

## State Targeted Response Grant Project Narrative

### Section A: Population of Focus and Statement of Need

#### A1: Communities and Demographic Groups at Highest Risk for Opioid Use Disorder (OUD)

Preliminary data analyses indicate that in 2015, there were 50,693 distinct enrolled individuals (“members”) within the Arizona Health Care Cost Containment (AHCCCS) claims and encounters system that received public behavioral health services where an OUD was present in the ICD-9 or ICD-10 codes across all diagnostic possibilities. Approximately 87% of these individuals were covered by Medicaid, and the remaining 13% of these individuals were covered by Federal Block Grants (Substance Abuse Prevention and Treatment Block Grant/Mental Health Block Grant), Federal Discretionary Grants or state funds. Of these 50,693 individuals, 90.8% received an OUD as the primary diagnosis. Opioid Dependency accounted for 81.09% of all primary diagnosis OUDs among the 46,007 individuals, representing 37,308 individuals receiving care specifically for opioid dependency in the public behavioral health system in 2015.

Of the 46,007 individuals with a primary diagnosis for OUDs in 2015, 54% were male and 46% were female. The majority of individuals were adults (91%), while youth under the age of 18 years accounted for 9%. Of the adults, one out of three individuals with OUD as the primary diagnosis fell below 100% of the poverty level. Approximately 4% were identified as pregnant women, and 12.7% of individuals with an OUD were on parole or probation. Fifty-six percent identified as White, 16% as Hispanic, 4% as American Indian, 4% as Black, 1% as Asian and 19% as Other/Unknown.

Of the adult individuals with OUDs, the greatest proportion fell within individuals 25-34 years (36.8%), followed by individuals 35 to 44 years (19.2%), then individuals 45 to 54 years (15.3%), then individuals 18 to 24 years (14.9%). Adults ages 55 and older accounted for 13.9%. At a statewide level, 2015 vital statistics data from the Arizona Department of Health Services (ADHS)<sup>1</sup> indicates similar patterns for opioid-related inpatient hospitalizations for youth (8.4%). However, the spread among adult age groups is less for individuals 25 to 54 years (23.3%, 16.7% and 15.0%, respectively), and more for individuals 18 to 24 years (20%) and for individuals 55 years and older (16.6%). These data may indicate that young adults as well as older adults may be at elevated representation in the statewide population relative to individuals receiving services in the public behavioral health system.

The majority of the individuals lived in urban areas (83%), with rural populations accounting for 17% of individuals with an OUD as primary diagnosis. Individuals living in Maricopa County, Arizona’s largest county and the county that accounts for 59.7% of Arizona’s total population represented the largest percentage of individuals with OUDs (55.2%). Pima County, Arizona’s second largest county, representing 15.3% of Arizona’s total population, represented 27.2% of individuals with OUDs, indicating an overrepresentation per population in this county.

<sup>1</sup> Arizona Department of Vital Statistics. Data provided for the purposes of this submission

Likewise, Mohave County, representing 3.1% of Arizona's total population, represented 4.0% of individuals with OUDs, and Gila County, representing 0.8% of Arizona's population, represented 1.1% of individuals with OUDs. In addition, individuals living in Yavapai and Graham Counties represented OUDs comparable to their population representation in Arizona – 3.2% and 0.5%, respectively. Pinal County, representing 5.2% of Arizona's total population, represented the 3.1% of individuals with OUDs and was the 5<sup>th</sup> highest percentage of counties representing individuals with OUDs.

In fiscal year 2016, there were 2,416 veterans enrolled to receive services in the public behavioral health system in Arizona. Of those, 45% (1,094) were receiving services for Substance Abuse Disorders. While no specific data is currently available on the percentage of veterans receiving OUDs services via the public behavioral health system, it is known that OUDs among members in the state Medicaid system account for approximately 34.3% of all substance use disorders. At minimum, this would suggest that approximately 372 veterans using the public behavioral health system met the diagnostic criteria for OUD in fiscal year 2016.

Looking at specific OUD outcomes, there were 2,722 members within AHCCCS who experienced a non-fatal opioid-related poisoning in 2015. Of these members, 30.5% had heroin-related events and 4.6% had methadone related events. The majority of the events (64.9%) involved other prescription opioids and synthetic narcotics. While gender differences were comparable for methadone and prescription opioids, with females accounting for slightly higher percentages of events than males (51.5% and 48.5%; 57.0% and 43.0%, respectively), there were significant differences between males and females for heroin (27.5% and 72.5%). Like OUDs, the majority of non-fatal opioid-related poisonings occurred among White individuals for heroin, methadone and prescription opioid related events (62.7%, 57.4% and 58.0%, respectively). While individuals who identified as White or Hispanic represented higher proportions of heroin-related events versus prescription related events, individuals who identified as Black or American Indian represented higher proportions of prescription opioid-related events versus heroin (see Table 1.).

<b>Table 1. Percentage of Non-Fatal Opioid Poisonings Events by Race, 2015 AHCCCS Claims and Encounters</b>			
	<b>Heroin</b>	<b>Methadone</b>	<b>Prescription/ Synthetic Opioids</b>
<b>Asian</b>	0.73%	0.74%	0.62%
<b>Black</b>	2.81%	1.47%	6.96%
<b>White</b>	62.71%	57.35%	57.98%
<b>Hispanic</b>	16.99%	13.24%	14.67%
<b>American Indian</b>	3.91%	8.09%	7.02%
<b>Other/Unknown</b>	12.84%	19.12%	12.74%

Also like OUDs, the majority of non-fatal opioid poisonings among AHCCCS members occurred for those living in urban areas across heroin, methadone and prescription opioid-related events (86.3%, 83.2% and 75.1%, respectively). Likewise, though accounting for the largest percentage, representation of heroin and prescription opioid non-fatal poisonings among members living in Maricopa County (55.8% and 56.5%, respectively) were slightly lower than the total Arizona population represented by Maricopa County (59.7%). Pima County, however, had a slight overrepresentation for prescription opioid-related

events (19.29%) among members with a non-fatal opioid poisoning and a significant disparity for heroin-related events (30.0%) relative to the 15.9% of the total Arizona population this county represents. Gila, Graham, Mohave and Navajo Counties – all rural Arizona Counties – also had overrepresentation of non-fatal prescription opioid poisonings (1.3%, 1.1%, 5.2% and 2.1%, respectively) relative to the proportion of the Arizona population that these counties represent (0.8%, 0.6%, 3.1% and 1.7%, respectively). Graham County also had disproportionate representation of heroin-related opioid poisonings (1.6%) relative to population status. Given that 1 in 4 prescription opioid-related non-fatal poisonings occurred among rural members, collectively, these data may suggest a disparity in the rural areas of Arizona for non-fatal opioid poisonings.

Further analyses will be required to determine the statistical significance of potential disparities, including adjusting for rate per population. Moreover, additional analyses are needed to examine Maricopa County in finer granularity. While the county as a whole appears to be representative of the population size represented in Arizona, it is likely an ecological fallacy is occurring at county-level analyses and that particular areas of this very large metropolitan area are disproportionately represented in OUD, non-fatal opioid poisonings and fatal opioid overdose deaths. Likewise, more analyses are needed to clearly identify disparities among tribal populations, veterans and military service members. These analyses will be conducted ongoing and geographic profiles will be finalized in the needs assessment deliverable required in this grant.

Current known rates per population for opioid-related deaths illustrate the need for more robust analyses across all opioid data in the state. According to ADHS vital statistics, there were 701 opioid-related deaths in Arizona in 2015, representing a rate of 10.27 individuals per 100,000 population. Approximately 63% of these deaths involved prescription opioids, while approximately 37% involved heroin. Males had higher rates per 100,000 population than females (11.90 and 8.65, respectively), and race/ethnicity rates per 100,000 population were as follows: White (12.94); Hispanic/Latino (7.04); Black or African American (6.43); American Indian (2.83) and Asian or Pacific Islander (2.83). Individuals 45-54 years of age had the highest prescription opioid mortality rate (12.1), followed by individuals age 35-44 years (10.8), then age 55-64 years (9.5) and then age 25-34 years (7.7). Rates dropped significantly thereafter, and were as follows: 85+ years (4.8); age 15-24 years (3.1); age 65-74 years (3.0); and age 75-84 years (2.8).

## **A2: Differences in Access, Service Use and Outcomes**

While Arizona's public behavioral health system is quite robust, the number of individuals with OUDs and the number of individuals needing the clinically indicated Medication Assisted Treatment (MAT) for OUDs has grown so quickly, that the system is struggling to meet the needs and meet them with the array of options individuals seeking MAT need to have available to them. For example, there are currently 35 Opioid Treatment Programs (OTPs) who are certified to provide methadone treatment for opioid replacement therapy. Thirteen of the OTPs, including the four jails located in the Phoenix Metropolitan Area, are not contracted with the Regional Behavioral Health Authorities (RBHAs) or Tribal Regional Behavioral Health Authorities (TRBHAs) who are responsible for the managed care of all individuals in the public behavioral health system, including American Indian. Of the 23 who are contracted with the RBHAs and/or TRBHAs, one is located in the city of Yuma in the Southwestern corner of the state, three are located in the whole of Northern Arizona, six are located in the city of Tucson (Pima County), one is on the Pascua Yaqui reservation, and the remaining thirteen are located in

the Phoenix Metropolitan Area. Essentially, individuals with OTPs in eight of Arizona's 15 counties would have to drive considerable distances in order to receive methadone daily dose treatment for opioid replacement therapy. This is especially pronounced for individuals living in the six rural counties representing the eastern third of the state.

Although the Affordable Care Act requires many insurers to cover addiction treatment benefits, many policies impose prior authorizations requirements, place limits on medication dosage and length of treatment, or require individuals to "fail first" at non-medication treatment options for one or even all medications. Many OTPs have shared the difficulties their clients have with their private insurance plans covering MAT. Many plans do not cover Methadone because it is considered maintenance and not a treatment medication which requires individuals to either pay out of pocket, up to \$300 per week, or forgo crucial treatment all together.

For Buprenorphine options for MAT, there are 290 current Buprenorphine-waivered providers in Arizona. Of these providers, 176 or 59% are located in the Phoenix Metropolitan Area, which maps on fairly well to the percent of OUDs accounted for by Maricopa County in the state. However, Pima County, that accounts for 27.2% of Arizona OUDs and has elevated rates of opioid overdoses proportional to other counties, only has 56 waivered providers or 17.9%. Likewise, Mohave, Gila and Graham Counties have overrepresentation of OUDs and opioid related overdoses proportional to population, but Mohave County only has only nine. Buprenorphine-waivered providers, Gila County has two and Graham County has one. Three rural counties in Arizona – Greenlee, La Paz and Santa Cruz currently have no Buprenorphine- waivered providers.

The opioid use by treatment capacity overlay map provided by the Substance Abuse and Mental Health Services Administration for this application supports the evidence of a treatment gap in Pima, Mohave, Gila, Graham, La Paz and Santa Cruz Counties evident in localized data. The SAMHSA map also identifies gaps in Apache, Navajo Counties and Yavapai Counties, as well as pockets with the Phoenix Metropolitan Area – and in particular, along the I-17 corridor.

In 2015, only 554 of the 46,007 individuals with OUDs in the AHCCCS claims and encounters data received MAT, illustrating a clear need to expand access to MAT for individuals with OUDs, including the under and uninsured.

### **A3: Nature of the OUD Problem, Current Resources, Service Gaps and Demonstrated Need**

The toll of the opioid epidemic has swept the nation. In 2015, over 33,000 people died nationwide from opioid-related overdoses,<sup>2</sup> representing a 2.8 fold increase since 2002. The majority of these deaths involved prescription opioids, with a swiftly increasing number accounted for by heroin. Arizona, like most states in the country, has witnessed the fall out of the opioid epidemic and the rising tide of opioid-related deaths. Between 2005 and 2015, the number of prescription opioid-related deaths increased 44.2% in the state, and the number of heroin- related deaths increased a shocking 693.3%. As mentioned previously, there were 701 opioid- related deaths in 2015. For prescription opioids, the highest growth rates across the decade between 2005 and 2015 occurred among individuals age 25-34 years (67.4% increase), followed by individuals age 55-64 years (58.3%). For heroin, the highest growth rates across the decade between 2005 and 2015 occurred among individuals age 15-24 (1400% increase), followed by individuals age 25-34 (1216.7% increase), with the latter group currently a minimum of 27% higher than

other age groups (range=27.3 to 163.2% difference).

Like opioid mortality rates, opioid morbidity rates have also increased dramatically in Arizona, with statewide opioid-related Emergency Department visits increasing 91.6% between 2010 and 2015, and opioid-related inpatient hospitalizations increasing 114.5% in the same timeframe. The largest growth rates occurred in five rural Arizona counties, ranging from 151.6% - 233.2% increases in the five years, with the most populous county – Maricopa County – seeing the sixth largest increase at 135.3%. Additionally, there has been a 96.9% increase in the number of individuals with an OUD receiving public behavioral health services in Arizona between 2010 and 2015, with the yearly costs paid differential increasing 113.7% over the five years.

Among the most profound outcomes has been the devastating impact on the number of newborns born opioid exposed. The latest available data on this variable from ADHS vital statistics data indicates that between 2008 and 2014, there has been a 218% increase in the number of babies born that were narcotic exposed and a 245% increase in the number of babies born who meet the rigorous criteria for Neonatal Abstinence Syndrome (NAS). While AHCCCS represents 51% of all births in the entire state of Arizona, the state Medicaid system was the payer for 79% of the NAS births, indicating a clear disparity. While the full extent of the teratogenic effects of these infants across their developmental lifespan is still unknown in the science, what remains clear is that cognitive, social, and emotional negative impacts are lessened when mom is supported in treatment and recovery, and when by doing so, mom and baby are kept together in safe, nurturing environments that promote trust and secure attachments<sup>3</sup>. The volume of prescription drugs dispensed in Arizona alone is contributing to the aforementioned outcomes. According to data from Arizona's Controlled Substance Prescription Monitoring Program (CSPMP), there were approximately 570 million schedule II-IV controlled substance pills prescribed in Arizona in 2015, of which nearly 60% were pain relievers.<sup>4</sup> That equates to roughly 90 schedule II-IV controlled substance pills for every person, adults and children, living in Arizona, and enough to medicate every adult around the clock for two weeks straight. This number increases dramatically to four weeks straight for Mohave County and to three weeks straight for Pima and Gila Counties. At the same time, data from the CSPMP reveals that only 61% of prescribers in Arizona are signed up to use the CSPMP to mitigate diversion and the dangerous drug combinations of opioids, benzodiazepines and muscle relaxers that are contributing to the increased opioid overdoses. Based on probability and access alone, the mass supply of prescription opioids in Arizona communities is a major contributing factor to the rates of prescription drug misuse and related negative consequences in our state.

There are numerous other contextual factors that have contributed to the influx of prescription opioids in Arizona. On the demand side of the equation, you have an uninformed public who are relatively unaware of the potential risks involved with prescription opioid misuse. This lack of awareness has led to a multitude of problematic behaviors, including: individuals taking prescription opioids for recreational purposes; individuals taking more of their own medication than prescribed; individuals mixing prescription opioids with alcohol and other prescription and illicit drugs; people sharing medications with others; and people failing to properly store and dispose of unused, unneeded and expired medication in their home as a method of deterring potential misuse.

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<sup>2</sup> National Institute of Drug Abuse, Overdose Death Rates from CDC Wonder, January 2017 <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>

<sup>3</sup> A Longitudinal Study on Substance Use and Related Problems in Women in Opioid Maintenance Treatment from Pregnancy to Four Years after Giving Birth. 2014. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4024055/>

An additional factor contributing to rates of prescription opioid misuse in Arizona involves the direct expectations of the health consumer around the concept of pain management. For many pain patients, the expectation is to achieve minimal or zero pain, rather than to effectively self-manage pain using strategies across the continuum of pain inherent in acute and chronic pain situations. For a variety of reasons, some patients may be unwilling to consider non-narcotic alternatives to prescription opioid treatment. Many prescribers often have difficulty knowing how to assess and balance the legitimate pain needs of their acute and chronic pain patients while both ensuring patient safety and minimizing patient complaints that may affect reimbursement, performance evaluations and promotions, and in some cases, their ability to remain employed. Other patients may simply be unaware of opioid alternatives or too hesitant to ask questions about them during their care. As a result, a portion of the long-term opioid patients are at risk for dangerously high doses or dangerous drug combinations – putting this population at risk for accidental overdoses due to respiratory distress complications.

For a subset of the Arizona population, the physiologic dependence involved with long-term and high-dose prescription opioids turns to addiction. For many reasons, including increased tolerance and the need for a stronger opioid, the need to avoid painful withdrawals, increased access to heroin and decreased costs of heroin, many users make the shift. According to the Arizona High Intensity Drug Trafficking Area (HIDTA) Threat Assessment<sup>5</sup>, heroin seizures have increased 90% in the four years between 2011 and 2015, with 622 kilograms seized in 2015 alone. As a border state, Arizona is a primary staging and distribution hub for Mexican black tar heroin, Mexican brown heroin, and Mexican white heroin. Essentially, Arizona communities have become flooded with readily available and cheaper alternatives to prescription opioids. Adding to the danger of the heroin supply influx, is the number of seizures for fentanyl in both powder and pill form. In an inter-agency opioid bulletin provided to AHCCCS by the Arizona HIDTA in early February, 2017, there were more than 5,000 counterfeit fentanyl pills seized in Arizona in 2016. Even more frightening is the growing reports among local law enforcement in Arizona that fentanyl is being laced in with the heroin supply. For an unsuspecting user who is expecting a typical dose, the result is deadly. While hard data on the prevalence of fentanyl-related overdoses is not yet available in Arizona, the concern for the impact of fentanyl in the community is well-warranted. The culminating result of the increased supply and aforementioned contextual factors has created a vicious cycle of increased prescription opioid and heroin misuse and abuse, dependency, addiction and the need for treatment in Arizona. In 2016, 6.6% of Arizona's 8<sup>th</sup>, 10<sup>th</sup> and 12<sup>th</sup> grade youth reported prescription drug misuse in the past 30 days, and 0.3% reported past 30 day heroin use. Among these youth, prescription drugs are the fourth most commonly used substance, following alcohol, tobacco, and marijuana.<sup>6</sup>

The majority of youth prescription drug misuse involved prescription opioids (61.1%), and of the past 30 day youth misusing prescription opioids, one in three reported “cocktailing” opioids together with alcohol. While the percentage of youth misusing prescription drugs decreased 39.4% between 2010 and 2014, there was a 4.8% increase in past 30 day youth prescription drug misuse between 2014 and 2016.

Although there are currently no local longitudinal estimates of adult opioid misuse and abuse in Arizona, data from the ADHS administered Behavioral Risk Factor Surveillance System does illustrate a snapshot of adult prescription drug misuse in Arizona. In 2014, 19.6% of Arizona adults reported misusing prescription drugs in the past 30 days and 56.8% reported misusing them in their lifetime.

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<sup>4</sup> Arizona Board of Pharmacy. Controlled Substance Prescription Monitoring Program data provided for the purpose of this submission.

While no local demographics or trends are yet available on these data, estimates from the 2015 National Survey on Drug Use and Health (NSDUH)<sup>7</sup> indicates that young adults age 18 to 25 years have significantly higher rates of prescription drug misuse compared to younger youth and individuals 26 years of age and older. In addition, individuals with mental illness, and in particular major depressive episodes were identified as having significantly higher rates of prescription opioid misuse. The NSDUH data also indicates that 18 to 25 year olds have significantly higher rates of heroin use compared to other age counterparts.

Localized data among Arizona's college students further supports the previously mentioned data that highlights the young adult population as a relevant target group for making a meaningful impact on the opioid epidemic in Arizona. For example, 2015 data from the National College Health Assessment (NCHA) among students attending Northern Arizona University in Flagstaff, AZ indicates that 7.2% of the student body has misused prescription opioids in the past 12 months – a rate 32.2% higher than the national average for college students. In addition, 14.1% of the student body at this University indicated use of illicit drugs, including heroin – a rate 25.6% higher than the national average for college students. The same survey among students attending the University of Arizona (UA) in Tucson, AZ in 2016 indicated past 12 month misuse of prescription pills at 10.0% - a rate 62.2% higher than the national average for college students and with prevalence rates on the rise since 2015. These data also indicated that past 12 month heroin use among UA students was at 0.8% of the student body and among the highest rates seen in history.

Likewise, data from NCHA made available by Arizona State University (ASU) in Tempe, AZ for the purposes of this application not only identifies similar trends of prescription drug misuse among the student body, but further delineates subgroups with significantly greater proportions of prescription opioid misuse and heroin use. These populations included: students with disabilities; students with a history of or currently being treated for alcohol or other drug addiction; students diagnosed or treated for depression, anxiety or other mental illnesses within the past 12 months; students who seriously had considered attempting suicide in the past 12 months; students who had engaged in high risk drinking (binge drinking) in the past two weeks; students who had used alcohol or marijuana in the past 30 days; students who had experienced sexual violence in the past 12 months, students who identified as non-heterosexual; students who identified as Hispanic, Native American and Asian; International students; and transfer students who previously attended a community college. According to the NCHA at ASU, 20.4% of students with one or more disabilities reported they had used prescription drugs without medical supervision, and 1.7% had used opioids within the past 30 days, indicating a very clear disparity among the national estimates of college age prescription opioid misuse and abuse. Moreover, 28.8% of students who engaged in high-risk drinking during the previous two weeks had misused prescription drugs within the past 12 months, and 1.5% had used opioids within the previous 30 days. Given the high correlation of respiratory distress from the dangerous combination of alcohol and opioids, a clear high risk group seems overwhelmingly apparent among our young adult college students in Arizona. Collectively, with the increased misuse and abuse of opioids in Arizona across all demographic and geographic boundaries has come the increase in dependency and addiction and the rising rates of the OUDs described previously. The mass influx of this need has created considerable challenges for Arizona's public behavioral health system to meet the growing needs of this population.

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<sup>5</sup> Arizona HIDTA Threat Assessment, 2016\_

<https://www.azhidta.org/default.aspx/MenuItemID/214/MenuGroup/Public+Website+Home.htm>

<sup>6</sup> Arizona Criminal Justice Commission. 2016 Arizona Youth Survey data provided to AHCCCS for analyses.

<sup>7</sup> NSDUH. 2015. Prescription Drug Use and Misuse in the United States: Results from the 2015 National Survey on Drug Use and Health.

As mentioned previously, while Arizona does have some current resources to identify, engage and retain individuals with OUDs in treatment, there is a clear need for expansion, especially around access to MAT. While there are some existing resources to prevent OUDs and opioid-related deaths in Arizona, there is a clear need to expand these efforts to ensure the maximum return-on-investment of these resources, and moreover to ensure the health, well-being and safety of Arizona citizens. The proposed activities below are designed to meet the capacity, programmatic and resource gaps currently identified in Arizona and to provide a comprehensive state targeted approach to reducing the impact of the opioid epidemic in Arizona.

## **Section B: Proposed Implementation Approach**

### **B1: Purpose, Goals and Objectives**

The overarching goal of the project is to increase access to Opioid Use Disorder (OUD) treatment, coordinated and integrated care, recovery support services and prevention activities to reduce the prevalence of OUDs and opioid-related overdose deaths. The project approach includes developing and supporting state, regional, and local level collaborations and service enhancements to develop and implement best practices to comprehensively address the full continuum of care related to opioid misuse, abuse and dependency.

#### **Administration**

**Goal 1: Expand infrastructure and build capacity through a multi-sector Opioid Monitoring Initiative among health care providers, government and tribal agencies, law enforcement, agencies serving veteran and military service members and private organizations to streamline timely capturing, reporting and sharing of opioid-related data to inform iterative decision-making processes.**

**Objective 1.1:** By June 15, 2017, develop a statewide needs assessment using epidemiological data to identify the prevalence of opioid misuse and abuse; related harms; the number and location of opioid treatment providers; providers offering opioid use disorder services in the state; existing activities by funding source that currently addresses opioid use prevention, treatment and recovery; and gaps in these activities.

**Objective 1.2:** By July 30, 2017, develop a comprehensive state strategic plan to address the gaps in prevention, treatment and recovery identified in the needs assessment.

**Objective 1.3:** By August 15, 2017, increase real-time decision-making by disseminating consistent opioid incident reports, opioid assessments and event-based alerts among all sectors, as measured by the number and type disseminated.

#### **Prevention**

**Goal 2: Increase prevention activities to reduce OUDs and opioid-related deaths**

**Objective 2.1:** By July 30, 2017, decrease opioid-related overdose deaths by purchasing and distributing initial and replacement Naloxone kits for law enforcement.

**Objective 2.2:** By April 30, 2019, increase the number of Prescription Drug Drop Boxes and awareness of take-back events in rural Northeastern and Western counties of the state and increase the number of pounds collected by 100% statewide as measured by Law Enforcement reporting for data collections



and evaluation.

**Objective 2.3:** By April 30, 2019, increase the knowledge and awareness of communities on the Arizona Prescription Drug Misuse and Abuse Initiative by providing comprehensive training and technical assistance throughout the state on the implementation of the Statewide Initiative Strategic Plan-Rx Toolkit as measured by Pre-Post Training evaluations, development of community strategic plans and data collections.

**Objective 2.4:** By August 31, 2017, a total of 20 Area Agencies on Aging staff will be trained in the WISE and Mental Health First Aid evidence-based programs, as measured by proof of participation in events such as sign-in sheets and/or certificates of participation.

**Objective 2.5:** By April 30, 2019 increase health care empowerment and medication management by Wellness Initiative for Senior Education (WISE) Program participants as measure by pre-post program evaluation.

**Objective 2.6:** By April 30, 2019, increase awareness of unique risk factors and warning signs of mental health problems in adults over the age of 65 by Mental Health First Aid for Older Adult participants as measure by pre-post training evaluation.

**Objective 2.7:** By April 30, 2019, increase the number of providers who are educated on Screening, Brief Intervention and Referral to Treatment (SBIRT) and agree to implement SBIRT at their place of employment, as measured by post training surveys.

**Objective 2.8:** By April 30, 2019, increase the number of individuals who have received screenings, brief interventions and referrals to treatment, as measured by penetration data.

**Objective 2.9:** By April 30, 2019, increase the number of providers who are educated on the evidence-based *Motivational Interviewing*, as measured by counting the number of providers who participate in education events where *Motivational Interviewing* is being taught.

**Objective 2.10:** (Ongoing), Ensure all sub-grantees are maintaining fidelity to their programs, as measured by (at a minimum) quarterly monitoring activities.

**Objective 2.11:** By April 30, 2019, increase interest and awareness about the Governor's Office of Youth, Faith and Family (GOYFF) Prevention, Treatment and Recovery Locator, as measured by demographic reporting including the number of people who accessed the website located at <http://substanceabuse.az.gov/>.

## **Treatment**

### **Goal 3: Improve access to, participation and retention in comprehensive Medication Assisted Treatment (MAT) services to treat OUD.**

**Objective 3.1:** By April 30, 2019, increase knowledge and capacity and reduce stigma related to MAT services by developing and providing education materials and training workshops to Arizona providers, key stakeholders and the community, as measured by the number of events and individuals reached; the number of new MAT providers; and pre-post changes in knowledge, attitudes and awareness.

**Objective 3.2:** By April 30, 2019, increase OUD treatment access and success by building infrastructure

and capacity for peer support expansion to assist with MAT treatment navigation, retention, and long-term recovery, as measured by the number of new peer supports and type of direct service activity.

**Objective 3.3:** By December 30, 2017, increase access to MAT by enhancing regional “Centers of Excellence” services to streamline 24 hour access to care by coordinating intake and assessment; review of MAT and OUD treatment options; referral to community treatment; assignment to peer support; and opioid overdose education and Naloxone access, as measured by number of intakes, number of referrals, treatment retention rates in follow up care and self-report days of opioid misuse/abuse.

**Objective 3.4:** By August 15, 2017, increase OUD treatment access and success by implementing hospital and emergency department (ED) discharge projects in “hotspot” areas to provide coordinated community services, including MAT referrals, peer support and Naloxone access to individuals released from a hospital or ED following an opioid-related event, as measured by the number of individuals and number of referrals and the number of individuals receiving MAT inductions in EDs.

**Objective 3.5:** By August 15, 2017, increase access to MAT through an opioid diversion and incarceration alternative project among community providers and law enforcement, as measured by the number of intakes, referrals, treatment retention rates in follow up care and self-report days of opioid misuse/abuse.

**Objective 3.6:** By August 15, 2017, increase access to MAT among individuals reentering communities from correctional settings by expanding existing efforts to identify MAT eligible individuals prior to release and engaging these individuals with peer supports designed to help them navigate to MAT services upon release from correctional settings, as measured by the number of intakes, referrals, treatment retention rates and self-report days of opioid misuse/abuse.

**Objective 3.7:** By August 15, 2017, increase recovery supports for pregnant and parenting women receiving OUD treatment, including MAT, by expanding existing efforts for nurse home visiting programs for women involved with the Department of Child Safety, as measured by the number of individuals reached, the number of visits and the number of women successfully completing the program.

**Objective 3.8:** By December 1, 2017 increase access to MAT services by providing increasing capacity among existing MAT residential settings and OUD recovery homes, as measured by number of number of individuals treated.

## **B2: Existing Resources**

Other state and federal resources that currently address the objectives of the proposed projects include the Centers for Disease Control and Prevention (CDC) Prevention for States grant; SAMHSA’s Partnership for Success (PFS) grant; Bureau of Justice Assistance (BJA) Harold Rogers grant; SAMHSA’s Medication Assisted Treatment-Prescription Drug Opioid Addiction (MAT-PDOA) grant; SAMHSA’s Substance Abuse Prevention and Treatment Block Grant (SABG); Centers for Medicare and Medicaid Services (CMS) funds for Medicaid covered services; and the Arizona Parents Commission on Drug Education and Prevention Grant Program. The CDC funds focus on enhancing the state Controlled Substance Prescription Monitoring Program (CSPMP), increasing the number of prescribers signed up to use the CSPMP, community and health system interventions in six counties, and the evaluation of Naloxone training for law enforcement. Likewise, the Harold Rogers grant focuses on prescriber awareness of controlled

substance prescribing patterns, largely focused on opioid prescribing, by supporting the Arizona Board of Pharmacy to develop and disseminate individual prescriber report cards delineating prescribing practices relative to taxonomy (e.g., number of prescriptions and pills by drug type, number of patients in excess of 120 MEDDs, number of patients prescribed combinations of opioids and benzodiazepines). Both the PFS and Parents Commission grants fund community-based prevention activities to raise awareness of the risks of prescription drug misuse and are largely focused on youth ages 12-17 and their parents. SAMHSA's MAT- PDOA grant involves a "reach in" project to identify MAT eligible individuals reentering the community from correctional settings and coordination to MAT treatment. Currently, the grant only funds activities in two counties in Arizona – Maricopa and Pima Counties. Current CMS funds provide services for OUD treatment, including MAT, for AHCCCS Medicaid covered members and via providers contracted with the Managed Care Organizations (MCOs). Current SABG funds are used to provide Substance Use Disorder treatment for non-Medicaid eligible individuals (under and uninsured individuals) and non-Medicaid covered services for Medicaid eligible individuals through Regional Behavioral Health Authorities (RBHAs) that serve as behavioral health MCOs. Additionally AHCCCS has contracted with a local non-profit to fund a community-based Naloxone education and distribution project utilizing SABG funding.

Through the Governor's Office of Youth, Faith, and Family (GOYFF) SABG funds are utilized to provide services for both High School and Middle/Junior High School prevention programs. The Middle/Junior High School program educates families and youth on the dangers of substance abuse, as well as fosters and cultivates student and parent health and wellness choices in regard to substance use through education and outreach. The High School program focuses on bringing deeper and more impactful substance use prevention and early intervention services to youth throughout the state through their high schools. The Department of Liquor License and Control partners with alcohol and drug prevention coalitions and non-profits to further the development of social host laws; and provide training to establishments that sell alcohol. *I've Got Something Better* is a statewide marketing campaign providing healthy alternatives available to help Arizona's youth avoid substance use and abuse.

The proposed activities within the Opioid STR grant will work synergistically with these existing activities by: (1) creating a new streamlined data-driven decision-making process to target and tailor treatment and prevention resources where they are most needed in the state; (2) expanding modes and type of training statewide for OUD prevention and treatment providers, law enforcement and community members around OUD and overdose prevention, MAT and integrated care models; (3) expanding law enforcement access to Naloxone kits to prevent opioid overdose deaths; (4) expanding navigation and access to MAT and integrated treatment and recovery systems through new venues, new providers, new model processes and by increasing the number of high risk individuals served; and (5) increasing the ability to ensure the likelihood of recovery success by expanding peer support services, recovery homes and recovery supports to pregnant and parenting women.

**B3: Implementation Timeline**

Months post grant award	Key Activities/Milestones	Responsible Staff
One month post award	1. Opioid Monitoring Initiative started	Shana Malone (Project Director, AHCCCS)
	2. AHCCCS will finalize and provide funding allocation notification to RBHAs and/or TRBHAs and Contractors	Shana Malone
	3. Finalize contracts with sub-grantees	GOYFF
Two months post award	4. Needs assessment and capacity assessment complete	Shana Malone; Opioid Epidemiologist; Data Intelligence Analyst
	5. Strategic Planning Sessions	Shana Malone; Project Coordinator
	6. RBHAs and/or TRBHAs will finalize contracts with identified providers	RBHAs and/or TRBHAs
	7. AHCCCS will finalize contracts with identified providers	Shana Malone
	8. Finalize agreement through Office of Procurement with sub-grantees	GOYFF
	9. Orientation for sub-grantees	GOYFF
	10. Needs assessment for training and workforce development	GOYFF, sub-grantees
Three months post award	11. State strategic plan finalized	Shana Malone; Project Coordinator
	12. Finalize Treatment Evaluation Plan and data collection methodology	Shana Malone
	13. Hire and train additional positions related to project (i.e. Correctional Health Liaison, Peer Supports, Care Coordinators, etc.)	AHCCCS RBHAs and/or TRBHAs, and additional contractors
	14. Begin treatment service delivery	AHCCCS RBHAs and/or TRBHAs, and additional contractors
	15. Hire additional positions related to grant (i.e. Rx Toolkit Community trainer, Project Coordinator, SBIRT Program Coordinator, SBIRT Data Collection Specialist, etc.)	GOYFF, sub-grantees
	16. Finalize plan for prevention data collection and performance measurements	GOYFF

<b>Months post grant award</b>	<b>Key Activities/Milestones</b>	<b>Responsible Staff</b>
Four months post award	17. Implementation - Start prevention service delivery	GOYFF, sub-grantees
Six months post award	18. Progress Report	AHCCCS, ADHS, DCS, GOYFF
Monthly	19. Conduct trainings, education and outreach activities	Contracted providers, Project Coordinator, GOYFF, sub-grantees
	20. Implement service delivery to identify, engage and retain MAT eligible individuals in treatment and recovery	AHCCCS RBHAs and/or TRBHAs
	21. Project oversight phone call (occurring at minimum monthly for the first 6 months)	Shana Malone, Project Coordinator, RBHAs and/or TRBHAs, and additional AHCCCS contractors, GOYFF
	22. Collect performance and evaluation measures	Shana Malone, Project Coordinator, GOYFF
	23. Receive, analyze, and respond to monthly summary report	Shana Malone, Project Coordinator, GOYFF
Quarterly	24. Project oversight phone calls	Shana Malone, Project Coordinator, RBHAs and/or TRBHAs, and additional AHCCCS contractor, GOYFF
	25. Review progress with state workgroup	Shana Malone; Project Coordinator
Bi-annual	26. Site reviews	GOYFF, sub-grantees
Annually	27. Annual report submitted to AHCCCS	ADHS, DCS, GOYFF
	28. Annual report submitted to SAMHSA	Shana Malone; Project Coordinator
	29. Strategic planning session to review progress and review implementation activities	Shana Malone; Project Coordinator
	30. Review sub-grantee contracts	GOYFF
On-going	31. Disseminate multi-sector opioid bulletins and event-based blasts	Shana Malone; Project Coordinator; Opioid Epidemiologist;

Months post grant award	Key Activities/Milestones	Responsible Staff
		Data Intelligence Analyst
	32. Assess project implementation, provide and coordinate technical assistance as needed	Shana Malone, Project Coordinator, GOYFF

#### **B4: Administration and Infrastructure Costs**

AHCCCS is requesting \$336,540 in administrative and infrastructure costs. These costs will be used to support two positions critical to the success of grant implementation. The Project Director position at AHCCCS will be responsible for overall coordination of grant activities and ensuring activities are completed in accordance with the proposed timeline, including all required activities, deliverables and performance measure processes. The Project Director will oversee the needs assessment, capacity assessment and state strategic plan, and will assist in localized evaluation of projects and data for the multi-sector opioid incident reports and event-based blasts proposed in the Opioid Monitoring Initiative project. The Project Coordinator position at AHCCCS will be responsible for assisting the Project Director with coordinating training, education and outreach activities, stakeholder involvement, as well as assistance with required grant deliverables and reporting requirements. A grant accountant position will also be covered with administration costs to support financial reporting and deliverables. Additional funds will be used to cover printing and supplies for educational materials to support the projects and for travel to facilitate consensus building, model implementation, technical assistance and coordination of projects.

#### **B5: Prevention Activities**

The prevention activities that will be implemented as part of Arizona's comprehensive approach to address the opioid crisis includes the required activity of primary and secondary prevention approaches proven to reduce OUDs and OUD associated deaths. For primary and secondary prevention, the following activities will be implemented:

As one mechanism to address the abundant supply of prescription opioids available in the community, the Governor's Office for Youth Faith and Families (GOYFF) will use funds from the Opioid STR grant to market and host prescription drug take back events and purchase and place prescription drug drop boxes in areas with identified gaps -- rural Northeastern and Western counties in the state. The new boxes will supplement the existing 130 current boxes currently available in the state and ensure that the whole of Arizona has viable options for properly disposing of their unused, unneeded and expired medication.

To increase the reach of awareness and education about prescription drug misuse and abuse in Arizona, GOYFF will print, disseminate and train communities, coalitions, health care practitioners, law enforcement and youth on ways to address the opioid epidemic and prevent opioid overdoses in all 15 Arizona counties. The Arizona Prescription Misuse and Abuse Initiative Implementation plan was created by key stakeholders in Arizona to provide guidance for the execution of the Arizona Rx Drug Misuse and

Abuse Initiative model and the Arizona Rx Toolkit. The plan, model and toolkit consist of five strategies executed across sectors within localized communities and were designed to collectively prevent prescription drug misuse and abuse and the deleterious associated outcomes. The strategies, goals, objectives and action items have all been successfully piloted in three geographic areas in Arizona<sup>8</sup>, with substantial data to demonstrate the efficacy of the model (<http://www.azcjc.gov/acjc.web/rx/default.aspx>). The five strategies include:

Strategy 1: Reduce illicit acquisitions and diversion of Rx drugs

Strategy 2: Promote responsible prescribing and dispensing policies and practices

3: Enhance Rx drug practices and policies among law enforcement

Strategy 4: Increase public awareness and patient education about Rx drug misuse and abuse

5: Enhance assessment and referral to substance abuse treatment

Older adults receive a high proportion of prescription drugs in the U.S. due to increased likelihood of being prescribed long-term and multiple medications<sup>9</sup>. Improper use is common, whether because of cognitive decline or attempting to save money by using their medications sparingly or taking another person's remaining medications. Additionally, commonly prescribed medications – opioids for pain and benzodiazepines used to treat anxiety and sleep disorders – are addictive and can increase the risk of falls and memory/retention issues affecting up to 17 percent of older adults<sup>10</sup>. Co-morbid health conditions, age-related changes in drug metabolism; potential interactions with prescribed drugs, over-the-counter medications, dietary supplements and alcohol; and cognitive decline make drug misuse a special concern.<sup>11</sup> To address this high risk group, GOYFF will oversee training and dissemination in high risk counties of two evidence-based programs: the Wellness Initiative for Seniors (WISE) and Mental Health First Aid for Older Adults. Both of these programs complement each other in addressing the risk factors older adults face for mental health and substance abuse issues and accomplish the goals of this project as a primary prevention intervention in reducing the number of older adults with OUDs and opioid-related deaths among this population. To improve the health of individuals potentially using alcohol or drugs in a risky manner, GOYFF will partner with Health Choice Integrated Care (the RBHA serving Northern Arizona Counties), the University of Arizona, Arizona State University and Northern Arizona University to expand training and use of the Screening, Brief Intervention & Referral to Treatment (SBIRT) model. The model has been used successfully since 2012 in Northern Arizona and the availability of the Opioid STR funds will allow for an expansion beyond the original model by providing emphasis on opioid use, abuse and addiction and utilization within all three major University health clinics, counseling centers and urgent care facilities. The goal on this project is to create a sustained network of SBIRT-educated providers who are versed in the SBIRT model and Motivational Interviewing and to increase the number of individuals receiving screenings and referral to treatment.

<sup>8</sup> Arizona Criminal Justice Commission. 2015. Statistical Analysis Center Publication. Retrieved from [http://www.azcjc.gov/ACJC.Web/Rx/Rx\\_Evaluation%20Report.pdf](http://www.azcjc.gov/ACJC.Web/Rx/Rx_Evaluation%20Report.pdf)

<sup>9</sup> Centers for Disease Control and Prevention. (2010) Prescription Drug Use Continues to Increase: U.S. Prescription Drug Data for 2007-2008. NCHS Data Brief No. 42, September 2010. Hyattsville, MD. Retrieved from: <http://www.cdc.gov/nchs/products/databriefs/db42.htm>

<sup>10</sup> Center for Substance Abuse Treatment. (1998). *Substance abuse among older adults*. Treatment Improvement Protocol (TIP) Series, No. 26. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from [www.ncbi.nlm.nih.gov/books/NBK64422/](http://www.ncbi.nlm.nih.gov/books/NBK64422/)

<sup>11</sup> National Institute on Drug Abuse. (2015). Prescription drug abuse: Older adults. Retrieved from [www.drugabuse.gov/publications/research-reports/prescription-drugs/trends-in-prescription-drug-abuse/older-adults](http://www.drugabuse.gov/publications/research-reports/prescription-drugs/trends-in-prescription-drug-abuse/older-adults)

Marketing of GOYFF's Prevention, Treatment and Recovery Locator will supplement all previously described prevention activities.

Secondary prevention approaches will also include allowable activities related to increasing access to Naloxone to reduce the number of OUD associated deaths; and the allowable activities around education and training of OUD prevention and treatment providers on the SAMHSA Opioid Overdose Prevention Toolkit and the CDC opioid prescribing guidelines.

The Naloxone project will involve supplementing existing work conducted by the Arizona Department of Health Services on the CDC grant to provide training to law enforcement on the administration of Naloxone by now purchasing and equipping law enforcement with initial and replacement Naloxone kits. The costs associated with initial and replacement kits have been a known barrier for law enforcement in this effort, and the proposed funds would serve to reduce that barrier. Essentially, by coupling the training costs through the CDC grant with the purchase of the kits in the Opioid STR grant, enough law enforcement could be trained and carrying Naloxone to cover the majority of Arizona's population in the event of a first responder scenario.

## **B6: Treatment and Recovery Support Services**

The treatment and recovery support services that will be implemented as part of Arizona's comprehensive plan to address the opioid crisis will all focus on ways to identify, engage and retain individuals with OUDs in MAT. A key foundational project to accomplishing this goal involves an allowable activity of reducing the stigma around MAT services, enlisting more providers to become Buprenorphine waived MAT providers and helping OTPs create a viable landscape for expansion into underserved communities. This project will involve a broad education movement around the science and benefit of MAT for OUDs and will target four groups: (1) community members to gain the momentum and support for increasing access to MAT; (2) opioid users and friends, family and loved ones of opioid users to increase awareness of all MAT options and locations of MAT providers; (3) potential MAT providers (e.g., nurse practitioners, PCPs, existing SUD treatment providers) to expand the network of options, especially in rural areas, and promote integration between opioid replacement therapy and psychosocial services; and (4) key stakeholders that can assist in efforts to navigate and promote individuals with OUDs to MAT (e.g., courts, probation, law enforcement, health plans).

An additional foundational project will involve the required activity of building the infrastructure and capacity to expand statewide peer support services. Funding for this project will include increasing peer support services across Arizona for navigation and recovery support work. These individuals will receive pre-employment training and credentialing and will assist OUD individuals with understanding their MAT treatment options; assist with navigation to the right OUD treatment provider that fits the individual's needs; and assist with navigation to additional services that may be needed to promote successful recovery (e.g., housing, job placement, food subsidies, transportation services to appointments). Most importantly, these individuals will provide routine "check-ins," modeling of a recovery lifestyle, and social supports to their peers. The peer support expansion will be a critical component to all of the treatment activities proposed here-in, and collectively, the key component for ensuring the likelihood of early engagement in services, successful treatment retention, and long-term recovery success.

Five projects will be implemented to address the required activity of increasing access to all FDA approved forms of MAT for OUD on the AHCCCS drug formulary (i.e., Methadone, Buprenorphine and



Naltrexone): (1) Enhancing Centers of Excellence (COE) services for streamlined and expanded access to MAT options; (2) A hospital discharge project to navigate OUD individuals to MAT; (3) An opioid diversion and incarceration alternative project; (4) Expansion of the current early identification of MAT eligible individuals reentering communities from correctional settings (an additional required activity); (5) Expansion of MAT residential and recovery home services. Populations identified through the needs assessment will be the target population, including but not limited to: tribal populations, veterans and military service members, young adults and individuals living in high needs geographic areas. An additional recovery support project will involve expanding access to nurse home visits for pregnant and parenting women involved in the Department of Child Safety system who are currently undergoing OUD treatment.

The Centers of Excellence model will follow a similar approach to efforts taken in Massachusetts<sup>12</sup> to create regional “opioid urgent care centers.” These centers will become the hub of community-based efforts to navigate individuals to the appropriate level of treatment and the MAT option appropriate for their individual situation and needs. The vision is that the COEs would provide 24 hour access to intake, assessment and review of all MAT and OUD treatment options, with warm-hand off referrals within 24 hours to the appropriate MAT provider, peer support assignment, and Naloxone access and education to prevent opioid overdose. These centers would serve as the drop-in center for first responders, law enforcement and concerned family members who are unable to locate services on their own and would ensure that an in-the-moment safe haven is available for OUD individuals when they are ready for treatment. The vision is that these centers will not only reduce costly visits to the Emergency Department (ED), but increase the viability of navigating OUD individuals successfully into MAT programs and ensure a higher likelihood of retention in those programs through assigned peer supports. The funds allocated to this project will be used to contract with existing agencies to expand operational hours, allocated space and staff resources to accommodate the needs of OUD individuals seeking immediate treatment. Likewise, the hospital discharge project will follow a similar model to the COE model. This project will be implemented in “hot spot” hospitals with high rates of opioid-related events and will focus on a coordinated discharge plan. MAT options, peer supports and Naloxone will be provided at time of discharge to help increase the likelihood that OUD individuals will engage with MAT programs and be retained in the treatment and recovery process. In addition, regional EDs will be selected to participate in an ED-Initiated Buprenorphine Project with care coordination services for office-based follow-up care provided. This project will follow the parameters of the NIDA funded Yale project<sup>13</sup> that demonstrated that initiation of MAT at time of ED visit was associated with significantly higher rates of engagement in addiction treatment. The vision is that this project will curb revolving door costs in high utilization areas and decrease opioid overdose situations through increased access to MAT and peer supports. As one mechanism to increase access to MAT, the Opioid STR funds will be used to launch an opioid diversion and incarceration alternative project among community providers and law enforcement. The project will involve key stakeholder meetings among city leadership, law enforcement, prosecutors, courts, and community-based OUD treatment providers to gain consensus on model processes, as well as training for selected jurisdictions. Implementation would involve options for law enforcement to divert low-level drug offenders with evidence of OUDs to case managers that would then connect these individuals with MAT treatment options, peer supports and other services to ensure successful engagement and retention in treatment and recovery. Costs associated with this project would primarily be used to fund training and staff salaries for case managers at existing agencies to execute the navigation to MAT and care coordination.

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<sup>12</sup> Boston University Faster Pathways <https://www.bumc.bu.edu/emergencymedicine/2016/10/26/faster-paths/>

As a mechanism to address the required activity of increasing access to MAT among individuals reentering communities from criminal justice settings, the Opioid STR funds in Arizona will focus on expanding the existing effort to identify, engage and retain MAT eligible individuals in services upon release from correctional settings. The STR funds will predominately be used to pay for salaries of individuals who will “reach in” and identify individuals with an OUD who are set to be released from correctional facilities in the counties not already supported by the model or for supplemental assistance in the two counties where it is currently implemented. The reach- in identification component is the most critical, as it is not an activity covered elsewhere, and the lack of early identification prior to release creates an incredible disruption in care post-release. Additional funds will be used for aligning peer support systems to ensure successful navigation post-release for all needed services and to provide increased likelihood of MAT retention and recovery success.

To increase recovery supports and increase the likelihood of treatment success among vulnerable populations, the Opioid STR funds will be used to support expansion of the Substance Exposed Newborn Safe Environment (SENSE) program. This program supports post-partum mothers with OUD treatment and intensive home-visiting to create options for mom and baby to remain together. SENSE has demonstrated high efficacy, with data over a two year period showing that 90.3% of the families that complete the SENSE program had no Department of Child Safety reports 6 months after completion of services. Grant dollars for this project would be used to train and fund 18 new nurse positions across the state that are required for the home-visiting model and that are essential to the successful retention and recovery process for these mothers.

Finally, to increase access to MAT services among individuals requiring residential and recovery home services, the Opioid STR funds in Arizona will focus on expanding the services of existing providers. Funds will predominately be used for remodel projects to increase capacity for the growing number of OUD individuals needing residential treatment and/or for expanding services among existing recovery homes. Preference will be given to those facilities who provide access to all FDA approved forms of MAT on the AHCCCS drug formulary and who serve either a broad range of the OUD population or who serve a subset of the population determined by the AHCCCS conducted needs assessment to be at highest risk. Additional preference will be given to those facilities who implement corresponding approved evidence-based psychosocial therapies in conjunction with MAT.

## **B7: Methods to Identify, Recruit and Retain Population**

For the proposed prevention activities, identification, recruitment and retention of the community residents for participation in the Rx Drug Misuse and Abuse Initiative model and toolkit training will include utilizing the Rx Core Group memberships to work with local community representatives to identify capacity needs and implement activities to address them.

Participants in the older adult prevention project will be identified, recruited and retained by local Area Agencies on Aging in each respective county to ensure localized expertise in the language, beliefs, norms, values and socioeconomic factors of the specific regions served. Participants will include older adults, older adult caregivers and professionals serving older adult populations.

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<sup>13</sup> Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. <https://www.ncbi.nlm.nih.gov/pubmed/25919527>

For the SBIRT project, individuals will be identified through the use of appropriate intake and assessment tools, including the Opioid Risk Tool, the Alcohol Use Disorders Identification Test (AUDIT C), the Drug Abuse Screening Test (DAST), and the Cannabis Use Disorder Test (CUDIT-R). Recruitment will occur with students engaged with discipline offices, living in residence halls, campus health clinics and academic advisors. Additional recruitment methods will include awareness events on campus and incoming student screenings. Retention will occur through follow-ups conducted by providers and project coordinators to determine follow through on the recommendations and referrals made. All Universities will ensure services are culturally sensitive and inclusive.

For the proposed treatment activities, MAT eligible individuals will be identified through the use of appropriate intake and assessment tools. Recruitment of individuals into MAT will be voluntary, and conducted through a review of all MAT options available to the individual with the choice of the intended course of treatment left to the individual. Providers will be required to review all available MAT for OUD options with MAT eligible individuals and providers and peer supports will help navigate MAT eligible individuals to the option selected as best fit by the individual. Retention efforts will largely focus on the use of peer supports and care coordinators to ensure that individuals participating in MAT are receiving both the opioid replacement therapy selected as well as the corresponding psychosocial services selected. Peer supports and care coordinators will also assist in identifying social determinants that may pose barriers to successful retention in MAT services and helping individuals in MAT treatment navigate to additional resources that they need to be successful in retaining the course of their MAT treatment plan, with added social supports ongoing to ensure the highest likelihood of success for sustained recovery. Resources will be predominately targeted to populations identified in the needs assessment, including but not limited to, tribal populations, veterans and military service members, young adults and individuals living in high needs geographic areas.

All providers will utilize The American Society of Addiction Medicine Criteria (ASAM) dimensions and philosophy of assessment. Assessments will collect information regarding the presence of co-occurring medical, mental health, and substance use. This information will inform providers of how to plan for effective care coordination and treatment of the individual. AHCCCS does not mandate that a specific assessment tool or format be used but requires certain minimum elements to ensure that the consideration the language, beliefs, norms, values, and socioeconomic factors of OUD populations. These elements include the following information:

- a) Presenting concerns;
- b) History of present illness, including review of major psychiatric symptoms (i.e., mood, depression, anxiety, psychosis, suicidal ideation, homicidal ideation, and other behavioral health symptoms) and frequency/duration of symptoms;
- c) Psychiatric history, including history of previous psychiatric hospitalization(s) and psychotropic medication trial(s);
- d) Medical history, current medications, including over the counter (OTC) medications, allergies and other adverse reactions;
- e) Legal history, including pending litigation, Court Ordered Evaluation/Court Ordered Treatment (COE/COT) history, criminal justice history;
- f) Substance use history including type of substance, duration, frequency, route of administration, longest period of sobriety, and previous treatment history;
- g) Substance use screen for adults age 18 and older using the American Society of Addiction Medicine (ASAM) Criteria Third Edition);

- h) Cultural needs (i.e. age, ethnicity, race, national origin, sex, gender, gender identity, sexual orientation, tribal affiliation, disability);
- i) Risk assessment;
- j) Family history;
- k) Educational history/status;
- l) Employment history/status;
- m) Housing status/living environment;
- n) Social history;
- o) Mental status examination;
- p) Bio-psycho-social formulation;
- q) Diagnoses codes.

To further support the language, beliefs, norms, values and socioeconomic factors of the OUD population, AHCCCS has an annual Cultural Competency Plan which outlines goals, strategic plan timelines and initiative activities with measurable outcomes including the National Standards for culturally and Linguistically Appropriate Services (CLAS). The work plan is a “living” document which allows for modifications to projects, activities and accomplishments as goals are reached, gaps are identified, and needs are met with the overall goal of improving culturally and linguistically competent coordination of care and provision of services to individuals accessing and receiving services. AHCCCS requires each contractor and RBHA to have a comprehensive cultural competency plan outlined in AHCCCS Contractor Operations Manual.

To support the comprehensive cultural competency plan, all contracted provider employees must complete the required trainings such as *Cultural Competency 101: Embracing Diversity, Culturally Linguistically and Appropriate Services* (CLAS Standards) and *Limited English Proficiency (LEP)* courses that are designed to address the importance of providing services in a culturally competent and linguistically appropriate manner. Continuing education in Cultural Competency is also offered by the Regional Behavioral Health Authorities. Examples that are currently being used in the system are: (1) *Demographic and Outcome Data User Set Data Elements 109 (Gender Identity) and 110 (Sexual Orientation)*; (2) *Child Family Team Strengths, Needs, Cultural Discovery*; (3) *In Our Own Voice*; (4) *Interpretation and Translation Services: Meeting the Needs of LEP Members*; (5) *Cultural Wisdom: The Indigenous World View as a Model for Social and Environmental Justice*; (6) *A Culture-Centered Approach to Recovery*; and (7) *Military Cultural Competence*.

Family-Centered Care is integral to service planning. Providers are required to discuss culture with the individual and/or family and incorporate cultural factors in service planning. Monitoring of cultural indicators of the quarterly Quality Management Aggregate data for adult and children providers occurs on a regular basis. Also, the Annual Network Inventory is conducted to ensure that the network broadly represents the demographics of our diverse population (cultural, linguistic and disability related services).

Understanding the impact and importance of cultural and linguistic needs of individuals accessing and receiving service in the mental health system supports the whole health and wellness of the individual. When seeking and receiving services, individuals are advised and/or informed of their right to receive interpretation and translation services at multiple points of the service delivery process. Examples: delivery of rights at intake and assessment; Member Handbook delivery, member’s rights and responsibilities, consent form containing information of right to interpretation and translation services;

and vital documents and forms contain information about interpretation and translation services. AHCCCS has developed a monitoring system to ensure members have been informed of their right to receive interpretation and translation services into their preferred language.

### **B8: Number of Unduplicated Individuals Receiving Treatment and Recovery Services**

Through the collective treatment projects proposed, treatment and recovery services will be provided to 5,069 unduplicated individuals in year one and 7,604 unduplicated individuals in year two, for a total of 12,673 unduplicated individuals over the 2 year program period. The types of services to be provided include but are not limited to: intake, assessment; medication evaluation, administration and management of clinically appropriate medication assisted treatment for OUD; group and individual counseling; case management and care coordination; and peer support and other recovery support services. The numbers of these services will be determined by the care coordination and clinical treatment teams involved in the projects and delivered at a frequency that is determined clinically necessary. Anticipated outcomes of the project include: an increase in the number of OUD prevention and treatment providers trained on MAT for OUD; integrated care and navigation and referral processes; an increase in the number of providers implementing MAT; an increase in the number of OUD individuals receiving comprehensive MAT services; an increase the number of people who receive OUD recovery services; a decrease in the number and rates of opioid misuse, abuse and dependency; and a decrease in the number and rates of opioid overdose-related deaths. The number of estimated unduplicated individuals was derived through data analyses of members enrolled in the public behavioral health system in Arizona that were determined MAT-eligible with an Opioid Use Disorder diagnosis that received behavioral health services funded through Medicaid, Federal Block Grants (SABG/MHBG), Federal Discretionary Grants, or State funds) during calendar year 2015. A conservative estimate of reaching no less than 10% of the distinct members presenting with an OUD was used in year one. Once the systems of delivery processes and navigation systems are fully operational, it is estimated that the reach in year two can expand to reaching no less than 15% of the distinct members presenting with an OUD.

## **Section C: Proposed Evidence-Based Service/Practice**

### **C1: Prevention and Treatment System Design and Model**

#### **Prevention**

##### *Community Education and Implementation of the Arizona Rx Toolkit*

To increase community awareness and efforts to prevent OUDs and opioid-related deaths, funding will be used to hire one full time Rx Toolkit Community trainer. This will also include incurred travel for Train the Trainer events, as well as the rental costs to secure training facilities. To continue with the dissemination of toolkits, funding will also be used to cover the printing and assembly costs for each toolkit provided at the trainings. Additional funding will support local and state level implementation of the five strategies included in the toolkit.

Needs assessment and community capacity building will formulate Arizona's approach to implementing all of the Rx Toolkit elements. Given the high stage of readiness to implement proven statewide prevention strategies, community-level needs assessment and planning efforts will focus on engaging community residents in how, where and when to implement the AZ Rx Toolkit elements. Following the community capacity-building model used in the pilot project, communities will receive intensive,

ongoing support from the Rx Core Group and the Rx Toolkit Community Trainer in building capacity to conduct program planning, implementation and evaluation. This will include training – both in webinar and in person - on topics such as the Rx360 Adult and Youth Curriculum and on locating and using the data indicators for needs assessment.

Communities will also be directed to complete a strategic plan for implementing the Rx Toolkit elements in their jurisdictions, including timelines for implementation and roles and responsibilities of key agencies and organizations. Technical assistance - in person, via telephone and email -will be offered in participant recruitment and retention and local Rx Toolkit model implementation while maintaining fidelity. Pre and Post training evaluation materials with written instructions including the timetable for data collection will be provided. Funding from this grant will provide the needed resources to fully implement the Rx Toolkit both statewide through community substance abuse prevention coalitions at the local level.

#### *Primary Prevention in Older Adults*

The Area Agency on Aging, Region One will oversee the training and implementation of the WISE and Mental Health First Aid programs across five counties in Arizona that have demonstrated high risk for fatal opioid use. Region One has done similar prevention work since 1996 with SAMSHA funding administered by the various contracted Regional Behavioral Health Authorities in Maricopa County, AZ. This prevention work has focused on mental health, suicide prevention and medication misuse and abuse including the abuse of prescription drugs. It currently coordinates and oversees the Maricopa County Behavioral Health Advocacy Coalition which is a community coalition that focusses on suicide prevention and medication misuse. Region One is also a Licensed Behavioral Health Agency and Certified to bill Medicare and Medicaid for its behavioral health services. Region One has been in business as a non-profit for over 43 years in Maricopa County, serving over 90,000 older adults annually through its 60 programs and services and 50 contracts. Although the work for this project will expand outside of Region One's service area, the Arizona Association of Area Agencies on Aging is strong and has good partnerships to expand this work statewide. Region One has the experience and capacity to oversee and support the other Regions.

The main partnering organizations for this project will be the other Area Agencies on Aging serving Gila, Yavapai, La Paz and Mohave County. All have expertise in delivering evidenced- based programs to the older adult populations in their regions. They each have ties to their local communities and the regions their Area Agency serves. As is typical with the scope of service for most Area Agencies on Aging, all of the Area Agencies on Aging participating in this project have wide partnership networks that include senior centers, housing sites, healthcare providers and other local or regional grass roots/community-based organizations that help them serve their specific populations including any specific cultural population.

The WISE program will be implemented as a six-week course that is delivered in small groups and covers topics ranging from stress management and strategies for healthy living to medication management and prescription drug abuse and is delivered by trained substance abuse prevention specialists who have gone through WISE's formal training curriculum. Participants also receive tools and resources for home so they may put into practice what they are learning. Mental Health First Aid will be implemented with fidelity as an eight-hour program that introduces participants to the warning signs and risk factors of mental health problems such as depression and anxiety. Although this can be delivered to adults of any age, there is a specific curriculum for those who regularly interact with older adults such as caregivers, nursing professionals, social workers or even neighbors and volunteers. The older adult module focusses

on the need for early intervention and how to help an older adult who may be experiencing a mental health issue.

#### *Expansion of SBIRT*

To prevent the number of individuals with OUDs, four entities will contract with GOYFF to implement the SBIRT model in their respective areas of service as follows:

#### **Health Choice Integrated Care (Northern Arizona RBHA)**

Pre-screen data will be collected during appointment check-in, screenings are completed in initial contact in private exam or treatment rooms with a Medical Assistant or Registered Nurse, brief interventions will be facilitated by Physicians or Medical Assistants, and treatment referrals, when needed, will be a team effort amongst participants, family members, the dedicated SBIRT staff members, treatment facilities and the HCIC SBIRT Coordinator. All aspects of the SBIRT project will be required to take place in private, confidential settings where staff use evidence-based motivational interviewing techniques to elicit participation and motivation to change use and related behaviors, improving health outcomes.

**GOAL 1: Educate the public to understand the risks of prescription drug use to avoid misuse in the first place.**

**GOAL 2: Ensure responsible prescribing practices, including increasing education of healthcare providers and prescribers to better understand how medications can be misused and to identify patients in need of treatment.**

**GOAL 3: Build a successful, sustained network of SBIRT-educated providers throughout the State of Arizona by providing education on implementation strategies and offering mentorship support from providers already active in the model.**

**GOAL 4: Improve access to resources to promote cessation of smoking through patient and provider education and marketing materials distribution such as use of ASHLINE and other similar Arizona-centered resources.**

Targeted population categories include adults (18 or older) seen in emergency departments/rooms (EDs/ERs) and in primary care settings in Arizona. Training will be provided related to culturally sensitive approaches and interventions to dedicated staff that interface with patients of various ethnic, racial, socioeconomic, gender and cultural backgrounds during the SBIRT process. This training will be developed on a site-to-site basis to accommodate the specific needs of each site. Many patients seen through North Country Healthcare, a Federally Qualified Health Center (FQHC), are low-income, housing-challenged, and/or unemployed or underemployed individuals and families. NCHC has excelled in meeting Culturally and Linguistically Appropriate Services (CLAS) standards during the initial SBIRT grant period. Overall program support for all populations will center on HCIC's hiring of two specialized full-time staff the SBIRT Program Coordinator and the SBIRT Data Collection Specialist

Current Arizona SBIRT Grant providers will be utilized to complete the requirements of the proposed program. Providers will be responsible for the provision and completion of SBIRT screenings, Follow-up interviews, and dissemination of SBIRT and Motivational Interviewing information and training. Current

providers have already had at least three years each of assessing patient satisfaction as a parallel process to SBIRT services and changes to which staff members handle each aspect of the SBIRT model were made to accommodate patient and family members' feedback. The well-informed, patient-focused providers include:

- North Country Healthcare (NCHC) – Will provide mentorship and training to Outpatient Care Facilities located in Geographical Service Area (GSA) 1, as well as mentorship and training to NAZ Community Colleges.
- Flagstaff Medical Center (FMC) – Will provide mentorship and training to Inpatient Care Facilities located in GSA 1.

HCIC will collaborate in close partnership with Arizona State University (ASU), the University of Arizona (UA), as well as current Arizona SBIRT Grant provider Northern Arizona University (NAU) to reach the specified target populations. HCIC will utilize the current network of Northern Arizona (NAZ) Behavioral Health Homes to refer treatment identified by the SBIRT screening process.

The SBIRT Grant project involves a screening process and a data collection process. The data collection is part of the Government Performance and Results Act (GPRA).

- Positive pre-screens for misuse and abuse of opioids will utilize the **Opioid Risk Tool (ORT)**. Available for no-cost use and reproduction via <https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf>. The ORT is shown to find 40% misuse, 20% abuse and 2-5% have a dependence on prescribed opioids.
- Positive pre-screens for risky use of alcohol will utilize the **Alcohol Use Disorders Identification Test (AUDIT C)**. Available in the public domain for no-cost use and reproduction via [http://www.dhcs.ca.gov/services/medi-cal/Documents/tool\\_auditc.pdf](http://www.dhcs.ca.gov/services/medi-cal/Documents/tool_auditc.pdf)
- Positive pre-screens for tobacco use will utilize an evidence-based screening tool to be confirmed with providers and GOYFF prior to use.
- Mentorship by experienced SBIRT providers with new providers will ensure adherence to EBPs.

### **Arizona State University**

SBIRT and Motivational Interviewing (MI) will be used by staff and student paraprofessionals who provide services to groups identified in the previously mentioned data as high risk for opioid use and will refer the students to screening (online or in person) and brief intervention through confidential sources at ASU Counseling and Health Services. ASU offices have made referrals to the counseling and health care providers at ASU, but without the aid of motivational interviewing techniques. Through MI and SBIRT processes, more students will be referred appropriately to screening and services, and will be assisted through their treatment and recovery.

Groups identified for training in Motivational Interviewing to refer students to SBIRT providers include Disability Resources Staff, who provide support for students with disabilities; the Dean of Students Office, which oversees victims advocacy and investigates disciplinary violations, including for alcohol and other drug use; collegiate recovery staff, who provide programs and support for students in recovery from addiction to alcohol and other drugs; student volunteers of the Sun Devil Support Network, who provide support for victims of sexual violence; student mental health promotion peer educators; and student employees and paraprofessionals in housing, wellness, sexual violence prevention and response.



ASU Counseling and Health Services staff will receive training in SBIRT, both to identify students who come in for services at these centers which provide confidential services, as well as to respond with SBIRT appointments for students referred through other offices who have received training in motivational interviewing and referral strategies.

Community College partnerships will be established to explore ways to engage their counseling staff in SBIRT on their campuses. Starting with Mesa Community College, and Chandler- Gilbert Community College, which are large colleges serving students in the East Valley. ASU will partner with counseling directors at these community colleges to learn more about their needs and how to meet their needs for motivational interviewing and SBIRT training.

Additional training will be provided with the aim to sensitize staff and student paraprofessional teams about student drug use and the language, beliefs, norms and values, and socioeconomic factors, among students who misuse prescription drugs, heroin and other opiates. In other words, how to talk with students about drug use in terms and methods that resonate with the students. This will aid staff and student paraprofessionals to become better able to engage with and respond to students within these communities. Further, ASU will engage teams in learning how prescription drug and opiate use plays out in the disabled student community, to assist in better meeting the service needs and outcomes of the disabled student population.

Targeted recruitment efforts will occur with students engaged with the discipline office; students who live in the residence halls; Academic Advisors; Advisors of Multicultural and International student groups; and students visiting the health and counseling services at ASU

ASU will assemble a project advisory group with representatives from the involved departments to discuss and coordinate assessment, plans and implementation of the project. Specifically, this group will discuss input they receive from their teams regarding the project, the training received, the processes needed to ensure compliance with the methods and data collection, and additional support needed by their teams to ensure the success of the project and in service to the students in need. Further, ASU will host discussions to include representatives from high-risk student populations identified in our data (disabled, those who abuse alcohol and other drugs, students in recovery, students with mental health conditions, and students identifying as lesbian, gay, bi-sexual, transgender and queer, as well as ensuring that students of color and international students are included in the discussions. The purpose of these discussions will be to learn from students how they would like SBIRT to be delivered within their peer groups and the programs and services they access. These discussions will assist the project team in knowing how best to engage these high risk groups in identifying barriers to services among their peers, and to help reduce these barriers.

### **Northern Arizona University**

Northern Arizona University (NAU) Campus Health Services has been a part of the Health Choices Integrated Care (HCIC) Screening Brief Intervention and Referral to Treatment (SBIRT) grant since 2014. The university has created a successful alcohol and drug-screening program that identifies students who are abusing substances and provides them with appropriate resources and interventions. This model relies on robust training for health care providers to allow them to effectively conduct brief interventions using motivational interviewing. To date, all providers have completed extensive in person and online training on conducting brief interventions. NAU has a co-located Health Education office where providers can make a warm hand off for individuals who may be at risk of dependence or require

more in-depth interventions. To date Campus Health Services has screened 6,899 students for substance misuse with 25% of those scoring in the moderate to high-risk range based on responses on the Alcohol Use Disorders Identification Test (AUDIT) and Drug Abuse Screening Test (DAST). Data from a sample of repeat patients indicate that 63% of patients decreased their AUDIT scores and 56% decreased their DAST scores at follow up appointments.

**Goal 1: Expand existing SBIRT program to include Urgent Care setting within Campus Health Services and to the Office of Student Life and Housing and Residence Life conduct offices.**

*SBIRT Expansion: Urgent Care Clinical Setting*

Expansion of NAU's existing SBIRT services to include the urgent care setting allows the university to reach some of its most high-risk patients. This will require a full time master's level behavioral health specialist to use tablets to pre-screen patients at check in for their medical appointments. Screening instruments used will be the AUDIT, DAST and CUDIT-R. Patients scoring as high risk for substance abuse will receive a brief intervention, brief treatment or referral to community treatment. The behavioral health specialist will also be responsible for providing follow up and coordination of care for any patients who are referred out for treatment/recovery services. This person will also manage data collection and monitor a list of patients needing recovery services. This staff will work in consult with medical and counseling services as well as the Behavioral Health Specialist to provide integrated care management.

*SBIRT Expansion: Build Capacity within other campus offices*

The SBIRT process will be piloted in two (2) additional offices where many students are seen for violating alcohol and drug policies. Both the Office of Student Life and Housing and Residence Life will be served by a full time Alcohol and Drug Prevention Specialist who will facilitate all aspects of SBIRT with students who are sanctioned for alcohol and drug conduct violations. This will provide an additional level of expertise and an evidence-based approach for early intervention in settings where this does not typically occur. It will also provide a point of access to treatment for those who may be in need of additional services. Again, the AUDIT, DAST and CUDIT-R screening instruments will be used to identify these at-risk students.

**Goal 2: Provide training and educational resources on prescription drug misuse for clinical and campus staff.**

Extensive training on prescription drug misuse will be offered to campus and community stakeholders. The goal of the training(s) will be to increase the ability to recognize prescription drug misuse and respond effectively. Inclusion of external stakeholders will also serve to build capacity across campus and within the community to reach those at risk for prescription drug misuse.

**Goal 3: Increase primary prevention of prescription drug misuse within Medical Services.**

New and effective educational resources, including available technology, will be identified and shared with Medical Providers to be distributed to any students receiving a prescription with high abuse potential.

**Goal 4: Develop and distribute a social marketing campaign regarding prescription drug misuse.**

Create and widely distribute a social marketing campaign that educates students and the broader community about risks associated with a variety of drugs as well as information about signs and symptoms of dependence.

**Goal 5: Provide seamless coordination of comprehensive drug and alcohol prevention efforts related to the grant.**

A full time Alcohol and Other Drug Program Coordinator will coordinate all grant related prevention activities and serve as a liaison to the grantor. The position is responsible for ensuring compliance with grant expectation and for implementing the SBIRT model to the required standards and guidelines/fidelity. This person will also coordinate trainings, develop educational materials, conduct program evaluation activities, provide supervision for the behavioral health provider and will develop a peer to peer education training program. The peer educators will be paid for their service and will provide prevention education at NAU and at local community colleges.

**Goal 6: Improve coordination of care for patients at high risk for mental health disorders and substance abuse.**

Campus Health Services would like to apply a Care Manager role not only to the primary care setting, but also in urgent care to capture a larger portion of patients. The implementation of a Care Manager role in a primary care and urgent care setting can help manage the health of a population while decreasing health risks, such as the abuse of opioids. A Care manager will stratify high risk patients in all areas, including substance use and mental health, follow and monitor risky behaviors, and improve retention by ensuring students receive the necessary care and resources they need.

**The University of Arizona (UA)**

UA Campus Health Service (CHS) has a full-service medical clinic, Counseling & Psych Services (CAPS) Department and Health Promotion and Preventive Services Department. These units have a long history of working together, in collaboration with other departments on campus, to provide the continuum of services needed to address substance use, misuse and abuse among our students. CHS convenes a cross-disciplinary substance abuse team that meets monthly to discuss issues on campus.

In 2005, UA received an SBIRT grant from SAMHSA-CSAT that focused specifically on college students. Through this grant, CHS providers, counselors and prevention staff were trained in motivational interviewing. Screening questions were added to the medical history form completed at intake into CHS for any type of medical service and providers were trained to note on the clinical file whether the screen was positive or negative, whether they did MI with the individual for a positive screen and if they made a referral to treatment at CAPS or within the community. If individuals were referred to brief treatment on campus, they participated in Brief Alcohol Screening and Intervention for College Students (BASICS). This is a very strong, evidence-based program that UA has been implementing and evaluating for over 15 years.

In 2005, through funding from the U.S. Department of Education, UA began asking all incoming students to complete Electronic Check Up to Go. This brief online screening collects information about students' substance use (including opioids) and provides immediate feedback about their levels of use and risk. There are also links to resources on and off campus as well as online. UA has continued this program through other funding and approximately 6000 students complete this program annually.

The current funding will extend and enhance the existing programming at UA and, potentially, at Pima Community College (PCC) to address polysubstance abusing population that includes, but is not limited to, opioids. The UA will use the following screening tools: SBIRT (Screening, Brief Intervention and

Referrals to Treatment), including MI, BASICS and Electronic Check Up to-go. To extend and expand the existing programming, the UA proposes to do the following:

1. Provide SBIRT/MI training to clinical, counseling and prevention staff within the UA CHS. Although many providers were trained through the initial 2005 SBIRT grant, there has been considerable turnover since that grant ended in 2009 and, even for those who have gone through this training, many have expressed interest in a refresher training.
2. Provide SBIRT/MI training to staff members in other departments on campus who collaborate with on these issues including the Dean of Students, Residence Life and Campus Police. All of these departments intervene with students prior to referral to CHS. This will greatly expand the reach of SBIRT across campus.
3. Provide SBIRT/MI training to staff members at PCC including, but not limited to, counselors, student life staff and campus police. This training will build on the work currently being done through the SPF-PFS grant.
4. Provide education through media and in person (newsletters, student newspaper, interviews, presentations, etc.) that includes self-assessment tools and information about available services and how to access them.
5. Develop posters and outreach materials to inform students, parents and the UA/PCC community members of polysubstance abuse risk and available resources.
6. Provide awareness events on UA and PCC campuses where students can be screened, receive immediate feedback and information about resources on campus. Direct referrals can also be made at these events.
7. Conduct brief screening (CHS and partners at UA and PCC) to identify high-risk students, conduct MI to engage students (first level of brief intervention) and make referrals, as needed, for the more in-depth screening and appropriate levels of intervention and treatment either within CAPS or out in the Tucson community (including BASICS at UA and PCC).

#### *Expansion of Naloxone and Provider Education*

To prevent OUD overdose, the ADHS Office of Injury Prevention will be responsible for purchasing Naloxone kits to be distributed and used by trained peace officers and law enforcement throughout Arizona. ADHS will work collaboratively with local, county and state law enforcement agencies who have participated in required training to provide initial and replacement kits as needed throughout the grant funded years.

To prevent OUD overdose morbidity and mortality among high-risk members in the community, AHCCCS currently has a community-based education and distribution project. These activities will continue under the current funding (SABG) and will not be a funded project under the Opioid STR grant.

Likewise, AHCCCS is currently working with Managed Care Organizations and professional associations to raise awareness and increase targeted education for preventing the prevalence of OUD and OUD overdoses. These activities enhance the existing efforts occurring through ADHS and include educate providers on safe opioid prescribing for acute and chronic pain conditions; co-prescribing Naloxone; educating patients on overdose prevention; integrated care coordination; and referral to MAT. No additional funding from the Opioid STR grant will be used for these projects.

## **Treatment**

As of July 1, 2016, AHCCCS serves as the Single State Authority on substance abuse, providing oversight, coordination, planning, administration, regulation and monitoring of all facets of the public behavioral health system in Arizona. AHCCCS contracts with three Regional Behavioral Health Authorities and Tribal Regional Behavioral Authorities (RBHAs and/or TRBHAs) to oversee the provision of behavioral and physical health services across the state. This structure allows organizations to provide services in a manner appropriate to meet the unique needs of individuals and families residing within their respective areas. Each RBHA is responsible for client evaluation and diagnosis, service and treatment planning, case management, coordination with the physical health care providers, and providing all behavioral health services through contracts with behavioral health providers.

The rising opioid epidemic in Arizona has created an incredible burden on the current system, and in particular around the capacity to identify, engage and retain OUD individuals in treatment. The proposed treatment projects in the Opioid STR grant will address these capacity gaps by allowing the RBHAs and/or TRBHAs to expand their network of providers and navigate OUD individuals, including those under and uninsured, to comprehensive MAT services and to ensure successful retention and recovery. Additionally the STR grant funds will allow for AHCCCS to extend MAT education to the provider network of the acute care contractors/health plans to extend the reach of this education to physical health providers.

### *MAT Education and Provider Capacity*

A substantial amount of stigma and misinformation exists about the science and clinical benefit of using MAT in conjunction with psychosocial therapies to treat individuals with OUDs. The divide on this topic occurs at all levels of the system, from the individual opioid user, to family members and loved ones, to potential providers, and key stakeholders and decision makers that either come into contact with OUD individuals or who make policy and practice decisions about OUD individuals.

Funds on this grant would support a statewide effort to reduce the stigma around the use of MAT to remove barriers to OUD individuals, including the under and uninsured, and accessing all FDA approved forms of MAT treatment on the AHCCCS drug formulary. RBHAs and/or TRBHAs, health plans, and leveraged partners will use existing resources and develop new resources as necessary to educate the community, provider networks, and decision-makers on the utility of MAT for combatting the opioid epidemic. In addition, based on the results of the needs and capacity assessment, the RBHAs and/or TRBHAs, acute health plans and leveraged partners will work with the professional associations to enlist new Buprenorphine waived providers among primary care physicians, nurse practitioners and physician's assistants in underserved areas of the state, including accessing appropriate training to become a waived provider. Education and outreach efforts will occur via web and in-person trainings, as well as through dissemination of material. Targeted efforts will be made to support marketing of MAT provider locations to individuals with OUDs, family and loved ones, and across provider networks in the state.

### *Peer Support System*

To increase systems efficiency for successfully navigating OUD individuals to treatment and to increase recovery success, the RBHAs and/or TRBHAs will work with contracted providers to expand the use of peer supports services across Arizona. Currently Peer Support Services are available to members enrolled in Arizona's publicly funded behavioral health system, including individuals receiving services through Medicaid and SABG. Most commercial insurance plans do not cover peer support services, so

emphasis will be placed on engaging and enrolling individuals with an OUD that are under and uninsured. Services will be stratified by need and population size and aligned with the site selection of the remaining treatment projects to ensure adequate support. The RBHAs and/or TRBHAs will ensure that the peer supports take the required AHCCCS approved pre-employment training and credentialing process, and the contracted providers will be expected to incorporate peer support throughout the continuum of care from identification, navigation, participation and retention, with peer support services available to individuals at all levels and intensity of services. Providers will be expected to involve individuals with lived experience in designing their peer support service delivery system and will be expected to have peer supports capable of navigation services as well as ongoing recovery support services. More detail on the involvement of peer supports is provided below.

#### *Centers of Excellence*

Arizona currently has a robust crisis system for navigating individuals with mental health and substance abuse issues to Urgent Psychiatric Care Centers in metropolitan areas. However, the increasing need for immediate access and crisis response for individuals with OUD has created gaps in service delivery within the system and there is an additional growing need to expand access to these services among rural communities. To increase timely access to care, the RBHAs and/or TRBHAs will identify regional Centers of Excellence (COE) serving target populations identified in the needs assessment that through the Opioid STR funds can increase existing capacity for MAT by expanding space, staff and hours of operation. The requirement will be that the centers must be open 24/7 and provide intake, assessment and review of all FDA approved MAT options for OUD treatment on the AHCCCS drug formulary, with preference given to sites that have the capacity to induct and provide MAT options on-site, where appropriate. Medical staff at the COE will be expected to provide the most clinically appropriate medication for each individual ensuring each individual has a choice and voice in medication treatment. The COEs will also be required to have care coordinators on site that will coordinate access to follow-up care, provide Naloxone education and access, and to connect OUD individuals with a peer support. For individuals requesting non-MAT options, the care coordinator will be responsible for identifying available options in the community and for coordinating follow-up care.

During assessment COE staff will screen the individual for tobacco use and if an individual reports tobacco use, staff will discuss Tobacco Cessation with them and will provide them Tobacco Cessation resources from the Center for Disease Control (<http://www.cdc.gov/tobacco/campaign/tips/partners/health/mental/index.html>) as well as Arizona's ASHLine (<http://ashline.org/>). The ASHLine contains a comprehensive collection of online cessation resources as well as a toll-free number that allows individuals to speak with a Quit Coach to assist with their tobacco cessation. Additionally the ASHLine provides information on nicotine replacement therapies and provides guidance on how to obtain these medications at low or no cost to the individual.

Peer supports will help the individual begin the process of navigation. The COE care coordinator, in conjunction with the peer support will provide a warm hand off to community MAT providers within 24 hours, ensuring that transportation needs are met. Other peer support activities may include providing navigation assistance for additional supports, helping the individual access the EBPs for psychosocial services, social support to increase treatment retention and facilitating access to recovery services.

#### *Hospital to Community Discharge Planning Coordination*

To increase care coordination and access to MAT, Hospitals will be selected by ADHS using "hot spot" analyses of high utilization OUD and non-fatal opioid poisoning data and invited to participate. Participant hospitals will engage in a hospital to community discharge planning project under the

coordination of ADHS to provide individuals released from a hospital following an opioid-related event with coordinated community services. Coordinated community services may include, but not be limited to providing: access to naloxone, referrals to treatment (including medication assisted treatment), referrals to housing, referrals to medical service providers and referrals to social service providers. This care coordination will be provided to individuals regardless of insurance coverage with specific emphasis on the under and uninsured to ensure they are aware of OUD treatment services, including MAT, available to them. Funds will be utilized to coordinate participant meetings, purchase supplies, cover in-state travel expenses, and to contribute toward salaries of individuals who will be developing, implementing, and assessing the effectiveness of the two year program.

#### *ED-Initiated Buprenorphine*

To increase access to MAT among high risk individuals, including those identified in the needs assessment, Emergency Departments will be selected by AHCCCS and ADHS using “hot spot” analyses of high utilization OUD and non-fatal opioid poisoning data and invited to participate. The selected EDs will implement the ED-BNI + Buprenorphine for Opioid Dependence evidence-based program developed by the Yale School of Medicine. The selected EDs will coordinate with the RBHA and/or TRBHA in their area in order to coordinate ongoing treatment services. ED staff will complete a two-step screening process using the Mini-International Neuropsychiatric Interview (MINI) to identify eligibility for MAT services for patients 18 years of age or older who present with moderate-to-severe OUD. The provider will discuss buprenorphine treatment and implement the Brief Negotiation Interview using motivational interviewing and cognitive-behavioral strategies to determine if there is a patient-centered agreement for treatment. If the patient agrees to a referral agreement, the provider will coordinate the patient’s first appointment and either conduct initial buprenorphine induction pre- discharge and/or provide sufficient dosage until the follow-up appointment within 48-72 hours.

The selected EDs will also be required to provide Naloxone education and access, and to connect OUD individuals with a peer support prior to discharge. For individuals requesting non-MAT options or non-Buprenorphine forms of MAT, the provider will help the patient identify available options in the community and coordinate follow-up care.

Peer supports will help the individual begin the process of post-discharge navigation, ensuring that transportation needs are met for the coordinated follow-up appointment. Other peer support activities may include providing navigation assistance for additional supports, helping the individual access the EBPs for psychosocial services, social support to increase treatment retention and facilitating access to recovery services.

#### *Opioid Diversion and Incarceration Alternative*

To increase access to MAT and avoid costly incarceration of individuals with OUDs, a minimum of five jurisdictions identified through the AHCCCS conducted needs assessment as high prevalence OUD areas will be selected to implement pre- and/or post-booking diversion processes that will navigate low-level OUD drug offenders to community based treatment. In the selected jurisdictions, the RBHAs and/or TRBHAs will contract with existing providers to fund additional care coordinator positions that will provide on-call services in the selected jurisdictions. The RBHAs and/or TRBHAs and their providers will work with law enforcement, jails, courts, prosecutors and other key stakeholders to coordinate a model system for service delivery. As point of contact, the care coordinators will be responsible for obtaining transportation of the individual to an approved treatment facility, including but not limited to the COEs described above, reviewing all available forms of MAT and navigating OUD individuals in the diversion process to the appropriate level and type of treatment selected.

The care coordinator will also be required to ensure that the individual has been provided Naloxone education and has access to a kit either through a prescription or through the AHCCCS community distribution network, and that the individual has been connected to a peer support. The care coordinator and peer support will work together to arrange follow up care for the treatment plan. Peer supports will help the individual begin the process of navigation. Other peer support activities may include providing navigation assistance for additional supports, helping the individual access the EBPs for psychosocial services, social support to increase treatment retention and facilitating access to recovery services. The care coordinator will be responsible for managing any communication or reporting to courts or prosecutors that may be required in post- booking models of service delivery.

#### *Early Identification of MAT Eligible Individuals Reentering Communities from Correctional Settings*

To increase access to treatment among individuals reentering communities from correctional settings, the Opioid STR funds in Arizona will focus on expanding the existing effort to identify, engage and retain MAT eligible individuals in services upon release from correctional settings.

The RBHAs and/or TRBHAs will be responsible for contracting with providers that will hire Correctional Health Liaisons to support this project across Arizona. The Correctional Health Liaison will be the point of contact for coordination with criminal justice entities, and will have the responsibility of identifying MAT eligible individuals pre-release, reviewing MAT options with the individual, providing brief Naloxone education, and providing assignment to peer support to ensure follow up to treatment post-release. For individuals requesting non-MAT options, the provider will help the individual identify available options in the community and coordinate follow-up care plans with the peer support.

Once the release date has been identified, the peer support may help facilitate transportation from jail or prison to the individual's initial appointment at the identified provider. The RBHAs and/or TRBHAs will ensure that all contracted providers providing post-release assessment for this population, conduct Naloxone education and provide kit access either through a prescription or through the AHCCCS community distribution network at time of intake. Other peer support activities may include providing navigation assistance for additional supports, helping the individual access the EBPs for psychosocial services, social support to increase treatment retention and facilitating access to recovery services.

#### *Expansion of SENSE Program for Pregnant and Parenting Women*

In Arizona, many challenges compound the issue of meeting the service and support needs of pregnant and postpartum women with OUDs. Recovery supports that recognize the additional support needed for mom in the caregiver role of her new infant are critically needed. To fill this gap, the Department of Child Safety will be responsible for identifying, training and procuring the services of new nurses across all Arizona counties to expand access to recovery supports that will improve the long-term recovery success of this population.

As part of a comprehensive treatment and recovery plan, the nurses will conduct two in-home visits with postpartum mothers. The visits will involve screenings for an array of maternal health measures that can affect her treatment and recovery success, including post-partum depression and tobacco use. In addition, to address caregiving stressors that can affect the mother's treatment and recovery success, the nurse will also cover a vast number of infant development topics and tips for mom on how to handle the difficult sleep and feeding patterns and regulatory irritability often present in opioid-exposed newborns.



### *Expansion of Residential and Recovery Home Capacity*

To increase access to treatment and recovery services among individuals with OUD, the RBHAs and/or TRBHAs in conjunction with AHCCCS will use the capacity and needs assessment data to identify areas of need and network gaps for residential and OUD recovery home facilities. The RBHAs and/or TRBHAs will increase their provider network as needed to provide the necessary services to meet the need in their communities. It will be required that these residential and OUD recovery home facilities provide access to and allow all FDA approved MAT services on the AHCCCS drug formulary. The RBHAs and/or TRBHAs will require the providers to use the approved evidence-based practices for psychosocial therapies outlined in this grant as part of their service delivery model.

## **C2: Opioid Use Prevention and Treatment EBPs**

### **Prevention EBPs**

**Wellness Initiative for Seniors (WISE)** is specifically designed to improve health behaviors related to lifestyle choices, healthcare empowerment, and use of prescription and over-the-counter medications. Focused on the “health belief model of behavior change,” WISE “provides older adults with the information and resources they need to maintain a healthy lifestyle”. The six-week course is delivered in small groups and covers topics ranging from stress management and strategies for healthy living to medication management and prescription drug abuse and is delivered by trained substance abuse prevention specialists who have gone through WISE’s formal training curriculum. Participants also receive tools and resources for home so they may put into practice what they are learning.

**Mental Health First Aid** which is coordinated by the National Council for Behavioral Health and is an eight-hour program that introduces participants to the warning signs and risk factors of mental health problems such as depression and anxiety. Although this can be delivered to adults of any age, there is a specific curriculum for those who regularly interact with older adults such as caregivers, nursing professionals, social workers or even neighbors and volunteers. “Since 2008 the core Mental Health First Aid Course has been delivered to hundreds of thousands of people across the US including hospital staff, employers, and business leaders, faith communities, law enforcement and general public.” The older adult module focusses on the need for early intervention and how to help an older adult who may be experiencing a mental health issue. Typically older adults with serious mental illness (SMI) are served by mental health providers or state Medicaid programs but a large number of older adults without a current or past SMI diagnosis suffer from depression and anxiety thus the need for trainings like mental health first aid which are geared to older adult helpers is especially important as they need those around them to recognize the warning signs before it leads to harmful behaviors such as substance abuse and/or suicide.

**SBIRT** consists of three major components: **Screening** — a healthcare professional assesses an individual for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting. **Brief Intervention** — a healthcare professional engages an individual showing risky substance use behaviors in a short conversation, providing feedback and advice, utilizing motivational interviewing techniques. **Referral to Treatment** — a healthcare professional provides a referral to brief therapy or additional treatment to individuals who screen in need of additional services. Providers utilizing the SBIRT model administer two pre-screen questions, the Alcohol Use Disorders Identification Test (AUDIT), and Drug Abuse Screening Test (DAST) to individuals while waiting to be seen by their treatment provider.

### **Treatment EBPs**

In addition to the clinically indicated use of evidence-based medications described above, the following are evidence-based practices (EBPs) that will be used for treatment activities:

**Motivational Interviewing:** MI is a semi directive, client-centered counseling style that elicits behavior change by helping clients explore and resolve ambivalence. It facilitates the development of the trusting relationship and the decision to make a change. Past research has supported that a brief motivational intervention delivered in a walk-in healthcare clinic by peer counselors was associated with improved abstinence rates and reductions in opioid and cocaine use<sup>14</sup>. Provider staff will use motivational interviewing techniques to build rapport and engage individuals beginning during outreach and continuing throughout course of treatment. The use of MI will be critical for engaging MAT eligible individuals into treatment.

**Cognitive Behavioral Therapy:** To ensure a comprehensive MAT strategy that includes the use of evidence-based psychosocial approaches, the use of CBT will be endorsed as the psychosocial therapy of choice for the majority of the population. This model of therapy helps individuals with OUDs and other substance use disorders to recognize and challenge dysfunctional thoughts and behaviors that can lead to a relapse, including coping with cravings and cue exposures, relaxation training and social skill and problem solving skill training. CBT has been identified by the National Institutes of Health as the highest rated form of psychosocial therapy for efficacious OUD treatment and for increasing the effectiveness and adherence to opioid replacement therapy<sup>15</sup>. The use of CBT will be critical for the retention of individuals in MAT, as well as for enhancing the likelihood of long-term recovery success.

**ED-BNI + Buprenorphine for Opioid Dependence:** This model is designed for individuals 18 years of age and older who present with moderate-to-severe OUD in the Emergency Department or other healthcare settings. The model has been shown to be effective for decreasing opioid use and OUDs.<sup>16</sup> The model has also demonstrated ability to increase retention in MAT treatment compared to referral only or brief intervention models<sup>17</sup>. To ensure fidelity to the model, selected Emergency Departments in Arizona, will be trained to use the model, including training or technical assistance needed for the following components: conducting the Mini-International Neuropsychiatric Interview (MINI), motivational engagement for post-discharge treatment, identifying obstacles to treatment, induction of the medication and facilitated follow up appointment with a community based MAT provider within 72 hours. This program will be critical for reaching individuals with the most pervasive OUDs and who are at highest risk for opioid overdose.

**The American Society of Addiction Medicine Criteria:** The ASAM Criteria is an ongoing, multidimensional, person-centered, holistic treatment philosophy of care. The ASAM Criteria requires clinicians to effectively assess utilizing the criteria through assessment at individual's admission, service planning, treatment and discharge or transfer to higher or lower levels of care. Through utilizing the ASAM Criteria, provider staff will recognize the dimensional interaction and holistic treatment approach that is essential to effective integrated treatment. Under the ASAM Criteria an individual's care is delivered along a flexible continuum, tailored to the needs of the individual, and guided by a collaboratively developed treatment plan<sup>18</sup>. Utilizing The ASAM Criteria will allow individuals to feel engaged and that they have a voice in their treatment planning. Providers will utilize The ASAM Criteria at minimum at time of intake and discharge, and any time an individual has a significant life event that could affect their treatment.

### **C3: Selected EBPs and Reducing Disparities**

For prevention activities, the Governor’s Office of Youth, Faith, and Family (GOYFF) elected to collaborate with Health Choice Integrated Care (HCIC), Northern Arizona University (NAU), Area Agency on Aging (AAA), Arizona State University (ASU), University of Arizona (UA) and Arizona Department of Health Services (ADHS) for Opioid STR because these entities share the agency’s commitment to reduce and ameliorate disparities within their communities. Whether it is ASU educating the public about *Reducing Health Disparities in Refugees by Screening for Distress* (ASU SIRC September 5, 2012); UA’s research on why minorities in Arizona face a disproportionate share of the state’s obesity, diabetes, and metabolic disease burden; or NAU’s travel to American Indian Reservations to recruit students they would not otherwise reach, all of the selected sub-grantees are eager to partner with the GOYFF for the next opportunity to implement culturally competent primary and secondary prevention programs that impact disparity.

For treatment activities, AHCCCS intends to use the above mentioned treatment EBP’s to reduce disparities as they have been proven to be effective according to controlled research studies for individuals who have an OUD. Additionally, we will ensure that the services are culturally competent delivered in an effective, understandable and respectful manner, compatible with service recipients’ preferred language and cultural beliefs.

### **C4: EBP Modification**

This section is not applicable due to the use of EBPs discussed above.

### **C5: EBP Monitoring**

For prevention activities, the GOYFF recognizes the importance of implementing programs to fidelity and while there is no intent to modify the foundation of the SBIRT program’s implementation, the agency will still require its sub-grantees to build in monitoring activities on the front end, to ensure their programs are being implemented with accuracy and consistency, and in doing so remain uncompromised. In turn, the GOYFF will also oversee the programs’ fidelity through quarterly reporting, (a minimum of) annual site visits, the provision of technical assistance, data submitted through the GPRA, and through data validation activities performed by the GOYFF. Should it be determined that a sub-grantee has “drifted”, the GOYFF will provide technical assistance until the sub-grantee resumes adherence to the appropriate procedures. Conversely, should a sub-grantee demonstrate ongoing consistency in implementing the program, the GOYFF may slowly decrease the frequency in which it will conduct data validation activities.

For treatment activities, AHCCCS understands the importance of implementing an evidenced- based program or practice as intended in order to maintain a high degree of fidelity. For this reason, the project does not intend to modify implementation of the evidenced-supported program in any significant way that could jeopardize the success of the project. The Project Director and other AHCCCS staff will meet no less than quarterly with contracted providers and the selected sites to ensure that the delivery of the EBPs are implemented according to the EBP guidelines.

## Section D: Staff and Organizational Experience

### D1: Capacity and Experience of Applicant Organization

Arizona has a long history of implementing significant and innovative initiatives related to integration and care coordination in the provision of physical and behavioral health services. Through an administrative initiative to integrate the administration of physical and behavioral health services as of July 1, 2016, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) and the Arizona Health Care Cost Containment System (AHCCCS) merged to fully integrate the implementation and oversight of federally funded behavioral and physical care services. The integration of ADHS/DBHS and AHCCCS builds stronger and better informed delivery of behavioral and physical health services through Arizona's Medicaid and SAMHSA programs.

In addition to overseeing the managed care organizations that provide Medicaid-funded physical health care services, AHCCCS now serves as the Single State Authority on substance abuse. AHCCCS is the single agency responsible for matters related to behavioral health and substance abuse and provides oversight, coordination, planning, administration, regulations, and monitoring of all facets of the public behavioral health system in Arizona. Through this integration, the staff are responsible for the application, implementation, and oversight of SAMHSA block and discretionary grants. These positions include the SOTA/Opioid Treatment Network and National Treatment Network representatives. With the integration of physical and behavioral health services within one state agency, AHCCCS is in the best position to expand MAT treatment, increasing enrollment in MAT services, and improving treatment outcomes for individuals with an opioid use disorder.

AHCCCS currently contracts with three RBHAs to administer integrated managed care delivery services in three distinct geographic service areas (GSAs) throughout the State. This regionalized system allows local communities to provide services in a manner appropriate to meet the unique needs of individuals and their families. Additionally AHCCCS has intergovernmental agreements (IGAs) with tribal entities, Tribal Regional Behavioral Health Authorities (TRBHAs), the primary purpose of which is to coordinate the delivery of comprehensive behavioral health services to all eligible persons assigned by the administration to the tribal entity. AHCCCS requires RBHAs to maintain a comprehensive network of behavioral health providers that deliver prevention, intervention, treatment and rehabilitative services to a variety of populations including children and adolescents, adults with Serious Mental Illnesses (SMI), adults with General Mental Health Disorders (GMH), and persons with Substance Use Disorders (SUD/SA). AHCCCS recognizes the interconnectivity of an individual's physical health and behavioral health and the importance to assist and promote whole body healthcare for all Arizonans. AHCCCS has supported integrated healthcare through various activities including educating healthcare providers, policy makers and the community as well as addressing systemic barriers to integration. All three RBHAs are fully responsible for coordinated and integrated behavioral and physical healthcare for Medicaid eligible adults with SMI.

<sup>14</sup> Bernstein, J., Bernstein, E., Tassiopoulos, K., Heeren, T., Levenson, S., & Hingson, R. (2005). Brief motivational intervention at a clinic visit reduces cocaine and heroin use. *Drug and Alcohol Dependence*, 77, 49-59.

<sup>15</sup> NIH: Evidence Based Psychosocial Interventions in Substance Use <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4031575/>

<sup>16</sup> SAMHSA's National Registry of Evidence-based Programs and Practices, ED-BNI + Buprenorphine for Opioid Dependence <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=132#hide1>

<sup>17</sup> Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. <https://www.ncbi.nlm.nih.gov/pubmed/25919527>

<sup>18</sup> ASAM Criteria <http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria>

Through our many initiatives and individual employees, AHCCCS has strong ties to grassroots and community-based organizations that are rooted in the culture and language of the OUD population. Several of our staff have built strong relationships with local substance abuse prevention coalitions, substance abuse treatment organizations, re-entry programs and recovery programs operating at the community level. Our Project Director, for example, has been working collaboratively with local substance abuse prevention coalitions for over seven years, and was the lead coordinator between the efforts of the community and the state during the pilot project to develop the model for the Arizona Rx Drug Misuse and Abuse Initiative. Our Criminal Justice Project Manager has a strong history of working with key community stakeholders and coalitions across the state to improve access to care for individuals reentering the community from criminal justice settings. Staff in our Systems of Care division have built incredible relationships with numerous local behavioral health and substance abuse treatment providers, and key staff in our Office of Individual and Family Affairs have developed incredible relationships with the community, including the model system for peer support networks in the state of Arizona.

## **D2: Capacity and Experience of Partner Organizations**

The Arizona Department of Health Services (ADHS) was one of the original agencies involved in the statewide effort that began five years ago to develop and implement strategies to combat the growing opioid epidemic in Arizona. ADHS has taken the lead in the state on developing and marketing guidelines for safe opioid prescribing and opioid policies in Emergency Departments, prescriber education and critical enhancements to the state Controlled Substance Prescription Monitoring Program. ADHS also has access and knowledge of critical data on opioid-related mortality and morbidity, and a history of data-driven decision-making on strategies to combat the opioid epidemic in Arizona. In addition, the agency has been involved in numerous localized community outreach efforts aimed at raising awareness of opioid-related risks, tips for proper storage and disposal of prescription medication and for developing Naloxone training for law enforcement. ADHS currently co-chairs the Arizona Rx Drug Misuse and Abuse Initiative's Rx Core Group and is the leader in the state on coordinating efforts around chronic pain management and enlisting collaboration among key local medical champions on the Health Care Advisory Committee for the Rx Core Group efforts.

The Arizona Governor's Office for Youth, Faith and Family (GOYFF) has also played a critical role in streamlining efforts across opioid-related prevention and treatment activities in the state by coordinating tasks among the Arizona Substance Abuse Partnership, the Substance Abuse Taskforce, and co-chairing the Arizona Rx Drug Misuse and Abuse Initiative's Rx Core Group. GOYFF has enlisted the help of several key state and local champions to identify solutions to the opioid epidemic in Arizona and has been instrumental in enlisting call-to-action among the various sectors involved. GOYFF is also the implementation agency for the SABG prevention funding, the Screening, Brief Intervention and Referral to Treatment (SBIRT) grant, the Partnership for Success Grant, and the Parents Commission on Drug Education and Prevention Grant and has expanded primary prevention activities targeting youth and parents across the state, as well as the broader general public through media and marketing methods. GOYFF has strong relationships within local communities, especially among local non-profit organizations and the local substance abuse prevention coalitions in Arizona.

For the purpose of the Opioid STR grant, the GOYFF will collaborate with the following entities to develop programs that are culturally and linguistically competent, and meet their unique community's needs:

### Area Agency on Aging (AAA)

The Area Agency on Aging, Region One has done similar prevention work since 1996 with SAMSHA funding administered by the various contracted Regional Behavioral Health Authorities in Maricopa County, AZ. This prevention work has focused on mental health, suicide prevention and medication misuse and abuse including the abuse of prescription drugs. It currently coordinates and oversees the Maricopa County Behavioral Health Advocacy Coalition which is a community coalition that focusses on suicide prevention and medication misuse. Region One is also a Licensed Behavioral Health Agency and Certified to bill Medicare and Medicaid for its behavioral health services. Region One has been in business as a non-profit for over 43 years in Maricopa County, serving over 90,000 older adults annually through its 60 programs and services and 50 contracts. Although the work for this project will expand outside of Region One's service area, the Arizona Association of Area Agencies on Aging is strong and has good partnerships to expand this work statewide. Region One has the experience and capacity to oversee and support the other Regions.

### Health Choice Integrated Care (HCIC)

In 2012, the GOYFF partnered with Health Choice Integrated Care (HCIC) and northern Arizona providers to improve the health of individuals using alcohol or drugs in a risky manner under the SBIRT model. In the past five (5) years, Northern Arizona has successfully paved a clear path for using this evidence-based practice in hospital emergency departments, primary care practices integrating behavioral health services, behavioral health practices integrating primary care and university campus health services departments. HCIC will utilize funding from STR to enhance and expand programming beyond its existing model, by training providers who are not familiar with SBIRT.

### Northern Arizona University (NAU)

In 2014, NAU partnered with HCIC and the GOYFF to implement SBIRT at the university's health center. While SBIRT screenings started with screening its students, in 2016 AZ SBIRT expanded to include NAU faculty. Like its students, staff received screenings, brief interventions, brief treatments and were referred for treatment, when appropriate. NAU has a history of collaborating with the GOYFF, HCIC, and multiple other community agencies and stakeholders to provide progressive prevention programs.

### University of Arizona (UA)

In 2015 through 2016, the UA partnered and collaborated with 59 separate agencies, coalitions and providers, and have participated in numerous federal grants. Most recently, the UA is a participant in the Partnership for Success grant, for which they have implemented prevention activities at the UA, as well as at two additional campuses- Embry Riddle Aeronautical University and Pima Community College. The UA is noted for its ability to see beyond its own programs to work with system stakeholders to improve prevention and treatment services throughout all of Arizona.

### Arizona State University (ASU)

ASU is the proud recipient of the SAMHSA SBIRT Student Training grant. The university has developed a credited SBIRT course and has expanded its training from college students and medical health providers, to include dental practitioners. ASU has also been instrumental in expanding AZSBIRT's reach beyond northern Arizona by collaborating with HCIC to provide free education and training to interested physicians in central and southern Arizona. ASU will utilize STR funding to enhance its programming by progressing beyond training and education, to actually implementing SBIRT in all four (4) of its health clinics. The university has an extensive history of working with federal grants and other government funding.

### D3: Staff and Key Personnel

**Project Director:** Shana Malone was recently hired by AHCCCS to oversee strategic planning and implementation of the agency's initiative to reduce OUDs and OUD deaths. Ms. Malone has over 15 years of experience managing federal grant-based projects, and was the coordinator for community-based strategies and lead evaluator on the Arizona Rx Drug Misuse and Abuse Initiative pilot project. Ms. Malone will dedicate 50% of her time to this project and will be responsible for overseeing all deliverables, performance measures and implementation strategies to ensure the success of this project.

**Project Coordinator:** This is not a currently filled position. The Project Coordinator will be 1 FTE who will dedicate 100% of their time to coordinate training, education and outreach activities; stakeholder involvement; fidelity monitoring; and assistance with required grant deliverables and reporting requirements. Minimum requirements of this position will be a master's degree in public health or social science. Individuals with experience in substance abuse treatment, care coordination, and those with some data analytical background will be preferred.

**Grant Accountant:** The Grant Accountant will be 100% dedicated to this project and will provide support to the grant program staff, perform grant-related post-award functions, including financial analysis and reporting. The Grant Accountant will be responsible for reviewing Contractor Expenditure Reports in accordance with grant requirements.

**Opioid Epidemiologist:** This position will be housed at the Arizona Department of Health Services and is not a currently filled position. The Opioid Epidemiologist will be 1 FTE who dedicates 100% of their time to assist with data collection and analyses for the needs assessment, capacity assessment and performance measures deliverables. The Opioid Epidemiologist will assist with localized evaluation of projects and data for the multi-sector opioid incident reports and event-based blasts proposed in the Opioid Monitoring Initiative project. Minimum requirements of this position will be a master's degree in Epidemiology, Public Health, statistics, policy informatics or other related field or a bachelor's of science in life sciences and three years of experience in disease surveillance or other relevant area of Public Health. Individuals with prior Public Health experience, knowledge of population based research methods, experience working with large datasets and the ability to translate statistical data into lay reports and presentation will be preferred.

**Data Intelligence Analyst:** This position will be housed at a central law enforcement agency to be determined and is not a currently filled position. The Data Intelligence Analyst will be 1 FTE who dedicates 100% of their time to assist with data collection and analyses for the needs assessment and who will be the point person on developing and disseminating the multi-sector opioid incident reports and event-based blasts proposed in the Opioid Monitoring Initiative project. Minimum requirements of this position will be a master's degree in criminal justice, statistics or related field. Individuals with knowledge of criminal justice and drug-related law enforcement data, experience with data mining, and experience with computer programming or informatics and technology will be preferred.

**Program Coordinator:** This is not a currently filled position at the Governor's Office of Youth, Faith and Family. The Program Coordinator will be 1 FTE who will dedicate 100% of their time providing trainings on the Rx Toolkit to communities, coalitions, health care practitioners, law enforcement and youth to address the opioid epidemic and prevent opioid overdose in all 15 Arizona counties. Minimum

requirement of this position will be a Bachelor's degree in public administration, social and or public policy. Experience in the state system; contract monitoring, including federal and state funding streams will be preferred.

**Deputy Director:** Tonya Hamilton serves at the Governor's Office of Youth, Faith and Family's Deputy Director of operations which includes oversight and strategic planning of grants that come into the office. Tonya Hamilton has 20 years of experience overseeing state and federal grant-based projects and has extensive knowledge of Arizona state systems. Ms. Hamilton will work closely with the lead agency; AHCCCS to oversee the prevention carve out of this grant and ensure all deliverables are being met.

**Correctional Health Liaisons:** These are not currently filled positions. Contracted providers will hire these positions upon grant award. The minimum requirements for these positions will be 2 years working with individuals with substance use disorders as well as 2 years working with criminal justice involved individuals. These positions will also require that the individuals meet the Arizona requirements to Behavioral Health Technician and have experience conducting intakes and coordinating care. These positions will be no less than 1 FTE per selected site conducting the reentry from criminal justice settings project.

**Care Coordinators:** These are not currently filled positions. Contracted providers will hire these positions upon grant award. The minimum requirements for these positions will be 2 years working with individuals with substance use disorders. These positions will also require that the individuals meet the Arizona requirements to Behavioral Health Technician and have experience conducting intakes and coordinating care. These positions will be no less than 1 FTE per selected site conducting the Centers of Excellence model and as needed to support care coordination and treatment navigation for the hospital discharge and diversion projects.

**Peer Support Specialists:** These are not currently filled positions. Contracted Providers will hire these positions upon grant award. The minimum requirements for this position will be for the individuals to have lived experience with substance use disorder and for those assigned to the reentry project to have experience with criminal justice system involvement. This position will also require evidence of successfully navigating the public behavioral health and criminal justice systems. These positions will be FTE, with an estimated 60 positions across Arizona.

**SENSE Nurses:** These are not currently filled positions. The Department of Child Safety will work with contracted providers to hire and train these positions upon grant award. The minimum requirements for this position will be for individuals to have a bachelor's of nursing degree, with experience in pediatric nursing. These positions will be contracted providers and paid a pre- determined amount per home visit.

**State Opioid Treatment Authority (SOTA):** This position is currently filled by Michelle Skurka. Ms. Skurka is the System of Care and Grants Administrator at AHCCCS and has over 6 years being designated as the SOTA. Ms. Skurka will not be funded through this grant but as Administrator and SOTA will be involved in the administrative oversight as needed.

**Arizona National Treatment Network and Women's Services Network Representative (NTN/WSN):** This position is currently held by Lesley Wimmer Kelly. Ms. Wimmer Kelly has been with the System of Care and Grants unit at ADHS/DBHS and now AHCCCS for over two years and is currently a Manager within the unit. During this time Ms. Wimmer Kelly has been responsible for the coordination,



implementation, and oversight of initiatives and projects related to treatment under the Substance Abuse Prevention and Treatment Block Grant (SABG) and is the Project Director on the MAT-PDOA grant. Ms. Wimmer Kelly will not be funded through this grant but will be involved to ensure coordination of projects.

#### **D4: Key Staff Member Experience at the Applicant Organization**

**Project Director:** Shana Malone has extensive experience on prevention, intervention and public health projects funded by NIH, NSF, BJA, BJS and the Robert Wood Johnson Foundation. Ms. Malone has doctoral training in multi-systemic translational research, statistics and program evaluation, as well as clinical training and experience in systems therapy and substance abuse counseling. In addition, Ms. Malone has five years of experience working with various stakeholders in Arizona on a multi-systemic approach to addressing the opioid epidemic, including law enforcement, the medical community, the treatment community and the community prevention community. As such, Ms. Malone is well-versed in the localized needs, culture and disparities occurring in the OUD population in Arizona and well poised to lead the project.

**Project Coordinator:** The Project Coordinator to be hired by AHCCCS will be required to have a minimum of a master's degree in public health or relevant social science field, with experience in substance abuse treatment preferred. This requirement ensures that the Project Coordinator has baseline skills and understanding of models, modes and delivery systems for efficacious population-level health initiatives, and more specifically, the acumen to understand how these models can be best executed within the parameters and reality of the Arizona substance abuse treatment landscape. The ideal candidate for this position will have excellent foundational knowledge of the opioid epidemic; the ability to facilitate dialogue and solutions among multi-sector colleagues, stakeholders and partners; and the ability to translate basic research and data to these colleagues to gain consensus and for iterative data-driven decision-making. Given the heavy focus on data-driven decision-making, the ideal candidate will also have some experience with analyzing data and packaging data for dissemination or the ability to learn these methods under the direction of the Project Director.

#### **D5: Ensuring consumer, client and family input**

To ensure that the input from consumers, clients and families is gathered to inform assessment, planning and implementation of the project, AHCCCS will host public forums (web-based and in-person) to ensure that their needs and requests are included in strategic planning and implementation. AHCCCS will also leverage its Office of Individual and Family Affairs to actively solicit feedback from their community liaisons and community outreach networks. In addition, several town halls and community stakeholder meetings will be planned during the assessment and planning phase, and AHCCCS will work to ensure that representatives from consumer, clients and families are present during these meetings.

### **Section E: Data Collection and Performance Measurement**

#### **E1: Ability to Collect and Report**

As the administrator of the SABG funds, AHCCCS staff in the System of Care and Grants unit have extensive knowledge of submitting data in compliance with the SABG standard reporting requirements. These staff will work with the Project Director and Project Coordinator to ensure that the data

submitted on this grant follows the guidelines and procedures required by SAMHSA. For the additionally required performance measures, the ability to collect the measures will be as follows:

1. Number of people who receive OUD treatment through the Opioid STR funds will be collected through contracted providers involved in the four projects to streamline MAT eligible individuals to MAT treatment.
2. Number of people who receive OUD recovery services through the Opioid STR funds will be collected through contracted providers providing peer support services. Recovery will be defined as services delivered beyond the initial navigation to MAT treatment, unless otherwise directed by SAMHSA.
3. Number of providers implementing MAT through the Opioid STR funds will be collected through contracted providers who receive new MAT eligible individuals as a result of the four projects to streamline MAT eligible individuals to MAT treatment.
4. Number of OUD prevention and treatment providers trained, to include NPs, PAs, as well as physicians, nurses, counselors, social workers and case managers through the Opioid STR funds will be collected by AHCCCS staff, partners or contracted providers conducting training. Additional detail on this measure will also be collected by tabulating the number of new MAT providers in Arizona pre-and-post the education and enlistment of new MAT providers project.
5. Numbers and rates of opioid use for individuals receiving direct treatment services by the Opioid STR funds will be collected through contracted providers. For statewide estimates, opioid use can be collected for youth ages 12-17 years through the Arizona Youth Survey on even years only. These data include prescription opioids as well as heroin and are available at state, county and local levels. Numbers and rates of prescription opioid misuse can be collected annually for adults through the Behavioral Risk Factor Surveillance System at the state level. There is no current statewide assessment of all opioid misuse and abuse among adults that includes heroin or other opiates in Arizona. The last estimate to conduct such a survey was over \$2 million to reach a representative statewide sample. Arizona would have to rely on NSDUH estimates for this measure and could additionally provide supplemental proxy data through vital statistics mortality data and through AHCCCS claims and encounters data on the number and rate of individuals with OUDs.
6. Numbers and rates of opioid overdose-related deaths will be calculated from the Arizona Department of Health Services vital statistics mortality data.

## **E2: Data collection, management, analysis and reporting plan**

For localized evaluation on prevention activities, a formal process, impact and evaluation model will be developed by GOYFF to ensure that activities and impact of the prevention activities are appropriately tracked and monitored. This will include, at minimum, pounds of medication collected in the drop boxes and take back events supported through these funds; the number of events and technical assistance activities related to the Rx Toolkit trainings and dissemination; and the number of trainings and direct services to individual in the older adult prevention project.

Primary Prevention in Older Adult outcomes and outputs will be measured by pre post-test and sign-in sheets for both Wise and Mental Health First Aid for Older Adults.

For the SBIRT prevention project, the number of participants, participating providers and departments, and locations will be collected, along with the number of referrals made to treatment, the number of individuals referred who made/kept appointments, and percent changes in visits for opioid misuse and

abuse. Questionnaires will be used to evaluate the MI and SBIRT trainings sessions (in development). Diagnostic codes associated with visits at ASU Counseling and Health Services will be accessed each semester to assess number of individuals seen for substance abuse problems during implementation of the project.

For localized evaluation on treatment activities, a formal process, impact and evaluation model will be developed by the Project Director when the statewide strategic plan is finalized, and data collection methods and analytical strategies will also be finalized at that time. Described below are the methods that will be used for the known performance measures and proposed objectives described in section B1 of this application.

For all performance measures that are process evaluation measures (i.e., 1-4 above), standardized matrix report forms will be developed by the Project Director to tabulate number of individuals reached by mode, type of service, and type of provider. Modes would include, at minimum, the venues and processes defined in the four projects designed to streamline access to MAT for individuals with OUDs. Type of service would, at minimum, detail the FDA approved forms of MAT on the AHCCCS drug formulary and the type of corresponding EBP implemented, as well as peer support services. Provider types will include, at minimum, delineation of care coordination, peer navigators, peer support specialists, physician, nurse practitioner, and behavioral health provider. Contracted providers will submit monthly reports to the Project Coordinator.

Additional process measures that will be tracked will include the number of trainings by type, location and provider type; the number of new and existing MAT providers; the number of new and existing peer supports; the number of intakes by location; number of referrals to MAT; number retained in MAT services; number of Naloxone kits distributed and MAT treatment attrition numbers. Contracted providers will submit monthly reports to the Project Coordinator.

Providers receiving training will complete pre-tests prior to training to assess their knowledge, attitudes, awareness and behavior. Post-tests will occur following the training and at a 6 month follow up to determine training efficacy. Care coordinators, liaisons and peer supports will also complete monthly narratives to identify successes and barriers in the navigation, participation and retention of MAT eligible individuals in treatment. All measures will be reported to the Project Coordinator.

Numbers and rates of heroin use or misuse of prescription opioids in a non-prescribed manner among individuals receiving treatment services will be collected via self-reported average days per week of use and misuse at time of MAT intake and at 30, 90, and 180 days where possible.

Care coordinators will be responsible for obtaining the data and reporting up to the Project Coordinator.

At the statewide level, misuse and abuse will be collected via extant self-report survey questions through the AYS and BRFSS questionnaires. The AYS uses a split convenience sample (previously participating schools) x random sample (new schools) and samples over 50,000 8<sup>th</sup>, 10<sup>th</sup> and 12<sup>th</sup> graders every other year on even years. AHCCCS currently has a data sharing agreement with the Arizona Criminal Justice Commission and the Project Director will be responsible for obtaining and analyzing these data for baseline and ongoing measures. The BRFSS uses a random digit dial methodology to sample approximately 15,000 Arizona adults 18 years and older living at home and is available on an annual basis. The Opioid Epidemiologist will be responsible for providing these data to the Project Director for reporting.

Numbers and rates of opioid-related overdose deaths are collected via death certificate data and entered into the ADHS vital statistics database. These numbers are available currently on an annual basis, but through a data enhancement project currently underway at ADHS, they may become available on a more readily available basis. The Opioid Epidemiologist will be responsible for providing these data to the Project Director for reporting. In addition, through the Opioid Monitoring Initiative proposed as part of this process and the integration of current vital statistics, AHCCCS data, law enforcement and county coroner/medication examiner data, these data are also expected to become timelier. The Opioid Epidemiologist and the Data Intelligence Analyst will be responsible for providing these data to the Project Director for reporting.

Data management on process-related performance measures will occur at AHCCCS, with contracted providers and partners reporting independent numbers no less than quarterly to be aggregated by the Project Coordinator. Data integrity checks will be overseen by the Project Director. Data management and analysis on impact and outcome measures will occur across the partner agencies involved in the Opioid Monitoring Initiative and fed into AHCCCS to ensure a central location for consistent packaging and reporting to SAMHSA and for public dissemination. The Opioid Epidemiologist, the Data Intelligence Analyst and the Project Director will create reporting templates for cross-sector bulletins and event-based blasts, and the Project Director will create dashboards for iterative monitoring. The Project Director and Project Coordinator will create and submit the annual reports due to SAMHSA.

Qualitative data from the narratives will be analyzed using content analyses and computer based coding for themes. Quantitative impact and outcome data will be analyzed primarily through descriptive statistics and include percent reporting, rate per population and ratios where appropriate. Standard formulas for measuring rates of change over time and rates of difference by group will be conducted to monitor progress towards expected decreases in opioid misuse and abuse and rates of opioid-related overdose deaths. All quantitative data will involve analyses to determine disparities and group differences. For localized evaluation efforts, standard t-tests and ANOVAs will be conducted on pre-post surveys to measure participant changes in knowledge, attitudes, awareness and behavior. For localized evaluation efforts on MAT efficacy, event history analyses, and other higher order predictive statistics will be conducted by the Project Director on a subset of members in the AHCCCS claims and encounters database receiving MAT to determine comparative success for the three types of MAT modalities. If possible, local evaluation efforts will also include the Project Director analyzing treatment success among providers and venues associated with the five treatment projects designed to streamline access to MAT.

### **E3: Quality Improvement Process**

In order to identify progress towards meeting target numbers and objectives in the implementation plan, the Project Director will conduct monthly and quarterly reviews of performance measures and available impact measures. The quarterly results will be summarized by the Project Director into a progress report and highlight any sub-population disparities in access, retention or service utilization. The Project Coordinator will work with providers to develop plans to correct any disparities identified. The quarterly progress reports will also be reviewed by an inter-agency workgroup that includes AHCCCS, ADHS, DCS, the Governor's Office and key stakeholders. These data will be used to guide any alterations, amplifications or redirections needed in the corresponding statewide strategic plan and activities.