Mercer

Government Human Services Consulting

Case File Review Findings Fiscal Year 2023

Substance Use Block Grant

Arizona Health Care Cost Containment System
Division of Behavioral Health and Housing

August 21, 2024

Contents

Section 1

Executive Summary

The State of Arizona (Arizona or State), Arizona Health Care Cost Containment System (AHCCCS) engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop and implement an independent peer review for persons who received substance use treatment services through federal Substance Use Block Grant (SUBG) funds between July 1, 2022, and June 30, 2023. To ensure compliance with 45 CFR § 96.136, Mercer uses an independent case review (ICR) process. Mercer completed ICRs for the State in state fiscal year (SFY) 2020, SFY 2021, and SFY 2022 for AHCCCS, with this report representing the fourth year, allowing identification of year-over-year trends in continuous improvement of services.

For this current ICR process, a qualitative data collection component was added through the use of focus groups. Focus groups were conducted with AHCCCS Complete Care plans with Regional Behavioral Health Authorities (ACC-RBHAs), providers, and members. Findings from the ICRs helped to frame a guided interview format to use with focus group participants, to create a learning collaborative environment to help enhance program application and practice. This is the second year the focus groups were added to the process. Therefore, as with the quantitative data, any trends from the focus groups are noted below and in Appendix D.

The core dimensions and elements of the ICR tool have remained substantively the same for several years, predating the involvement of Mercer. Mercer worked with AHCCCS to refine the tool from year to year, to review the data elements collected, ensuring they are still relevant. Annually, Mercer performed interrater reliability testing to measure the degree of consistency among the review team's findings. In 2024, AHCCCS decided to include formal validation activities that include face, construct, and content validity of the review tool. The purpose of this validation is to evaluate the degree to which the survey measures what it intends to measure. Results of the validation have been provided to AHCCCS. Changes to the tool were not incorporated into the SFY 2023 ICR, but will be implemented in future years.

The purpose of the annual review is to examine the compliance of participating Medicaid-enrolled agencies serving persons who received substance use services through the Block Grant against treatment standards, including quality, appropriateness, and efficacy of treatment services as documented in the member records. The ICR also provides a process to continuously improve the treatment services provided to individuals diagnosed with substance use disorder within the state (see 45 CFR § 96.136 for ICR requirements) to improve member outcomes and recovery.

Consistent with the statute, Mercer licensed clinicians, experienced with alcohol and drug abuse treatment (i.e., licensed clinical social worker, two registered nurses, licensed clinical mental health counselor, licensed clinical addictions specialist, certified alcohol and drug counselor), examined the following aspects of the treatment records as part of the case file review process:

- Admission criteria (e.g., American Society of Addiction Medicines)/intake process
- Assessments and ongoing criteria (e.g., American Society of Addiction Medicines)
- Treatment planning, including appropriate referral, (e.g., prenatal care, tuberculosis, and human immunodeficiency virus services)
- Documentation of implementation of treatment services
- Engagement and reengagement
- Discharge and continuing care planning
- Indications of treatment and national outcomes (e.g., employment, education, law enforcement involvement)

In addition to the statutorily required treatment, Mercer also examined aspects of the treatment records related to assessment and addressing social determinants of health (SDoH), evidence-based treatment practices, peer support services, women's services, and opioid-specific services.

The State provided a universe of 245 records for the ICR. Of those 245 records, 19 were deemed unusable due to reasons such as the record not being complete or the member not returning after their initial assessment. Additionally, 26 records were determined to be an oversample, leading Mercer to analyze the data from a total of 200 usable records for the ICR. The files included in this review sample represented 74% of the providers in Arizona who receive SUBG funds, which exceeds the minimum statutory requirement of 5% for this review.

Overview of Key Findings

Specific findings from the ICR are presented in the body of the report, in aggregate and broken down by ACC-RBHA:

- Arizona Complete Health (Southern Arizona)
- Care 1st (Northern Arizona)
- Mercy Care (Central Arizona)

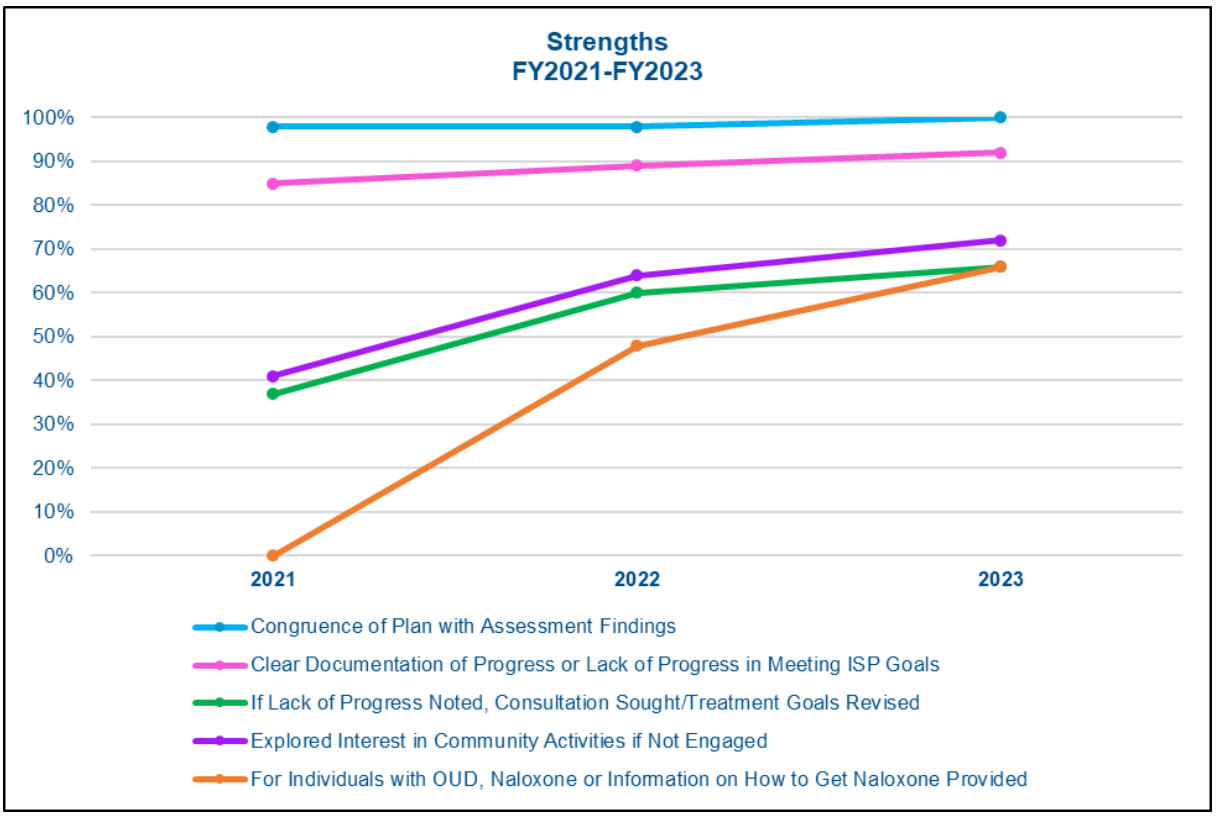
Key findings identify how the documentation demonstrates the overall effectiveness and quality of the SUBG service delivery system in Arizona. This includes how providers perform in the identification, engagement, and response to member needs through the provision of substance use disorder treatment services. Mercer also aggregated and analyzed the data by rendering providers and will make this information available separately to AHCCCS for program oversight and improvement. The following section on strengths and opportunities represents a summary of the major themes found across the system.

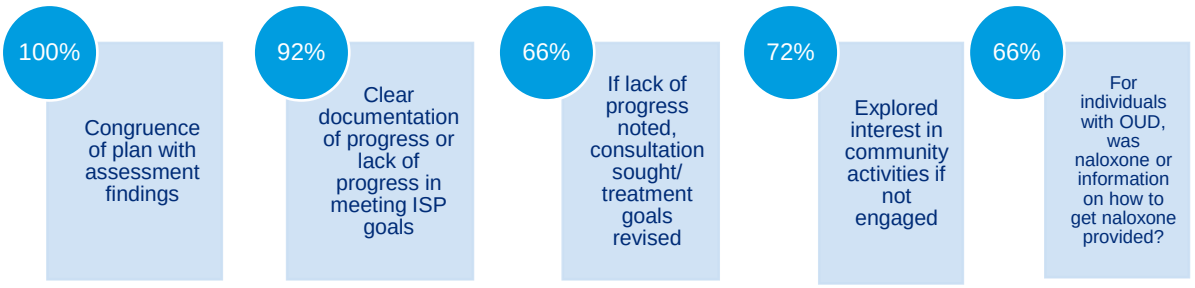
Strengths

In the review of the 2023 statewide aggregate data, there were several areas of strengths identified that have demonstrated improvement each year over the periods of 2021, 2022,

and 2023 (reflected in Graph 1). Congruence of the treatment plan tied to the assessment was 98% for 2021 and 2022, reaching 100% in 2023 findings. Clear documentation of progress or lack of progress toward treatment plan goals in the documentation has also been steadily improving, from 85% in 2021 to 92% in 2023. If lack of progress was noted, the provider sought consultation and/or revised the treatment plan 66% in 2023, an increase from 60% in 2022, and a significant increase from 37% in 2021. In terms of exploring engagement in community activities, if the member was not engaged at intake, there was a significant increase year over year, with 41% in 2021, increasing to 64% in 2022, and reaching 72% in 2023. In the area of harm reduction for individuals with an opioid use disorder (OUD) diagnosis, this measure was new in 2021, but increased from 48% in 2022 to 66% in 2023, demonstrating an increase in access to an important harm reduction medication for the OUD population.

Graph 1 – Year Over Year Aggregate Strengths

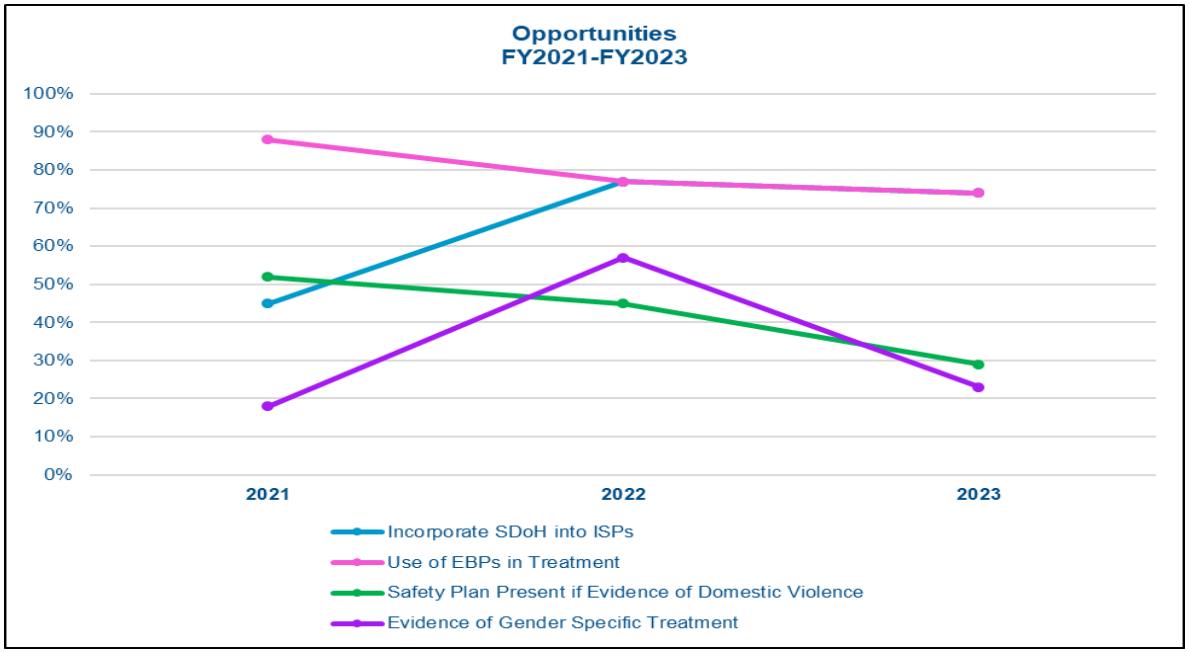




Opportunities

Opportunities identified (see Graph 2 below) as a result of the 2023 ICR include the incorporation of SDoH into the individual service plan, which has steadily declined over the past three years, from 79% in 2021 to 77% in 2022, with a significant decline to 45% in 2023. The use of evidence-based practices in treatment has also declined from 88% in 2021 to 77% (153 of 200 cases) in 2022 and 74% in 2023 (148 of 200 cases). For victims of domestic violence, although the sample size was small, there was still a year-to-year decline of evidence of a safety plan, from 52% in 2021 to 43% (12 out of 28 possible cases) in 2022, and only 29% (5 out of 17 possible cases) in 2023. Finally, there has been a decrease in the offering of gender-specific treatment services for women. This finding did increase from 18% in 2021 to 57% (37 out of 65 possible cases) in 2022 but declined to 23% (12 out of 53 possible cases) in 2023.

Graph 2 – Year Over Year Aggregate Opportunities



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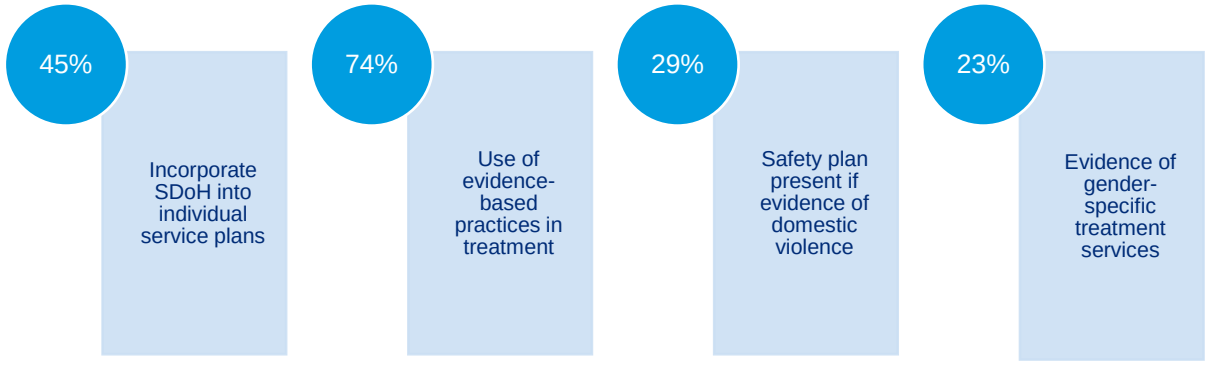


Recommendations

The following recommendations are presented as areas of improvement for consideration, based on the analysis of documented services though the ICR process. A more detailed outline of recommendations can be found in Section 6 of this report.

Consistent with prior year recommendations, there would be benefit in training on additional evidence-based practices as well as incorporating SDoH into treatment. Focus groups with ACC-RHBAs and providers did note that efforts are being made to increase availability of evidence-based practices, which may impact future findings. Gender-based services would also benefit from a focus on increased evidence-based practices such as trauma informed care and assessment for co-occurring conditions such as eating disorders.[1] It was noted that an additional concern in the area of SDoH was a lack of available resources for areas such as housing and transportation, which may be contributing to the decline in this area.

[1] TIP 51 Substance Abuse Treatment Addressing the Specific Needs of Women (samhsa.gov)

Section 2

Background and Introduction

Arizona Health Care Cost Containment System (AHCCCS) serves as the single state authority to provide coordination, planning, administration, regulation, and monitoring of all facets of the State public behavioral health (BH) system. AHCCCS contracts with managed care organizations, known as AHCCCS Complete Care (ACC) plans to administer the Medicaid and Kids Care (Title XIX/XXI) programs. Three of the ACC plans are ACC plans with Regional Behavioral Health Authorities, known as ACC-RBHAs, which administer Non-Title XIX/XXI BH programs, including the Substance Use Block Grant (SUBG). The current ACC-RBHAs are Arizona Complete Health (AzCH) (Southern Arizona), Care 1st (Northern Arizona), and Mercy Care (MC) (Central Arizona). Effective October 1, 2022, Care 1st replaced Health Choice as the Northern ACC-RBHA.

Consistent with the requirements of 45 CFR § 96.136, AHCCCS contracted with Mercer as the independent peer review contractor to perform the annual SUBG independent case review (ICR) for state fiscal year (SFY) 2023. Mercer also completed the independent review of the three previous years (SFY 2020, SFY 2021, and SFY 2022). Mercer does not have any reviewers employed as treatment providers or who have administrative oversight for any programs under review. Further, Mercer's peer review personnel performed this review independently (i.e., separately) from SUBG funding decision makers. The Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded the SUBG to AHCCCS each year since the current program was established in 1993; the block grant requires AHCCCS to produce, on an annual basis, an independent peer review of the treatment services provided with SUBG funds.

Goals of the Independent Case Review

The primary objective of this review is to determine that the level of quality and appropriateness of care being provided through the use of SUBG funds is in accordance with federal SUBG requirements noted in 45 CFR § 96.136 and to determine whether the provision of substance use disorder (SUD) services aligns with the program goals for the Arizona SUBG. According to State guidance, *quality* is the provision of treatment services, which, within the constraints of technology, resources, and patient/member circumstances, will meet accepted standards and practices to improve patient/member health and safety status in the context of recovery. *Appropriateness* means the provision of treatment services, consistent with the individual's identified clinical needs and level of functioning.

For the current year, SFY 2023, AHCCCS program goals for the SUBG include:

1. To ensure access to a comprehensive system of care, including employment, housing services, case management, rehabilitation, dental services, and health services as well as SUD services and supports

2. To promote and increase access to evidence-based practices for treatment, to effectively provide information and alternatives to youth and other at-risk populations to prevent the onset of substance use or misuse
3. To ensure specialized, gender-specific, treatment as specified by AHCCCS and recovery support services in outpatient/residential treatment settings for females who are pregnant or have dependent children and their families
4. To ensure access for underserved populations, including youth, residents of rural areas, veterans, pregnant women, women with dependent children, people who inject drugs, and older adults
5. To promote recovery and reduce risks of communicable diseases
6. To increase accountability through uniform reporting on access, quality, and outcomes of services

AHCCCS decided to assess the level of quality and appropriateness of SUD treatment in the state through an examination of clinical records maintained by programs receiving SUBG funds. A team of Mercer licensed and certified clinicians (who have expertise in managed care, block grants, SUD treatment, American Society of Addiction Medicine [ASAM] criteria, and clinical best practices) systematically reviewed each of the files selected as part of the review sample. These independent clinicians examined SUD treatment records for the presence (or absence) of previously selected, evidence-based factors that would be expected to be present in high-quality, appropriate treatment (which includes engagement, planning, and discharge).

The following domains were examined to determine the appropriate treatment engagement, planning, and discharge activities (see Appendix A for specific review items in each domain):

- Intake and treatment planning, to include identification of social determinants of health (SDoH) needs
- Placement criteria and assessment
- Best practices
- Treatment, support services, and rehabilitation services
- Gender-specific (female only)
- Opioid-specific
- Discharge and continuing care planning (only for successful treatment completions or decline of further services)
- Reengagement (only for decline of further services or chose not to appear for services)
- National Outcome Measures (NOMs) at intake and discharge

Content of Records Reviewed

Based upon the requirements of the annual ICR report to SAMHSA, a sample of treatment records was requested and provided by the ACC-RBHAs. Clinical records vary from provider to provider but typically include the following key documents and captured data elements, which were evaluated:

- Demographic information
- Initial assessment
- Risk assessment and safety plan
- Crisis plan
- Individual service plan (ISP)
- ASAM patient placement criteria (initial and ongoing)
- Medication record
- Medical screenings
- Results of diagnostic testing, including illicit substance use testing
- Progress notes (e.g., therapy [individual and group], case management, etc.)
- Medication-assisted treatment (MAT) documentation
- Evidence of outreach and engagement efforts
- Discharge or termination of treatment summary

Mercer used these documents, and any others contained in the individual records, to assess the level to which providers receiving SUBG funds in Arizona are providing comprehensive and timely assessment, planning, engagement, treatment, and discharge services to members with a SUD diagnosis.

Section 3
Methodology

AHCCCS provided the files for the ICR through the State's secure file transfer protocol. No files were downloaded or saved to Mercer staff computers or hard drives. All Mercer staff that had access to AHCCCS files complete Protected Health Information and Health Insurance Portability & Accountability Act training annually and were also debriefed on AHCCCS privacy practice expectations. All member record files were stored and accessed through a secure file transfer protocol site managed by AHCCCS. Each Mercer reviewer received a secured sign-in to the agency's site to ensure all file health information remained protected. Each case was assigned a sample ID for data entry of the results of the case review. Mercer completed all ICR activities virtually, with no on-site reviews or in-person team meetings, during the ICR part of the independent peer review.

Data entry of findings from each case review was entered by Mercer clinicians into a customized, password-protected, Microsoft Access review tool.

Sampling

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

- Substance use members with a substance use treatment service and an episode of care (EOC) funded by the SUBG during SFY 2023: July 1, 2022 through June 30, 2023
- Disenrolled/EOC end date before or on June 30, 2023
- At least 18 years of age during the treatment episode
- Disenrolled due to completing treatment, declining further service, or lack of contact
- Must have received substance use treatment during the treatment period. Treatment was defined by identifying individuals that had at least one paid claim for a substance use service during SFY 2023 for any ASAM level of care (LOC)
- Must have been enrolled in a treatment center for at least 30 days
- Must not be enrolled in a Tribal Regional Behavioral Health Authority

The sampling methodology used by AHCCCS excluded individuals who:

- Did not have any treatment service encounters during the EOC
- Only had assessment services and no treatment services during the EOC
- Only had a withdrawal management hospitalization encounter during the treatment episode (ASAM. Level 4/4 WM)
- Only had services provided by an individual private provider

Based on these inclusion and exclusion criteria, AHCCCS supplied 245 treatment records for the ICR. Mercer randomly selected 200 files to be used in the initial review, with the remainder being held as an oversample. Twenty-six files were determined to be unusable for review purposes (e.g., an exclusion criterion was found in the file, or the treatment dates were out of range) and were replaced from the oversample.

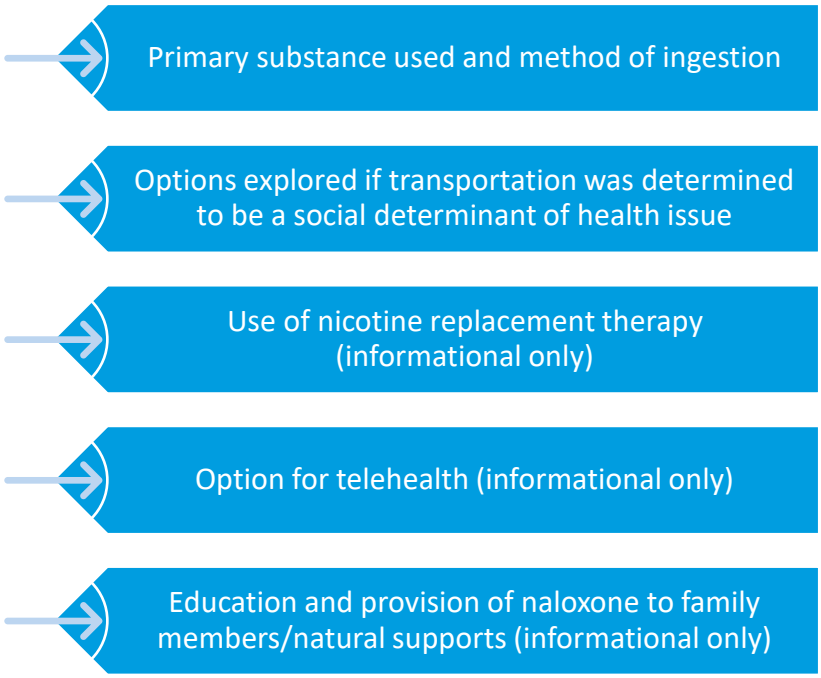
File Tool Review

As with the prior SUBG review, the Mercer team used the previously updated SFY 2022 ICR tool as the source for development of the SFY 2023 ICR tool. The e-version of the tool, which was developed in Microsoft Access, allowed the review team to record review results in a format more conducive to analyzing the data and producing year-over-year trending and useful tables for presentation.

To ensure information collected continues to be in alignment with current developments in the substance use treatment system, Mercer collaboratively reviewed the existing ICR tool with AHCCCS and five new items incorporated into the tool. These items are listed below for reference. Some items collected are noted to be informational only, as they are not requirements of providers but are meant to provide additional information on the SUBG system to AHCCCS. Primary substance used and method of ingestion have been added for demographic purposes. No items from the previous tool were deleted, allowing all previously collected elements to be compared across years.

File Review Tool Enhancements

The items listed below were additions/enhancements to the SFY 2023 ICR tool:



Inter-Rater Reliability

The review team from Mercer consisted of licensed clinicians and certified counselors (two registered nurses, two master's level BH providers, and one certified alcohol and drug counselor). A sixth member of the team provided data analytic services and ensured consistency in the application of project standards. All of the reviewers participated in conducting ICRs in the previous year.

To ensure consistency in the use of the file review tool, the Mercer review team participated in an inter-rater reliability (IRR) training session followed by an IRR test prior to the initiation of the review process. The test consisted of a vignette that approximated the information included in a SUD treatment record as well as a unique live record for each reviewer. Participants used the ICR tool to score the vignette and live records, consistent with the review training session provided by the senior engagement advisor, who is a licensed clinical social worker, and the ICR Tool Instructions (Appendix B).

The Mercer senior engagement advisor facilitated the IRR and recorded the answers from each individual reviewer. Any items that yielded inconsistent results were discussed with each reviewer. As a result of this discussion, the team reached a consensus decision on how items would be scored. The initial review of the vignette and live records yielded an IRR average score of 90%, while the team reached 100% agreement following discussion and consensus building.

Throughout the evaluation, which occurred during April and May 2024, the senior engagement manager maintained frequent contact with individual reviewers, answered questions regarding the application of the ICR Tool Instructions, and ensured the consistent application of the tool scoring methodology. Additionally, to ensure fidelity to the scoring approach, the team met biweekly during the review process for group debriefs and problem-solving related to the application of the ICR Tool Instructions.

Data Analysis

Mercer clinicians entered findings from each individual case review into a customized, password-protected, Microsoft Access review tool. After the reviews were complete, the data was exported into Microsoft Excel and aggregated into a final blinded dataset for analysis purposes. Data checks were performed to ensure consistent and complete data was received. Descriptive statistics were calculated to summarize the characteristics of the findings from the case reviews. The analysis focused on measures of variability, with tables and graphs reflecting the dispersion of data for key case review goals. Output tables were programmed with formulas reflecting the instructions for record review data entry (Appendix B). Results were technically peer reviewed for accuracy and reasonableness.

Limitations

Although IRR methodology, tool training, and reviewer coaching facilitates accurate review findings for the ICR results, individual experience, as well as discipline-specific education in substance use treatment, may still result in some irregularities in interpretation of case review contents. Mercer did not design the original ICR tool used in the file review process, nor did Mercer complete a separate and independent validation of the tool. Therefore, Mercer cannot attest to the reliability and validity of the tool used in the current ICR. AHCCCS requested

that Mercer conduct a validation of the tool for use in next year's ICR. The results of the validation were provided to AHCCCS for incorporation into future reviews.

The data collection period of review for this project (July 1, 2022–June 30, 2023) includes some lingering impact of the COVID-19 pandemic during the beginning of the sample period, which introduced multiple complicating factors into the SUD treatment landscape (e.g., loss of in-person treatment, implementation of telehealth practices, etc.). The federal unwinding of the Public Health Emergency occurred March 31, 2023, and there should no longer be any further impact from the pandemic in next year's ICR. There is no reliable way to fully account for COVID-19's multiple impacts on individual member choices (e.g., reactions to the shift to telehealth interventions, treatment efficacy of virtual SUD treatment, and the resultant treatment outcomes). As described in more detail in the sections below, there is evidence that programming is returning to pre-COVID levels. This includes more in-person assessments, treatment planning, and treatment sessions. Many providers have maintained a hybrid model, allowing members to receive services both in-person and virtually, which has been of benefit for SDoH concerns, such as transportation and lack of childcare that may have prevented access to services in the past.

The trajectory of the COVID-19 pandemic from SFY 2020 through SFY 2023 may impact year-over-year results. An additional limitation may be the variability due to updates in the tool, which may have impacted validity or reliability. Further variables, such as the pandemic-driven shift from in-person treatment to telehealth, introduced unknown impacts on treatment outcomes that would not have been seen in any prior year ICRs. Therefore, Mercer advises caution against the comparison of ICR findings across time periods before and during the COVID-19 pandemic without further validation and evaluation of the results.

Section 4

Aggregate Case File Review Findings

The SUBG independent case review findings are organized throughout this section in aggregate by both ACC-RBHA and individual evaluation measures. This also includes demographic snapshots, records reviewed (broken down by ACC-RBHA), as well as gender and age of the population sampled. Additionally, statistics on the reasons for case closure, referral to the program, and SUBG-funded providers sampled are included for comparison purposes as in past years' reports.

Sample Demographics

The State provided a universe of 245 records for the ICR. Of those 245 records, 19 were deemed unusable due to reasons such as the record not being complete or the member not returning after their initial assessment. Additionally, 26 records were determined to be an oversample, leading Mercer to analyze the data from a total of 200 usable records for the ICR. Mercer's record review represented 26% of the AzCH records, 11% of the Care 1st records, and 64% of the MC records of the respective records provided (see Table 4-1 below).

The sample of records reviewed closely mirrors the percentages of members enrolled in each ACC-RBHA. This reflects a comparably sufficient sample for each of the ACC-RBHAs, based upon the records that were made available at the time of the review.

Table 4-1: Distribution of Case File Review Sample by ACC-RBHA

ACC-RBHA	Universe of Records Received for ICR Review (including oversample)	Number of Usable ICR Records Reviewed	Number of ICR Records Reviewed but Unusable	Unusable ICR Records Reviewed as a Percent of Universe	ICR Sample Records Reviewed as a Percent of Universe	Percent of ICR Records Reviewed
AzCH	61	51	4	7%	84%	26%
Care 1st	41	21	2	5%	51%	11%
MC	143	128	13	9%	90%	64%
Total	**245**	**200**	**19**	**8%**	**74%**	**100%**

Table 4-2 shows the gender and age distribution by ACC-RBHA. Overall, the mean age served in the sample was 41.1 years, with a median of 39.0 years. Twenty seven percent of the sample identified as female, 73% male, and no members identified as "Other". The youngest age represented in the total sample was 19 years of age. The age of the oldest represented was 72 years.

Table 4-2: Distribution of Case File Review Sample by Gender and Age

ACC-RBHA	Sample Cases	Percent of Sample	Gender						Age (Years)	
			Female		Male		Other			
			N	%	N	%	N	%	Mean	Median
AzCH	51	25.5%	7	14%	44	86%	0	0%	38.0	35.0
Care 1st	21	10.5%	5	23%	16	77%	0	0%	42.6	41.0
MC	128	64.0%	42	33%	86	67%	0	0%	41.7	41.5
Total	**200**	**100%**	**54**	**27%**	**146**	**73%**	**0**	**0%**	**39.0**	**39.0**

Sample Characteristics

Members chosen for the sample must have been disenrolled or have had an EOC with a closure date within SFY 2023 (July 1, 2022 to June 30, 2023), with a final case closure date no later than June 30, 2023. Any documentation included in records that were outside of this date range was not considered for this review. Closure reasons include *Client Declined Further Service*, *Lack of Contact*, *Treatment Completion*, and *Transfer* (individual was incarcerated, moved, or no longer on Medicaid). The most frequent reason for case closure during this period was *Lack of Contact* (38%), followed by *Treatment Completion* (33%). This represents a reversal over last year's finding as *Treatment Completion* was the most common reason for case closure.

Table 4-3: Distribution Based on Case Closure Reason

ACC-RBHA	Number of Sample Cases	Client Declined Further Treatment		Lack of Contact		Treatment Completion		Transfer	
	N	N	%	N	%	N	%	N	%
AzCH	51	14	28%	24	47%	12	24%	1	2%
Care 1st	21	4	19%	6	29%	11	52%	0	0%
MC	128	32	25%	46	36%	43	34%	7	6%
Total	**200**	**50**	**25%**	**76**	**38%**	**66**	**33%**	**8**	**4%**

The rates for the most frequent source of referral to SUD treatment are shown in Table 4-4 below. "Criminal Justice/Correctional" includes the Administrative Office of the Courts, Arizona Department of Corrections, Arizona Department of Juvenile Corrections, jail/prison, and probation. "Other" includes physical health providers, State agencies, crisis, and unknown sources. Overwhelmingly, self-referral or referral by family or friends was the most frequent referral source (62%, which is 6% higher than the previous period of 54%).

Table 4-4: Source for Referral

ACC-RBHA		Criminal Justice/ Correctional		Other BH Provider		Self/Family/ Friend		Other	
	Sample Cases	N	%	N	%	N	%	N	%
AzCH	51	19	37%	4	8%	26	51%	2	4%
Care 1st	21	6	29%	1	5%	14	67%	0	0%
MC	128	25	20%	13	10%	78	61%	12	9%
Total	**200**	**50**	**25%**	**18**	**9%**	**118**	**59%**	**14**	**7%**

Aggregate Review Findings

The tables (4-5 through 4-15) below contain the aggregate record review findings. As noted in the Methodology section, a majority of the measures remain the same as those used in the previous year. Tables reflecting new measures do not have a comparison to previous years' findings, and the new measure is flagged in the 2021 findings column. The denominators primarily consisted of the sum of "Yes" or "No" responses and, as such, differ across the measures. The denominators of certain indicators were based on the number of "Yes" responses from a prior question when applicable. For example, the denominators for I.C.1 through 9 equate to the numerator for *I.C. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?* Certain measures allowed for a response of "Not Applicable" (N/A); N/As are not included in any denominator, consistent with prior years' analyses. Measures marked with an asterisk in the "N/A" column indicate that "N/A" was not a valid response option for that measure. Additionally, certain measures included an option for missing documentation. Narrative information was also collected on the following measures (see full set and description of measures in Appendix A) and incorporated into the Findings section prior to the respective table. Throughout each table, improvements (green) and declines (pink) have been color coded to reflect the comparison of findings from the previous year's review period. **In some cases, a number may be higher than the previous year but is coded pink due to the outcome being a negative trend.** For example, a question about whether or not documentation was present may have a higher number of responses but is, in fact, a negative finding, as the documentation should have been present. **These items are noted with a double asterisk**. For findings in which the results are the same from one year to the next, results have been shaded in grey to indicate no change. In the N/A column, N/A was not an option for some questions. In those instances, a dash was used instead of a number to indicate N/A was not an option.

Finally, a Comments tab allowed reviewers to enter narrative detail regarding the reviewed record, to complete the clinical picture as needed.

Although these findings represent an aggregation of data from record reviews and an underlying root cause analysis for trends has not been conducted, additional qualitative information on the potential reasons for the findings in different areas can be found in Appendix D under focus group summary discussions. These discussions point to strengths

and areas of opportunities and concerns, as noted by providers and ACC-RBHAs, that could have an impact on results from record reviews.

Measure I — Intake/Treatment Planning Key Findings

Initial Behavioral Health Assessment

Mercer reviewed 200 total records for the State and found 97% of the records contained evidence that an initial BH assessment was completed within 45 days of the initial appointment. As part of the initial assessment, providers successfully documented compliance with the required components of the assessment (Items C1–9), with a range of 17% to 100%. The highest scoring areas include *completion of risk assessments* (100%), and *the BH assessment described the intensity and frequency of substance use* (97%).

The areas of lowest performance were documentation of review of the Prescription Drug Monitoring Program (PDMP) (17%, down from 22% in FY 2022), hepatitis C, human immunodeficiency virus (HIV), and other infectious disease screening 44%, down from 53% in FY 2022), and tuberculosis (TB) screening (40%, down from 46% in FY 2022). The low performance area metrics were the same as the previous period, with metrics all decreasing from prior year results. The consistent decline in reviewing the PDMP is important to note, as 42% of members were diagnosed with an opioid use disorder (OUD). Not all providers are required to check the PDMP to determine whether an individual has been prescribed a controlled substance. The Center for Disease Control (CDC) recommends, at a minimum, it should be reviewed for individuals receiving opioids for pain, but does note other considerations. Targeted providers prescribing additional substances should review the PDMP, although PDMP information could be useful for all providers to determine whether information collected in biopsychosocial assessments regarding controlled substances prescribed and used is accurate.[2]

New items added this year in the assessment section include a review of substances used and methods of use. Opioids were the most commonly used substance at 42%, followed closely by alcohol at 41%. Smoking was the primary method of ingestion at 47%, followed by oral at 44%. Substances documented under the free text box marked “Other” included fentanyl, Ecstasy, and benzodiazepines.

Individual Service Plan

Record reviews found an ISP was completed for the member’s treatment within 90 days of the initial appointment in 94% of the reviewed cases. One hundred percent of these cases demonstrated congruence between the ISP and presenting concerns. This represents a 5% decrease from prior results for ISP completions and a 2% increase from the last review for ISP congruence and presenting problems. Another strength to note is 100% of the ISPs documented measurable objectives and timeframes to address the identified needs. This is a 4% increase from last year.

Thirteen percent of ISPs were developed with participation of the member’s family support/network (the same as last year at 13% previously). Support is a critical component of

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recovery and treatment. Focus groups with providers had targeted questions related to family engagement that noted several reasons for limited family participation, including many individuals in treatment having lost family connections and requiring time to reengage, with some success in reunification as individuals go through longer-term treatment.

Reviewers also noted whether or not SDoH were considered and incorporated as part of the ISP. This number significantly declined from 77% in SFY 2022 to 45% in SFY 2023. SDoH concerns were stratified by access to medical care (20%, down from 23% the previous year), housing (21%, a decrease from 39% last year), food insecurity (4%, the same as the previous year), domestic violence (3%, a decrease from 5% in the previous year), and unemployment (24%, a significant decrease from 41% in the previous year). Transportation was added as a SDoH in the current year review, and 11% of cases reflected transportation as a SDoH concern.

Table 4-5: Assessment and Individual Service Plan

	Denominator	# of Yes 2023	% of Yes 2023	# of N/A 2023	% of Yes FY 2022	% of Yes FY 2021
A. What was the primary substance used?*						
• Opioids	200	84	42%	-	New Measure	
• Marijuana	200	34	17%	-	New Measure	
• Alcohol	200	82	41%	-	New Measure	
• Amphetamines	200	50	25%	-	New Measure	
• Cocaine	200	21	11%	-	New Measure	
• Other (please list)	200	8	4%	-	New Measure	
B. What was the method of ingestion?*						
• Smoking	200	94	47%	-	New Measure	
• Oral	200	88	44%	-	New Measure	
• Inhalation	200	22	11%	-	New Measure	
• Injection	200	13	7%	-	New Measure	
• Transdermal	200	0	0%	-	New Measure	
• Other (please list)	200	15	8%	-	New Measure	
C. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	200	193	97%	1	97%	95%
Did the behavioral health assessment:						
1. Address substance-related disorder(s)?	193	167	87%	0	99%	100%

	Denominator	# of Yes 2023	% of Yes 2023	# of N/A 2023	% of Yes FY 2022	% of Yes FY 2021
2. Describe the intensity/frequency of substance use?	193	184	95%	0	93%	96%
3. Include the effect of substance use on daily functioning?	193	185	96%	0	93%	96%
4. Include the effect of substance use on interpersonal relationships?	193	181	94%	0	95%	90%
5. Was a risk assessment completed?	193	193	100%	0	100%	99%
6. Document screening for TB?	193	84	44%	0	46%	42%
7. Document screening for hepatitis C, HIV, and other infectious diseases?	193	77	40%	0	53%	26%
8. Document screening for emotional and/or physical abuse/trauma issues?	193	186	96%	0	95%	97%
9. Document that review of the PDMP was completed?	169	30	18%	23	22%	29%
D. Was there documentation that charitable choice requirements were followed, if applicable?	20	17	85%	176	69%	75%
E. Was an ISP completed within 90 days of the initial appointment?	193	181	94%	3	99%	98%
Was the ISP:						
1. Developed with participation of the family/support network?	181	24	13%	122	13%	8%
2. Congruent with the diagnosis(es) and presenting concern(s)?	181	181	100%	0	98%	98%

	Denominator	# of Yes 2023	% of Yes 2023	# of N/A 2023	% of Yes FY 2022	% of Yes FY 2021
3. Measurable objectives and timeframes to address the identified needs?	181	181	100%	0	96%	96%
4. Addressing the unique cultural preferences of the individual?	181	180	99%	0	93%	84%
5. Were SDoH issues considered as part of, and incorporated into, the ISP?	181	82	45%	0	77%	79%
a. Access to Medical Care	181	36	20%	-	23%	New Measure
b. Housing	181	38	21%	-	39%	New Measure
c. Food Insecurity	181	7	4%	-	4%	New Measure
d. Domestic Violence	181	5	3%	-	5%	New Measure
e. Unemployment	181	43	24%	-	41%	New Measure
f. Transportation	181	20	11%	-	New Measure	

*Substance used and method of ingestion represent information on preferred substances. In some cases, multiple substances were reported as the primary substance for members with polysubstance use conditions because it was hard to discern in the record.

Measure II — Placement Criteria/Assessment Key Findings

Reviewers found that 83% of records reviewed used ASAM Patient Placement Criteria to determine the appropriate level of service. This is the same result as SFY 2022, denoting a trending decrease of 9% from 2021 when this metric was 92%. In records in which ASAM Placement Criteria was used, documentation showed that 87% of the member received the LOC identified by the ASAM criteria. This represents a 9% decrease from last year's results. Documentation demonstrated the use of the ASAM criteria to reassess the proper LOC during treatment in 43% of cases, which was an 11% decrease from the previous review. In fiscal year (FY) 2023, providers documented performance to 58% on the use of other (or additional) assessment tools during the course of treatment, indicating improvement across the three-year review period, from 41% in 2021 to 50% in 2022 and 58% in 2023, increasing the use of standardized assessments of substance use in general, despite the decline in the use of ASAM criteria. Additional assessment tools used are as follows:

- Comparative Pain Scale

- Substance Abuse Subtle Screening Inventory
- DSM 5
- Screening Instrument for Substance Abuse (UNCOPE)
- Clinical Opioid Withdrawal Scale
- Protocol for Responding To and Assessing Patient Asset, Risk, and Experience
- Drug Abuse Screening Test (DAST)
- Cut, Annoyed, Guilty, and Eye-Opener (CAGE)
- Addiction Severity Index
- Michigan Screening Alcohol Test
- URICA
- DLA-20
- CASII
- PRAPARE
- PHQ-9
- AASE
- GAD-7
- CIWA
- Columbia Suicide Scale
- PHQ-2
- Global Assessment of Functioning (GAF)
- CRAFFT
- ACES

Table 4-6: Placement Criteria/Assessment

	Denominator	# of Yes 2023	% of Yes 2023	# of N/A 2023	% of Yes FY 2022	% of Yes FY 2021
A. Was there documentation that ASAM dimensions were used to determine the proper level of care at intake?	200	166	83%	0	83%	92%
If the ASAM Placement Criteria were used, the level of service identified was:						
Level 0.5: Early Intervention	166	2	1%	-	1%	1%
OMT: Opioid Maintenance Therapy	166	45	27%	-	16%	19%
Level 1: Outpatient Treatment	166	70	42%	-	45%	63%
Level 2: Intensive Outpatient Treatment/Partial Hospitalization	166	32	19%	-	12%	10%
Level 3: Residential/Inpatient Treatment	166	34	20%	-	42%	24%
Level 4: Medically Managed Intensive Inpatient Treatment	166	0	0%	-	1%	1%
B. Did the member receive the level of services identified by the placement criteria/assessment?	166	144	87%	0	96%	93%
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	166	72	43%	0	54%	50%
D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	200	115	58%	0	50%	41%

Measure III — Best Practices Key Findings

Using evidence-based practices (EBPs) when providing services can support recovery from substance use disorders, prevent relapse, and improve other outcomes. The use of EBPs can also ensure consistency across facilitators and programs. Reviewers found that 74% of

sampled cases contained documentation that EBPs were used in treatment; this is a 3% decrease from the last reporting period. The top three most widely used EBPs found were motivational enhancement/interviewing therapy (53%, up from 44% previously), cognitive behavioral therapy (44%, down from 82% previously), and relapse prevention therapy (27%, down from 54% previously). MAT for substances, including alcohol and opioids, was documented in 37% of all case files (down from 41%); this is a 4% decrease. Seventy-four percent of individuals were prescribed methadone, the most frequently used medication (5% increase from previous reporting period). Twelve percent of individuals were prescribed Suboxone, the second most frequently used medication.

Consistent with last year's review, reviewers did not find evidence of Adolescent Community Reinforcement Approach (ACRA), Beyond Trauma: A Healing Journey for Women, and Contingency Management being used by SUD programs during this review period. While evidence of the use of Moral Re-conation Therapy (MRT) and Thinking for a Change were present in the last review, they were not present during this review period. Wellness Recovery Action Plan (WRAP) use did increase 2% from the previous year, when it was not used at all.

The EBPs listed in the master tool were compiled based on the most commonly utilized practices in the field but were not meant to be all-inclusive. A review of the EBPs chosen next year should be done to ensure they continue to be appropriate and capture the most commonly used methodologies.

Reviewers were able to note other EBPs used under an option marked "Other," with a free text box to denote the EBP delivered. Thus, the findings are complete for the universe of records reviewed, as all EBPs were able to be captured. Additional interventions (7%) used by providers included:

- Acceptance and Commitment Therapy
- Living in Balance
- 12-Step Program

As part of the EBP data collection, reviewers identified 45% of cases (3% increase) in which the provider offered peer support services as part of treatment. Of these cases, reviewers found that 60% agreed to and received peer support services as part of treatment. It should be noted this is a 6% decrease from previous results. Reviewers also tracked the number of cases that had evidence of screening for ongoing substance use during treatments and found this happened in 55% of cases (11% decrease).

Table 4-7: Best Practices

	Denominator FY 2023	# of Yes FY 2023	% of Yes FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. Were EBPs used in treatment?	200	148	74%	77%	88%
• Cognitive Behavioral Therapy (CBT)	148	65	44%	82%	56%

	Denominator FY 2023	# of Yes FY 2023	% of Yes FY 2023	% of Yes FY 2022	% of Yes FY 2021
• Dialectal Behavioral Therapy (DBT)	148	19	13%	12%	11%
• Helping Women Recover	148	2	1%	0%	2%
• Matrix	148	14	9%	10%	16%
• Moral Re-conation Therapy (MRT)	148	0	0%	1%	3%
• Motivational Enhancement/Interviewing Therapy	148	78	53%	44%	27%
• Relapse Prevention Therapy (RPT)	148	40	27%	54%	15%
• Seeking Safety	148	1	1%	11%	5%
• SMART Recovery	148	12	8%	18%	10%
• Thinking for a Change	148	0	0%	1%	1%
• Trauma Recovery and Empowerment Model (TREM)	148	1	1%	1%	0%
• Trauma-Informed Care (TIC)	148	2	1%	11%	2%
• Wellness Recovery Action Plan (WRAP)	148	3	2%	0%	1%
• Other Practices or Program	148	11	7%	24%	27%

Table 4-8: Medication Assisted Treatment and Peer Support

	Denominator FY 2023	# of Yes FY 2023	% of Yes FY 2023	% of Yes FY 2022	% of Yes FY 2021
Medication-Assisted Treatment	200	73	37%	41%	31%
A. The following medication was used in treatment:					
Alcohol-Related					
• Acamprosate (Campral)	73	1	1%	0%	0%
• Disulfiram (Antabuse)	73	1	1%	1%	3%
Opioid-Related					
• Subutex (buprenorphine)	73	2	3%	4%	3%
• Methadone/Levo-Alpha-Acetylmethadol (LAAM)	73	54	74%	69%	73%

	Denominator FY 2023	# of Yes FY 2023	% of Yes FY 2023	% of Yes FY 2022	% of Yes FY 2021
• Narcan (naloxone)	73	16	22%	0%	5%
• Vivitrol (long-acting naltrexone)	73	3	4%	5%	5%
• Suboxone (buprenorphine-naloxone)	73	9	12%	22%	18%
B. Was screening for substance use/abuse conducted during the course of treatment?	200	109	55%	66%	55%
C. Was certified peer support offered as part of treatment?	200	90	45%	42%	26%
D. If yes to C, were certified peer support services used as a part of treatment?	90	54	60%	66%	52%

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

The most frequently used treatments were case management (92%, up 10%), individual counseling/therapy (75%, down 3%), and group counseling/therapy (69%, down 11%). For those individuals who received counseling, 51% attended more than 11 sessions (6% decrease), 15% attended six to 10 sessions (4% increase), and 34% attended zero to five sessions (2% increase). One individual received family counseling in the previous reporting period, and three individuals participated in family counseling/therapy this review period. Although only a slight increase, it is a move in a positive direction.

Reviewers also tracked the number of files in which documentation supported attendance in self-help or recovery group sessions. Sixty-six percent of cases had no documentation of attending self-help or recovery group sessions compared to 57% in the previous reporting period. Of those that did document this metric (34%), 10% of individuals have documentation they attended zero times during treatment, 4% attended one to four times, 7% attended five to 12 times, 2% attended 13 to 20 times, and 13% of individuals attended 21 or more times during treatment.

Table 4-9: Treatment/Support Services/Rehabilitation Services

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A 2023	% of Yes FY 2022	% of Yes FY 2021
A. The following services were used in treatment:						
• Individual counseling/ therapy	200	149	75%	0	79%	63%
• Group counseling/therapy	200	138	69%	0	80%	75%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A 2023	% of Yes FY 2022	% of Yes FY 2021
• Family counseling/therapy	200	3	2%	0	1%	0%
• Case management	200	184	92%	0	82%	78%
B. Was there clear documentation of progress or lack of progress towards the identified ISP goals?	200	184	92%	3	89%	85%
C. The number of completed counseling/therapy sessions during treatment was:						
• 0–5 sessions	199	68	34%	0	32%	36%
• 6–10 sessions	199	29	15%	0	11%	16%
• 11 sessions or more	199	102	51%	0	57%	49%
D. Was the individual given any education on self-help or recovery groups?	199	132	66%	1	74%	New Measure
E. Documentation showed that the member reported attending self-help or recovery groups the following number of times:						
• No documentation	200	132	66%	0	57%	80%
• 0 times during treatment	200	19	10%	0	4%	5%
• 1–4 times during treatment	200	7	4%	0	6%	6%
• 5–12 times during treatment	200	13	7%	0	6%	3%
• 13–20 times during treatment	200	4	2%	0	6%	2%
• 21 or more times during treatment	200	25	13%	0	23%	5%
F. If there was evidence of lack of progress towards the identified goal, did the provider revise the treatment approach and/or seek consultation to facilitate positive outcomes?	106	70	66%	91	60%	37%
G. If the member was unemployed during intake, was there evidence that the	88	71	81%	110	84%	75%

		Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A 2023	% of Yes FY 2022	% of Yes FY 2021
	individual's interest in finding employment was explored?						
H.	If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	69	49	71%	114	64%	38%
I.	If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	89	64	72%	101	64%	41%
J.	Does the documentation reflect that substance abuse services were provided?	200	192	96%	0	91%	95%
K.	Was member's access to a primary care physician (PCP) or other medical provider explored?	200	161	81%	15	79%	79%

Measure V — Gender-Specific Key Findings

The total number of women's case files in the sample was 57. Providers documented 17 cases with a history of domestic violence; of those, 29% documented the completion of a safety plan. In SFY 2021, 21 women's case files documented a history of domestic violence, with 52% of these cases having a completed safety plan. Notably, this metric denotes an area for follow up, as the data shows a steady decrease in performance across the three-year review period from 52% to 45% to 29% in the current review period. The review indicated one individual was pregnant during the course of treatment. The review indicated that this individual had no documentation supporting that SUD provider staff made efforts to coordinate care with the women's PCP and/or obstetrician. There was also no evidence of education on the effects of substance use on fetal development. These services may have

been provided but not documented. Gender-specific treatment services provided also decreased from last year from 57% to 23%.

Table 4-10: Gender-Specific (Female Only)

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A 2023	% of Yes FY 2022	% of Yes FY 2021
A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	17	5	29%	41	45%	52%
B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	1	0	0%	56	50%	75%
C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?	1	0	0%	56	50%	50%
D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/ psychosis?	3	1	33%	54	67%	50%
E. If the female had dependent children, was there documentation to show that childcare was addressed?	16	13	81%	40	83%	91%
F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	53	12	23%	4	57%	18%

Measure VI — Opioid-Specific Key Findings

Reviewers observed documentation indicating an OUD diagnosis in 45% of the cases, compared to 54% of the cases in SFY 2022. Of these cases, 81% demonstrated evidence of education on MAT as a treatment option, and 97% of those who were provided this

education were also referred to a MAT provider. Documentation showed MAT providers educated the member on overdose, naloxone, and steps to take in the event of an overdose in 67% of the cases, and 66% were either directly provided naloxone or provided resources on where they could obtain naloxone. It should be noted that this represents significant improvement in overdose event education and naloxone provision or resource referral, a finding mirrored in the provider focus group, where an emphasis on increased efforts toward harm reduction was discussed. These metrics were 47% and 48% respectively during the last review. Education on the effects of polysubstance abuse with opioids was provided in 68% of the cases (14% increase). In 97% of cases, providers referred members with withdrawal symptoms to a medical provider.

Table 4-11: Opioid-Specific Key Findings

	Denominator	# of Yes 2023	%of Yes FY 2023	# of N/A	% of Yes FY 2022	% of Yes FY 2021
A. Was there documentation of a diagnosed OUD?	200	90	45%	0	54%	40%
B. Was there documentation that the member was provided MAT education as a treatment option?	90	73	81%	0	85%	81%
C. If yes to VI B, were they referred to a MAT provider?	73	71	97%	9	93%	95%
D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	37	36	97%	54	98%	89%
E. If a physical health concern related to pain was identified, were alternative pain management options addressed?	18	13	72%	73	76%	56%
F. If member is a pregnant female, did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?	1	0	0%	81	33%	33%
G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to	90	60	67%	0	47%	52%

	Denominator	# of Yes 2023	%of Yes FY 2023	# of N/A	% of Yes FY 2022	% of Yes FY 2021
take in the event of an opioid overdose?						
H. Was the individual provided with naloxone or information on how to obtain naloxone?	90	59	66%	0	48%	New Measure
I. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	90	61	68%	0	54%	47%

Measure VII — Discharge and Continuing Care Planning Key Findings

The SFY 2023 sample found that 70% of cases contained evidence that a relapse prevention plan was completed with individuals who completed treatment or declined further surveys. This is the same finding from SFY 2022, in which 70% of cases documented the completion of a relapse prevention plan. Reviewers found that providers documented offering resources pertaining to community support in 58% of these cases and documented coordinating care with other agencies at the time of discharge in 68% of cases.

Table 4-12: Discharge and Continuing Care Planning (completed only if member completed treatment or declined further services)

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. Was there documentation present that a relapse prevention plan completed?	177	124	70%	0	70%	58%
B. Was the individual reassessed at the time of discharge using ASAM criteria to determine an appropriate LOC?	177	50	28%	0	48%	New Measure
C. Was the individual referred to the appropriate LOC based on the ASAM determination?	46	45	98%	75	95%	New Measure
D. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized	177	103	58%	0	67%	63%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
support services (e.g., crisis line)?						
E. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?	96	65	68%	81	61%	71%

Measure VIII — Reengagement Key Findings

In 84% of cases in which a member declined further services or did not appear for scheduled services, providers followed up with a phone call at times when the member was expected to be available. In addition to phone calls, providers also followed up with a mailed letter to the member (65%), contacting other agencies (3%), visiting the member's home (43%), or calling the member's emergency contact (10%). Of note, some providers employed more than one communication method to attempt to reengage a member that had disengaged from services. Other methods of outreach used by providers included:

- Internal staffing discussions to determine reengagement strategies
- Email communication

Table 4-13: Reengagement Key Findings (completed only if member declined further services or chose not to appear for scheduled services)

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?	105	88	84%	0	84%	83%
B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	77	50	65%	5	59%	71%
C. Were other attempts made to reengage the individual, such as:						
• Home visit?	30	13	43%	0	31%	31%
• Call emergency contact(s)?	30	3	10%	0	25%	27%
• Contacting other involved agencies?	30	1	3%	0	31%	46%
• Street Outreach?	30	0	0%	0	0%	0%

Measure IX — National Outcome Measures Key Findings

Each of the seven NOMs for Measure IX is depicted in Tables 4-14 and 4-15. Fluctuation in denominators reflects missing documentation of status at intake and discharge, if applicable. This may be partly attributable to the high number of discharges to lack of contact, making the discharge information unattainable.

In the cases in which the NOMs were documented at intake and discharge, improvement in each metric was noted. The table below shows the results for each NOM at intake and discharge. Results for each ACC-RBHA for each NOM improved at discharge. The number of individuals who reported a recent arrest at intake was 8%, this number decreased to 2% at discharge. Sixty-five percent of individuals reported abstinence from alcohol/drugs at discharge while 30% reported abstinence at intake. Most notably, individuals reported participating in social support and recovery groups 21% of the time at intake and 64% of the time at discharge (43% increase).

NOM results were reviewed and compared at intake and discharge. Results of this comparison fluctuate from year to year. The NOM results in the tables below display shading indicating either increases or decreases (with corresponding green or pink shading) from intake to discharge in the same year. Sixty-seven percent of individuals at discharge were abstinent from drugs and alcohol in 2022 compared to 65% in 2023, a 2% decrease. Sixty-seven percent of individuals participated in social support recovery in the preceding 30 days at discharge in 2022 versus 64% in 2023, a 3% decrease.

Table 4-14: 2023 National Outcome Measures

	At Intake			At Discharge		
	Denominator	# of Yes FY 2023	% of Yes FY 2023	Denominator	# of Yes FY 2023	% of Yes FY 2023
A. Employed?	193	103	53%	132	78	59%
B. Enrolled in school or vocational educational program?	177	4	2%	130	6	5%
C. On disability or retired?	161	20	12%	126	13	10%
D. Lived in a stable housing environment (e.g., not homeless)?	193	154	80%	130	111	85%
E. Arrested in the preceding 30 days?	184	15	8%	131	3	2%

	At Intake			At Discharge		
	Denominator	# of Yes FY 2023	% of Yes FY 2023	Denominator	# of Yes FY 2023	% of Yes FY 2023
F. Abstinent from drugs and/or alcohol?	189	56	30%	119	77	65%
G. Participated in social support recovery in the preceding 30 days?	200	42	21%	122	78	64%

Table 4-15: 2022 National Outcome Measures

	At Intake			At Discharge		
	Denominator	# of Yes FY 2022	% of Yes FY 2022	Denominator	# of Yes FY 2022	% of Yes FY 2022
A. Employed?	196	72	37%	117	44	38%
B. Enrolled in school or vocational educational program?	182	7	4%	112	5	4%
C. Lived in a stable housing environment (e.g., not homeless)?	174	23	13%	112	102	79%
D. Arrested in the preceding 30 days?	193	134	69%	129	4	3%
E. Abstinent from drugs and/or alcohol?	178	20	11%	120	86	67%
F. Participated in social support recovery in the preceding 30 days?	190	58	31%	128	108	84%

Informational Only

The outcomes for the items noted in the Methodology section that were recorded for informational only purposes are provided in the table below. Of note are the findings that 61% of individuals were given the opportunity to receive services via telehealth, potentially increasing their ability to successfully access and complete treatment, and 57% of family members and natural supports were given education and access to naloxone, an important harm reduction strategy for people who use opioids. When reviewers found evidence that

transportation was considered as part of the ISP process it was noted that the types of transportation considered were public or provider-supplied transport options.

Table 4-16: Informational Only Outcomes for Items Noted in Methodology Section

	Denominator	# of Yes FY 2023	% of Yes FY 2023
Use of nicotine replacement therapy	73	3	4%
Option for telehealth	200	121	61%
Education and provision of naloxone to family members/natural supports	90	51	57%

Section 5

Case File Review Findings by ACC-RBHA

This section of the report includes findings organized by ACC-RBHA, including narratives and Tables 5-1 through 5-35. The reporting methodology remains consistent from Section 4 — Aggregate Findings to Section 5. The denominators consist of the sum of "Yes" and "No" responses and differ across measures. Some denominators are based on the number of "Yes" responses from a prior question when applicable. N/A responses are not included in any denominator, consistent with prior years' analyses. Measures marked with an asterisk in the "N/A" column indicate that "N/A" was not a valid response option for that particular measure. Additionally, certain measures included an option for missing documentation. Additional narrative information was collected, as noted in Section 4, and is incorporated into the finding's narrative prior to the table.

Arizona Complete Health

AzCH has responsibility for AHCCCS members in the southern region of the state. AzCH is assigned to members who live in Greenlee, Graham, Cochise, Santa Cruz, Pima, Yuma, and La Paz counties. Mercer reviewed provider treatment records from eight separate clinics under AzCH's area of responsibility. In the previous review, the AzCH sample performed better than the state across multiple metrics. The highlights below were observed within the data collected:

- Providers completed a BH assessment within 45 days of the initial appointment in 100% of the cases that contained an ISP, which was above average for the state (97%).
- Providers used ASAM dimensions to determine the proper level of care at intake 90% of the time, slightly above the state average of 83%.
- There was documentation that certified peer support was offered as part of treatment 61% of the time, well above the state average of 45%
- Reviewers found documentation present that a relapse prevention plan was completed 56% of the time compared to the state average of 70%.

It is worth noting for this reporting period, each performance metric described above was again higher than the state average, with the exception of the charitable choice requirement. AzCH did not have any charitable choice cases in this review; therefore, the denominator was zero.

Measure I — Intake/Treatment Planning Key Findings

Initial Behavioral Health Assessment

Mercer reviewed 51 total records for AzCH and found 100% of the records contained evidence that an initial BH assessment was completed within 45 days of the initial appointment. As part of the initial assessment, providers successfully documented compliance with the required components of the assessment (Items C1–9) with a range of 13% to 100%. Overall, the areas of lowest performance remain consistent from the previous year. Hepatitis C, HIV, and other infectious disease screening, and TB screening each decreased while review of PDMP increased from 8% in 2022 to 13%. Hepatitis C, HIV, and other infectious disease screening decreased 24% this reporting period, down from 44% to 20%. TB screening also decreased from 51% to 33%.

Alcohol was the primary substance used at 43%, with amphetamines as the next highest primary substance at 35%. This is a variation from the State findings of opioids as the substance most often used. The primary method of ingestion was smoking at 53%, with oral as the next most common at 43%.

Individual Service Plan

Providers developed an ISP for the members' treatment (within 90 days of the initial appointment) in 100% of the reviewed cases (a 5% increase from the previous year). In 100% of these cases (up 3%), the providers developed the ISP in congruence with the presenting concerns. Fourteen percent of ISPs (down 1%) were developed with the participation of the member's family or other supports (when the member consented to allow participation from these sources).

Table 5-1: Assessment and Individual Service Plan

	Denominator	# of Yes SFY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. What was the primary substance used?						
• Opioids	51	16	31%	-	New Measure	
• Marijuana	51	9	18%	-	New Measure	
• Alcohol	51	22	43%	-	New Measure	
• Amphetamines	51	18	35%	-	New Measure	
• Cocaine	51	12	24%	-	New Measure	
• Other (please list)	51	1	2%	-	New Measure	
B. What was the method of ingestion?						
• Smoking	51	27	53%	-	New Measure	
• Oral	51	22	43%	-	New Measure	
• Inhalation	51	11	22%	-	New Measure	

	Denominator	# of Yes SFY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
• Injection	51	2	4%	-	New Measure	
• Transdermal	51	0	0%	-	New Measure	
• Other (please list)	51	3	6%	-	New Measure	
C. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	51	51	100%	0	100%	98%
Did the behavioral health assessment:						
1. Address substance-related disorder(s)?	51	51	100%	0	100%	100%
2. Describe the intensity/frequency of substance use?	51	51	100%	0	93%	95%
3. Include the effect of substance use on daily functioning?	51	50	98%	0	98%	89%
4. Include the effect of substance use on interpersonal relationships?	51	49	96%	0	100%	77%
5. Was a risk assessment completed?	51	51	100%	0	100%	98%
6. Document screening for tuberculosis (TB)?	51	17	33%	0	51%	49%
7. Document screening for Hepatitis C, HIV, and other infectious diseases?	51	10	20%	0	44%	33%
8. Document screening for emotional and/or physical abuse/ trauma issues?	51	48	94%	0	98%	95%
9. Document that review of the Prescription Drug Monitoring Program (PDMP) was completed?	46	6	13%	5	8%	23%

	Denominator	# of Yes SFY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
D. Was there documentation that charitable choice requirements were followed, if applicable?	3	2	67%	46	0%	100%
E. Was an ISP completed within 90 days of the initial appointment?	51	51	100%	0	95%	98%
Was the ISP:						
1. Developed with participation of the family/support network?	51	7	14%	34	15%	9%
2. Congruent with the diagnosis(es) and presenting concern(s)?	51	51	100%	0	97%	96%
3. Measurable objectives and timeframes to address the identified needs?	51	50	98%	0	95%	96%
4. Addressing the unique cultural preferences of the individual?	51	50	98%	0	95%	82%
5. Were social determinants of health issues considered as part of, and incorporated into, the ISP?	51	23	45%	0	85%	88%
a. Access to Medical Care	51	8	16%	-	33%	New Measure
b. Housing	51	4	8%	-	72%	New Measure
c. Food Insecurity	51	3	6%	-	8%	New Measure
d. Domestic Violence	51	2	4%	-	10%	New Measure

	Denominator	# of Yes SFY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
e. Unemployment	51	14	27%	-	69%	New Measure
f. Transportation	51	5	10%	-	New Measure	New Measure

Measure II — Placement Criteria/Assessment Key Findings

ASAM Patient Placement Criteria were used at intake to determine the appropriate level of service in 90% of the cases reviewed, down 3% from the previous year. Of these cases, documentation showed that 74% received the LOC identified by the ASAM criteria (down 15% from the previous reporting period). Providers documented the use of the ASAM criteria to reassess the proper LOC during treatment in 24% of cases, down 10%. In 57% of the reviewed case files, providers documented the use of other (or additional) assessment tools during the course of treatment, an increase from 20% the previous year. Providers may be using tools other than the ASAM for reassessment, leading to the change in frequency of reassessment from ASAM to other tools. These tools included:

- URICA (used once)
- DLA-20 (used once)
- CASII (used once)
- PRAPARE (used twice)

Table 5-2: Placement Criteria/Assessment

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. Was there documentation that the ASAM dimensions were used to determine the proper level of care at intake?	51	46	90%	0	93%	95%
If the ASAM Patient Criteria were used, the level of service identified was:						
Level 0.5: Early Intervention	46	0	0%	-	3%	4%
OMT: Opioid Maintenance Therapy	46	9	20%	-	8%	5%
Level 1: Outpatient Treatment	46	21	46%	-	24%	55%
Level 2 Intensive Outpatient Treatment/Partial Hospitalization	46	14	30%	-	11%	16%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
Level 3: Residential/Inpatient Treatment	46	5	11%	-	68%	24%
Level 4: Medically Managed Intensive Inpatient Treatment	46	0	0%	-	0%	2%
B. Did the member receive the level of services identified by the placement criteria/assessment?	46	34	74%		89%	93%
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	46	11	24%		34%	44%
D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	51	29	57%		20%	43%

Measure III — Best Practices Key Findings

Seventy-six percent of sampled BH case files contained documentation that EBPs were used in treatment (a decrease of 14% from previous period). Of these, CBT was the most widely used EBP (41%, down from 70%). MAT was documented in 25% of the case files (1% increase). Of the 13 individuals who received MAT, Suboxone was the most frequently used medication (54%). Three interventions were not documented as having been used during this review period: ACRA, Beyond Trauma: A Healing Journey for Women, and Contingency Management (these interventions were also not used in the previous reporting period). Helping Women Recover was up 3% in 2023, not being used at all in 2022.It is important to note that only seven women were included in this year's sample, representing 14% of the sample size, which may skew the findings on gender-specific services. Additional interventions used by providers included:

- Acceptance and Commitment Therapy (used three times)
- Living in Balance (used two times)
- 12-step education (used one time)

In 61% of cases, providers offered certified peer support services (an increase of 7% from 2022), and in 65% of those cases, the services were provided as part of treatment (down from 86%). The EBP of screening for ongoing substance use during treatment occurred in 47% of the reviewed cases (down from 76%).

Table 5-3: Best Practices

	% of Yes FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. Were EBPs used in treatment?	76%	90%	83%
The following EBPs were used in treatment:			
• Cognitive Behavioral Therapy	41%	70%	60%
• Dialectal Behavioral Therapy	13%	24%	2%
• Helping Women Recover	3%	0%	0%
• Matrix	13%	3%	23%
• Moral Re-conation Therapy	0%	3%	4%
• Motivational Enhancement/Interviewing Therapy	41%	35%	13%
• Relapse Prevention Therapy	33%	51%	13%
• Seeking Safety	0%	27%	13%
• SMART Recovery	13%	41%	10%
• Thinking for a Change	0%	3%	2%
• Trauma Recovery and Empowerment Model	3%	3%	0%
• Trauma-Informed Care	3%	11%	4%
• Wellness Recovery Action Plan	5%	0%	2%
• Other Practices or Program	10%	32%	33%

Table 5-4: Medication-Assisted Treatment and Peer Support

	Denominator FY 2023	# of Yes 2023	% of Yes 2023	% of Yes 2022	% of Yes 2021
Medication-Assisted Treatment	51	13	25%	24%	26%
A. The following medication was used in treatment:					
Alcohol-Related					
• Acamprosate (Campral)	13	0	0%	0%	0%
• Disulfiram (Antabuse)	13	0	0%	0%	0%
Opioid-Related					
• Subutex (buprenorphine)	13	0	0%	10%	7%

	Denominator FY 2023	# of Yes 2023	% of Yes 2023	% of Yes 2022	% of Yes 2021
• Methadone/ Levo-Alpha-Acetylmethadol (LAAM)	13	5	38%	60%	53%
• Narcan (naloxone)	13	2	15%	0%	7%
• Vivitrol (long-acting naltrexone)	13	0	0%	0%	13%
• Suboxone (buprenorphine-naloxone)	13	7	54%	30%	27%
B. Was screening for substance use/abuse conducted during the course of treatment?	51	24	47%	76%	50%
C. Was certified peer support offered as part of treatment?	51	31	61%	54%	26%
D. If yes to C., were certified peer support services used as a part of treatment?	31	20	65%	86%	40%

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

This reporting period, providers used case management as the most common service type (96%), followed by group counseling/therapy (67%), and individual counseling/therapy (53%). There was a significant decline from individual counseling/therapy from 93% to 53% and in group counseling/therapy from 95% to 67%. Case management significantly increased from 80% to 96%. These differences are significant in both percentage and order of use. Providers did not document the provision of family counseling in any of the reviewed cases (0%). Of those individuals who received counseling, 42% attended more than 11 sessions (down from 88%); 42% attended five or fewer sessions. Seventy-three percent of BH case files did not contain documentation regarding the number of self-help or recovery group sessions completed during treatment (an increase from 41%). Of those that did document this metric, 8% of cases documented zero attendance at the self-help or recovery group sessions while 12% attended 21 or more times during treatment, a 20% decline.

Table 5-5: Treatment/Support Services/Rehabilitation Services

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. The following services were used in treatment						
• Individual counseling/ therapy	51	27	53%	0	93%	50%
• Group counseling/ therapy	51	34	67%	0	95%	66%
• Family counseling/ therapy	51	0	0%	0	0%	0%
• Case management	51	49	96%	0	80%	86%
B. Was there clear documentation of progress or lack of progress towards the identified ISP goals?	51	48	94%	0	100%	83%
C. The number of completed counseling/therapy sessions during treatment was:						
• 0–5 sessions	50	21	42%	0	10%	40%
• 6–10 sessions	50	8	16%	0	2%	14%
• 11 sessions or more	50	21	42%	0	88%	46%
D. Was the individual given any education on self-help or recovery groups	50	29	58%	1	85%	New Measure
E. Documentation showed that the member reported attending self-help or recovery groups the following number of times:						
• No documentation	51	37	73%**	0	41%	78%
• 0 times during treatment	51	4	8%	0	0%	10%
• 1–4 times during treatment	51	1	2%	0	5%	2%
• 5–12 times during treatment	51	3	6%	0	5%	2%
• 13–20 times during treatment	51	0	0%	0	17%	2%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
• 21 or more times during treatment	51	6	12%	0	32%	7%
F. If there was evidence of lack of progress towards the identified goal, did the provider revise the treatment approach and/or seek consultation to facilitate positive outcomes?	28	19	68%	22	88%	55%
G. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	25	21	84%	25	88%	75%
H. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	21	14	67%	29	69%	28%
I. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	23	14	61%	27	84%	31%
J. Does the documentation reflect that substance abuse services were provided?	51	47	92%	0	93%	91%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
K. Was member's access to a PCP or other medical provider explored?	51	38	75%	2	85%	94%

Measure V — Gender-Specific Key Findings

Providers documented three women's case files with a history of domestic violence; of these, none of them contained a safety plan. This sample contained zero pregnant women, as well as no women having given birth in the past year. Of the case files for women who had dependent children, 100% documented a determination that adequate childcare was assessed. Gender-specific services were documented in 38% of cases, a decrease from 76% the year before.

Table 5-6: Gender-Specific (Female Only)

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	3	0	0%	5	67%	80%
B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	N/A	N/A	N/A	8	0%	0%
C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?	N/A	N/A	N/A	8	0%	0%
D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?	N/A	N/A	N/A	8	100%	0%
E. If the female had dependent children, was there	1	1	100%	6	100%	83%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
documentation to show that childcare was addressed?						
F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	8	3	38%	0	76%	11%

Measure VI — Opioid-Specific Key Findings

For this sub-sample, providers documented OUD diagnosis in 35% of the cases (down 14%). Of these cases, providers educated 67% (down 13%) of the members on MAT as a treatment option, and 100% of those were referred to a MAT provider, an increase of 12%. Documentation showed MAT providers educated the member on overdose, naloxone, and steps to take in the event of an overdose in 44% of the cases (up 19%). Education on the effects of polysubstance abuse with opioids was provided in 39% of the cases (up 4%%). In 100% of cases, providers referred members with withdrawal symptoms to a medical provider. There were no pregnant women in the sample size, leading to the finding of zero for documentation of education about the safety of methadone and/or buprenorphine during pregnancy.

Table 5-7: Opioid-Specific Key Findings

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. Was there documentation of a diagnosed OUD?	51	18	35%	0	49%	31%
B. Was there documentation that the member was provided MAT education as a treatment option?	18	12	67%	0	80%	89%
C. If yes to VI B, were they referred to a MAT provider?	12	12	100%	1	88%	88%
D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	4	4	100%	14	100%	90%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
E. If a physical health concern related to pain was identified, were alternative pain management options addressed?	2	0	0%	16	50%	50%
F. If member is a pregnant female, did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?	N/A	N/A	N/A	17	0%	N/A
G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?	18	8	44%	0	25%	39%
H. Was the individual provided with naloxone or information on how to obtain naloxone?	18	8	44%	0	30%	New Measure
I. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	18	7	39%	0	35%	44%

Measure VII — Discharge and Continuing Care Planning Key Findings

In 83% of the reviewed cases, providers documented the completion of a relapse prevention plan for members who completed treatment or declined further services (up 3%). Providers documented offered resources pertaining to community support in 43% of these cases (down 41%). For those members engaged with other agencies, providers actively coordinated with these agencies at the time of discharge in 75% of the cases, an increase of 6%.

Table 5-8: Discharge and Continuing Care Planning (completed only if member completed treatment or declined further services)

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. Was there documentation present that a relapse prevention plan was completed?	46	38	83%	0	80%	57%
B. Was the individual reassessed at the time of discharge using ASAM criteria to determine an appropriate level of care?	46	7	15%	0	40%	New Measure
C. Was the individual referred to the appropriate level of care based on the ASAM determination?	7	7	100%	15	94%	New Measure
D. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g., crisis line)?	46	20	43%	0	84%	62%
E. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?	16	12	75%	30	69%	76%

Measure VIII — Reengagement Key Findings

In 97% of cases in which the member declined further services or chose not to appear for scheduled services, providers followed up with a phone call at times when the member was expected to be available (up 3%). In 83% of these cases, providers mailed a letter to the member requesting contact (up 14%). Other activities taken by providers to make contact included visiting the member's home (63%) and calling the member's emergency contact (11%). Other outreach activities included emails and contact with probation officers.

Table 5-9: Reengagement Key Findings

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?	31	30	97%	0	94%	75%
B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	24	20	83%	3	69%	71%
C. Were other attempts made to reengage the individual, such as:						
• Home visit?	19	12	63%	-	63%	46%
• Call emergency contact(s)?	19	2	11%	-	25%	23%
• Contacting other involved agencies?	19	0	0%	-	13%	31%
• Street Outreach?	19	0	0%	-	0%	0%

Measure IX — NOMs Key Findings

Each of the six AzCH NOMs for Measure IX is depicted in Table 5-10. Denominators are impacted by missing documentation of status at intake and discharge if applicable. The graphs below show the member's status for each NOM at intake and discharge. Results for AzCH for each NOM improved at discharge. Data suggests improvement in employment status, an increase in school or vocational educational program enrollment, living in a stable housing environment, abstinence from drugs or alcohol, and participation in recovery social support. Most notably, 26 members were abstinent at discharge (up from 22 members at intake).

94% of individuals at discharge participated in social support recovery in the preceding 30 days in 2022 compared to 59% in 2023, a 35% decrease. There was a 9% decrease in individuals remaining abstinent from drugs and/or alcohol at discharge when comparing 2023 and 2022 data. There were zero individuals arrested in the preceding 30 days at discharge in both 2022 and 2023. Additionally, there was a 41% increase in individuals who were employed in this reporting period as compared to 2022.

Table 5-10: 2022 and 2023 AzCH National Outcome Measures

2023	At Intake			At Discharge		
	Denominator	# of Yes FY 2023	% of Yes FY 2023	Denominator	# of Yes FY 2023	% of Yes FY 2023
A. Employed?	50	25	50%	24	14	58%
B. Enrolled in school or vocational educational program?	44	0	0%	24	0	0%
C. On disability or retired?	34	4	12%	22	1	5%
D. Lived in a stable housing environment (e.g., not homeless)?	51	42	82%	24	22	92%
E. Arrested in the preceding 30 days?	49	4	8%	25	0	0%
F. Abstinent from drugs and/or alcohol?	48	22	46%	26	16	62%
G. Participated in social support recovery in the preceding 30 days?	51	13	25%	22	13	59%
2022	**At Intake**			**At Discharge**		
	Denominator	# of Yes FY 2022	% of Yes FY 2022	Denominator	# of Yes FY 2022	% of Yes FY 2022
A. Employed?	40	2	5%	29	5	17%
B. Enrolled in school or vocational educational program?	36	1	3%	27	3	11%
C. On disability or retired?	32	8	25%	28	7	25%
D. Lived in a stable housing environment (e.g., not homeless)?	39	20	51%	30	21	70%
E. Arrested in the preceding 30 days?	35	6	17%	29	0	0%
F. Abstinent from	38	13	34%	28	20	71%

2023	At Intake			At Discharge		
	Denominator	# of Yes FY 2023	% of Yes FY 2023	Denominator	# of Yes FY 2023	% of Yes FY 2023
drugs and/or alcohol?						
G. Participated in social support recovery in the preceding 30 days?	41	2	5%	31	29	94%

Informational Only

The outcomes for the items noted in Methodology section that were recorded for informational only purposes found that 53% were provided with an option for telehealth, potentially allowing for an increase in access to services and successful completion of treatment. Only 6% of family members and natural supports were provided with education and access to naloxone, an area for potential improvement to increase harm reduction efforts in the opioid user population in the area. When reviewers found evidence that transportation was considered as part of the ISP process it was noted that the types of transportation considered were public or provider-supplied transport options.

Table 5-11: Informational Only Outcomes for Items Noted in Methodology Section

	Denominator	# of Yes FY 2023	% of Yes FY 2023
Use of nicotine replacement therapy	13	1	8%
Option for telehealth	51	27	53%
Education and provision of naloxone to family members/ natural supports	18	1	6%

Care 1st

Care 1st has responsibility for AHCCCS members in the northern region of the state. Care 1st is assigned to members who live in Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai counties. Mercer reviewed provider treatment records from seven separate clinics under Care 1st's area of responsibility. In the previous review, the Care 1st sample performed better than the state across multiple metrics. It should be noted that Care 1st began operations on October 1, 2022. Comparisons to previous year results may be skewed as a different vendor, Health Choice, was operating in the Northern region before that date. The highlights below were observed within the data collected:

- Certified peer support was offered 38% of the time in treatment, lower than the state average of 45%.
- Members were provided substance abuse services as outlined in the ISP 100% of the time, slightly higher than the state average of 96%.

- Referral to a medical provider for members with withdrawal symptoms occurred in 100% of the cases reviewed within this region as compared with the state average of 97%.
- Documentation that ASAM dimensions were used to determine the proper level of care at intake occurred in 67% of the cases reviewed compared to the state average of 83%.

It is worth noting for this reporting period, for many metrics, there was mixed performance compared with the state average. The metric below the state average for this reporting period included Use of ASAM dimensions to determine proper LOC.

Measure I — Intake/Treatment Planning Key Findings

Initial Behavioral Health Assessment

A total of 21 records from Care 1st were reviewed by Mercer, with 20 records having evidence of an initial behavioral assessment being completed within 45 days of the initial appointment. The highest completion was seen with addressing substance-related disorders, intensity, frequency, and effects of usage on daily functioning. Also noted, was that risk assessments were completed on 100% of records. The areas of lowest performance were documentation of the PDMP (5%), hepatitis (10%), and TB (20%) screenings. Providers successfully documented compliance with the required elements of the assessment (Items C1-9) in a range of 5% to 100%.

Alcohol was the most common primary substance used at 57%, with amphetamines as the second most common substance used at 38%. This number does not reflect the statewide finding of opioids being the substance most commonly used. The most common method of ingestion was oral at 57% followed by smoking at 33%.

Individual Service Plan

An ISP for the member's treatment was developed by providers in 85% of the reviewed cases. There was family involvement of 12%, which was a decrease from 29% in 2022. Objectives and timeframes were established in 100% of records, and 88% addressed the cultural preferences of the member. SDoH was incorporated into the ISP 29% of the time, with the state average being 45%. Lack of access to medical care was the most common SDoH noted at 24%.

Table 5-12: Care 1st Assessment and Individual Service Plan

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A 2023	% of Yes FY 2022	% of Yes FY 2021
A. What was the primary substance used?						
• Opioids	21	7	33%	-	New Measure	
• Marijuana	21	4	19%	-	New Measure	
• Alcohol	21	12	57%	-	New Measure	
• Amphetamines	21	8	38%	-	New Measure	
• Cocaine	21	0	0%	-	New Measure	

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A 2023	% of Yes FY 2022	% of Yes FY 2021
• Other (please list)	21	1	5%	-	New Measure	
B. What was the method of ingestion?						
• Smoking	21	7	33%	-	New Measure	
• Oral	21	12	57%	-	New Measure	
• Inhalation	21	2	10%	-	New Measure	
• Injection	21	5	24%	-	New Measure	
• Transdermal	21	0	0%	-	New Measure	
• Other (please list)	21	1	5%	-	New Measure	
C. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	21	20	95%	0	95%	73%
Did the behavioral health assessment:						
1. Address substance-related disorder(s)?	20	20	100%	0	100%	100%
2. Describe the intensity/frequency of substance use?	20	19	95%	0	100%	91%
3. Include the effect of substance use on daily functioning?	20	19	95%	0	100%	95%
4. Include the effect of substance use on interpersonal relationships?	20	19	95%	0	95%	82%
5. Was a risk assessment completed?	20	20	100%	0	100%	95%
6. Document screening for TB?	20	4	20%	0	38%	41%
7. Document screening for hepatitis C, HIV, and other infectious diseases?	20	2	10%	0	33%	18%
8. Document screening for emotional and/or physical abuse/trauma issues?	20	20	100%	0	86%	95%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A 2023	% of Yes FY 2022	% of Yes FY 2021
9. Document that review of the PDMP was completed?	20	1	5%	0	11%	17%
D. Was there documentation that charitable choice requirements were followed, if applicable?	2	0	0%	19	0%	100%
E. Was an ISP completed within 90 days of the initial appointment?	20	17	85%	0	100%	95%
Was the ISP:						
1. Developed with participation of the family/support network?	17	2	12%	10	29%	0%
2. Congruent with the diagnosis(es) and presenting concern(s)?	17	17	100%	0	100%	100%
3. Measurable objectives and timeframes to address the identified needs?	17	17	100%	0	95%	95%
4. Addressing the unique cultural preferences of the individual?	17	15	88%	0	86%	71%
5. Were SDoH issues considered as part of, and incorporated into, the ISP?	17	5	29%	0	67%	67%
If yes, which domains?						
a. Access to Medical Care	17	4	24%	-	10%	New Measure
b. Housing	17	1	6%	-	24%	New Measure
c. Food Insecurity	17	0	0%	-	0%	New Measure
d. Domestic Violence	17	0	0%	-	10%	New Measure
e. Unemployment	17	1	6%	-	38%	New Measure

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A 2023	% of Yes FY 2022	% of Yes FY 2021
f. Transportation	21	0	0%	-	New Measure	
g. Other (please list)						

Measure II — Placement Criteria/Assessment Key Findings

ASAM dimensions were used in 67% of the reviews completed by Mercer. 2022 data showed 73%, with a slight lapse in progress. The state average for ASAM dimensions is 83%. Of the cases that were assigned an ASAM dimension, 86% received the level of services identified by the placement or criteria assessment, this is a decrease of 8% from 2022. The state average is 87%. Other assessment tools were also noted as being used, and this was measured as 67%, which is an increase from 50% in 2022. Some of those additional assessment tools used were:

- PHQ-9, AASE (used four times)
- GAD-7 (used three times)
- CIWA (used once)
- Columbia Suicide Scale (used three times)

Table 5-13: Care 1st Placement Criteria/Assessment

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. Was there documentation that ASAM dimensions were used to determine the proper level of care at intake?	21	14	67%	0	73%	83%
If the ASAM Patient Placement Criteria were used, the level of service identified was:						
Level 0.5: Early Intervention	14	0	0%	-	0%	1%
OMT: Opioid Maintenance Therapy	14	0	0%	-	0%	16%
Level 1 Outpatient Treatment	14	7	50%	-	44%	45%
Level 2: Intensive Outpatient Treatment/ Partial Hospitalization	14	1	7%	-	13%	12%
Level 3: Residential/ Inpatient Treatment	14	8	57%	-	44%	42%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
Level 4: Medically Managed Intensive Inpatient Treatment	14	0	0%	-	0%	1%
B. Did the member receive the level of services identified by the placement criteria/ assessment?	14	12	86%	0	94%	96%
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	14	8	57%	0	38%	54%
D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	21	14	67%	0	50%	50%

Measure III — Best Practices Key Findings

EBP was used in 76% of the records reviewed; this is a marked decrease from 2022, which was 86%. Motivational Enhancement/Interviewing Therapy was used most often, at 56%, which is a significant improvement from 21% last year. Two members received MAT services, with two receiving methadone, one receiving Vivitrol, and one receiving Suboxone. Thirty-eight percent of members were offered certified peer support as part of their treatment, but only 25% of those used certified peer support, which is another marked decrease from 80% in 2022.

Additional interventions used by providers included:

- PRIME for life (used one time)
- 12-step education (used twice)

Table 5-14: Care 1st Best Practices — EBPs

	% of Yes FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. Were EBPs used in treatment?*	76%	86%	77%
The following EBPs were used in treatment:			
• Cognitive Behavioral Therapy	50%	74%	39%
• Dialectal Behavioral Therapy	6%	11%	26%
• Helping Women Recover	0%	0%	0%
• Matrix	6%	16%	26%

	% of Yes FY 2023	% of Yes FY 2022	% of Yes FY 2021
• Motivational Enhancement/ Interviewing Therapy	56%	21%	13%
• Relapse Prevention Therapy	19%	58%	17%
• SMART Recovery	0%	5%	9%
• Thinking for a Change	0%	5%	0%
• Trauma-Informed Care	0%	11%	0%

Table 5-15: Care 1st Best Practices — MAT and Peer Support

	Denominator FY 2023	# of Yes FY 2023	% of Yes FY 2023	% of Yes FY 2022	% of Yes FY 2021
Medication-Assisted Treatment	21	2	10%	18%	10%
B. The following medication was used in treatment:					
Alcohol-Related					
• Acamprosate (Campral)	2	0	0%	0%	0%
• Disulfiram (Antabuse)	2	0	0%	0%	33%
Opioid-Related					
• Subutex (buprenorphine)	2	0	0%	0%	0%
• Methadone/Levo-Alpha-Acetylmethadol (LAAM)	2	1	50%	50%	33%
• Narcan (naloxone)	2	0	0%	0%	0%
• Vivitrol (long-acting naltrexone)	2	1	50%	25%	0%
• Suboxone (buprenorphine-naloxone)	2	1	50%	25%	33%
B. Was screening for substance use/abuse conducted during the course of treatment?	21	3	14%	41%	43%
C. Was certified peer support offered as part of treatment?	21	8	38%	45%	37%
D. If yes to C., were certified peer support services used as a part of treatment?	8	2	25%	80%	27%

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

Group and individual counseling was documented as occurring markedly less frequently than in 2022. This year's individual therapy decreased from 86% to 62% while group counseling/therapy decreased from 91% to 62%. There was a 10% decrease in case management as well. The number of sessions completed was 33% of 0–5 sessions, 14% completed 6–10 sessions, and 52% completed 11 or more sessions. Most key findings in the Treatment/Support Services/Rehabilitation saw a decrease in documentation of services provided. The largest loss was observed in meaningful community activity, from 46% down to 14%. There was an increase in referral to a medical provider from 68% to 76%, a positive finding, especially due to the finding that lack of medical care was the primary need identified in a review of SDoH at intake.

Table 5-16: Care 1st Treatment/Support Services/Rehabilitation Services

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. The following services were used in treatment:						
• Individual counseling/ therapy	21	13	62%	0	86%	57%
• Group counseling/ therapy	21	13	62%	0	91%	70%
• Family counseling/ therapy	21	0	0%	0	5%	0%
• Case management	21	16	76%	0	86%	77%
B. Was there clear documentation of progress or lack of progress towards the identified ISP goals?	21	19	90%	0	91%	67%
C. The number of completed counseling/therapy sessions during treatment was:						
• 0–5 sessions	21	7	33%	0	27%	50%
• 6–10 sessions	21	3	14%	0	23%	10%
• 11 sessions or more	21	11	52%	0	50%	40%
D. Was the individual given any education on self-help or recovery groups?	21	13	62%	0	82%	New Measure
E. Documentation showed that the member reported attending self-help of recovery groups the following number of times:						
• No documentation	21	12	57%	0	27%	87%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
• 0 times during treatment	21	1	5%	0	5%	3%
• 1–4 times during treatment	21	1	5%	0	23%	3%
• 5–12 times during treatment	21	3	14%	0	14%	3%
• 13–20 times during treatment	21	2	10%	0	5%	0%
• 21 or more times during treatment	21	2	10%	0	27%	3%
F. If there was evidence of lack of progress towards the identified goal, did the provider revise the treatment approach and/or seek consultation to facilitate positive outcomes?	9	4	44%	12	64%	40%
G. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	4	1	25%	17	55%	50%
H. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	5	1	20%	16	44%	17%
I. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in	7	1	14%	14	46%	13%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
such an activity was explored?						
J. Does the documentation reflect that substance abuse services were provided?	21	21	100%	0	86%	90%
K. Was member's access to a PCP or other medical provider explored?	21	16	76%	1	68%	53%

Measure V — Gender-Specific Key Findings

The denominator for this group was two members who identified as female. Of these two, one was identified as having a safety plan completed. There were no pregnant or dependent children less than one year of age. There was identification of four dependent children, and documentation was found showing childcare was addressed in all cases. Gender-specific services were not provided in any of the five relevant cases reviewed.

Table 5-17: Care 1st Gender-Specific (Female Only)

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	2	1	50%	4	50%	29%
B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	N/A	N/A	N/A	5	0%	N/A
C. If the female was pregnant, did documentation show evidence of education on the effects of substance use on fetal development?	N/A	N/A	N/A	5	0%	N/A
D. If the female had a child less than one year of age, was there evidence that a screening was completed	N/A	N/A	N/A	5	0%	N/A

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
for postpartum depression/psychosis?						
E. If the female had dependent children, was there documentation to show that childcare was addressed?	4	4	100%	1	0%	80%
F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	5	0	0%	0	14%	10%

Measure VI — Opioid-Specific Key Findings

OUD was discovered in 10% (two members) of the sample. This is a marked decrease from 2022 results (18%). Of those two members, providers documented that MAT education occurred with only one of them, and referrals were completed by a MAT provider for one (50%). Of the two members diagnosed with OUD, only one received information related to overdose education and how to react in the event of an overdose. Also, only one individual was given information on how to obtain naloxone.

Table 5-18: Care 1st Opioid-Specific

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. Was there documentation of a diagnosed OUD?	22	2	10%	0	18%	13%
B. Was there documentation that the member was provided MAT education as a treatment option?	2	1	50%	0	100%	50%
C. If yes to VI B, were they referred to a MAT provider?	1	1	100%	0	100%	100%
D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	1	1	100%	1	100%	100%
E. If a physical health concern related to pain was identified, were alternative pain management options addressed?	N/A	N/A	N/A	2	0%	0%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
F. If member is a pregnant female, did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?	N/A	N/A	N/A	2	N/A	N/A
G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?	2	1	50%	0	25%	25%
H. Was the individual provided with naloxone or information on how to obtain naloxone?	2	0	0%	0	25%	New Measure
I. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	2	1	50%	0	50%	50%

Measure VII — Discharge and Continuing Care Planning Key Findings

A relapse prevention plan was completed on 56% of the members, which is a slight decrease from 61% in 2022. Care 1st providers documented the individual was referred to the appropriate LOC using ASAM determination 80% of the time. Documentation at discharge of staff actively coordinated with other involved agencies was 42%, a decrease from 65% the year before. This also may be related to missing information.

Table 5-19: Care 1st Discharge and Continuing Care Planning (completed only if member completed treatment or declined further services)

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. Was there documentation present that a relapse prevention plan completed?	16	9	56%	0	61%	27%
B. Was the individual reassessed at the time of	16	5	31%	0	39%	*

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
discharge using ASAM criteria to determine an appropriate level of care?						
C. Was the individual referred to the appropriate level of care based on the ASAM determination?	5	4	80%	7	100%	*
D. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g. crisis line)?	16	10	63%	0	72%	23%
E. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?	12	5	42%	4	65%	24%

Measure VIII — Reengagement Key Findings

If a member declined services or chose not to appear for further services, 80% of the providers attempted to contact a member via phone. If the phone call was unsuccessful, a follow-up letter was sent to members 67% of the time. Both of these results are similar to findings in 2022 and 2021. There was one call made to an emergency contact.

Table 5-20: Care 1st Reengagement (completed only if member declined further services or chose not to appear for scheduled services)

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?	10	8	80%	0	82%	86%
B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	9	6	67%	1	67%	58%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
C. Were other attempts made to re-engage the individual, such as:						
• Home visit?	2	0	0%	-	0%	50%
• Call emergency contact(s)?	2	1	50%	-	0%	50%
• Contacting other involved agencies?	2	0	0%	-	100%	25%
• Street outreach?	2	0	0%	-	0%	0%

Measure IX — NOMs Key Findings

The tables below illustrate both intake and discharge comparisons for NOMs. There was missing information in both categories, which reflects the fluctuations in denominators. Employment information at intake saw a significant increase from 2022, and employment information at discharge also saw an increase, with 2022 discharge information of 80% while 2023 was 90%. There were also noticeable improvements from 2022 in abstinence from drugs and/or alcohol, 2022 was 79%, with 2023 at 100%. The number of individuals arrested within 30 days at discharge remained consistent at 0% across both years.

Table 5-21: 2023 Care 1st National Outcome Measures

	At Intake			At Discharge		
	Denominator	# of Yes FY 2023	% of Yes FY 2023	Denominator	# of Yes FY 2023	% of Yes FY 2023
A. Employed?	20	15	75%	10	9	90%
B. Enrolled in school or vocational educational program?	18	0	0%	11	0	0%
C. On disability or retired?	19	2	11%	11	1	9%
D. Lived in a stable housing environment (e.g., not homeless)?	21	18	86%	11	11	100%
E. Arrested in the preceding 30 days?	18	4	22%	11	0	0%
F. Abstinent from drugs and/or alcohol?	20	5	25%	11	11	100%

	At Intake			At Discharge		
	Denominator	# of Yes FY 2023	% of Yes FY 2023	Denominator	# of Yes FY 2023	% of Yes FY 2023
G. Participated in social support recovery in the preceding 30 days?	21	4	19%	11	8	73%

Table 5-22: 2022 Care 1st National Outcome Measures

	At Intake			At Discharge		
	Denominator	# of Yes FY 2022	% of Yes FY 2022	Denominator	# of Yes FY 2022	% of Yes FY 2022
A. Employed?	21	10	48%	12	8	80%
B. Enrolled in school or vocational educational program?	20	1	5%	12	2	17%
C. On disability or retired?	17	3	18%	12	1	8%
D. Lived in a stable housing environment (e.g., not homeless)?	21	17	81%	15	12	80%
E. Arrested in the preceding 30 days?	19	4	21%	12	0	0%
F. Abstinent from drugs and/or alcohol?	20	7	35%	14	11	79%
G. Participated in social support recovery in the preceding 30 days?	22	3	14%	15	15	100%

Informational Only

The outcomes from the items noted in the Methodology section recorded for informational only purposes noted that 64% of individuals were given an option to receive services via telehealth, potentially allowing individuals to have greater access to treatment and more successful outcomes. Neither of the two individuals with OUD had education or naloxone access given to family members or natural supports. This finding may be due to a lack of

family or natural support engagement in treatment. When reviewers found evidence that transportation was considered as part of the ISP process, it was noted that the types of transportation considered were public or provider-supplied transport options.

Table 5-23: Informational Only Outcomes of Items Noted in Methodology Section

	Denominator	# of Yes FY 2023	% of Yes FY 2023
Use of nicotine replacement therapy	2	0	0%
Option for telehealth	22	12	64%
Education and provision of naloxone to family members/natural supports	2	0	0%

Mercy Care

Measure I — Intake/Treatment Planning Key Findings

Mercy Care is a not-for-profit health plan that has responsibility for AHCCCS members in the central and south-central regions of Arizona. MC is assigned to members who live in Gila, Maricopa, and Pinal counties. One hundred and twenty-eight (128) records were reviewed by Mercer subject matter experts. The highlights below were observed in the data that was collected:

- Screening for hepatitis C, HIV, and other infectious diseases was completed in 93% of records, significantly higher than the state average of 40% and the FY 2022 review, in which 59% of MC records contained documentation that supported this screening was completed.
- Screening for TB was completed in 96% of records compared to the state average of 44%. This is also a significant increase from the FY 2022 review, in which 46% of MC records contained documentation that supported TB screening was completed.
- Review of the PDMP was completed in 22% of records, above the state average of 17% of records. This, however, was a decrease from FY 2022, in which review found that 27% of MC records had reviewed the PDMP.

Initial Behavioral Health Assessment

Mercer reviewed a total of 128 total records for MC and found that 93% had a BH assessment completed within 45 days of the initial appointment. Compliance with the required components of the BH assessment (items C1–9) ranged from 22% to 99%. Documentation that review of the PDMP was completed, which was 22% for FY 2023 and a decrease from FY 2022, in which 28% of records reviewed contained this documentation. In 52% of records in the FY 2023 review, there was documentation of the effects of substance use on interpersonal relationships, a decrease from FY 2022, in which 91% of records met this requirement. Reviewers found that in 99% of the records reviewed, there was documentation of the impact of substance use on daily functioning, an increase from the FY2022 review when 89% of records met this requirement.

Opioids were the most commonly used substance at 48%, which may be driving the statewide finding of opioids being the most commonly used substance as the highest number of records are from MC. Alcohol was the second most commonly used substance at 34%. Smoking was the most common form of ingestion at 47%, followed by oral at 38%.

Individual Service Plan

MC providers completed an ISP within 90 days of the initial appointment in 93% of the records reviewed. This is a slight decrease from FY 2022, in which 98% of the records met this requirement. One hundred percent (100%) of the ISPs were congruent with the individual's diagnosis and presenting concerns, which represents a slight increase from FY 2022 results, which were 97%.

An additional strength from the FY 2023 review was ISPs having measurable objectives and timeframes to address the identified needs (100% of records met this requirement). Another area of strength was that 100% of records followed Charitable Choice requirements, when applicable. Areas of opportunity identified in FY 2023 include involving family and support networks in the ISP process (albeit an improvement from the 9% found in the previous review; only 13% of records met this measure.) A lack of housing was the primary SDoH need identified at 29%, followed by a lack of employment at 24%.

Table 5-24: MC Assessment and Individual Service Plan

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. What was the primary substance used?						
• Opioids	128	61	48%	-	New Measure	
• Marijuana	128	21	16%	-	New Measure	
• Alcohol	128	43	34%	-	New Measure	
• Amphetamines	128	24	19%	-	New Measure	
• Cocaine	128	9	7%	-	New Measure	
• Other (please list)	128	6	5%	-	New Measure	
B. What was the method of ingestion?						
• Smoking	128	60	47%	-	New Measure	
• Oral	128	49	38%	-	New Measure	
• Inhalation	128	9	7%	-	New Measure	
• Injection	128	6	5%	-	New Measure	
• Transdermal	128	0	0%	-	New Measure	
• Other (please list)	128	11	9%	-	New Measure	
C. Was a behavioral health assessment completed at	128	114	93%	1	96%	98%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
intake (within 45 days of initial appointment)?						
1. Address substance-related disorder(s)?	122	116	95%	0	97%	100%
2. Describe the intensity/frequency of substance use?	122	113	93%	0	91%	97%
3. Include the effect of substance use on daily functioning?	122	121	99%	0	89%	99%
4. Include the effect of substance use on interpersonal relationships?	122	63	52%	0	91%	99%
5. Was a risk assessment completed?	122	65	53%	0	91%	100%
6. Document screening for tuberculosis (TB)?	122	117	96%	0	45%	39%
7. Document screening for Hepatitis C, HIV, and other infectious diseases?	122	114	93%	0	58%	24%
8. Document screening for emotional and/or physical abuse/trauma issues?	122	116	95%	0	93%	99%
9. Document that review of the Prescription Drug Monitoring Program (PDMP) was completed?	103	23	22%	18	28%	33%
D. Was there documentation that charitable choice requirements were followed, if applicable?	15	15	100%	110	73%	72%
E. Was an ISP completed within 90 days of the initial appointment?	122	113	93%	3	98%	98%
Was the ISP:						
1. Developed with participation of the	113	15	13%	79	9%	8%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
family/support network?						
2. Congruent with the diagnosis(es) and presenting concern(s)?	113	113	100%	0	97%	98%
3. Measurable objectives and timeframes to address the identified needs?	113	113	100%	0	96%	95%
4. Addressing the unique cultural preferences of the individual?	113	113	100%	0	93%	87%
5. Were SDoH issues considered as part of, and incorporated into, the ISP?	113	54	48%	0	77%	78%
If yes, which domains?						
a. Access to Medical Care	113	24	21%	-	22%	New Measure
b. Housing	113	33	29%	-	31%	New Measure
c. Food Insecurity	113	4	4%	-	4%	New Measure
d. Domestic Violence	113	3	3%	-	3%	New Measure
e. Unemployment	113	28	25%	-	33%	New Measure
f. Transportation	113	15	13%	-	New Measure	
g. Other (please list)						

Measure II — Placement Criteria/Assessment Key Findings

MC providers used the ASAM Patient Placement Criteria to determine the appropriate level of care at intake in 83% of records. Of those cases, 92% of individuals received the services identified in their ASAM LOC determination. Fifty percent of records found that providers used the ASAM Patient Placement Criteria during the course of treatment to determine the clinically indicated next level of care. Additional assessment tools were used to identify clinical needs in 56% of the records reviewed, and providers used the following tools:

- PHQ-9 (used 32 times)
- UNCOPE (used three times)

- Columbia Suicide Severity Scale (used 8 times)
- GAD-7 (used 15 times)
- PHQ-2 (used 10 times)
- Addiction Severity Index (used twice)
- Global Assessment of Functioning (GAF) (used twice)
- PRAPARE (used twice)
- DAST (used seven times)
- CRAFFT (used three times)
- ACES (used eight times)
- CAGE (used five times)

The following chart includes the data from FY 2023, as well as FY 2022 and 2021 for comparison.

Table 5-25: MC Placement Criteria/Assessment

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?	128	106	83%	0	80%	95%
If the ASAM Patient Placement Criteria were used, the level of service identified was:						
Level 0.5: Early Intervention	106	2	2%	-	1%	0%
OMT: Opioid Maintenance Therapy	106	36	34%	-	21%	29%
Level 1: Outpatient Treatment	106	42	40%	-	52%	66%
Level 2: Intensive Outpatient Treatment/ Partial Hospitalization	106	17	16%	-	13%	6%
Level 3: Residential/ Inpatient Treatment	106	21	20%	-	32%	26%
Level 4: Medically Managed Intensive Inpatient Treatment	106	0	0%	-	1%	0%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
B. Did the member receive the level of services identified by the placement criteria/assessment?	106	98	92%	0	97%	96%
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	106	53	50%	0	63%	54%
D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	128	72	56%	0	60%	45%

Measure III — Best Practices Key Findings

FY 2023 record review found that 73% of providers documented the use of an EBP in treatment, a slight increase from 71% in 2022, but a significant decrease from 93% in 2021. This continues a downward trend since FY 2021 when 93% of records contained documentation of EBP use. There was a 44% decrease in the utilization of CBT in treatment. Motivational Enhancement/Interviewing Therapy was the most commonly used EBP, with evidence of use in 57% of cases.

In addition to the EBPs listed above, there was a text cell in which Mercer staff could enter additional EBPs not listed. Mercer staff found evidence that MC providers also used the following:

- Living in Balance (used four times)
- Acceptance and Commitment Therapy (ACT) (used twice)

The FY 2023 pull did not include any adolescents, which could be the reason no adolescent-focused EBPs were observed. Forty-two of the 128 MC records pulled were for women, and only 23% of those records had evidence of gender-specific treatment services, most often through the utilization of women-only groups. However, several women-focused EBPs were not used by MC providers in treatment.

Table 5-26: MC Best Practices — EBPs

	% of Yes FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. Were EBPs used in treatment?	73%	71%	93%
The following EBPs were used in treatment:			
• Cognitive Behavioral Therapy	44%	88%	58%

	% of Yes FY 2023	% of Yes FY 2022	% of Yes FY 2021
• Dialectal Behavioral Therapy	14%	8%	12%
• Helping Women Recover	1%	0%	3%
• Matrix	9%	12%	11%
• Motivational Enhancement/Interviewing Therapy	57%	52%	37%
• Relapse Prevention Therapy	26%	55%	16%
• SMART Recovery	8%	12%	11%
• Thinking for a Change	0%	0%	1%
• Trauma-Informed Care	1%	11%	1%

FY 2023 records found only a slight decrease to individuals receiving MAT for OUD. Utilization of MAT treatments other than Methadone decreased in 2023. Although Narcan use has increased noticeably, Suboxone treatments have decreased 20% since 2022.

Table 5-27: MC Best Practices — MAT

	Denominator FY 2023	# of Yes FY 2023	% of Yes FY 2023	% of Yes FY 2022	% of Yes FY 2021
Medication Assisted Treatment (MAT)	128	58	45%	47%	39%
A. The following medication was used in treatment:					
Alcohol-Related					
• Acamprosate (Campral)	58	1	2%	0%	0%
• Disulfiram (Antabuse)	58	1	2%	2%	2%
Opioid-Related					
• Subutex (buprenorphine)	58	2	3%	3%	2%
• Methadone/Levo-Alpha-Acetylmethadol (LAAM)	58	48	83%	74%	82%
• Narcan (naloxone)	58	14	24%	0%	5%
• Vivitrol (long-acting naltrexone)	58	2	3%	5%	2%
• Suboxone (buprenorphine-naloxone)	58	1	2%	22%	14%
B. Was screening for substance use/abuse conducted during the course of treatment?	128	82	64%	65%	60%
C. Was certified peer support offered as part of treatment?	128	51	40%	36%	23%
D. If yes to C., were certified peer support services used as a part of treatment?	51	32	63%	56%	69%

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

Case management was the most common service observed in the FY 2023 sample at 93%. An increase of 12% from 2022. Individual therapy was the second most common service, found in 85% of records, with group therapy found in 71% of records. Reviewers found family counseling was documented in 2% of the records reviewed, a slight but significant increase from the previous findings of no family therapy. In records that documented the provision of individual or group therapy, 31% attended between 0–5 sessions, 14% attended between 6-10 sessions, and 55% attended 11 sessions or more.

In addition to therapy and case management services, 70% of records indicated the individual was provided education or assistance on accessing self-help or recovery groups. For these individuals, 4% attended between 1–4 self-help/recovery groups during treatment, 55% attended between 5–12 self-help/recovery groups during treatment, 2% attended 13–20 times during treatment, and 13% attended 21 or more self-help/recovery groups. Similar to

2022, 65% of records did not contain documentation showing the individual attended self-help/recovery groups.

If an individual demonstrated a lack of progress in meeting their ISP goals, program staff sought out consultation or revised the ISP 68% of the time. This is a 14% increase from 2022.

Table5-28: MC Treatment/Support Services/Rehabilitation Services

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. The following services were used in treatment:						
• Individual counseling/ therapy	128	109	85%	0	72%	71%
• Group counseling/ therapy	128	91	71%	0	73%	80%
• Family counseling/ therapy	128	3	2%	0	0%	0%
• Case management	128	119	93%	0	81%	74%
B. Was there clear documentation of progress or lack of progress towards the identified ISP goals?	128	117	91%	3	85%	91%
C. The number of completed counseling/therapy sessions during treatment was:						
• 0–5 sessions	128	40	31%	0	41%	29%
• 6–10 sessions	128	18	14%	0	11%	18%
• 11 sessions or more	128	70	55%	0	48%	53%
D. Was the individual given any education on self-help or recovery groups	128	90	70%	0	70%	New Measure
E. Documentation showed that the member reported attending self-help or recovery groups the following number of times:						
• No documentation	128	83	65%	0	66%	79%
• 0 times during treatment	128	14	11%	0	5%	3%
• 1–4 times during treatment	128	5	4%	0	3%	9%
• 5–12 times during treatment	128	7	5%	0	4%	3%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
• 13–20 times during treatment	128	2	2%	0	3%	3%
• 21 or more times during treatment	128	17	13%	0	19%	4%
F. If there was evidence of lack of progress towards the identified goal, did the provider revise the treatment approach and/or seek consultation to facilitate positive outcomes?	69	47	68%	47	54%	30%
G. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	59	49	83%	59	90%	82%
H. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	43	34	79%	70	67%	55%
I. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	59	49	83%	60	58%	59%
J. Does the documentation reflect that substance abuse services were provided?	128	124	97%	0	90%	97%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
K. Was member's access to a PCP or other medical provider explored?	128	107	84%	12	78%	82%

Measure V — Gender-Specific Key Findings

Providers documented 12 women's case files with a history of domestic violence. Of these, only four contained evidence that a safety plan was completed (33%). This is a decrease from FY 2022, in which 38% of records contained a safety plan when there was evidence of domestic violence. This metric was 56% in 2021, showing a three-year decline. Providers documented only a single pregnant woman, with no evidence of documentation of care coordination. This represents, again, a decrease from FY 2022 in which 50% of case files noted care coordination for pregnant women, and a further decrease from FY 2021, in which 100% of case files for pregnant women contained documentation that supported care coordination with the woman's PCP or obstetrician.

This sample included 11 women that had other dependent children. In these cases, there was evidence of coordination of childcare services in eight of those instances (73%). This is a decrease from 86% in 2022. It should also be noted that reviewers were only able to find evidence of gender-specific treatment services in 23% of the relevant cases. This is a significant decrease from 57% in 2022.

Table 5-29: MC Gender-Specific (Female Only)

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A 2023	% of Yes FY 2022	% of Yes FY 2021
A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	12	4	33%	32	38%	56%
B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	1	0	0%	43	50%	100%
C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?	1	0	0%	43	50%	67%
D. If the female had a child less than one year of age, was there evidence	3	1	33%	41	60%	67%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A 2023	% of Yes FY 2022	% of Yes FY 2021
that a screening was completed for postpartum depression/ psychosis?						
E. If the female had dependent children, was there documentation to show that childcare was addressed?	11	8	73%	33	86%	100%
F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	40	9	23%	4	57%	23%

Measure VI — Opioid-Specific Key Findings

Providers identified a diagnosis of OUD in 86% of the cases, a 26% increase from FY 2022. Of these, 97% were educated on MAT as a treatment option, and 97% of these individuals were referred to a MAT provider. Providers educated individuals 73% of the time on unintentional opioid overdose, naloxone, and steps to take in the event of an overdose, and provided the individual with naloxone or information on how to obtain naloxone 73% of the time.

Table 5-30: MC Opioid-Specific

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. Was there documentation of a diagnosed OUD?	70	60	86%	0	60%	51%
B. Was there documentation that the member was provided MAT education as a treatment option?	60	58	97%	0	85%	81%
C. If yes to VI B, were they referred to a MAT provider?	32	31	97%	8	94%	98%
D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	16	13	81%	39	98%	89%

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
E. If a physical health concern related to pain was identified, were alternative pain management options addressed?	70	60	86%	55	79%	64%
F. If member is a pregnant female, did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?	N/A	N/A	N/A	71	33%	33%
G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?	70	51	73%	0	54%	58%
H. Was the individual provided with naloxone or information on how to obtain naloxone?	70	51	73%	0	54%	New Measure
I. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	70	53	76%	0	59%	47%

Measure VII — Discharge and Continuing Care Planning Key Findings

Case review found that 67% of records contained a relapse prevention plan that was completed for individuals that completed treatment or declined further services, this is a 2% decrease from FY 2022 (69%). Sixty-three percent of cases had documentation supporting that resources for community support, including recovery, self-help, and other services, were offered.

This review found that MC providers are referring to the appropriate LOC based on ASAM determination in all cases in which a discharge ASAM assessment was documented. There

are also increases to the number of members being referred to community resources (63%, up from 61% in 2022) and that staff are actively coordinating with other relevant agencies (71% in 2023, up from 59% in 2022). It should be noted that there was a decrease in discharge reassessments using ASAM criteria to determine appropriate LOC (down to 33% from 55% in 2022).

Table 5-31: MC Discharge and Continuing Care Planning (completed only if member completed treatment or declined further services)

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A 2023	% of Yes FY 2022	% of Yes FY 2021
A. Was there documentation present that a relapse prevention plan completed?	115	77	67%	0	69%	69%
B. Was the individual reassessed at the time of discharge using ASAM criteria to determine an appropriate level of care?	115	38	33%	0	55%	New Measure
C. Was the individual referred to the appropriate level of care based on the ASAM determination?	34	34	100%	53	94%	New Measure
D. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g. crisis line)?	115	73	63%	0	61%	75%
E. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?	68	48	71%	47	59%	80%

Measure VIII — Reengagement Key Findings

MC providers noted a slight decrease in reengagement telephone contact from 81% in 2022 to 78% in 2023. This has been a continued area of decline from 89% in 2021. Follow-up letters requesting contact also slightly declined from 56% in 2022 to 55% in 2023. Home visits and contacting other involved agencies occurred in 11% of cases respectively.

Table 5-32: MC Reengagement (completed only if member declined further services or chose not to appear for scheduled services)

	Denominator	# of Yes FY 2023	% of Yes FY 2023	# of N/A FY 2023	% of Yes FY 2022	% of Yes FY 2021
A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?	64	50	78%	0	81%	89%
B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	44	24	55%	15	56%	75%
C. Were other attempts made to reengage the individual, such as:						
• Home visit?	9	1	11%	-	0%	0%
• Call emergency contact(s)?	9	0	0%	-	17%	22%
• Contacting other involved agencies?	9	1	11%	-	33%	78%
• Street outreach?	9	0	0%	-	0%	0%

Measure IX — NOMs Key Findings

Each of the seven MC NOMS for Measure IX is depicted in Tables 5-33 and 5-34. The denominator is determined and compared for both intake and discharge. Denominators are impacted by missing documentation of status at intake and discharge.

While the review has shown an increase in the number of individuals participating in social support recovery at intake versus at discharge, there was a slight decrease of participation at discharge at 64% compared to the prior year at 78%. Abstinence from drugs and/or alcohol showed a slight decline from 65% in 2022 to 61% in 2023. Employment status at discharge increased from 41% in 2022 to 56% in 2023.The number of individuals arrested within the past 30 days at discharge decreased from 5% in 2022 to 3% in 2023.

Table 5-33: 2023 MC National Outcome Measures

	At Intake			At Discharge		
	Denominator	# Yes FY 2023	% Yes FY 2023	Denominator	# Yes FY 2023	% Yes FY 2023
A. Employed?	123	63	51%	98	55	56%
B. Enrolled in school or vocational educational program?	115	4	3%	95	6	6%

	At Intake			At Discharge		
	Denominator	# Yes FY 2023	% Yes FY 2023	Denominator	# Yes FY 2023	% Yes FY 2023
C. On disability or retired?	108	14	13%	93	11	12%
D. Lived in a stable housing environment (e.g., not homeless)?	121	94	78%	95	78	82%
E. Arrested in the preceding 30 days?	117	7	6%	95	3	3%
F. Abstinent from drugs and/or alcohol?	121	29	24%	82	50	61%
G. Participated in social support recovery in the preceding 30 days?	128	25	20%	89	57	64%

Table 5-34: 2022 MC National Outcome Measures

	At Intake			At Discharge		
	Denominator	# Yes FY 2022	% Yes FY 2022	Denominator	# Yes FY 2022	% Yes FY 2022
A. Employed?	133	59	44%	75	31	41%
B. Enrolled in school or vocational educational program?	124	5	4%	72	0	0%
C. On disability or retired?	123	12	10%	71	8	11%
D. Lived in a stable housing environment (e.g., not homeless)?	131	96	73%	83	69	83%
E. Arrested in the preceding 30 days?	122	10	8%	77	4	5%
F. Abstinent from drugs and/or alcohol?	130	37	28%	85	55	65%
G. Participated in social support recovery in the preceding 30 days?	135	12	9%	82	64	78%

Informational Only

The outcome of items noted in the Methodology section that were recorded for informational only purposes found that 63% of cases were offered telehealth as an option, allowing for increased access to services and opportunity for successful treatment completion. An opportunity for harm reduction for people who use opioids is noted under the provision of

education on, and access to, naloxone for family members and natural supports, as this opportunity was documented in none of the 70 cases. When reviewers found evidence that transportation was considered as part of the ISP process, it was noted that the types of transportation considered were public or provider-supplied transport options.

Table 5-35: Informational Only Outcome of Items Noted in Methodology Section

	Denominator	# of Yes FY 2023	% of Yes FY 2023
Use of Nicotine Replacement Therapy	58	2	3%
Option for Telehealth	128	80	63%
Education and provision of naloxone to family members/natural supports	70	0	0%

Section 6
Recommendations

Carryover Recommendations from FY 2021 and FY 2022 ICRs

- **Consider changes to sampling methodology for future reviews.** As an option in future reviews, AHCCCS should consider increasing validity and reliability by using a more randomized sampling methodology. One method for achieving this would be to have the independent reviewer randomly select the sample cases to be reviewed (from the entire population of files that meet inclusion criteria) and then ask the ACC-RBHAs to supply those specific records. This would add some time to the process (when compared to having the ACC-RBHAs select files to provide), but it would increase confidence in the results and contribute to overall project validity. Mercer has used this sampling methodology in support of the Priority Mental Health Services review, which is conducted annually for AHCCCS. An additional benefit of using this sampling methodology is that the independent reviewer would have the opportunity to stratify the sample and increase the number of cases from small subpopulations that are reviewed (e.g., women, older adults, and transition-age youth). For example, this year's review only captured one additional pregnant woman (making three versus last year's two). This small representation within the sample makes it difficult to draw conclusions for this group. By using an appropriate sampling methodology, the independent reviewer could increase the representation of subpopulations in the sample while maintaining the randomness necessary for increased validity and reliability.
- **Clinical consideration for improved quality of care includes the following considerations:**
  - **Training and technical assistance on the importance and development of relapse plans at every LOC.** There were several instances where, upon discharge from one LOC to the next, the relapse plan was listed as an activity for the next provider. Relapse plans along an individual's full course of treatment are essential in their recovery.
  - **Training and technical assistance on the importance of and development of safety plans in cases of domestic violence.** The findings reflected that just over 50% of the women who shared being involved in a domestic violence situation had a documented safety plan. This measure, in particular, has declined year over year for the last three review periods. This is a missed opportunity by the treatment team that could have an impact on that member's level engagement and success in recovery.
  - **Expanding the focus of ICR next year to also target the older adult (aged 55 years and older) population.** With that added goal to increase the percent of older adults (aged 55 and older) that receive treatment in the BH system, who are diagnosed as having a SUD, and gathering feedback from the ACC-RBHAs and providers on the needs, strengths, and challenges for this age group would be advantageous in crafting specific questions and areas of focus. This feedback could

then be used to update the ICR tool and process for the next review to better assess performance toward this goal.

  - **Training and technical assistance on the importance of SDoH in treatment planning and care.** This builds off the recommendation from FY 2020 to encourage the ongoing focus on SDoH in treatment. Providers continue to document SDoH needs in the assessment. However, the SDoH findings are still lagging in the incorporation into treatment to actively work to address individual obstacles to recovery. Missed opportunities included goals and measurable strategies to address unemployment, housing, and transportation.
  - **Training and technical assistance to improve knowledge and skills for work with the justice-involved population.** This could also include an additional focus of the ICR targeted to the management of issues and interventions for justice-involved members, with the added goal to decrease recidivism and improve resocialization post-release to support recovery.
  - **Consider increasing available hours of services to allow individuals to work and still receive treatment.** Allowing for flexible hours to accommodate work schedules could result in improved engagement in some cases. Several of the records that were closed due to lack of engagement reflected that the reason for loss of contact was due to conflicting work commitments.

- **Consider additional training in EBPs for substance abuse treatment.** CBT and motivational interviewing remain common EBPs, and while they can be effective treatment modalities, other options more specific to substance use may be more efficacious, especially specific options for other groups such as women, pregnant women, or the elderly. During provider focus groups, it was noted that providers are most likely to have only used one of the curricula, such as the Matrix Model, in their training program, which may cause other options to be lower due to a preference of providers for a certain model. An additional variable that can impact the use of specific EBPs is the cost of and access to training and technical assistance on a specific practice. If it is difficult to find training or the training is costly, providers might select an EBP in which training is more accessible and less expensive. In addition, during the provider focus group interviews, it was noted that when the providers train clinicians in new evidence-based models, they often lose their investment in the staff and the model as the clinicians leave the agency for higher-paying jobs in the private sector.
- **Consider methods to increase family involvement in treatment.** Family involvement in treatment has been consistently low over the past three years, although there has been some improvement. Many individuals may not be ready to involve family members at the beginning of treatment due to poor relationships as a result of behaviors while using substances, stigma, lack of transportation, or family members may also have their own SUD. Exploring both the reasons for a lack of family engagement and potential solutions, such as the use of technology, to engage family members virtually or determine other sources of natural support as part of the treatment process, would assist in developing ongoing support for the member to retain gains made in treatment upon discharge. During member focus groups, it was noted that there was a desire for an increase in family engagement, especially toward the latter part of treatment, to increase family reintegration upon treatment completion.

- **Consider methods to coordinate with other agencies upon member discharge.** Individuals utilizing SUBG services do not have the same entitlements as individuals receiving Medicaid, and other resources may be difficult to obtain, such as a PCP other than a federally qualified health clinic or housing or employment resources, especially for those with a criminal background. Using peer supports to help identify resources and making warm hand-offs for individuals moving to a lower level of care may be two ways to address the coordination of needs when members discharge from treatment.

New Recommendations from FY 2023 ICR

- **Offer Training on ASAM criteria**. ASAM criteria are an internationally recognized set of dimensions for assessment of individuals with substance use as well as a continuum of substance use service settings. Additionally, the ASAM Criteria 4th Edition was released in 2023. Changes include a simplification of LOC, specificity within the dimensions, an increased emphasis on harm reduction, updating standards for co-occurring care, and emphasizing person-centered treatment planning. Although not currently required by any funding agency, such as SAMHSA, training on the new ASAM criteria will assist providers in improving system delivery and in offering the most current best practices in substance use treatment, updating terminology, simplifying levels of care and building specificity within the dimensions.
- **Increase efforts toward reengagement and harm reduction.** Focus group participants also noted that one of the primary reasons people leave early is a lack of contact due to ambivalence or relapse. Efforts to address this have included education and talking to members to let them know that, if they use, they can still come back and will not be discharged due to a positive toxicology. In addition, multiservice agencies that may provide other services, such as physical health or mental health treatment, attempt to educate members that they can still utilize physical health or other services even if they relapse or discontinue substance use treatment services. A more cohesive statewide educational effort may assist in educating members about the ability to receive services despite a relapse as well as educate members and families about harm reduction. Mobile services may also assist in engagement efforts to provide services to those lacking in transportation, where appropriate. Increased harm reduction efforts related to access to naloxone were reflected in ICR findings as a strength, and additional efforts, such as education on substance use, work to destigmatize substance use, and seeking treatment, should continue, as well as continued efforts to engage members in different ways such as through mobile MAT and primary care offices.

Appendix A
Case File Review Tool

Note: Newly added items for the 2023 ICR have been highlighted in yellow.

File Review Tool

Substance Abuse Prevention and Treatment	
Case File Review Findings for Measure I-IX	
I	**Intake/Treatment Planning**
A. What was the primary substance used? 1. Opioids 2. Marijuana 3. Alcohol 4. Amphetamines 5. Cocaine 6. Other (please list)	
B. What was the method of ingestion? 1. Smoking 2. Oral 3. Inhalation 4. Injection 5. Transdermal 6. Other (please list)	
C. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	
Did the behavioral health assessment:	
1. Address substance-related disorder(s)?	
2. Describe the intensity/frequency of substance use?	
3. Include the effect of substance use on daily functioning?	
4. Include the effect of substance use on interpersonal relationships?	
5. Was a risk assessment completed?	
6. Document screening for tuberculosis (TB)?	
7. Document screening for Hepatitis C, HIV, and other infectious diseases?	
8. Document screening for emotional and/or physical abuse/trauma issues?	

Substance Abuse Prevention and Treatment	
Case File Review Findings for Measure I-IX	
9. Documentation that review of the Prescription Drug Monitoring Program (PDMP) was completed?	
D. Was there documentation that charitable choice requirements were followed, if applicable?	
E. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	
Was the ISP:	
1. Developed with participation of the family/support network?	
2. Congruent with the diagnosis(es) and presenting concern(s)?	
3. Measurable objectives and timeframes to address the identified needs?	
4. Addressing the unique cultural preferences of the individual?	
5. Were social determinants of health issues considered as part of, and incorporated into, the ISP? If yes, which domains? a. Access to Medical Care? b. Housing? c. Food Insecurity? d. Domestic Violence? e. Unemployment? f. Transportation? g. What options were explored if transportation was determined to be a social determinant of health issue? h. Other?	
II	**Placement Criteria/Assessment**
A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?	
1. If the ASAM Patient Placement Criteria were used, the level of service identified was:	
Level 0.5: Early Intervention	
OMT: Opioid Maintenance Therapy	
Level 1: Outpatient Treatment	
Level 2: Intensive Outpatient Treatment/Partial Hospitalization	
Level 3: Residential/Inpatient Treatment	
Level 4: Medically Managed Intensive Inpatient Treatment	
B. Did the member receive the level of services identified by the placement criteria/assessment?	
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	
D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment? If yes, please list in box below:	

Substance Abuse Prevention and Treatment	
Case File Review Findings for Measure I-IX	
III	**Best Practices**
Were evidence-based practices used in treatment?	
1. The following evidence-based practices were used in treatment:	
Adolescent Community Reinforcement Approach (ACRA)	
Beyond Trauma: A Healing Journey for Women	
Cognitive Behavioral Therapy (CBT)	
Contingency management	
Dialectal Behavioral Therapy (DBT)	
Helping Women Recover	
Matrix	
Moral Re-conation Therapy (MRT)	
Motivational Enhancement/ Interviewing Therapy (MET/MI)	
Relapse Prevention Therapy (RPT)	
Seeking Safety	
SMART Recovery	
Thinking for a Change	
Trauma Recovery and Empowerment Model (TREM)	
Trauma-Informed Care (TIC)	
Wellness Recovery Action Plan (WRAP)	
Other Practices or Programs (please list in box below):	
Medication Assisted Treatment (MAT)	
1. The following medication was used in treatment:	
Alcohol-related	
Acamprosate (Campral)	
Disulfiram (Antabuse)	
Opioid-related	
Subutex (buprenorphine)	
Methadone/Levo-Alpha-Acetylmethadol (LAAM)	
Narcan (naloxone)	
Vivitrol (long-acting naltrexone)	
Suboxone (buprenorphine-naloxone)	
Nicotine	
Nicotine Replacement Therapy	

Substance Abuse Prevention and Treatment	
Case File Review Findings for Measure I-IX	
A. Was screening for substance use/abuse conducted during the course of treatment?	
B. Was certified peer support offered as part of treatment?	
If yes to III.I.D, were certified peer support services used as a part of treatment?	
C. Was telehealth offered as an option to receive treatment?	
IV	**Treatment/Support Services/Rehabilitation Services**
	A. The following services were used in treatment:
	Individual counseling/therapy
	Group counseling/therapy
	Family counseling/therapy
	Case management
	B. Was there clear documentation of progress or lack of progress toward the identified ISP goals?
	C. The number of completed counseling/therapy sessions during treatment was:
	0–5 sessions
	6–10 sessions
	11 sessions or more
	D. Was there documentation that the member was educated on the use of self-help or recovery groups?
	E. Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:
	No documentation
	0 times during treatment
	1–4 times during treatment
	5–12 times during treatment
	13–20 times during treatment
	21 or more times during treatment
	F. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation to facilitate positive outcomes?
	G. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?
	H. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?
	I. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?
	J. Does the documentation reflect that substance abuse services were provided?

Substance Abuse Prevention and Treatment	
Case File Review Findings for Measure I-IX	
	K. Was member's access to a primary care physician (PCP) or other medical provider explored?
V	**Gender-Specific (Female and Female Identified only)**
	A. If there was a history of domestic violence, was there evidence that a safety plan was completed?
	B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?
	C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?
	D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?
	E. If the female had dependent children, was there documentation to show that childcare was addressed?
	F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?
VI	**Opioid Specific**
	A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?
	B. Was there documentation that the member was provided MAT education as a treatment option?
	C. If yes to VI B, were they referred to a MAT provider?
	D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?
	E. If a physical health concern related to pain was identified, were alternative pain management options addressed?
	F. If member is a pregnant female, did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?
	G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?
	H. Was the member provided with naloxone or information on how to obtain naloxone?
	I. Were family members/natural supports provided information on how to obtain naloxone/provided naloxone, and actions to take in the event of an opioid overdose, if applicable?
	J. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?
VII	**Discharge and Continuing Care Planning**
	(completed only if member completed treatment or declined further services)
	A. Was there documentation present that a relapse prevention plan completed?
	B. Was there documentation that ASAM criteria was reassessed at the time of discharge?
	C. If yes, was the individual referred to the appropriate level of care?
	D. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g. crisis line)?

Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
	E. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?					
VIII	**Reengagement**					
	(completed only if member declined further services or chose not to appear for scheduled services)					
	The following efforts were documented:					
	A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?					
	B. If telephone contact was unsuccessful, was a letter mailed requesting contact?					
	C. Were other attempts made to reengage the individual, such as:					
	Home visit?					
	Call emergency contact(s)?					
	Contacting other involved agencies?					
	Street Outreach?					
	Other (please list other identified outreach efforts in the box below)					
IX	**National Outcome Measures**					
	At Intake			At Discharge		
	Yes	No	Missing	Yes	No	Missing
A. Employed?						
B. Enrolled in school or vocational educational program?						
C. On disability or retired?						
D. Lived in a stable housing environment (e.g., not homeless)?						
E. Arrested in the preceding 30 days?						
F. Abstinent from drugs and/or alcohol?						
G. Participated in social support recovery in the preceding 30 days?						

Appendix B
Case File Review Instructions

AHCCCS Substance Use Prevention and Treatment Block Grant (SUBG) FY 2024 Case File Review Instructions

The items below correspond to the 2024 (Review Period July 1, 2022–June 30, 2023) SUBG Case File Review Tool. Each case file will contain **one treatment segment.** For the purposes of this review, only supporting documentation falling between the **"date of intake"** and the **"date of closure"** for the selected treatment segment will be reviewed. The date of intake and date of closure are pre-populated on the case file review tool. The length of treatment will range from 30 days to 365 days. There must be at least one episode of care, otherwise the **case should not be used,** and a replacement case from the oversample should be requested.

1. **Intake/Treatment Planning:**

   A. **Primary substance use**: This is a new question added to the tool to collect/confirm the primary substance used that is the focus of the referral and treatment. Since this is intended to capture the **primary** substance, only choose **one** response for this question. Choose **"Other"** if the primary substance is not listed. List the other substance in the text box provided.

   B. **Method of substance ingested:** This is a new question and is intended to be the follow-up to the answer in **1.A.** Indicate the method of ingestion for the primary substance only. If the method of ingestion is not noted or clear in the record, please select **"Unknown."** Do not infer the method.

   C. **Assessment:** Review the case file to determine whether a **comprehensive** assessment was completed at intake **within 45 days of the initial appointment**. The addendum sections of the Core Assessment are completed based on the needs of the individual; however, a comprehensive assessment allowing for sound clinical formulation and diagnostic impression must be completed within 45 days of the initial appointment. Answer **YES**, if a comprehensive assessment was completed within 45 days of the initial appointment. Answer **NO**, if a comprehensive assessment is not present in the case file or if the assessment was not completed within 45 days of the initial appointment. Answer **N/A** if there is not a comprehensive assessment present, and the case closed prior to 45 days from the initial appointment

      For each component related to the assessment process below (i–ix), consider the information contained in the comprehensive initial assessment completed within 45 days of the initial intake appointment:

      i. Review the assessment to determine whether it addressed substance-related disorder(s). Answer **YES**, if the assessment addressed this component. If the assessment did not address a substance-related disorder, answer **NO**.

ii. Review the assessment to determine whether the assessment described the intensity/frequency of substance use. Answer **YES**, if the assessment addressed this component. If the assessment did not describe the intensity/frequency of substance use, answer **NO**.

iii. Review the assessment to determine whether the assessment included the effect of substance use on daily functioning. Answer **YES**, if the assessment addressed this component. If the assessment did not describe the effect of substance use on daily functioning, answer **NO**.

iv. Review the assessment to determine whether the assessment described how substance use affects the interpersonal relationships of the individual. Answer **YES**, if the assessment addressed this component. If the assessment did not describe how substance use affects the interpersonal relationships of the individual, answer **NO**.

v. Review the assessment to determine whether a risk assessment was completed. The risk assessment may be contained within the standardized core assessment or may consist of a comparable RBHA- or provider-specific form, but should be completed as part of the comprehensive assessment within 45 days of the initial appointment. Answer **YES**, if the assessment addressed this component. If the assessment did not address this component, answer **NO**.

vi. Review the assessment to determine whether it contains documentation of screening for tuberculosis (TB). Answer **YES**, if the assessment included documentation of screenings for TB. If the assessment did not contain documentation of screenings for TB, answer **NO**. Screening may include testing; education; referrals for screening and services; follow-up counseling that addresses identified services; and an evaluation of history, risk factors, and/or screening tools.

vii. Review the assessment to determine whether it contains documentation of screening for hepatitis C, HIV, and other infectious diseases. Answer **YES**, if the assessment included documentation of screenings for hepatitis C, HIV, and other infectious diseases screening. If the assessment did not contain documentation of screenings for hepatitis C, HIV, and other infectious diseases, answer **NO**. Screening may include testing; education; referrals for screening and services; follow-up counseling that addresses identified services; and an evaluation of history, risk factors, and/or screening tools.

viii. Review the assessment to determine whether it contains documentation of screening for emotional and/or physical abuse/trauma issues. Answer **YES**, if the assessment included documentation of screening for abuse/trauma issues. If the assessment did not contain evidence, answer **NO**.

ix. Review the assessment to determine whether the State's prescription drug monitoring program (PDMP) was reviewed to determine if the individual is receiving controlled substance prescriptions and if it is addressing potential patient concerns in treatment. Answer **YES**, if the assessment contains

documentation of review of the PDMP and **NO** if the assessment did not contain evidence.

D. **Charitable Choice:** Review the assessment to determine whether it contains documentation that charitable choice requirements were followed as outlined in 42 CFR Part 54. Answer **YES**, if the assessment included documentation that charitable choice requirements were being followed. If the assessment did not contain evidence, answer **NO**. Answer **N/A** if charitable choice did not apply in this case.

E. **Individual Service Plan (ISP):** Review the case file to determine whether an ISP was completed within **90 days** of the initial appointment. **The interim service plan should not be considered when responding to this question**. Answer **YES**, if an ISP was completed within 90 days of the initial appointment. Answer **NO**, if an ISP is not present in the case file or if the service plan was not completed within 90 days of the initial appointment. Answer **N/A** if there is not an ISP, and the case closed prior to 90 days from the initial appointment

For each component related to the ISP process below (i–v), consider the information contained in the ISP completed within 90 days of the initial intake appointment. Updates to the service plan should not be considered when responding to the questions below:

i. Review the service plan to determine whether it was developed with the participation of the individual's **family and/or support network**, when appropriate. If there is evidence that staff made efforts to actively engage the involved family members/support network in the treatment planning process, answer **YES**. If there is evidence that these individuals would have an impact on treatment planning, but there is no evidence of staff efforts to engage them, answer **NO**. Answer **N/A** if there is no family/support network or if the individual declined inclusion of others in the service planning process. Evidence of engagement attempts may include verbal or written efforts to solicit their input.

ii. Review the service plan to determine whether the scope, intensity, and duration of services offered was congruent with the diagnosis(es) and presenting concern(s). If the scope, intensity, and duration of services offered were congruent with the diagnosis(es), answer **YES**. If the scope, intensity, and duration of services offered were not congruent with the diagnosis(es), answer **NO**.

iii. Review the service plan to determine whether objectives are measurable and identify timeframes for the identified needs to be met. If the objectives are measurable and identify timeframes for the identified needs to be met, answer **YES**. If the objectives are not measurable and do not identify timeframes, answer **NO**.

iv. Review the service plan to determine whether it addressed the unique cultural preferences of the individual. Cultural preferences may include the influences and background of the individual with regard to language, customs, traditions, family, age, gender, ethnicity, race, sexual orientation, and socioeconomic class. If the unique cultural preferences of the individual were addressed, answer **YES**. If the unique cultural preferences of the individual were not addressed, answer **NO**.

v. Review the service plan to determine whether it addresses social determinants to see if SDOH were considered as part of, and incorporated into, the ISP. If SDOH were addressed, answer **YES**. If SDOH were not addressed, answer **NO**. If the answer is **YES**, the specific SDOH that were addressed should be noted below. If the SDOH noted was addressed, the answer should be **YES**. If it was not addressed the answer should be **NO**. If it does not apply to the individual, it should be **N/A.**

a. **Access to Medical Care.** This domain should consider whether or not the individual has access to a primary care physician and has had a physical within the past year.

b. **Housing.** This domain should consider whether the individual has secure housing (i.e., is not sleeping on couches and has no immediate danger of eviction or homelessness). Housing insecurity should be considered poor housing quality, unstable neighborhoods, overcrowding, and high housing costs relative to income.

c. **Food Insecurity.** This domain will consider whether the individual does not have access to sufficient food or food of an adequate quality to meet one's needs.

d. **Domestic Violence.** This domain is a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, psychological, or technological.

e. **Unemployment.** This domain refers to individuals who are old enough and are physically and mentally able to work but are not in paid employment or self-employment.

f. **Transportation.** This domain is a condition in which an individual is unable to regularly move from place to place in a safe and timely manner because one lacks the material, economic, or social resources necessary for transportation.

- **If transportation is selected, provide what type of transportation options were explored in the text box provided.** *Note: this is a new addition to the question.*

g. Other (please list): This item should include any domain that might be considered a social determinant of health not listed above. If indicated as a **YES**, the blank should be filled in with a brief description, such as childcare.

2. **Placement Criteria/Assessment:**

A. Review the case file to determine whether the American Society of Addiction Medicine (ASAM) dimensions were used at intake to determine the criteria to identify the appropriate level of care via the Patient Placement Criteria. If the ASAM tool was completed, answer **YES**. If the ASAM tool was not completed, answer **NO**. Providers are allowed to create their own ASAM document.

i. If the ASAM tool was completed at intake, select the level of care identified by the tool. If the case file has evidence of opioid maintenance therapy (OMT), please also mark that option in addition to the ASAM level of care. *Note: If OMT is selected here, we would expect additional information noted in the Opioid-related section on the Best Practices tab.*

Level 0.5: Early Intervention

OMT: Opioid Maintenance Therapy

Level 1: Outpatient Treatment

Level 2: Intensive Outpatient Treatment/Partial Hospitalization

Level 3: Residential/Inpatient Treatment

Level 4: Medically Managed Intensive Inpatient Treatment

ii. Review the case file to determine whether the individual received the level of care identified by the ASAM tool. If the individual received the level of services identified by the placement criteria/assessment, answer **YES**. If not, answer **NO**.

B. Review the case file to determine whether the individual received the level of care identified by the ASAM tool. If the individual received the level of services identified by the placement criteria/assessment, answer **YES**. If not, answer **NO**.

C. Review the case file to determine whether an ASAM tool was completed during the course of treatment at any time subsequent to intake/assessment. It is not necessary for the ASAM tool result to change if it is considered an updated tool. If an ASAM tool was completed after intake, answer **YES**. If an ASAM tool was not completed after intake, answer **NO**.

D. Review the case file to determine whether an assessment tool (can include other multi-dimensional placement criteria tools in lieu of ASAM) was utilized during treatment at any time subsequent to intake/assessment. If an additional assessment tool was completed after the intake ASAM, answer **YES**. If answer is **YES**, please list the name of the tool in the box below. If an assessment tool was not completed after the intake ASAM, answer **NO**.

3. **Best Practices:**

A. Review the case file to determine whether it contains evidence that evidence-based practices were implemented in treatment. Answer **YES**, if the case file contains evidence-based practices. If not, answer **NO**. If there is not sufficient documentation available to verify that evidence-based practice was used (e.g., an evidence-based practice was not mentioned in the treatment progress notes), answer **NO DOCUMENTATION**.

i. Identify **each** type of evidence-based practice documented in the case file:

- Adolescent Community Reinforcement Approach (A-CRA)
- Beyond Trauma: A Healing Journey for Women

- Cognitive Behavioral Therapy (CBT)
- Contingency management
- Dialectal Behavioral Therapy (DBT)
- Helping Women Recover
- Matrix
- Moral Re-conation Therapy (MRT)
- Motivational Enhancement/Interviewing Therapy (MET/MI)
- Relapse Prevention Therapy (RPT)
- Seeking Safety
- SMART Recovery
- Thinking for a Change
- Trauma Recovery and Empowerment Model (TREM)
- Trauma-Informed Care (TIC)
- Wellness Recovery Action Plan (WRAP)
- Other: Identify other evidence-based practices utilized (**Enter the evidence-based practice in the text box below.**)

B. Medication-assisted treatment (**for substance use treatment only**). If there was evidence of MAT, answer **YES**. Answer **NO** if there was no documentation of MAT. If **YES** is chosen, identify each medication used in the treatment of substance use:

- Alcohol- Related
- Acamprosate (Campral)
- Disulfiram (Antabuse)
- Opioid-Related
- Subutex (buprenorphine)
- Methadone/Leva-Alpha-Acetylmethadol (LAAM)
- Narcan (naloxone)
- Vivitrol (long-acting Naltrexone)
- Suboxone (buprenorphine – naloxone)
- Nicotine (Informational Only)
- Nicotine Replacement Therapy (Informational Only)

C. Review the case file to determine whether it contains evidence that the individual was screened for substance use/abuse during treatment. Answer **YES**, if the case file contains evidence that the individual was screened for substance use. Answer **NO** if documentation of screening for substance use was not present in the case file.

D. Review the case file to determine whether peer support/coaches (e.g., peer worker) were offered as part of the treatment continuum. If evidence is present in the case file, answer **YES**. If evidence is not present in the case file, answer **NO**. Answer **N/A** if the individual declined peer support services.

   i. If **YES** to D, review the case file to determine whether peer support/coaches were used as part of the treatment continuum. If evidence is present in the case file, answer **YES**. If evidence is not present in the case file, answer **NO**. If the answer to D is **NO**, do not answer this item.

E. Review the case file to determine whether telehealth was offered as an option to receive treatment. If evidence is present in the case file, answer **YES**. If evidence is not available in the case file, answer **NO**. *Note: This is a new question and is being collected for informational purposes only.*

4. **Treatment/Support Services/Rehabilitation Services:**

A. Review the case file to identify which services the individual received during the course of treatment. Answer **YES** next to each service received. Answer **NO** next to the services that were not received during treatment.

- Individual counseling/therapy
- Group counseling/therapy
- Family counseling/therapy
- Case management

B. Review the case file to determine whether documentation (e.g., progress notes) shows evidence of progress or lack of progress toward the identified treatment goals. If the documentation shows progress or lack of progress toward the identified treatment goals, answer **YES**. If the case file does not show evidence of progress or lack of progress toward the identified ISP goals, answer **NO**. Answer **N/A** if there is not an ISP present in the case file. You may also answer **N/A** if services provided are recent (in the 30 days) and there is no change in progress.

C. Review the case file to determine the number of counseling/therapy sessions the individual attended during the course of treatment. Treatment sessions include individual and group sessions. Select the appropriate response:

- 0–5 treatment sessions
- 6–10 treatment sessions
- 11 sessions or more

D. Review the case file to determine whether the individual was given any education on self-help or recovery groups and how they may be effective in attaining and retaining sobriety. This may include the individual being asked whether they would like information but declining. If information is offered, mark this item as **YES**. If there is no documentation of information being provided, mark this item as **NO**.

E. Review the case file to determine how many self-help or recovery group sessions (e.g., Alcoholics Anonymous, Narcotics Anonymous) the individual reported attending during the course of treatment. Select the appropriate response:

- No documentation
- 0 times during treatment (includes those individuals that were referred to self-help groups but did not attend)
- 1–4 times during treatment
- 5–12 times during treatment
- 13–20 times during treatment
- 21 or more times during treatment

F. If there was evidence of lack of progress toward the identified goal, review the case file to determine whether staff revised the treatment approach and/or sought consultation to facilitate symptomatic improvement. Answer **YES**, if the provider revised the treatment approach and/or sought consultation. If not, answer **NO**. Answer **N/A** if symptomatic improvement is present in the case file.

G. If the individual was **NOT** employed at the time of intake, review the case file to determine whether the individual's interest in finding employment was explored. Answer **YES**, if there is evidence that the individual's interest in finding employment was explored. If not, answer **NO**. Answer **N/A** if the individual was employed at the time of intake, or employment is not relevant to the individual's situation (e.g., the individual is participating in a vocational program).

H. If the individual was **NOT** involved in an education or vocational training program at the time of intake, review the case file to determine whether the individual's interest in becoming involved in a program was explored. Answer **YES**, if there is evidence that the individual's interest in becoming involved in an educational or vocational training program was explored. If evidence is not present, answer **NO**.

Answer N/A if the individual was involved in an education or vocational training program at the time of intake, or it is not relevant to the individual's situation (e.g., the individual was employed).

I. If the individual was NOT involved in a meaningful community activity (volunteering, caregiving to family or friends, and/or any active community participation) at the time of intake, review the case file to determine whether the individual's interest in becoming involved in a community activity was explored. Answer **YES**, if there is evidence that the individual's interest in a community activity was explored. Answer **NO** if the individual's interests were not explored. **Answer N/A if the individual was**

involved in a community activity at the time of intake or if it is not relevant to the individual's situation (e.g., the individual was participating in a vocational program or employed).

J. Review the case file to determine whether the documentation reflects that substance use services were rendered. If the documentation in the case file reflects that services were provided for the treatment of substance use, answer **YES**. Answer **NO** if documentation does not reflect that substance use services were rendered.

K. Review the case file to determine whether the documentation reflects that access to a primary care physician/other medical provider was explored. If the documentation in the case file reflects the exploration of a PCP, answer **YES**. Answer **NO** if documentation does not reflect exploration of a PCP. Answer **N/A** if medical services were not relevant for the individual treatment (i.e., indication of good health and no medical needs).

5. **Gender-Specific (Female and Female-Identified Only):**

If the patient is male and identifies as a male, this section of the database will be closed. You will not respond to the following Section 5 questions:

A. Review the case file to determine whether it includes a safety plan, **in which there are domestic violence issues present**. If the case file contains a safety plan, answer **YES**. If the case file does not contain a safety plan, answer **NO**. Answer **N/A** if there are no domestic violence issues present.

B. **If the individual was pregnant**, review the case file to determine whether there is evidence that staff coordinated substance use treatment with the physician/obstetrician. If there is evidence in the case file indicating that staff coordinated substance use treatment, answer **YES**. Answer **NO** if staff did not coordinate with the physician/obstetrician. Answer **N/A** if the service provider does not apply (**e.g., the individual was not pregnant**). Since an adult individual must give permission for release of information, this should be considered when responding. Coordination of care includes verbal or written efforts to solicit their input or share information.

C. **If the individual was pregnant**, review the case file to determine whether there is evidence that staff provided education pertaining to the effects of substance use on fetal development. Answer **YES** if the case file contains evidence. Answer **NO** if evidence is not present. **Answer N/A if the individual was not pregnant.**

D. If the individual has a child less than one year of age, review the case file to determine whether screening was completed for postpartum depression/psychosis. If evidence is present in the case file, answer **YES**. If evidence is not present in the case file, answer **NO**. Answer **N/A** if the individual does not have a child less than one year in age.

E. If the individual has dependent children, review the case file to determine whether childcare was addressed. If evidence is present in the case file, answer **YES**. If evidence is not present in the case file, answer **NO**. Answer **N/A** if the individual does not have dependent children.

F. Review the case file to determine whether gender-specific treatment services were offered and/or provided (e.g., women's-only group therapy sessions, female peer/recovery support/coaches) as part of the treatment continuum. If evidence is present in the case file, answer **YES**. If evidence is not present in the case file, answer **NO**. Answer **N/A** if the individual declined gender-specific services.

6. **Opioid-Specific (only for records that indicate opioid use):**

A. Review the case file to determine whether it contains evidence that the individual has a **diagnosed Opioid Use Disorder (OUD)**. Answer **YES**, if the case file contains evidence that the individual has been diagnosed with OUD. Answer **NO** if documentation an OUD was not present in the case file.

B. Review the case file to determine whether it contains documentation that medication-assisted treatment (MAT) education was a treatment option. If there is documentation that the member was offered MAT education as an option, answer **YES**. Answer **NO** if documentation is not present in the case file.

C. If the answer to **6.B.** was **YES**, and there is documentation that a referral was made to a MAT provider, answer **YES**. If the answer to **6.B.** is **YES**, but no referral to a MAT provider was made, answer **NO**. If the answer to **6I.B.** was **NO**, answer **N/A**.

D. Review the case file to determine whether there is evidence that the member had withdrawal symptoms that were addressed via referral and/or intervention with a medical provider. If there is evidence that the withdrawal symptoms were addressed via referral and/or intervention with a medical provider, answer **YES**. Answer **NO** if evidence shows that withdrawal symptoms were not addressed via referral and/or intervention with a medical provider. Answer **N/A** if no withdrawal symptoms were documented.

E. Review the case file to determine whether there is documentation that alternative pain management options were addressed if the member reported a physical health concern. Answer **YES** if alternative pain management options were addressed if the member reported a physical health concern. Answer **NO** if the member reported a physical health concern, and there is no evidence that alternative pain management options were addressed. Answer **N/A** if there is no evidence of physical health concerns related to pain.

F. If the individual is pregnant, review the case file to determine whether there is evidence that staff provided education pertaining to the safety of methadone and/or buprenorphine during the course of the pregnancy. Answer **YES**, if the case file contains evidence. Answer **NO** if evidence is not present. **Answer N/A if the individual is not pregnant.**

G. Review the case file to determine whether there is evidence that the member was provided relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose. Answer **YES**, if the case file contains evidence. Answer **NO** if evidence is not present.

H. Review the case file to determine whether the individual was provided with naloxone or information on how to obtain naloxone. Answer **YES**, if the case file contains evidence. Answer **NO** if evidence is not present.

I. Review the case file to determine whether the individual's family members/natural supports were provided with information on overdoses, naloxone education, information on how to obtain naloxone, and actions to take in the event of an opioid overdose. Answer **YES**, if the case file contains evidence. Answer **NO** if evidence is not present. Answer, **N/A** if the individual does not have any family involvement or has declined family involvement. *Note: This is a new question added for informational purposes only.*

J. Review the case file to determine whether there is evidence that the member was provided education on the effects of polysubstance use with opioids. Answer **YES**, if the case file contains evidence. Answer **NO** if the evidence is not present.

7. **Discharge and Continuing Care Planning (only completed if the individual completed treatment or declined further services):**

A. Review the case file to determine whether a relapse prevention plan was completed. If evidence is present in the case file, answer **YES**. If evidence is not present in the case file, answer **NO**.

B. Review the case file to see whether the individual was reassessed at the time of discharge using ASAM criteria to determine an appropriate level of care. If evidence is present in the case file, answer **YES**. If evidence is not present in the case file, answer **NO**.

C. If the answer to 7.B. is **YES**, review the case file to see whether the individual was referred to the appropriate level of care based on the ASAM determination. If evidence is present in the case file, answer **YES**, even if the referral is declined. If evidence is not present in the case file, answer **NO**. If the answer to 7.B. is **NO**, mark the response **N/A**.

D. Review the case file to determine whether there is evidence that staff provided resources pertaining to community supports, including recovery self-help groups and/or other individualized support services. If there is evidence that staff provided resource and/or referral information, answer **YES**. A **YES** response indicates that staff provided information and/or referral regarding at least one resource. If evidence is not present, answer **NO**.

E. Review the case file to determine whether staff actively coordinated with other involved agencies at the time of discharge. If there is evidence in the case file indicating staff attempted to coordinate/communicate with other involved agencies, answer **YES**. Answer **NO** if staff did not make efforts to coordinate with other involved agencies at the time of discharge. Answer **N/A** if there were no other agencies involved. Since an adult individual must give permission for other involved parties to participate in treatment, this should be considered when responding. Coordination of care includes verbal or written efforts to solicit their input or share information.

8. **Reengagement (only completed if the individual declined further services or chose not to appear for scheduled services, including closure for loss of contact):**

   Review the case file to determine whether the following outreach activities were conducted in an effort to re engage the individual prior to closure:

   A. **Contacting the individual (or legal guardian, if applicable) by telephone, at times when the person may be expected to be available (e.g., after work or school)** — Answer **YES** if telephone contact was attempted. Answer **NO** if telephone contact was not attempted.

   B. If telephone contact was unsuccessful, a letter was mailed requesting contact — Answer **YES** if a letter was sent to the individual. Answer **NO** if a letter was not sent to the individual. Answer **N/A** if attempts to reach the member through other means were successful.

   C. **Were other attempts made to reengage, such as:**

      - Home visit?
      - Call emergency contact(s)?
      - Contacting other involved agencies?
      - Street outreach
      - Other (please enter the type of reengagement in the box below).

      Review the case file to determine whether other attempts for outreach were made to reengage with the individual. If yes, **please select all that apply**.

9. **National Outcome Measures (NOMs):**

   For each measure below, answer **YES** or **NO** based on the individual's status at the time of intake and at the time of discharge. Answer **MISSING** if there is no documentation of the NOMs at time of intake and/or discharge:

   A. Employed at intake? Employed at discharge?

   B. Enrolled in school or vocational educational program at intake? Enrolled in school or vocational educational program at discharge?

   C. On disability or retired at intake? On disability or retired at discharge?

   D. Lived in a stable housing environment at intake (not homeless)? Lived in a stable housing environment at discharge (not homeless)?

   E. Arrested 30 days prior to treatment? Arrested 30 days prior to discharge?

   F. Was the individual abstinent from alcohol and/or drugs at intake? Was individual abstinent from alcohol and/or drugs at discharge?

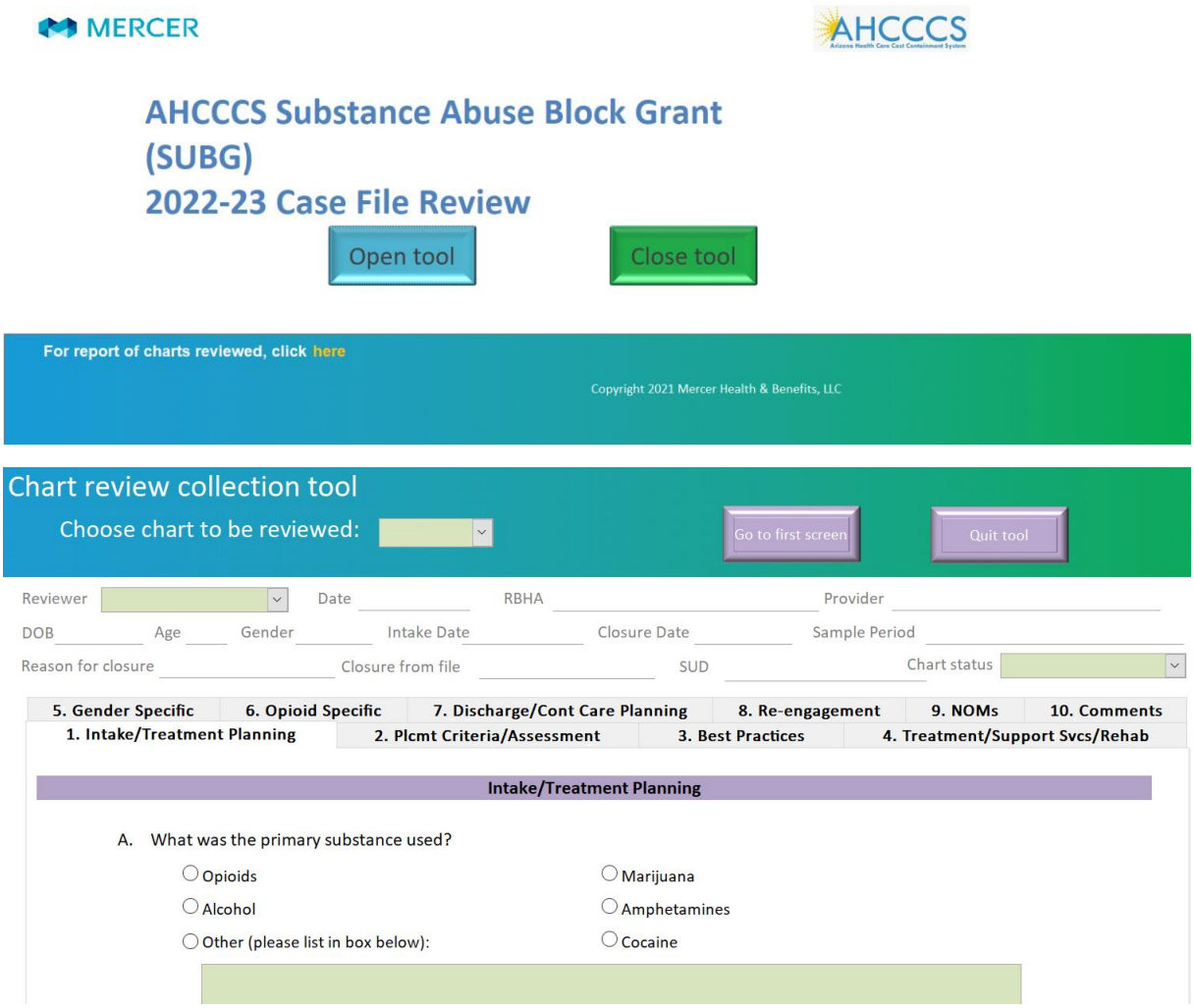
   G. Participated in Social Support Recovery 30 days prior to treatment? Participated in Social Support Recovery 30 days prior to discharge?

10. **Comments:**

Include any free text observations, strengths, and opportunities for improvement.

Appendix C
Case File Electronic Review Tool

Reviewers used an Access review tool prepopulated with relevant record data. Below are sample screen shots of the tool.



B. What was the method of ingestion?

- ○ Smoking
- ○ Inhalation
- ○ Transdermal
- ○ Oral
- ○ Injection
- ○ Unknown
- ○ Other (please list in box below):

C. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?

Did the behavioral health assessment:

- Address substance-related disorder(s)?
- Describe the intensity/frequency of substance use?
- Include the effect of substance use on daily functioning?
- Include the effect of substance use on interpersonal relationships?
- Was a risk assessment completed?
- Document screening for tuberculosis (TB)?
- Document screening for Hepatitis C, HIV and other infectious diseases?
- Document screening for emotional and/or physical abuse/trauma issues
- Documentation that review of the Prescription Drug Monitoring Program (PDMP) was completed?

D. Was there documentation that charitable choice requirements were followed, if applicable?

E. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?

Was the ISP:

- Developed with participation of the family/support network?
- Congruent with the diagnosis(es) and presenting concern(s)?
- Measurable objectives and timeframes to address the identified needs
- Addressing the unique cultural preferences of the individual?
- Were SDOH issues considered as part of, and incorporated into, the ISP?

If yes, choose all that apply.

- ○ Access to Medical Care
- ○ Food insecurity
- ○ Housing
- ○ Unemployment
- ○ Transportation (If transportation was determined as a need, describe options explored such as ride share or public transportation):
- ○ Domestic Violence
- ○ Other (please list in box below):

Appendix D
Stakeholder Findings

Focus Groups

Mercer organized five focus groups, to provide additional qualitative information to AHCCCS, including strengths and opportunities, areas of concern, and follow-up areas from the ICR such as methods to increase family engagement in treatment. The focus group sessions were facilitated virtually for ACC-RBHA staff and SUD providers, and facilitated in person for members. Mercer staff prepared outreach materials to engage interested participants from SUBG providers, members receiving SUBG services, and ACC-RBHA staff. Each focus group had a minimum of at least three participants. The focus groups were facilitated by two Mercer consultants, with notes of each focus group collected and transcribed for analysis. The goal of the focus groups was to provide qualitative information to AHCCCS to further enhance the findings of the ICR.

An interview format was used for the focus groups. Each session had a list of questions to prompt discussion, along with a structure that provided the opportunity for feedback on the SUD treatment process and service experience. Additionally, findings and associated questions arising from the ICR were utilized for discussion, clarification, and feedback. Objectives and questions for focus groups were outlined to provide consistency among interviewers for focus groups. After an introduction by Mercer, the following topic areas were posed as questions to each focus group and tailored based on the focus group demographic:

- What are the most significant changes in SUD treatment services that have improved treatment access, treatment completion, and outcomes in the last three (3) years?
- What are opportunities to change/improve the current SUD service system?
- What are new tools and/or services that you think are needed to improve treatment access, assessment, treatment completion, and outcomes?
- What are the most effective tools that are currently being used?
- What are successes or barriers you have encountered when engaging family or natural supports?
- What are successes or barriers you have encountered in testing for communicable diseases, including TB, HIV, and other sexually transmitted infections (STIs)?
- What practices or interventions are the most useful to individualize treatment plans to address the unique needs of each participant and their cultural preferences?
- Were there any tasks or situations that weren’t addressed due to a lack of resources?
- What would you change about the SUD assessment, treatment, and discharge process?

- How can the SUD system work together better to provide SUD services to the uninsured and underinsured?

Stakeholder Engagement Common Themes

SUBG Funding

Across all three groups, SUBG funding was discussed, with a consensus that it is critical to ensure that uninsured and underinsured individuals can access treatment. Both ACC-RBHAs and providers would appreciate more opportunities to be part of the SUBG planning process. Providers have noted that some RBHAs have changed the amount of funding available and how it is distributed. One provider noting they now can only have two SUBG funded individuals every thirty days. The provider noted this was a significant change from previous years, and they are unsure why this change came about. During member stakeholder sessions, members stated would appreciate clear communication on the length and amount of SUBG funded services they can receive, as this is often the only way they can access services. Several were unsure of whether or when funding might run out, and their peers were unable to provide any clarity.

Family and Natural Supports

This was another topic that was a strong theme in all three groups. ACC-RBHA and providers all discussed the struggle of engaging family and natural supports in treatment, and the need for education and training on best practices to support this.

Members were split on family and natural supports. Some indicated this was a need, and that their return to their family after completing treatment could be improved by providing their family psychoeducation, as well as facilitating family therapy sessions. Other members were clear in not wanting family involvement in treatment, most often because family was either not supportive, or a trigger for substance use.

ACC-RBHA Focus Group

Mercer conducted one focus group with 20 participants across the ACC-RBHAs on May 22, 2024. Participants included leadership and staff from Arizona Complete Health, Care 1st, and Mercy Care. The goal of the focus group was to identify strengths, discuss opportunities for improvements with the Arizona SUBG, and allow for an open dialogue about the system's strengths and weaknesses. Many of the participants had attended the previous year's focus group and noted it was a good opportunity to gain insights into the larger system and ideas for improving treatment strategies going forward.

Strengths

Strong System of Care and Continuity of Care

Participants reported that attending this focus group, as well as the one held the previous year, has allowed for increased input into the SUD system for the uninsured and underinsured. Soliciting member feedback was seen as an added value to the ICR process and was highlighted as noteworthy in the last two years. Moreover, participants expressed a sense of connectedness between providers, which supports transitions of care and is

meaningful for members. Collectively, the system of care shares a sense of urgency for treating individuals with SUD. The group stated sharing results and paying attention to common themes could lead to better outcomes for the members receiving services.

According to participants, SUBG services impact the overall continuum of care. The services allow providers to intervene with members who otherwise would not be able to receive services and can potentially prevent future readmissions. Members can receive therapeutic support services, in addition to withdrawal management, MAT services, and residential services. The therapeutic services address multiple life domains, including social determinants of health.

Outreach efforts and the ability to focus on outreach in the community has also been helpful. Participants felt these efforts led to an increase in utilization of SUBG services as more people in their communities become aware of treatment and recovery resources. Furthermore, participants highlighted how strategic community education efforts have impacted those facing an OUD by providing uninsured members education on and access to medications for OUD. These efforts have helped close the gap in access to treatment for this population.

Innovative Approaches to Access to Care

Participants identified the implementation of the hub and spoke model and family treatment models of care as areas of improvement for the Arizona substance use service delivery system. Specifically, care for pregnant and parenting people with OUD now includes collaborative partnerships with OB/GYNs, OUD providers, hospitals, and the Department of Child Safety (DCS) to create opportunities for families to stay together while supporting them. Providers have had to form new collaborative partnerships to effectively treat these members.

Participants felt providers and programs continue to adapt to regulation changes post COVID-19. The flexibility of telehealth, harm reduction approaches, and low barrier care impact service delivery and allow for improved access to services. In the 2023 discussion, ACC-RBHAs identified current gaps in population-specific, evidence-based practices that could benefit the communities they serve. One example was mobile MAT. Since the 2023 discussion, mobile MAT launched, which has provided better access to individuals in rural areas where MAT clinics are not available and/or transportation is a barrier to accessing services from a standing MAT clinic. Providers also indicated that opioid settlement funds assisted with reaching members diagnosed with OUD.

Transportation

The focus group was encouraged by the use of telehealth and other activities that are currently occurring to mitigate the transportation issue for members.

Opportunities

Family Engagement

Family members and natural supports can be a resource that supports people with SUD experience better recovery outcomes. According to participants, during the intake process, many members choose not to include family or other natural supports in their treatment. This

was the case the previous year as well. Members did routinely identify family members or natural supports that were aware of their substance use and supportive of treatment; however, based on documentation, these resources were not leveraged in treatment planning or treatment delivery. This is evident for this current review period, as data shows only 13% of charts indicated that the ISP was developed with the participation of family/natural supports. Enhancing provider education was one strategy identified by the ACC-RHBAs to help increase family support. Focus group members thought provider education and training curricula should address the importance of building the members support network around them and framing assessment questions about family involvement using more inclusive language.

Family Advisory Councils

Participants were asked whether there is a path to consistently engage and include family support during treatment, including the ability to bill for any of the services and supports provided to family members. Participants believe there is an opportunity to better engage families in billable programming outside of family groups and counseling. Participants indicated seeking input from family advisory councils on how to ensure family members are consistently engaged in treatment could be beneficial.

ICR Chart Criteria for Opioid Treatment Program Settings

It is uncommon for members to complete MAT; rather, they engage in lifelong recovery support in OTP settings. The charts pulled for ICR are likely ones that were closed for lack of contact. ACC-RHBAs expressed their concern to AHCCS regarding how this could potentially skew data for members receiving OTP services.

Health Equity

Providers indicated there were opportunities to better outreach and serve members that are part of special populations, including veterans, LGBTQIA+, individuals at higher risk of opioid use, and members who are pregnant. Providers expressed they saw needs in their community for these special populations to receive substance use treatment services, but clarity on whether providers could use funds to provide assertive engagement and outreach to educate these members on available services and funding resources, as well as ensuring there is SUBG funding available, were sometimes barriers to engaging these populations. The focus group did mention that the previous SUBG ICR focus group had included these populations. Ideally, SUBG funding, and all communication regarding SUBG funding, would be clear regarding the inclusivity of all populations able to receive SUBG-funded services, according to the focus group

Collaboration

The group did discuss how it would like more involvement in the fiscal year goal settings and assisting with grant applications with AHCCCS to provide better substance use services to the underinsured and uninsured residents of Arizona. The group also discussed how it would like to review opportunities for improvements prior to SUBG information being published.

AZ Provider Focus Group

Mercer facilitated a focus group discussion, with over 20 substance use providers that provide MAT, residential, and intensive outpatient services in Arizona, regarding agency programs and treatment highlights in the field of SUD treatment available via SUBG funding. The providers discussed a range of topics, including the challenges they face, services they offer, and the need for resources and support. Some key points mentioned include the increase in overdoses and the importance of harm reduction, the challenges of network adequacy and credentialing, the use of telehealth and its benefits, the need for culturally specific treatment for populations such as Native American women, the success and barriers in the justice system, the importance of engaging family and natural supports, and the impact of limited resources on treatment outcomes. The providers also discussed the use of MAT, and the reasons members may end early, as well as the need for individualized treatment plans and the challenges of addressing social determinants of health. Overall, the providers highlighted the need for improvements in the system, including better access to care, more resources, a shift towards treating substance use disorder as a chronic health condition, and reducing stigma.

Strengths

Harm Reduction

Providers felt strongly that harm reduction was an important part of the overall substance use treatment system, especially as they are seeing an increase in overdoses. Efforts have included increased access to and education on Narcan, including distribution methods such as harm reduction vending machines and vans distributing mobile resources. As education and public knowledge has increased, members have been more accepting of MAT and harm reduction efforts, and stigma has been reduced. Other strategies have included community outreach to the uninsured, peer training programs, and working with PCPs on providing induction and maintenance of MAT to increase treatment rates. One provider noted working with a local ED physician to initiate suboxone for individuals coming in for an overdose after they had been stabilized..

Justice System Engagement

Law enforcement and the judicial system, including federal probation and parole, were noted as key partners in diverting members with substance use disorders to treatment, instead of incarceration or engaging them in treatment upon reentry from incarceration. In some areas, services have been co-located in the courthouse to rapidly engage with members in need of services. One provider noted utilizing a SAMHSA reentry grant to grow from one staff person to four, allowing a presence in jails, treatment court, pretrial, and probation offices. Outreach teams have been effective with several populations, including family reunification courts, schools, and reentry programs. It was noted that undocumented individuals have an additional barrier to engagement due to difficulty in obtaining needed documentation.

Culturally Competent Resources

Several specific populations were identified as requiring culturally competent resources, ranging from Native Americans to the LGBTQIA+ community. One provider noted it is using a SAMHSA grant for all 22 tribes in Arizona, providing culturally specific treatment for Native

American women. They are also working with the health department to offer on-site testing for STIs monthly. Services for pregnant women, in general, were also noted to be more successful when they could treat infants at same time.

Providers noted an enormous increase in the number of referrals for children and adolescents, almost to the point of being unable to keep up with them. SUBG funds have been used to expand child and adolescent services, especially opioid and MAT treatment. Adolescents with dual diagnoses of mental health and substance use have especially increased, as well as adolescents with polysubstance use issues. Access to pediatric care was noted as a part of developing resources for the child and adolescent population. Some providers also noted concerns with adolescents who are victims of human trafficking.

Other providers noted that special populations of focus depend on location, such as areas with more retired people, serving members between 55 years and 70 years of age, many of whom start with prescriptions and move on to street drugs. Fentanyl is especially challenging, as members use more despite being already intoxicated and can use up to 40 to 50 pills a day because the intoxication wears off quickly. For these members, providers are working on a fentanyl specific curriculum.

Telehealth

The COVID-19 pandemic led to a steep learning curve in how to provide services virtually. Over time, telehealth led to increased treatment completion due to increased access for program participants. It was noted that for youth it is important that a parent or guardian is available during services to ensure safety. Many members do not have reliable transportation, and telehealth has assisted in overcoming transportation as an obstacle to treatment.

Providers have invested in different telehealth opportunities, such as a better platform with improved ability to serve members, and digital therapeutics, including daily meditations and virtual resources, to show progress and offer support and resources.

Some concerns noted were the balancing of virtual and in-person services as well as the access of members to telehealth resources. AHCCCS had allowed a lot of telehealth flexibility prior to pandemic; however, payors want to return to more in-person services. Medicaid requires an in-person contact at least once a year. An in-person visit prior to induction of methadone was also noted to be a barrier for some individuals. It was noted that audio-only services take a special skill set, and not all staff has that skill set. Additionally, it was noted that there is a need to address the digital divide, as many members do not have access to both computers and broadband, especially as internet is not as readily available on reservations for the 22 tribes.

Evidence-Based Practices

Many of the providers noted the use of EBPs congruent with the findings of the record review, including CBT, Seeking Safety, motivational interviewing, EMDR, MAT, and the use of peer supports. Other EBPs of note were plans to start gender-specific groups for women experiencing trauma, adding family groups and curricula, and developing LGBTIA+ programming. Wellbriety was noted as a best practice for the Native American population as well as White Bison meetings and culturally specific practices such as drumming.

Opportunities

Credentialing

Providers noted some challenges with credentialing, including not being able to become credentialed with all of the payors due to there not being a gap in network adequacy requiring a new provider. The administrative burden of the credentialing process was also noted to be challenging.

Resources

Providers in the northern region of the state noted difficulty in providing residential treatment from SUBG funds, with one residential provider stating it can only serve two members through SUBG funds every thirty days. Multiple providers agreed with, and supported this statement, through verbal and typed chat, making it difficult to discern whether these concerns are localized to the northern region or potentially more widespread. Other areas of note were difficulty accessing funding for medical detoxification. Injectable MAT also tends to take up more SUBG funding and is challenging to get, as it is not a pharmacy benefit. Providers expressed some frustration in trying to meet the needs of high-acuity members without adequate funding.

Other areas in which resources are lacking include engaging members with primary care needs, as uninsured individuals cannot get medication for conditions such as diabetes, which may, in turn, lead to another reason for disengagement. Additional areas of need are treatment resources for housing, transportation, and food security. It was noted that treatment is a luxury if a member cannot meet basic needs, and providers expressed feeling resources were declining, not improving.

An additional area of non-financial need for resources was finding and retaining qualified staff, as there are high rates of staff burnout. Other staffing barriers include the system constantly evolving to new criteria requiring additional training, higher demands on staff administratively, and a need for uniformity across payors to decrease burdensome processes such as different requirements for prior authorization of services. Finally, there is a need for pipelines to continue systems of care to take care of members.

Tuberculosis, Hepatitis C, and HIV Testing

Providers discussed difficulty with obtaining screenings for TB, hepatitis C, HIV, and other STIs as they made efforts to increase the number of members receiving screenings. One issue noted was the stigma of having an infectious disease, and providers are working to educate staff and the community to combat this. Screenings for STIs are also an area of focus for providers. Efforts to provide screening include bringing in other partners in the community to test and treat conditions, such as bringing HIV teams into residential treatment settings for testing and education. Additional barriers noted were that some testing requires a sliding scale fee, and blood tests can be difficult to obtain due to members suffering from dehydration.

Reengagement

Providers noted that one of the primary reasons members leave early is a lack of contact due to ambivalence or relapse. Efforts to address this have included education and talking to

members to let them know if they use, they can come back and will not be discharged due to a positive toxicology. Education is also provided from multiservice agencies that members do not need to discontinue all services if they relapse or stop using one particular service. Providers also conduct in-person outreach if the area is safe. Additional resources of note were digital applications to outreach members that also allow them to journal and can reroute the member if they are traveling near an area that may be high risk for relapse. Other methods for engagement noted were motivational interviewing, building rapport, education on harm reduction, and an increase in mobile vehicle support to increase access and decrease disengagement due to lack of transportation.

Family Engagement

Engaging family members continues to be a struggle for members who are in the early stages of substance use treatment, often because members with long histories of substance use have burned bridges with their family and support network, and need time to reengage and reestablish trust. Providers noted more success with members going through longer term treatment. Providers identified some ways of improving family engagement, such as using family liaison certified peer positions to work on family reunification. Also noted as a helpful tool in engaging families was Celebrating Families, which is currently being funded through a grant to pay for training and dinner as part of training. After hours and weekend hours for family services may also increase the opportunity for family engagement.

Specific to pregnant women, working with DCS can be an important part of keeping the mother engaged with the infant and any other children. Case management for pregnant women is an important resource, as is connecting with other stakeholders such as an OB/GYN. Hushabye Nursery was noted to be a good provider partner for this population. One barrier in working with this population is having hospitals work with providers as a partner and not seeing them as competitors.

Member Focus Groups

Mercer reviewed engagement methods used in 2023 and consulted with AHCCCS to improve member participation in focus groups in 2024. AHCCCS provided Mercer a list of all SUD providers receiving SUBG funds in the northern, central, and southern regions of Arizona. Mercer identified a residential treatment provider in the northern region, a MAT provider in the central region, and intensive outpatient/partial hospitalization provider in the southern region, to partner and host facilitated focus groups with members.

To further support member participation and engagement, Wal-Mart gift cards ($25 value) were provided to member participants.

Consistent with information obtained last year, all members were grateful that AHCCCS continues to manage and make available SUBG funds to provide treatment services to uninsured or underinsured individuals. Many reported that accessing treatment services helped them either begin or reenter recovery, access medications for both substance use and mental health issues, and begin to redefine their life without substance use. Several members expressed concern that if access to SUBG funded services ended, they would not be able to remain in treatment and would be at risk for return to use.

Strengths

Person-Centered Treatment Planning

All members indicated they remembered developing a treatment plan at the beginning of services and that they were directly involved in the development of goals. Goals included stopping substance use, getting fingerprint cards and identification, working on finding employment, meeting with counselors for support, and receiving case management. Members also indicated that treatment plans were routinely reviewed and updated to reflect any progress or barriers they encountered.

Services Received

Unlike the 2023, members that participated in the stakeholder sessions received a wide range of services (2023 members interviewed were all receiving MAT at a methadone treatment provider). Members reported receiving residential treatment services, intensive outpatient, and MAT (vivitrol, methadone and suboxone). These service providers supported members in finding safe, sober housing to live in, accessing medications to manage mental health symptoms (multiple members reported co-occurring mental health diagnoses), completing disability determination paperwork, facilitating improved transportation (regaining driver's licenses and accessing medical/AHCCCS transportation), therapy and counseling, and peer support services

Some members that were receiving MAT in the central region indicated they needed further support in applying for Medicaid. These members indicated they had received some initial support, specifically in obtaining and beginning their Medicaid application. The support had ended, and these members had not been able to successfully complete their Medicaid/AHCCCS application or submit it for review.

Peer Support Services

Several members indicated they were in the process of obtaining, or wanted to obtain, their peer support certification, in part, due to the role peers played in their treatment and recovery journey. One member stated that peers "Are everything. Without them, this wouldn't be possible." Members agreed that having someone on staff that had been through a similar experience helped make them feel comfortable and secure in sharing their story and that peers were often able to support them during difficult times in their recovery journey.

Opportunities

Primary Care Services

Members were split on their current ability to access primary care services. Many struggled and continue to struggle with applying for Medicaid/AHCCCS and identify a lack of insurance as a barrier to treating physical health issues. One member stated that they had not seen a primary care provider in years and were embarrassed to tell the doctor about their substance use.

Family Engagement

Specific to residential treatment, members indicated that restrictions around phone/video calls with family and natural supports was difficult, especially when there was either legal or DCS involvement.

An area of opportunity that was somewhat divided was engaging family members and natural supports in treatment. Some members were very clear in wishing there were more opportunities to not only engage with family members and natural supports while receiving treatment, but they also felt that family psychoeducation, family counseling, and support groups, like Ala-non, would be helpful.

Other members reported not wanting family involved or being able to identify when they wanted family involved. This group of members frequently cited that family had been a trigger for them, or that their family was not supportive, and attempts to engage them would be detrimental to their recovery process.

Staff Engagement and Retention

Additionally, one member prepared a written statement prior to attending the in-person stakeholder session to provide to Mercer. The member reported working in the health care field, specifically with data, since the 1990s, and observed that the electronic health record system did not appear to be user-friendly. They noticed there were multiple pages requiring multiple clicks, which took time away from staff working with members. More importantly, they observed a high level of turnover at the program they attended and wondered whether there had been any surveys completed to identify why staff are leaving. The member did their own research into possible interventions that could improve staff retention, which included better pay, and four-day work weeks to reduce burn out, stress levels, and increased overall work satisfaction.

Conclusion

Live stakeholder sessions, either virtual or in person, continue to provide depth and context to data Mercer staff finds in the ICR process. Qualitative data assists in understanding the findings of the quantitative review and provides additional context for methods of improving the quality of and access to services provided by the SUBG funds. Providers and members expressed appreciation for resources available with SUBG funding, although there was also frustration that there are limitations to funding leading to difficult decisions regarding priorities and difficulty in accessing full-person care options, such as pharmacy and medical care, to meet whole-person needs.

Family Engagement

Family engagement continues to be an area of discussion by ACC-RHBAs, providers, and members. Although family members may not be desired by the member to be engaged early in the treatment process, opportunities later in treatment for family therapy and education may be beneficial. It is important to note that some family members may not be supportive or may be triggers for use, but offering an opportunity for families, especially during evening and weekend hours, to allow for more flexibility in engagement, could be a valuable recovery resource if funding is available.

Evidence-Based Practices

EBPs continue to be an area of focus, and overall, there was a decrease in the documentation of EBPs in the quantitative portion of the ICR. Many providers did note they are bringing up new specific curricula for specific populations to reflect changes in the needs of the member population, such as for LGBTIA+ individuals and co-occurring populations, including children and adolescents. Implementation of planned EBPs should continue and be monitored.

Reducing Stigma

There was broad agreement in seeing substance use recognized and treated as a chronic health condition, and not a moral failing or weakness. Efforts to combat the stigma surrounding substance use and treatment through education could reduce barriers to seeking and receiving treatment. Reducing stigma could also lead to increased reengagement and implementation of harm reduction practices.

Additionally, it was noted that although a federal issue outside of AHCCCS purview, a review and potential revision of 42 CFR Part 2 could improve access to treatment as well as coordination of care across providers. Providers specifically cited this as sometimes posing a barrier to providing treatment and coordinating care to ensure members' needs are met.

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