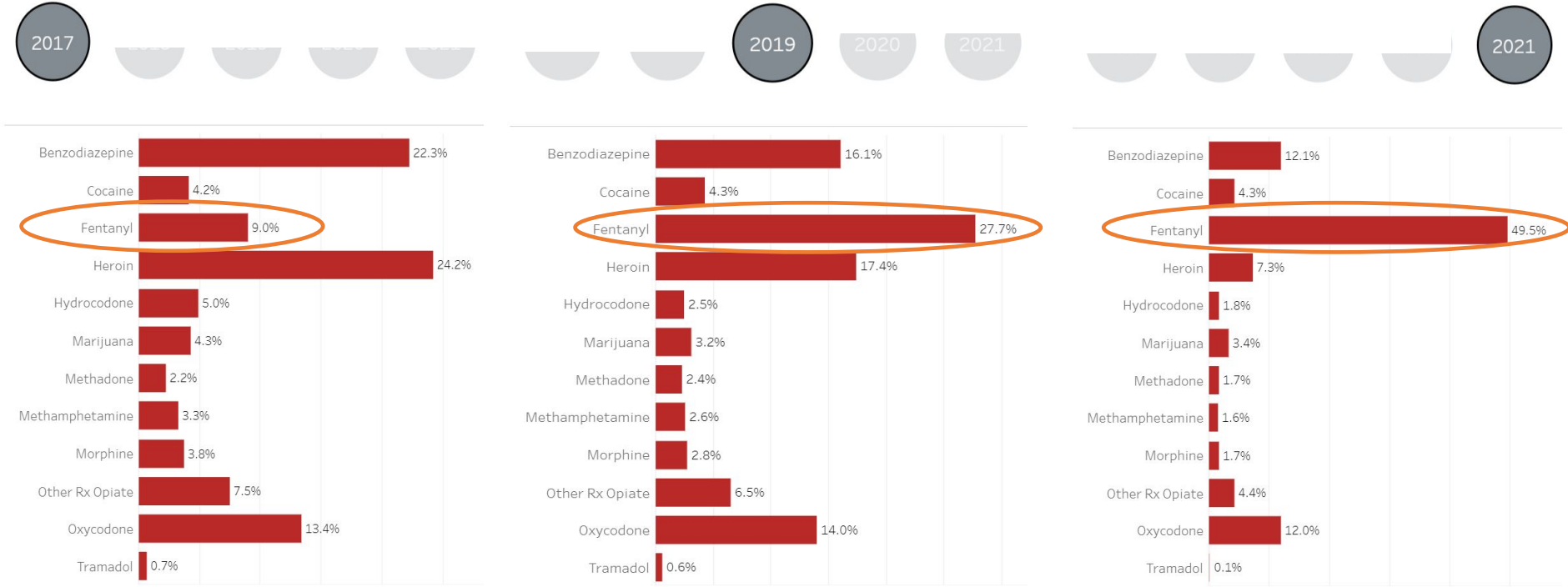
- Confirm which local counties will do suicide reviews – August 2021
- Begin trainings with local county health departments – Sept./Oct. 2021
- Establish local and state team rosters – Oct./Nov. 2021
- Begin case reviews – January 2022

As of the end of 2020:
More than 5 Arizonans/day were dying from opioid overdoses.
The leading cause being illicit fentanyl



Many of the overdose cases in Arizona involve more than one drug, including more than one opioid. These charts represent the types of drugs involved in both fatal and non-fatal overdoses.

Fentanyl significantly INCREASED from being present in only 9% of overdoses in 2017 to being present in half [illegible]ses in 2021.



Note: The above charts are counting the drug type(s) used, not the number of people. One person can be counted in more than one drug type if they used

Naloxone Dispensed

- 135,059 Naloxone kits dispensed by Arizona pharmacists 2017- July 15, 2021
- ADHS has distributed 41,925 (83,850 doses) Naloxone kits to law enforcement, county health departments, community health centers, hospital emergency departments, coalitions and harm reduction organizations 2020 -July 20, 2021

Questions

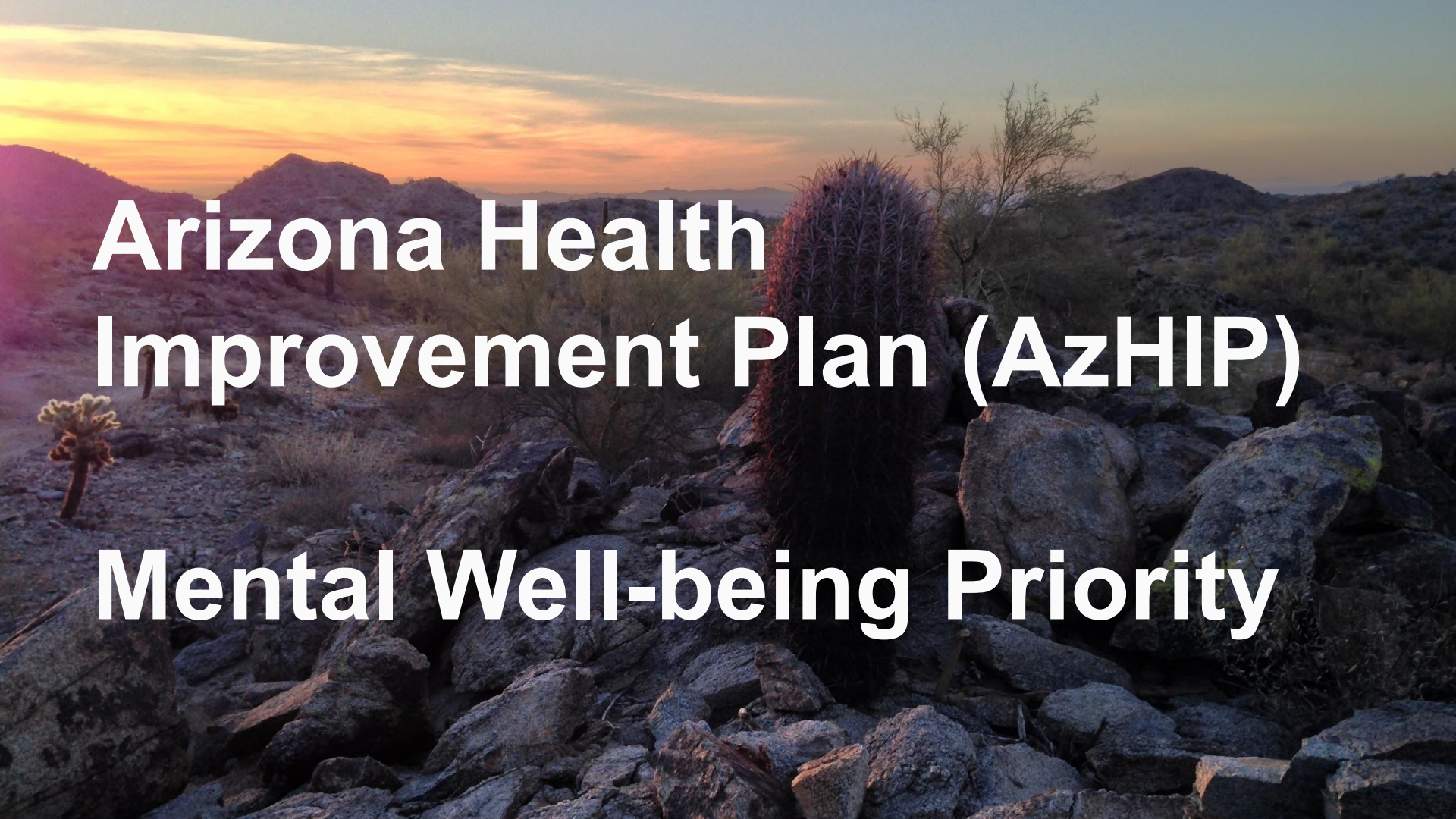
- Please send questions regarding the Suicide Mortality Review program to:

- Jacqueline Kurth at Jacqueline.kurth@azdhs.gov or
- Jessica Bell at Jessica.Bell@azdhs.gov

Mental Well Being Section AZHIP

Kelli Donley Williams, MPH, AHCCCS
Sheila Sjolander, ADHS

AHCCCS
Arizona Health Care Cost Containment System


Arizona Health
Improvement Plan (AzHIP)
Mental Well-being Priority

AzHIP Background

- 5-year community and data-driven
- Multi-sector approach
- Community Engagement
  - Steering Committee
  - Priority Core Team Members
  - Community Forum Participants
  - Action Item Leads
  - Implementation Teams

http://azhealth.gov/azhip/

AzHIP 2021 - 2025 Priorities

Priority Co-chairs

Candy Espino - Arizona Council of Human Service Providers
Teri Pipe - Arizona State University
Wayne Tormala (retired) - Arizona Department of Health Services

ADHS

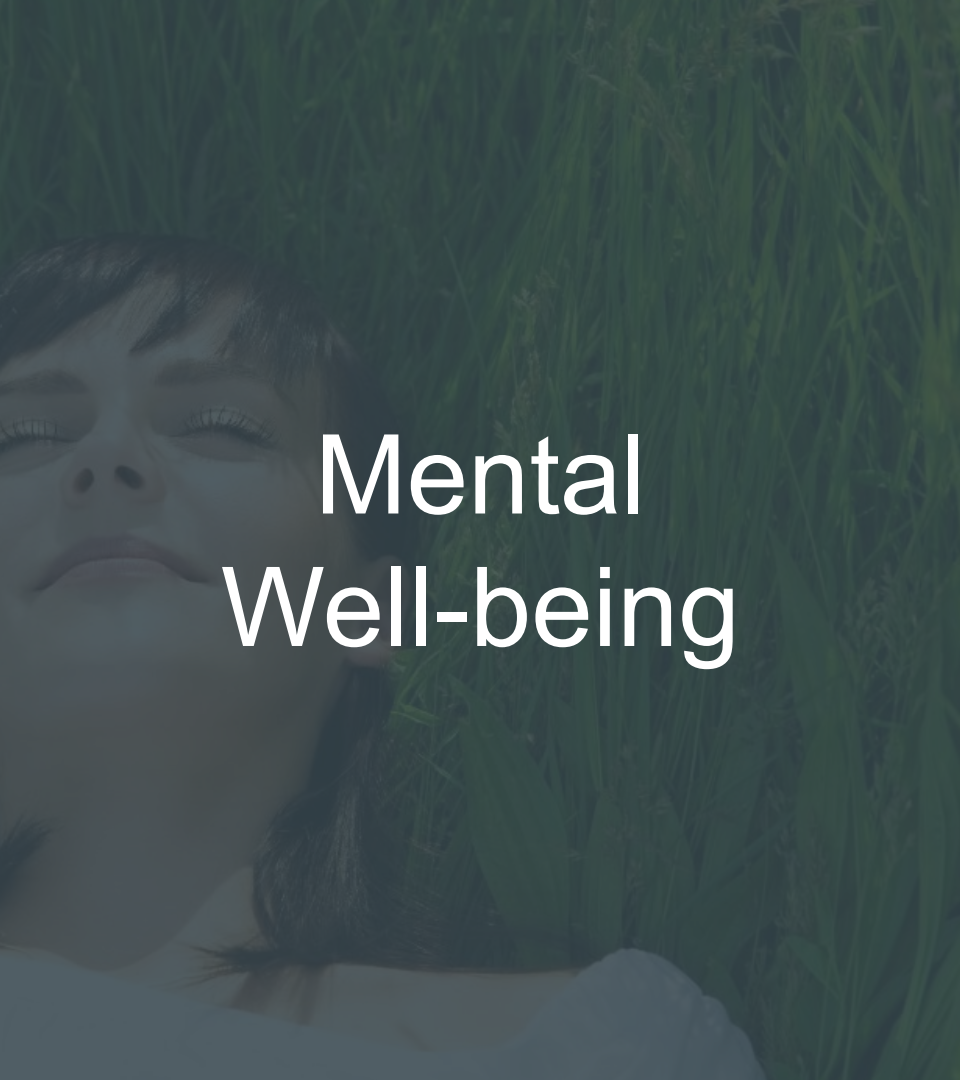
Core Team Members

Name	Organization
Hershel Clark	Black Hills Center for American Indian Health
Juliana Davis	Arizona Department of Economic Services/Refugee Health
Kelli Donley-Williams **	Arizona Health Care Cost Containment System (AHCCCS)
Shayne Galloway, PhD	Centers for Disease Control (CDC) / Arizona Department of Health Services
Shruti Gurudanti	Televeda, Inc.
Rev. Arnold Jackson	Mt. Moriah Community AME Church
Jacquie Kurth **	Arizona Department of Health Services
Julie Mack	Arizona Complete Health
Jeanette Mallery	Health Choice

Name	Organization
Suzanne Pfister	Vitalyst
Floribella Redondo-Martinez	Arizona Community Health Worker Association
Rachael Salley	Arizona Health Care Cost Containment System (AHCCCS)
Dr. Pilar Vargas	United Healthcare Community Plan
Lisa Villarroel, MD	Arizona Department of Health Services
Sala Webb	Department of Child Safety
Christine Wiggs	Blue Cross Blue Shield of Arizona
Col. Wanda Wright	Arizona Veterans Services
Cynthia Zwick	Wildfire

ADHS

*** Sub-team Leader*



Mental Well-being

Vision: A state of whole person well-being in which every individual experiences life-long growth and capacity-building, adapts to changing challenges and adversities, lives fully and fruitfully, and experiences a sense of belonging and meaning within their community - *adapted from the World Health Organization*

Mental Well-being

Strategy 1

Reduce opioid use & overdose fatalities

Strategy 2

Improve awareness of, and address, the impact of social isolation and loneliness on health

Strategy 3

Reduce suicide-related events

Reduce opioid use & overdose fatalities

Promote effective non-pharmacologic management of Chronic Pain to reduce unnecessary use of opioids

Tactic A:
Implement strategies in a manner that ensures cultural humility and health equity are a priority

Tactic B:
Educate consumers and providers on available treatments (medical community, chronic pain patients)

Tactic C:
Enhance access to treatment for substance use disorder, chronic pain, and mental health

Reduce opioid use & overdose fatalities

Develop and implement a stigma reduction and awareness campaign

Tactic A:
Increase mental health and wellness resources for families of people at risk

Tactic B:
Implement stigma reduction campaign

Tactic C:
Implement strategies in a manner that ensures cultural humility and health equity are a priority

Improve awareness of, and address, the impact of social isolation and loneliness on health

Increase public discourse on social isolation and loneliness, i.e. stigma, prevalence and impact on health

Tactic A:
Develop strategies which are population-based

Tactic B:
Create an outreach strategy that de-stigmatizes/ normalizes loneliness and sheds light on its impact on health

Tactic C:
Create awareness of social isolation issues among key stakeholders

Improve awareness of, and address, the impact of social isolation and loneliness on health

Make widely available actionable steps people can take to address loneliness

Tactic A:
Create resources and potential actions for persons identifying as lonely and for communities to combat loneliness

Tactic B:
Develop & launch public awareness campaign

Improve awareness of, and address, the impact of social isolation and loneliness on health

Create increased sense of community, and belonging, throughout Arizona, in more vulnerable populations

Tactic A:
Create community of practices to share information and address disconnects

Tactic B:
Design and launch community-based pilots that provide telehealth opportunities for select rural/underserved populations to acquire a sense of community and belonging.

Reduce Suicide-Related Events

Increase number of public facing/front-line staff who receive an approved evidence-based suicide prevention training

Tactic A:
Identify organizations (employers/ corporations, partners, providers, agencies, etc.) and front line/public facing staff to receive training

Tactic B:
Expand statewide training capacity in a manner that ensures cultural humility and health equity are a priority

Reduce Suicide-Related Events

Increase access to mental health management resources, with a particular focus on remote options (telehealth therapy/ psychiatry/ addiction support appointments, virtual support groups, mental health first aid, etc.)

Tactic A:
On-going surveillance of suicidal behaviors, risks, and protective factors

Tactic B:
Implement suicide prevention strategies in a manner that ensures cultural humility and health equity are a priority

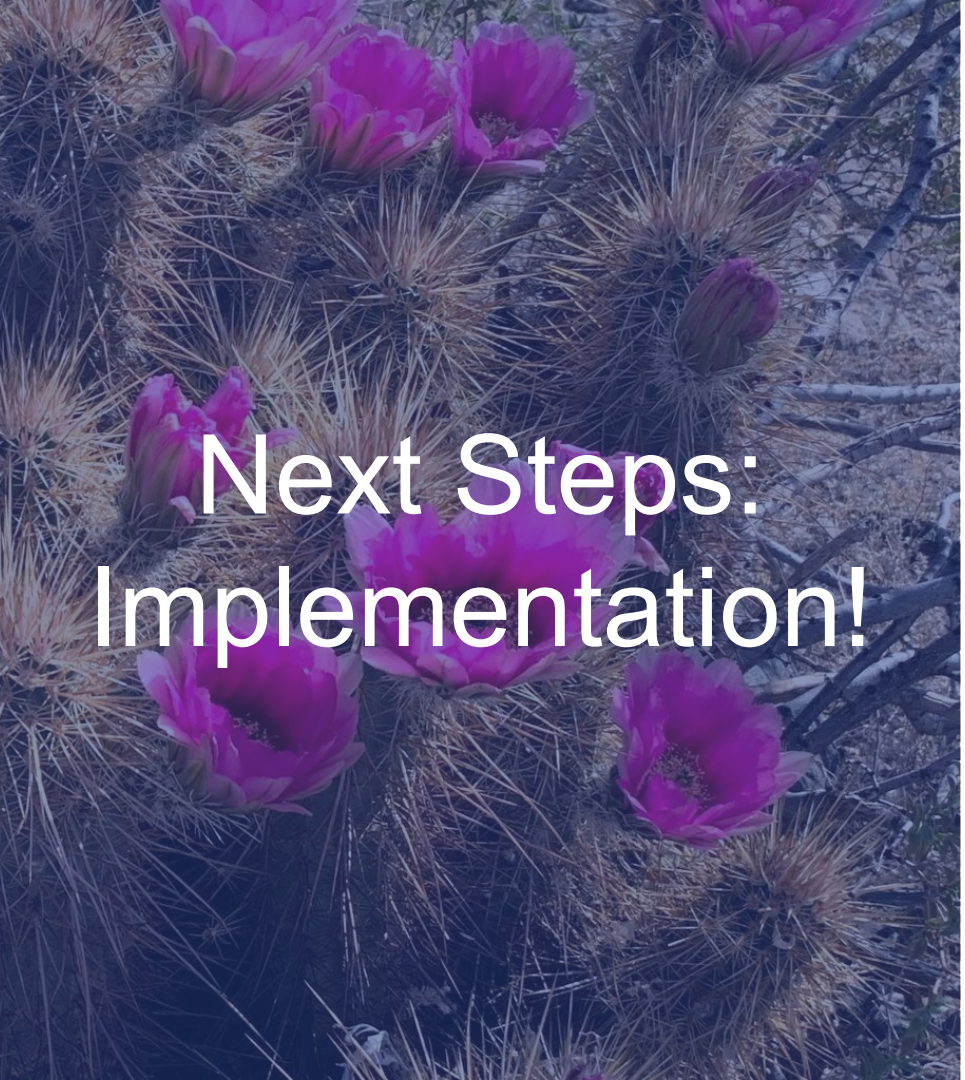
Reduce Suicide-Related Events

Increase awareness, and utilization, of population-based mental health and wellness resources/outreach where they exist; and develop strategies to close gap

Tactic A:
Communicate to the public at large (inclusive of higher risk populations)

Tactic B:
Coordinated communication among state and community stakeholders of prevention

Tactic C:
Implement suicide prevention strategies in a manner that ensures cultural humility and health equity are a priority



Next Steps: Implementation!

Implementation Team to begin meeting

Considerations of funding opportunities

Contact: azhip@azdhs.gov


Thank you

Child and Adolescent Psychiatry ED Holds

Dr Sandy Stein, Dr Gagan Singh and Dr Sutapa Dube, Bill Southwick

Banner University Health Plans

AHCCCS
Arizona Health Care Cost Containment System

Banner

Child and Adolescent Psychiatry ED Holds

A request for action and collaboration

July 23, 2021

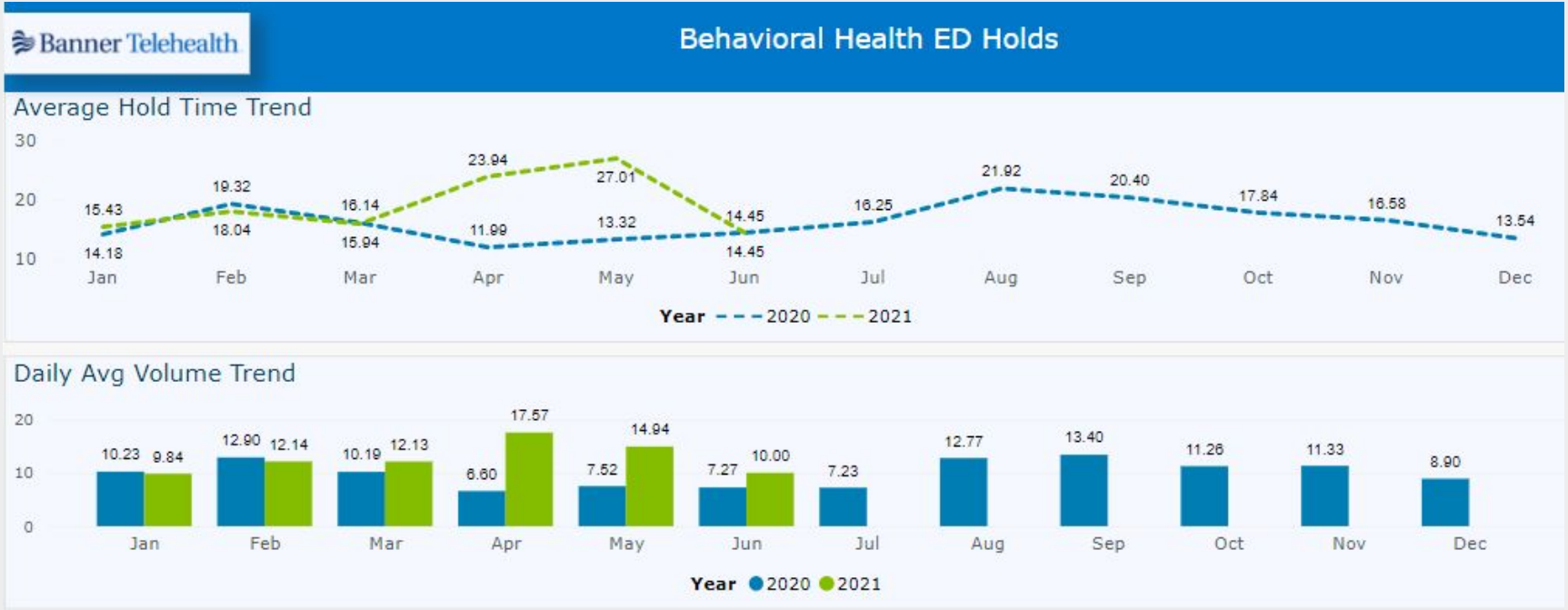
Dr Sandy Stein, Dr Gagan Singh and Dr Sutapa Dube, Bill Southwick

Banner University Health Plans

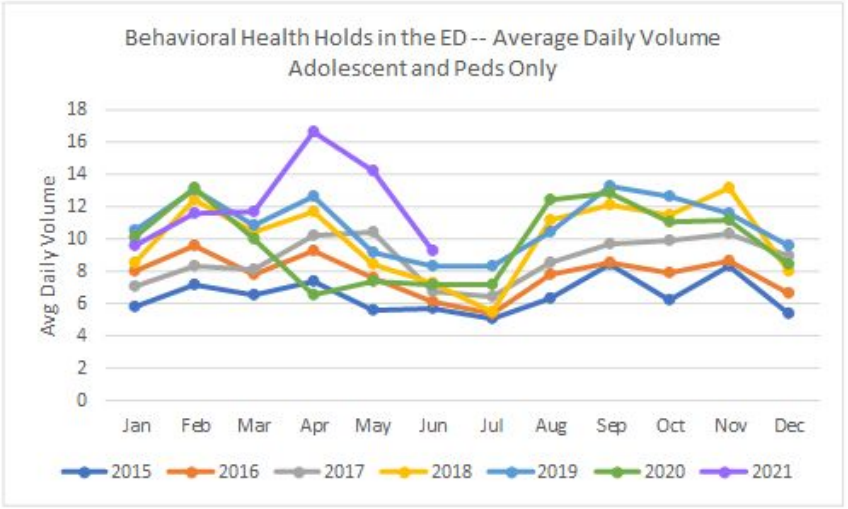
Child and Adolescent ED Holds and Volume Collaborative Group

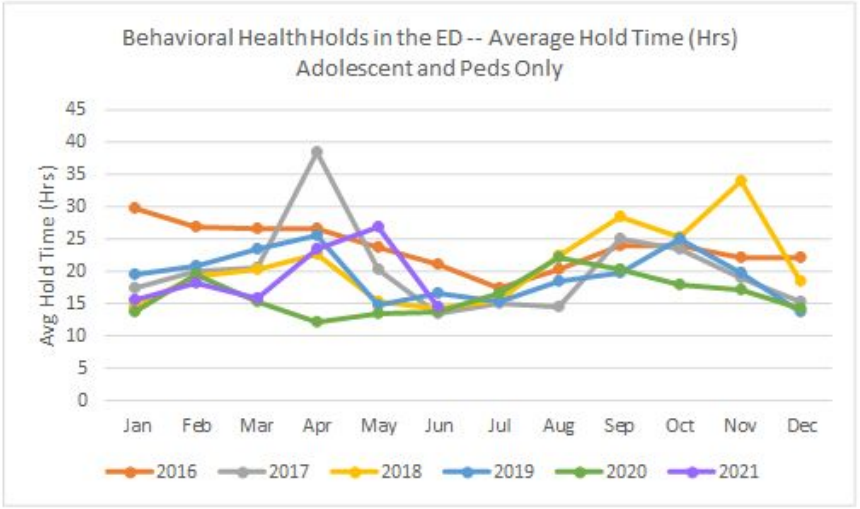
- We are seeing a significant increase in ED visits for children and adolescents with associated increases in ED hold times. The issue is the most acute for the more difficult to place kids. We are hoping for collaboration on ways to tackle this problem together.
- Robust participation from:
  - Banner Health, BUHP, UHC, MercyCare, DES, DDD, PCH, CPR, AHCCCS
- This is a significant community issue for Arizona
- Reviewing data, common trends and hope to explore solutions

Banner Maricopa County Eds for C&A ED Holds



Banner Maricopa County Trends Over Last 6 Years

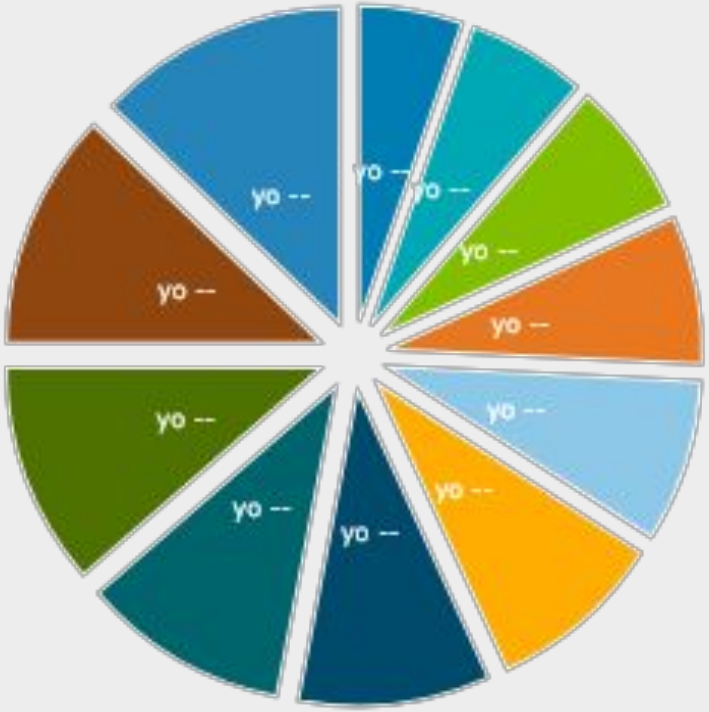




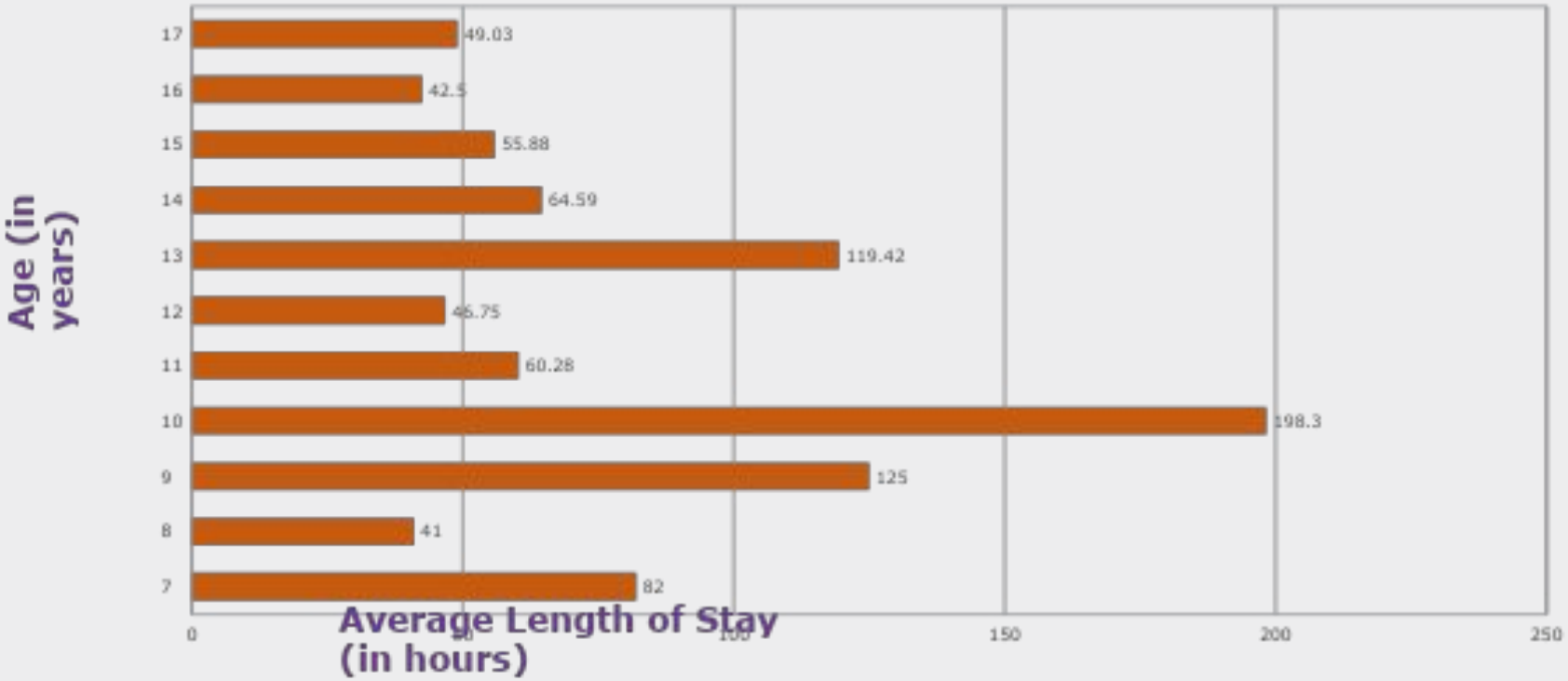
Banner Maricopa Breakdown of Long LOS Patients by Age and Time

	Age range		
LOS	12 and under	13 to 17 years	
	272	1235	Total
<12hour in ED	154 (57%)	600 (49%)	
>12hours in ED	118 (43%)	635 (51%)	
Break down of long LOS patients >12 hours)			
12-16 hours in ED	21 (18%)	144 (23%)	
16-20 hours in ED	22 (19%)	148 (23%)	
20-24 hours in ED	20 (17%)	111 (17%)	
>24 hours in ED	55 (46%)	235 (37%)	
Break down of Ultra long LOS patients			
48h-72h	12	55	
72-100h	7	23	
>100h	6	20	

BUHP Percentage of Members w/LOS > 24 Hours in ED by Age (July 2020 –June 2021)



BUHP Data on Average LOS in Emergency Department by Age (July 2020-June 2021)



Factors That Contribute to Long LOS

- Limited availability of specialized services for more complex kids
  - Limited number of facilities that take younger children <13 years
  - Limited number of facilities that will accept aggressive children
  - Limited number of placements for children with a developmental disability/ASD diagnosis
  - Limited services for kids with comorbid substance use
- Limited outpatient/wrap services
  - Covid restrictions/procedures have reduced physical in-home service availability
  - Need for more MST services
  - Need for more services for kids with complex trauma (DBT)
- Limited access to well trained providers
  - Child and Adolescent psychiatry evaluations in ED
  - Outpatient network/full continuum of services
  - Forensic behavioral health evaluations for kids at interface of psych and justice system
  - Therapy services

Factors That Contribute to Long LOS – con't

- Complexities of our system
  - Complexities with patient placement when no in-state services available
  - Need for thoughtful collaboration amongst various agencies
- Limited BHIF/BHRF and group home options
  - Limited relationships with out-of-state providers for children who have been denied a higher level of care in-state

Solutions

- Increased access for under 13-year-olds

Solutions

- Efforts at building additional DDD/ASD capacity
- Need for increased avenues for collaboration for building network
  - Who are we missing in our collaborative

Thank you!

Hushabye Nursery

Tara Sundem, MS APRN NNP-BC
Co-Founder, Executive Director
Hushabye Nursery

AHCCCS
Arizona Health Care Cost Containment System

Hushabye Nursery I hushabyenursery.org I 480-628-7500
Tara Sundem I RN, NNP-BC, MSN I tara.sundem@hushabyenursery.org

HUSHABYE NURSERY

The Tiniest Victims of the Opioid Crisis

More than 2 babies are born passively dependent in AZ every day.

Neonatal Abstinence Syndrome (NAS)
Neonatal Opioid Withdrawal Syndrome (NOWS)

Condition experienced by an infant after birth due to sudden discontinuation of exposure to certain drugs such as opioids that were used by their mother during pregnancy.

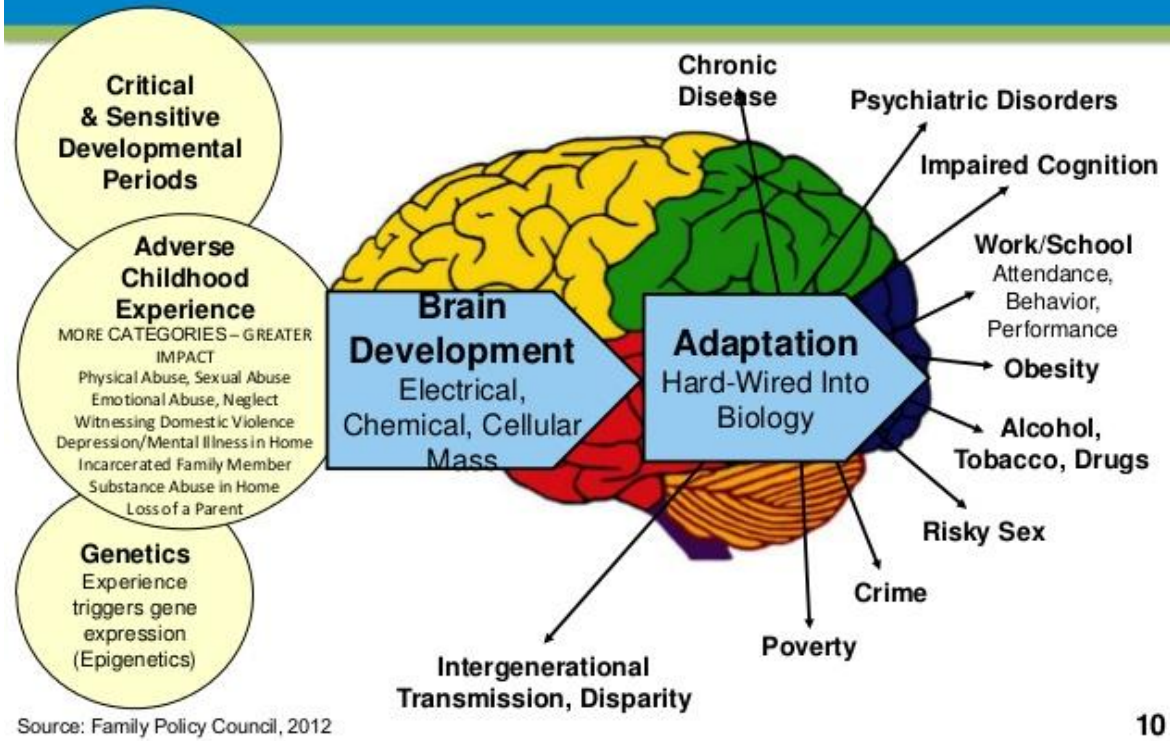
Prabhakar Kocherlakota

Pediatrics Aug 2014, 134 (2) e547e561; **DOI:** 10.1542/peds.2013-3524

The Future???

Infants with NAS/NOWS have 2 or 3+ ACE's at birth.

Lifespan Impacts of ACEs



Source: Family Policy Council, 2012

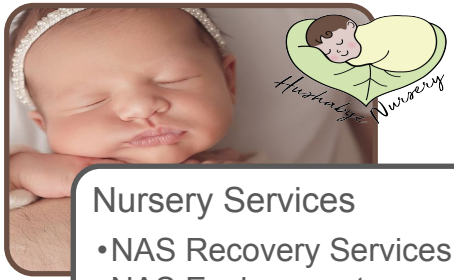
How can we improve outcomes???

Hushabye Nursery I hushabyenursery.org I 480-628-7500
Tara Sundem I RN, NNP-BC, MSN I tara.sundem@hushabyenursery.org

Hushabye Nursery's Care Model
NAS Center of Excellence

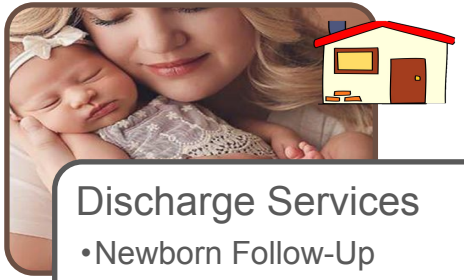
Prenatal Services

- Medical Care
- Addiction Treatment
- Counseling
- DCS Collaboration
- Medication Assisted Tx
- ~~Financial Guidance~~
- Home Visiting



Nursery Services

- NAS Recovery Services
- NAS Environment
- Specialized Training
- Nonjudgmental Environment
- Family Care Model



Discharge Services

- Newborn Follow-Up
- SENSE
- Pediatric specialists
- Developmental services
- Family Counseling
- Financial Guidance
- Home Visiting

Service Coordination
Access to Care

Hushabye Nursery I hushabyenursery.org I 480-628-7500
Tara Sundem I RN, NNP-BC, MSN I tara.sundem@hushabyenursery.org

HOPPE PROGRAM

Hushabye Opioid Pregnancy Preparation & Empowerment

Outpatient Services

- Peer Supports
- Trauma Specialist
- EMDR
- Counseling
- Transportation, food and housing support
- NAS education-diagnosis treatment and follow-up care
- Infant CPR
- Car Seat Education
- Safe Sleep Education
- Baby Supplies and Resources
- Care Coordination
- Evidence Based Parenting Classes such as Triple P Parenting
- Baby Soothing Education
- Social Connections
- SMART Recovery

Hushabye Nursery is Different.

NICU Model

Treat babies in bright, noisy, intense environment

Design NICU for premature babies, not NAS babies

Provide minimal education/limited resources

Restrict visitation and prohibit overnight stays

Ensure one caregiver to every three babies (1:3)

Staff teams with limited NAS training

Hushabye Model

Treat babies in quiet, dark, calm environment

Private nurseries

Educate families on how to care for NAS baby

Encourage moms to stay in-room 24/7

Ensure one caregiver per baby (1:1)

Hire specially-trained staff with passion for NAS babies

Promote bonding and breastfeeding

Use five Ss, rock up and down, 6th S-squat techniques

Wean and treat babies with medications as necessary

Eat Sleep & Console Treatment Model (ESC)

Validate Finnegan Neonatal Abstinence Scoring System

Provide outpatient behavioural health treatment onsite

Current NICU Environment

Inpatient Services

- Care for babies as they go through the withdrawal process
- Families may stay with their baby 24/7
- ESC model with Modified Finnegan assessment tool
- Phototherapy
- Gavage Feedings
- Pharmacologic care if needed
- DCS Support
- Family Education
- Counseling
- Family Coaching
- Lactation Support
- Developmental Specialist Consultations
- Trauma Support Specialist (EMDR)


inhale
exhale

Hushabye NAS infants treated with morphine **18%**
vs. 98% Industry Standard

6 DAYS **Hushabye NAS infants average length of stay in NICU**
vs. 22 days Industry Standard

Hushabye NAS infants average cost of hospitalization
$5,922
vs. $44,824 days Industry Standard

Percent of Hushabye infants who primarily breastfeed **44%**
vs. 20% Industry Standard

Percent of Hushabye Infants who were safely discharged to a biological parent
69%
85% if active with Hushabye Nursery prenatally. Industry Standard not reported.

Hushaby Nursery I hushabyenursery.org I 480-628-7500
Tara Sundem I RN, NNP-BC, MSN I tara.sundem@hushabyenursery.org

Call/Text 480-628-7500 for referral

Hushabye Nursery I hushabyenursery.org I 480-628-7500
Tara Sundem I RN, NNP-BC, MSN I tara.sundem@hushabyenursery.org

HUSHABYE BABIES

ADHS Update

Priscilla Lauro & Shane Brady

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Questions, Open Discussion & Wrap Up

Next Meeting: August 27th

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Thank you!

- See the Behavioral Health Task Force web page for meeting past meeting presentations - https://www.azahcccs.gov/AHCCCS/CommitteesAndWorkgroups/BehavioralHealthTaskForce.html

- Send future topics you want to discuss to lauren.prole@azahcccs.gov