Arizona Emergency COVID-19 Project

FY21 COVID-19 Programmatic Progress Report

December 20, 2021

Grantee Name/Grant Number: 1H79FG000250-01

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Period Covered: December 20, 2020 – September 30, 2021

Progress Updates

Instructions: Please describe successes, challenges and obstacles overcome in meeting the objectives. Note evidence-based practices being facilitated and use quantitative & qualitative data to show outcomes and progress for the following activities:

1. **Using quantitative and qualitative data please describe outcomes, progress, and challenges regarding the implementation of your evidence-based mental and/or SUD treatment services for individuals with SMI/SED or Co-Occurring including telehealth services. (70 percent of services)**

   The overarching goal of the Arizona Emergency COVID-19 Project is to address the increased need for substance abuse, mental health, and crisis support services to Arizonans that have been impacted by the COVID-19 pandemic. The first phase of the project included assessing needs and resources available to Arizonans and ensuring service gaps, barriers, and potential overlap were addressed before project implementation. These steps were critical to ensure the cohesive coordination of available resources in the state to address substance use and mental health needs. Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs) were contracted to manage local behavioral health service providers and Wellington Consulting Group was contracted to manage data collection and evaluation. All budgetary approvals were obtained among contractors, the Arizona Health Care Cost Containment System (AHCCCS), and the Substance Abuse and Mental Health Service Administration (SAMHSA). Service implementation began in October and November of 2020. The total number of program intakes between December 20, 2020, and September 30, 2021, was 482. The Governmental and Performance Results Act (GPRA) intake coverage rate in SAMHSA's Performance Accountability and Reporting System (SPARS) was 60.3 percent on September 30, 2021.

   Of the total enrollments, 252 (52 percent) individuals had diagnoses of Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) or co-occurring disorders. The barriers first reported by providers included medical coding for claims, issues around workflow management, and identifying eligible individuals. AHCCCS,

the RBHAs/TRBHAs, and providers quickly utilized a team approach to address these barriers and develop tools and strategies to resolve these challenges. The positive response to these initial challenges was evidenced by the high number of enrollments during this reporting period.

Between December 20, 2020 and September 2021, COVID-19 behavioral health providers implemented a number of program services including clinical health assessments, psychiatric evaluations, screenings for mental health, substance abuse, and/or co-occurring disorders, assessment and referrals to services for basic needs, individualized treatment plans, outreach and engagement with individuals who may be limited in access to services due to the pandemic or other barriers, brief therapy sessions, counseling and recovery support services, treatment coordination, and transportation services. Tribal subcontractors provided additional services such as life skills classes to include job readiness and money basic classes for individuals enrolled in the program. Programs also supported individuals in medication access, supportive employment services, resources related to employment, housing, vouchers for clothing and food, and COVID-19 testing and vaccines. Providers used a combination of face-to-face, virtual telehealth, and phone calls to address patient needs. Additionally, during the reporting period, the Arizona Emergency COVID-19 Project added another behavioral health provider, Intensive Treatment Systems (ITS), to the program utilizing supplemental grant funds to help expand and increase access to program services in central Arizona.

Reported challenges during the reporting period included participant cancellations or no-shows to counseling appointments, and lack of consistent participation of enrollees in services. To combat this challenge, providers implemented various engagement strategies including outreach, care coordination, transportation, and recovery support services. Providers indicated these services coupled with behavioral health interventions were invaluable and a key factor to increasing and maintaining engagement in all program services. Many participants utilized behavioral health residential facilities during this reporting period, and some aging and vulnerable participants were placed in skilled nursing facilities due to physical health issues. Providers maintained contact with participants during these transition periods and continued to provide support as needed. One tribal provider noted that finding eligible clients continued to be difficult as most individuals seeking services were eligible for the state Medicaid program (AHCCCS). To address this challenge, the providers outreached individuals in corrections who were not currently eligible for AHCCCS and needed services. The program also restructured its marketing and increased its enrollment.

Health Choice Arizona (HCA) was challenged in the recruitment of local service providers with the grant requirement to add COVID-19 services and GPRA administration to their

existing menu of services and processes. HCA developed an innovative approach to address this issue by hiring Program Coordinators to conduct outreach and referral to network providers. These coordinators were responsible for conducting intake, follow-up, and discharge GPRA, effectively removing this burden from the providers and increasing service coordination and care among the RBHA, the local behavioral health provider, and the individual receiving services. The implementation of this strategy resulted in enrollments and multiple intakes completed under two northern Arizona behavioral health providers.

2. **Using quantitative and qualitative data please describe outcomes, progress, and challenges regarding the implementation of evidence-based and population appropriate treatment services. (10 percent of services for health care professionals)**

The total number of intakes between December 20, 2020, and September 30, 2021, was 482. Fifteen (15) enrollments, making up 3 percent of all enrollments, were for individuals identified as health care professionals. The implementation of evidence-based and population appropriate treatment services for health care professionals was the biggest challenge. As noted in the mid-point progress report, discussions with RBHA contract administrators revealed numerous perceived challenges in serving healthcare professionals including:

- The need to ensure that healthcare professionals can enroll in services anonymously so as not to have to report mental health treatment to medical licensing boards,
- The need to address this through policy at the state level,
- The requirement of conducting a full GPRA intake,
- The need to identify healthcare professionals willing to come forward and participate in services, and
- The need to set up programs for healthcare professionals that include single encounter services.

RBHAs and providers noted that stigma was associated with healthcare professionals seeking behavioral health treatment. To address these concerns, AHCCCS allowed for single encounter services for healthcare professionals to be provided under this grant and tasked the RBHAs with developing methods for ensuring anonymity when enrolling. AHCCCS and Wellington Group obtained approval from SAMHSA to modify the GPRA intake process for healthcare professionals and to help reduce stigma and increase anonymity. Since modifications in November of 2020, one provider successfully enrolled fifteen healthcare professionals indicating barriers were reduced.

The successful strategies providers implemented to serve health care professionals included targeted marketing to healthcare professionals utilizing social media and providing access to outreach/check-in and treatment services after normal business hours. Other Emergency COVID-19 providers developed wellness programs targeting their

healthcare and behavioral health employees via access to virtual anxiety and stress relief classes, self-care workshops, and expanded Employee Assistance Program services. For example, the Pascua Yaqui Indian Tribe offered the employee assistance program through Jorgensen Brooks. The program sent out information on staying safe, crisis services available, the importance of self-care and self-care strategies, benefits related to COVID-19 and counseling services, and information on exercising on the reservation at the Wellness Center to help manage stress. Staff were given access to self-paced online learning class, and an Applied Suicide Intervention Skills Training was held in March 2021. Jorgensen Brooks continued to offer counseling services and coaching or therapeutic services to all employees. Finally, the program started planning a Health Department employee wellness retreat that will consist of many self-care and healing activities including music, meditation, interactive wellness, and dancing. Valle Del Sol, a provider, held training in March conducted by the Arizona Trauma Institute. The training was entitled Driving Out Stress: Overcoming Compassion Fatigue with Professional Resiliency and supported their health care providers.

3. **Using quantitative and qualitative data please describe outcomes, progress, and challenges regarding the implementation of evidence-based and population appropriate treatment services. (20 percent of services for population with less than SMI).**

The total number of intakes during this reporting period was 482, and 215 (45 percent) of these enrollments were individuals with a diagnosis less severe than an SMI. Providers received referrals from local school districts including parents who were struggling with online learning. Referrals were also received from other local organizations and community members responding to advertisements on social media, the Department of Child Safety (DCS) website, and through each agency's or RBHA enrollment specialists. Individuals received services under three conditions: 1) they did not have health insurance, 2) their current health insurance did not cover counseling, or 3) their insurance did not contract with a healthcare provider who is currently accepting referrals. Individuals enrolled in services received a variety of therapeutic services including brief interventions, individual and group therapy, and support services including but not limited to recovery support, transportation to medical appointments, education classes such as money basics, job skills, and life skills. Providers noted most of these participants actively engage in services, especially in utilizing counseling services and some recovery support services. A noted challenge when working with this group of individuals included recognizing that many of these participants had never obtained mental health treatment and were new to the system and the resources available to them. Many individuals also reported feeling impacted by stigma associated with mental health treatment services. Providers worked to reduce this stigma by educating enrollees on the benefits of mental health treatment and accessing resources.

4. Using quantitative and qualitative data please describe outcomes, progress, and challenges regarding the screening and assessing clients for mental, SUD & Co-Occurring disorders and develop appropriate treatment approaches, as needed.

The screening and assessment process included members participating in a comprehensive assessment with emphasis on the unique qualities and culture of the individual. The following elements outlined in the AHCCCS Medical Policy Manual (AMPM), Behavioral Health Assessments and Treatment/Service Planning policy are followed: *the model shall be strength-based, member-centered, family-friendly, culturally and linguistically appropriate, and clinically supervised. The model incorporates the concept of a "team," established for each member receiving behavioral health services*. The AMPM policy, Serious Mental Illness Eligibility Determination, is adhered to when assessing individuals for a SMI determination. This policy also outlines requirements associated with referral for a SMI Evaluation and SMI Eligibility. Behavioral health providers are required to assist individuals with applying for the following:

- Arizona Public Programs (Title XIX/XXI, Medicare Savings Programs, Nutrition Assistance, and Cash Assistance),
- Medicare Prescription Drug Program (Medicare Part D), including the Medicare Part D "Extra Help with Medicare Prescription Drug Plan Costs" low-income subsidy program, and
- Verification of U.S. citizenship/lawful presence prior to receiving Non-Title XIX/XXI covered behavioral health services at the time of intake for behavioral health services.

All Contractors adhere to AMPM, Behavioral Health Provider Requirements for Assisting Individuals with Eligibility Verification and Screening/Application for Public Health Benefits.

During the reporting period, the number of program intakes was 482, a 60.3 percent GPRA intake coverage rate. Providers continued to indicate most participants were eager to engage and actively participated in the assessment process, which includes the development of person-specific treatment plans. Therapists determined best practice approaches for individual treatment plans. Substance Use Disorder (SUD) staff assessed patient needs during the intake process, which included a comprehensive biopsychosocial assessment including screening for social determinants of health barriers, and an American Society of Addiction Medicine (ASAM) and Guide Right Assessment (GRA) for SUDs. Services, resources, and referrals were determined during the screening and assessment process. One provider, Gila River Health Care, provided support and services to individuals who were incarcerated in the Department of Rehabilitation Services at the Gila River Indian Community resulting in an increase in enrollments.

AHCCCS utilized supplemental funding to contract with the Arizona Department of Veterans Services (AZDVS) for outreach, screening and referral to active

service members, veterans, and their dependents to support and increase screening and enrollments in the Arizona Emergency COVID-19 Project. AZDVS initiated planning for implementation in April of 2021, hired staff, and developed protocols for screening and referring to clients to the Emergency COVID-19 Project. The evaluation team, Wellington Consulting Group, created a screening and referral portal for AZDVS staff to email referrals to Emergency COVID-19 providers. As of August 9, 2021, AZDVS staffed three outreach positions strategically located throughout the northern, central, and southern regions of the state. Outreach activities were conducted in high-incident zip codes of veteran suicidality, at events catering to veterans and their families, and with community organizations serving veterans, among others. AZDVS created a client lifecycle and standard of work for screening and treatment referrals and developed numerous partnerships for outreaching service members and their families. For example, a partnership was established with the Arizona Coalition for Military Families to utilize the Be Connected program and the Families' Risk Reduction Operations team to increase outreach and referrals. The Be Connected Program is a partnership between Arizona Coalition for Military Families, Solari Human and Crisis Services, and Community Bridges, Inc. The Be Connected Support Line and Community Navigators provided referrals to AZDVS staff who screened for eligibility for the Emergency COVID-19 Project. The Families' Risk Reduction Operations team assisted in identifying and prioritizing outreach to service members, veterans, and families in areas identified as high risk for suicide and other negative outcomes.

AZDVS staff began building rapport with non-veteran specific community providers in August 2021 conducting over 20 meetings with organizations to discuss the Emergency COVID-19 Project. Partners helped arrange opportunities for the AZDVS Emergency COVID-19 Outreach Staff to attend future community events and provide referrals for service members, veterans, and families. By September 2021, AZDVS outreach staff engaged with over 40 organizations and attended 12 events across the state. Attendance for events was low due to COVID-19 restrictions, however, as restrictions ease and public comfort levels increase, it is expected that attendance levels will increase. When screening and assessing clients, AZDVS identified individuals who were interested in treatment, but were reluctant to engage in services because they thought services were affiliated with the U.S. Department of Veterans Affairs. To address this misconception, AZDVS staff provided education to all participants on the differences between federal and state programs. AZDVS also found that some participants were apprehensive to discuss their treatment needs with AZDVS staff in outreach settings. AZDVS staff developed a follow-up process in confidential settings and tracked which coordinating community partners were successfully engaging with clients. AZDVS outreached in rural areas and identified the need to provide clients with transportation to behavioral health services based on the lack of providers in the area. AZDVS worked with community partners to brainstorm ways

to provide transportation to overcome this barrier. AHCCCS also worked with HCA to increase the number of providers in the northern Arizona.

5. **Using quantitative and qualitative data please describe outcomes, progress, and challenges regarding the implementation of recovery support services (nutrition services, peer support, childcare, educational/housing, etc.) Ensure ability to provide virtually as needed.**

Providers were well connected within their communities and were charged with ensuring a complete continuum of services and care provided to their members. Recovery support and case management services were utilized to manage all aspects of a members' care, ensure all services were provided according to the members' needs, and ensure services were provided in a comprehensive manner. Individuals who did not need direct substance abuse, mental health, and crisis services, but who needed recovery support services or general assistance services due to COVID-19 such as housing, food assistance, and utility assistance were connected with support service entities throughout the state. Once an enrollee's GPRA intake was completed, the client was referred to all services identified in their assessment, treatment plan and GPRA intake.

The Emergency COVID-19 Project found the implementation of recovery support services, the most utilized service, was essential to engagement in behavioral health services. Providers under the project assisted participants in accessing basic needs such as food boxes, supportive housing, personal care when needed, and transportation. Services also included education on proper Personal Protective Equipment (PPE) wear, Centers for Disease Control and Prevention (CDC) guidelines, and COVID-19 vaccines.

One provider, COPE Community Services, had a team of certified peer support specialists who provided socialization activities such as getting participants out of their homes (with social distancing in place) after quarantine, helping participants complete grocery shopping, and helping individuals attend necessary medical appointments. COPE Community Services noted that the impact of recovery support services was significant in helping reduce participants' anxiety and improve their overall well-being. One participant reported feeling like his peer support services saved his life, stating that he had severe depression and getting out of the house to accomplish daily tasks had been very difficult. However, with the help of his provider team he was able to get out of the house and accomplish daily tasks. Recovery support service providers also supported participants in obtaining their COVID-19 vaccines, helped clients obtain full time employment, and supported individuals in all aspects of their life including family life, parenting, finances, obtaining education, etc.

During this reporting period, enrolled clients received several recovery support and case management services or referrals for support services as indicated in the following table.

AHCCCS COVID-19 Recovery Support Service/ Referral/Case Management Service	Number of Individuals Provided with One or more Service and/or Referral
Recovery Support Services	
Peer Support Services	99
Life Skills Training	71
Transportation	64
Nutrition/Food Services	44
Physical Activity	31
Planned or Arranged Post Treatment Continuing Care	29
Recreational Activity	25
Aftercare Planning	24
Spiritual Activity	20
Social Support Groups	13
Parenting Skills Education	10
Educational Services	10
Family Counseling	5
Employment Readiness Training	4
Permanent Housing Arrangement	4
Employment Placement	5
Vocational Services	6
Transitional Housing	2
Community Reintegration Socio-Economic Support (State and Federal)	1
Childcare	0
Referrals to Services	
Individual Therapy	3
Cope Residential Treatment Services	1
Star Recovery Day Program	1
Residential Substance Use Disorder Treatment Facility	1
Opioid Treatment Program	1
Emergency Housing Voucher	1
Case Management	
Case Management Services	204

6. **Using quantitative and qualitative data please describe outcomes, progress, and challenges regarding the implementation of crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, meditation admin, and crisis stabilization.**

Arizona's crisis system is a national leader and a "best-practice" state in the provision of crisis care. Throughout the project, AHCCCS ensured the provision of an array of short-term crisis stabilization and behavioral health services across Arizona's urban, rural and

frontier communities. Crisis services were available to all individuals in Arizona at any time irrespective of Medicaid eligibility status. Crisis services included a full continuum of crisis intervention services including, but not limited to 24/7/365 crisis telephone services, mobile crisis response teams, and 24-hour substance use disorder/psychiatric crisis receiving and stabilization settings. Arizona's robust network of crisis providers ensured that individuals experiencing a behavioral health emergency were served quickly and appropriately within their communities. Interventions were solution- and recovery-oriented. They were focused on stabilizing the individual within their community and returning them to their baseline of functioning, while simultaneously ensuring receipt of appropriate follow-up services to mitigate future emergencies through preventive treatment or connection to community services.

One COVID-19 provider in Maricopa County, Valle del Sol, had a licensed clinician on call seven days a week to handle any emergencies that may arise after hours. Enrolled clients had access to the after-hours, on-call system. A crisis plan was developed, which included crisis contact numbers in Maricopa County including the warm line. Valle del Sol clients who experienced a crisis resulting in an emergency room or inpatient stay was visited by a member of the clinical team. Staff outreached patients after discharge to schedule a follow up appointment with a Crisis Transition Navigator. Another provider in Pima County, COPE Community Services, had several Emergency COVID-19 clients utilize their after-hours support line. Project staff were able to quickly connect with individuals in their time of need and were able to provide them with counseling and recovery support services the very next day. As noted previously, COPE Community Services helped place several clients in a behavioral health residential facility for immediate and intensive care. Another participant was able to access crisis services during a medication management appointment after the individual reported to his therapeutic team that he was feeling unsafe in the community. The patient was immediately transported by his Emergency COVID-19 outreach team to a Crisis Response Center for further evaluation and access to a higher level of care. The Outreach Worker maintained contact, provided support and medication management for the individual throughout the crisis.

Data Collection

1. **Requirement: Each grantee must collect and report client-level data at intake, every six months after intake and at discharge using GPRA. (Admin & Data Collection must not exceed 20 percent of budget)**

Total # Of Clients Served Between 4/20/20 – 12/19/21: 615

SMI/SUD and/or Co-occurring: # 325

Healthcare Professionals # 15

Less than SMI: # 275

Children 11 Years and Younger: # N/A

2. **Does SPARS accurately reflect the total intake and follow-up rates reported? (Y/N)**

Currently, SPARS accurately reflects the total intake and follow-up rates for this reporting period.

If no, please explain: Not Applicable

3. **How is data being used for Quality Improvement?**

The program evaluation team, Wellington Consulting Group, developed an online GPRA tracking tool for each provider to assist them in identifying enrolled clients, 6-month follow-up interview due dates, follow-ups completed, GPRA discharges, and their GPRA completion rate. Ongoing and continuous support in GPRA implementation was employed across providers. The Evaluator provided GPRA data updates at monthly meetings with AHCCCS, RBHAs/TRBHAs, and providers. Providers reported monthly on program updates, success, challenges, barriers, and actions to overcome barriers. Reports were reviewed by the AHCCCS Project Director, RBHA contract managers, and the evaluation team. Reported challenges and barriers were discussed during monthly meetings in order to identify any quality improvement issues that needed to be addressed with a focus on disparities in access/use/outcomes. Content analyses of monthly process narratives was utilized to identify characteristics of recruitment/retention plans, factors that facilitated /hindered implementation, and challenges and barriers experienced, and resolutions. The monthly meetings allowed for quick identification and resolution of challenges/barriers and planning for technical assistance needs.

Key Personnel & Budget

1. **The project is overseen by a project director at 80 percent level of effort. Please note in progress if there have been any key staff changes or level of effort.**

   There have been no key staff changes or level of effort.

2. **Have you met the stated timeline and budget proposed in the original application (or any changes in scope submitted)?**

   AHCCCS worked with providers to spend the original approved budgets. Each month, all Contractors must submit a Contractor Expenditure Report (CER) with backup documentation for reimbursement. Each CER is reviewed by AHCCCS Program and Financial staff to ensure funds are allowable. Additionally, each Contractor is expected to submit a monthly progress report to the evaluation team detailing progress, successes, and challenges.

   Back and forth budget negotiations between SAMHSA and AHCCCS, and AHCCCS and the Contractors/Subcontractors delayed the start of the project (April 20, 2020) resulting in obtaining budgetary approvals from SAMHSA in July and October of 2020, respectively. Once approved, service implementation began in October and November of 2020. This put our Contractors/Subcontractors a few months behind their 12-month timeline for the project. With the one-year No-Cost Extension (NCE) for the Parent Grant, four out of the five Parent Grant Contractors are on track to spend their funds by August 19, 2022. As such, spending for the Supplemental Grant has also been delayed. We hope to receive a NCE for the supplemental funds so that we can ensure we spend all of the allotted funds.

   There have been no changes to the initial scope submitted for the Arizona Emergency COVID-19 Project.

Outcomes, Challenges & Successes:

1. **What obstacles has your program encountered and what steps did you take to overcome these obstacles?**

   Providers worked through implementation plans and identified and enrolled eligible individuals. On average, providers enrolled 40 clients per month. As of September 30, 2021, there were 482 program intakes:

   - 252 enrollments (52 percent of total enrollments) SMI/SED or Co-occurring disorders,
   - 15 enrollments (3 percent of total enrollments) healthcare professionals, and
   - 215 enrollments (45 percent of total enrollments) mental health diagnosis less severe than SMI or general mental health disorders.

Each provider took a unique approach to marketing/outreaching and engaging clients such as collaborating with local school districts, providing flexible services both virtually and in the home during and after normal business hours, and providing access to brief counseling. One provider, COPE Community Services, noted that increasing access to supportive services, including recovery support and transportation increased engagement in treatment services. Staff also provided access to COVID-19 vaccinations for enrolled participants. Two providers, Valle del Sol and the Pascua Yaqui Indian Tribe, used funding to support health care providers who are employees of the organization/Tribe, obtained access to mental health treatment services through expanded/enhanced employee assistance programs.

Initial challenges to meeting intake coverage rate included months of negotiating budget proposals between Contractors/Subcontractors, AHCCCS, and SAMHSA resulting in implementation delays and internal adjustments to medical coding for claims and workflow processes/management. To address these challenges, AHCCCS, the RBHAs, and providers utilized a team approach to identify these issues during initial implementation. The RBHAs developed tools, strategies, and provided on-demand technical assistance. Additionally, HCA faced challenges in recruiting local service providers willing to add the required GPRA intake to their existing menu of services and intake processes. HCA hired Program Coordinators to help providers outreach and enroll clients with GPRA into treatment services. Since this corrective action, clients were enrolled by HCA into the Emergency COVID-19 Project. One of the tribal nation partners, Gila River Health Care (GRHC), experienced staff turnover resulting in program delays. There was also a change in their project scope finalized June 2021. The Tribe partnered with a local corrections facility to serve individuals involved in the criminal justice system. Since initiating this new focus, GRHC enrolled over 20 participants for services.

In early July 2021, AHCCCS finalized a contract with a state-approved contractor to conduct and implement the training and technical assistance component for the project to identify training needs for individuals with a Non-Title XIX/XXI enrollment (uninsured/underinsured), including those enrolled in this project. It is anticipated that training and technical assistance will improve the target GPRA rate, ultimately allowing more individuals who are uninsured/underinsured to access treatment services.

AHCCCS finalized a partnership with the AZDVS in April 2021 to develop and implement a targeted outreach and referral program for veterans, service members, and eligible family members with unmet treatment needs to be referred to the project's treatment providers. It was anticipated that this partnership with AZDVS would increase the number of referrals received for treatment services by Emergency COVID-19 providers.

In June and July 2021, AHCCCS requested all subcontractors with a GPRA intake and/or follow-up rate below 80 percent submit a Corrective Action Plan (CAP) outlining challenges and barriers, process improvement activities, and a 60-day CAP outlining activities and efforts to improve GPRA client intake and/or follow-up measures. These plans were put in place and monitored by RBHAs/TRBHAs, and the Emergency COVID-19 Project Director. Since implementing the CAP, the program has seen an improvement in both client intake and/or follow-up measures; the program will continue monitoring providers under corrective action to continue improvements.

During this reporting period, GPRA status updates were provided at monthly meetings with the RBHAs and TRBHAs and the contracted providers. The updates covered GPRA intakes, follow-up rates, follow-up GPRA due, and follow-up GPRA coming due. AHCCCS met with the TRBHAs discussing enrollments, follow-up rates, follow-up GPRA due, and follow-up GPRA coming due. On-going training and technical assistance in GPRA was offered as needed. An electronic system for collecting and tracking GPRA intakes, follow-ups, and discharges was deployed to assist in monitoring the GPRA actions.

2. **Please provide three (3) examples that demonstrate your program's successes in achieving the goals and objectives stated in the grant application and ensure that one of these examples highlights a person served in each of the target populations (SMI/SUD, Healthcare Practitioner, Other than SMI).**

- **Serving Health Care Practitioners:** The Pandemic Outreach Project (POP), an outreach-based program was provided through COPE Community Services (subcontractor). POP leveraged social media (Facebook, Instagram, and LinkedIn) to recruit new individuals. POP enrolled 15 healthcare professionals. Outreach workers supported individuals with multiple needs and conduct continuous check-ins. Services were provided after work hours to ensure accessibility. The Pascua Yaqui Indian Tribe implemented an employee assistance program (EAP) for their behavioral health and health care providers utilizing EAP Jorgensen Brooks. During the reporting period, EAP Jorgensen Brooks provided several employee outreach presentations by conducting self-care workshops. These presentations helped outreach employees in need of services while providing very timely skills for the workforce to support them during difficult times.

- **Serving individuals with SMI/SED or Co-Occurring Disorders:** A total of 252 individuals with SMI/SED or Co-Occurring Disorders were served during this reporting period. Participants received several behavioral health treatment and support services across the COVID-19 providers. Two participants enrolled in the POP program required a higher level of care than independent living and the POP program was able to connect and enroll them into a behavioral health residential facility. Both individuals showed improvements in their physical and behavioral health. An individual was enrolled in June and was initially unable to communicate their feelings, could not use public transportation, and was experiencing multiple

challenges completing daily life activities. This individual enrolled in the POP program and worked closely with her team including a therapist and an outreach worker. This person made great strides in recovery since enrollment and is now able to independently access many resources in the community, including utilizing public transportation, attending groups, and going to church. In August, the program enrolled an individual suffering from severe paranoia, anxiety, and depression, which made it hard for him to receive one-on-one supportive services and led to frequent inpatient facility stays. Despite reluctancy to receive one-on-one supportive services, the individual enrolled into the COVID-19 program. As a result of regular and consistent interactions with the same staff, the individual became comfortable with the one-on-one visits and worked with the team on a plan to minimize hospital visits and better organize his home environment. Another individual struggling with substance use, anxiety, and primary health care concerns was enrolled in the program in August. Through one-on-one coaching utilizing motivational interviewing, therapeutic, and support services with the POP team, the participant received coordinated care to obtain treatment for her ailments. She completed a colonoscopy with a primary care provider, attended Alcoholics Anonymous, and worked with the team on changing her diet to improve nutrition for healthier lifestyle. This success story illustrates the importance of coordinated care across behavioral and physical health domains to support comprehensive health and wellness. An individual who was experiencing heavy substance use was referred to and enrolled in the POP program in August. At intake, the individual reported being unable to remain sober for more than a few days, even when prescribed Methadone. The individual enrolled in the POP program and worked with her counselor and outreach worker. As of this writing, the individual has been sober for 52 days and is actively continuing treatment under the COVID-19 POP program. An individual struggling with substance use enrolled in the program in September and has been sober from alcohol for 30 days. During the program the individual engaged in the community, attended church regularly, and developed a prayer routine. She has worked with their therapeutic team to overcome her fear of doctors and successfully attended an appointment with a primary care provider for the first time with support from her therapeutic team.

- **Serving individuals with disorders less severe than SMI:** A total of 215 individuals with disorders less severe than SMI were enrolled and served during this reporting period. Clients were connected to both individual and group therapy services, recovery support services, and coordinated referrals as needed. Providing support services helped ensure clients feel connected to services. The GPRA intakes and other assessments helped determine a variety of needed community services/resources. In June, the COVID-19 provider in central Arizona, Valle Del Sol, enrolled an individual who did not have health insurance and was experiencing high levels of anxiety. The individual noted how stressful it was trying to find services without insurance. When the individual was told they would be able to receive services under the grant, they were in tears and expressed extreme gratitude that the program could make services available to them. The patient had been seeking help for months but was not able to find help through any agency until they

found the COVID-19 program. The individual was enrolled and received services. In July, Valle Del Sol enrolled a mother who could not afford to pay for services out of pocket and was suffering from postpartum depression. This individual was able to obtain a clinical assessment/evaluation with a psychiatric provider as well as a variety of needed therapeutic services to help her combat post-partum depression. In August, an individual enrolled in the program who could not afford behavioral health services out of pocket and who did not qualify for other payors of last resort. The individual was hospitalized several times and sought services after hospitalization with multiple agencies but was turned away due to inability to pay. This individual was enrolled in COVID-19 program and obtained a psychiatric evaluation and was enrolled in a full menu of behavioral health services, which eliminated hospital visits. In central Arizona, a female veteran suffering from depression and anxiety was referred to AZDVS by an AZDVS employee who learned of the project. AZDVS staff contacted the client and learned that she served in the National Guard with a less than honorable discharge and was found ineligible for U.S. Department of Veteran Affairs services. The individual had applied for AHCCCS (Medicaid), but her income was too high, and she did not have commercial insurance. AZDVS successfully referred her to a COVID-19 provider for enrollment in the program. Another veteran and a survivor of military sexual trauma approached AZDVS outreach staff at an outdoor festival event and explained how difficult it has been for him to obtain services through the U.S. Department of Veterans Affairs. The individual indicated he was ready to try to access mental health services. AZDVS staff screened him for eligibility for the COVID-19 project and successfully referred him into treatment eliminating all roadblocks.

3. **Please indicate any innovations or promising practices from your program that you would like to share with SAMHSA and your peers.**

Provider programs developed outreach and marketing strategies to recruit and enroll participants. Several providers collaborated with local school districts to identify and provide services to parents and/or family focused services. The programs also provided brief interventions/counseling, flexible services after normal business hours, in-home services, and increased support services to members to increase recruitment and engagement strategies. Two providers, Valle del Sol and the Pascua Yaqui Indian Tribe, used funding to support health care providers, who are employees of the organization/Tribe, so they could obtain access to mental health treatment services through expanded/enhanced employee assistance programs.

AHCCCS contracted with the AZDVS in April 2021 to develop an outreach and referral program for service members, veterans, and their dependents. AZDVS developed protocols for screening and referring clients to the COVID-19 project. The evaluation team, Wellington Consulting Group, created a screening and referral portal for AZDVS staff that allowed them to email referrals to COVID-19 providers. AZDVS created a client lifecycle

and standard of work for screening and treatment referrals and developed numerous partnerships for outreaching service members and their families.

4. Any other information you would like to share with SAMHSA regarding your program?

The Emergency COVID-19 Project wants to recognize how effective intensive support services/community outreach services have been for project participants in improving their daily lives. Having access to an outreach specialist who can provide regular in-person or virtual check-ins, transportation, care coordination across multiple life domains, and recovery support services helped ensure that individuals with complex needs have access to comprehensive wellness services. Support services helped participants attend vital treatment services, access basic needs, improve levels of independence and confidence, improve interpersonal relationships, etc. Focusing on comprehensive wellness demonstrated immeasurable improvement in participants' overall quality of life.

Optional Attachment(s)

Specify attachments (associated with the grant project) submitted with the progress report, such as:

- Evaluation report, workplan, statewide plan, minutes/summaries of meetings

  See Attachment 1: AHCCCS Az Emergency COVID-19 Evaluation Report

- Proclamations, awards, or citations

  Not applicable

- Press releases or Media Coverage

  Not applicable

- Publications (e.g., internal newsletters, professional journals, and presentations)

  See Attachment 2: AHCCCS Emergency COVID-19 Data Infographics

Attachment 1:

AHCCCS EMERGENCY COVID-19 PROJECT ANNUAL EVALUATION

(April 20, 2020 – September 30, 2021)

Presented to:
Arizona Health Care Cost Containment System

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Table of Contents

INTRODUCTION **3**

DATA SOURCES AND EVALUATION OVERVIEW **3**

EVALUATION RESULTS **4**

PROCESS EVALUATION RESULTS 4
OUTCOME EVALUATION RESULTS 10

CONCLUSION **28**

RECOMMENDATIONS **29**

Introduction

The Arizona Health Care Cost Containment System Emergency COVID-19 (AHCCCS ECOVID) project addressed the increased need for substance abuse, mental health, and crisis support services to Arizonans impacted by the COVID pandemic. This project prioritized outreach services utilizing the existing substance use, mental health, and crisis system to ensure individuals were met where they are and increased overall service utilization. Case management services managed all aspects of a member's care, ensured all services were provided according to members' needs, and ensured services were provided in a comprehensive manner. Individuals who did not need direct substance abuse, mental health, and/ or crisis services, but needed recovery support services or general assistance services due to COVID were connected with support service entities throughout the state.

The AHCCCS ECOVID project began on April 20, 2020, with an initial planning period. Arizona Health Care Cost Containment System (AHCCCS), the funded state agency, completed an inventory of resources available to Arizonans to identify service gaps, barriers, and potential overlaps prior to implementing funding. The work completed during the planning period facilitated the development of a plan that addressed Arizona's specific needs for substance use, mental health, and crisis services during the pandemic. Service delivery was initiated between September and November 2020 when AHCCCS sent the allocation letters to the Regional Behavioral Health Authorities (RBHAs) for signatures. This report covers the period of April 20, 2020 through September 30, 2021.

Data Sources and Evaluation Overview

The AHCCCS ECOVID project is funded by SAMHSA's Center for Substance Abuse Treatment (CSAT) and uses the CSAT Government Performance and Results Act (GPRA) data collection tool at specific time points as a funding requirement. GPRA data collection occurs as part of the client's enrollment in the program with a second data collection point occurring six months later. The third data collection interval occurs when the client is discharged from the program. Changes in drug alcohol use, family and living conditions, crime and criminal justice status, and social connectedness are measured by comparing the data collected at intake with six-month follow-up and discharge data.

Providers working with clients completed the GPRA and submitted the completed forms to the evaluation team as paper copies or through a web portal created by the evaluation team. The evaluation team submitted the GPRA data to SAMHSA using the SPARS data system. The web portal collects additional information on the services a client receives and referrals. A monthly process narrative on program implementation is completed by the providers each month. This additional information is utilized to address the following process and outcome evaluation questions developed for the AHCCCS ECOVID project:

Process Evaluation Questions:

1. How many individuals were reached through the project?
2. Is the project serving the target population adequately and appropriately?

3. How closely did implementation match the plan?
4. What types of changes were made to the original plan?
5. What effect did the changes have on the planned intervention and performance assessment?

Outcome Evaluation Questions:
1. What was the effect of intervention on key outcome goals?
2. What factors were associated with outcomes?
3. Was the intervention effective in maintaining the project outcomes at the six-month follow-up?
4. What program factors were associated with increased access to and enrollment in treatment services?
5. What was the effect of the AHCCCS ECOVID project on the level of collaboration between the integrated care system, recovery support services, and healthcare system on key outcome goals?

This evaluation report presents information related to the process and outcome evaluation questions using the intake GPRA interview data. Counts, frequencies, means, and percent changes are shown for available data. Follow-up data collection began in April 2021.

Evaluation Results

Service providers began identifying and enrolling clients in between September and November 2020 after contracts and allocations were finalized. Once a client was identified as eligible for the AHCCCS ECOVID project, an intake GPRA was completed. Service delivery began following the completion of the intake interview and was tracked through the data collection web portal created by the evaluation team. The data included in this evaluation report was collected from intake, follow-up, and discharge GPRAs completed between September 21, 2020 and September 30, 2021.

Process Evaluation Results

Process Evaluation Question 1: How many individuals were reached through the program?

Several items were used to measure this process evaluation question. The following table presents demographics collected between September 21, 2020 and September 30, 2021 for 500 eligible AHCCCS ECOVID participants. The N value for each demographic variable changed for some items because clients declined to provide specific information, such as their date of birth, or a specific variable was not applicable.

Nearly 70% of clients (69%) were screened for a co-occurring disorder with 30% having a positive result indicating a co-occurring disorder. Clients had a mean age of 40.9, ranging from 17 to 87 years old, and slightly more participants were female (57%) than male (42%). Sixty-three percent of clients identified as white and 46% are Hispanic/Latino. Ten clients (2%) selected more than one category for race. Thirty percent completed grade 12 with a high school diploma or a GED equivalent and 19% of clients had a Bachelor's degree or higher.

Demographic variables	Intake
1. Co-occurring Screen (%) (n = 500)	
Yes	69%
No	30%
Refused or Unknown	1%
2. Co-occurring positive screen status (%) (n = 346)	
Yes	30%
No	70%
3. Average Age in years (n = 495)	
Range 17 – 87 years old	40.9
4. Gender (%) (n = 500)	
Males	42%
Females	57%
Transgender	0%
Refused or Unknown	1%
5. Ethnicity (%) (n = 500)	
Hispanic	46%
Non-Hispanic	53%
Refused or Unknown	1%
6. Race (%) (n=500)	
American Indian	11.2%
Alaska Native	0.4%
Asian	1.0%
Black	8.4%
Native Hawaiian	1.0%
White	62.8%
Other	0.2%
Refused or Unknown	17.0%
7. Education (%) (n = 500)	
Never to 5th Grade	3%
6th Grade	2%
7th Grade	0%
8th Grade	1%
9th Grade	3%
10th Grade	3%
11th Grade	5%
12th Grade/HS diploma/equivalent	30%
College or University/1st year completed	11%
College or University/2nd year completed Associates Degree (AA/AS)	13%
College or University/3rd year completed	3%
Bachelor’s Degree	19%

Demographic variables	Intake
Vocational/Technical Program with no diploma	1%
Vocational/Technical Program diploma	3%
Don't know	3%
8. Ever served in the military? (%) (n = 500)	
Yes	4%
No	95%
Refused or Unknown	1%

Out of the 500 clients served, 240 individuals (48%) reached the six-month follow-up data collection window by September 30, 2021. An administrative or completed follow-up GPRA form was submitted for 149 individuals (62% of the 240 eligible individuals) with 106 clients completing the interview. This is a 44% follow-up completion rate (106 of the 240 eligible clients), which falls below the minimum 80% follow-up completion rate established by SAMHSA.

Discharge interviews were submitted for 50 clients (10% of the intakes). Fifteen individuals (30%) completed their treatment or recovery support services. Of the 35 termination discharges, 37% were for involuntary discharge due to nonparticipation, and 23% were for other reasons that included client received Medicaid coverage through AHCCCS or a change in the client's Title XIX status. The following table summarizes the reasons clients were discharged from the AHCCCS ECOVID program.

9. Discharge Reason (n=50)	Number / Percent
Completion/Graduation	15 / 30%
Termination	35 / 70%
Termination Reason:	
Left on own against staff advice with satisfactory progress	2 / 6%
Left on own against staff advice without satisfactory progress	2 / 6%
Involuntarily discharged due to nonparticipation	13 / 37%
Involuntarily discharged due to violation of rules	0 / 0%
Referred to another program or other services with satisfactory progress	2 / 6%
Referred to another program or other services with unsatisfactory progress	1 / 3%
Incarcerated due to offense committed while in treatment with satisfactory progress	0 / 0%
Incarcerated due to offense committed while in treatment with unsatisfactory progress	1 / 0%
Incarcerated due to old warrant or charged from before entering treatment with satisfactory progress	0 / 0%
Incarcerated due to old warrant or charged from before entering treatment with unsatisfactory progress	0 / 0%
Transferred to another facility for health reasons	2 / 6%
Death	4 / 11%
Other	8 / 23%
Other reason: Client called to disenroll and moved out of area	*1 / 12.5%*

9. Discharge Reason (n=50)	Number / Percent
Other reason: Has AHCCCS coverage, continuing under insurance	*1 / 12.5%*
Other reason: Change in Title Status/No longer Non-Title XIX	*6 / 75%*

The discharge GPRA interview was completed with 11 individuals (2% of the 500 intakes). Sixty-four percent of the individuals who completed the discharge GPRA interview were terminated from the AHCCCS ECOVID project.

The difference between the intake GPRA date and the discharge GPRA date determined how long clients received services through the AHCCCS ECOVID project. The 50 clients with a discharge GPRA had an average of 176.0 days in the AHCCCS ECOVID project. Among the 15 clients documented as graduating/ completing services, the average number of days was 200.7 (ranging from 91 days to 236 days), a 14% increase from the average for all discharged clients. The 35 clients terminated from the AHCCCS ECOVID project had an average of 166 days of service (ranging from 33 days to 288 days), a 6% reduction from the average for all discharged clients.

Process Evaluation Question 2: Is the project serving the target population adequately and appropriately?

Contractors agreed to serve 800 unduplicated individuals by August 19, 2022. In accordance with funding requirements, 70% of clients (560 individuals) should be persons with SMI/SEDs, 10% (80 individuals) should be healthcare practitioners, and 20% (160 individuals) should be individuals with less than SMI.

The 500 intake GPRAs (62% of the 800 target) indicated that the AHCCCS ECOVID project made progress toward the specified target population and subpopulation percentages. Of the 500 intakes, 54% were for individuals with SMI/SED or co-occurring disorders, 43% were individuals with less than SMI, and 3% were for healthcare practitioners. These percentages will be updated as enrollment continues through August 19, 2022.

The GPRA included a section on Behavioral Health Diagnoses using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). Up to three diagnoses could be selected with the option to identify the diagnosis as Primary, Secondary, or Tertiary. The following section presents the results for 500 intake GPRAs. Of the 500 clients, 461 individuals (92%) had a primary behavioral health diagnosis, 228 individuals (46%) also had a secondary diagnosis, and 71 individuals (14%) had a tertiary diagnosis. Nine individuals (2%) had at least one behavioral health diagnosis that was not ranked as primary, secondary, or tertiary.

8. Behavioral Health Diagnosis	# Primary	# Secondary	# Tertiary	No Ranking
F10.10 – Alcohol use disorder, uncomplicated, mild	24	4	2	1
F10.11 – Alcohol use disorder, mild, in remission	3	1	1	0
F10.20 – Alcohol use disorder, uncomplicated, modern/severe	9	13	8	0
F10.21 – Alcohol use, disorder, moderate/severe, in remission	1	3	2	0
F10.9 – Alcohol use, unspecified	10	4	2	0
F11.10 – Opioid use disorder, uncomplicated mild	4	1	0	0

8. Behavioral Health Diagnosis	# Primary	# Secondary	# Tertiary	No Ranking
F11.20 – Opioid use disorder, uncomplicated, moderate/severe	24	1	2	0
F11.21 – Opioid use disorder, moderate/severe, in remission	5	1	0	1
F11.9 – Opioid use, unspecified	2	1	0	0
F12.10 – Cannabis use disorder, uncomplicated, mild	1	5	3	0
F12.11 – Cannabis use disorder, mild, in remission	0	0	1	0
F12.20 – Cannabis use disorder, uncomplicated, moderate/severe	2	3	1	0
F12.21 – Cannabis use disorder, moderate/severe, in remission	1	2	1	0
F12.9 – Cannabis use, unspecified	2	2	0	0
F13.9 – Sedative, hypnotic, or anxiolytic use, unspecified	1	0	0	0
F14.20 – Cocaine use disorder, uncomplicated, moderate/severe	0	0	3	0
F14.21 – Cocaine use disorder, moderate/sever, in remission	1	0	2	0
F15.10 – Other stimulant use disorder, uncomplicated, mild	1	0	1	0
F15.11 – Other stimulant use disorder, mild, in remission	0	1	0	0
F15.20 – Other stimulant use disorder, uncomplicated, moderate/severe	4	1	6	0
F15.21 – Other stimulant use disorder, moderate/severe, in remission	0	2	0	0
F15.9 – Other stimulant use, unspecified	2	2	0	0
F19.10 – Other psychoactive substance use disorder, uncomplicated, mild	0	0	0	1
F19.11 – Other psychoactive substance use disorder, in remission	0	1	0	0
F19.20 – Other psychoactive substance use disorder, uncomplicated, moderate/severe	1	0	1	0
F19.21 – Other psychoactive substance use disorder, moderate/severe, in remission	1	0	0	0
F20 - Schizophrenia	9	1	0	0
F22 – Delusional disorder	2	0	2	0
F25 – Schizoaffective disorders	20	0	0	1
F28 – Other psychotic disorder not due to a substance or known physiological condition	1	0	0	0
F29 – Unspecified diagnosis not due to a substance or known physiological condition	3	1	0	0
F31 – Bipolar disorder	43	8	1	0
F32 – Major depressive disorder, single episode	34	19	2	0
F33 – Major depressive disorder, recurrent	99	29	3	1
F34 – Persistent mood [affective] disorders	2	2	0	0
F39 – Unspecified mood [affective] disorder	3	2	0	1
F40 – F48 – Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders	119	101	12	1

8. Behavioral Health Diagnosis	# Primary	# Secondary	# Tertiary	No Ranking
F50 – Eating disorders	1	2	0	1
F51 – Sleep disorders not due to a substance or known physiological condition	0	0	1	0
F60.2 – Antisocial personality disorder	1	0	0	0
F60.3 – Borderline personality disorder	1	2	4	0
F60.0, F60.1, F60.4 – F69 – Other personality disorders	6	2	3	0
F70–F79 – Intellectual disabilities	0	1	1	0
F90 – Attention-deficit hyperactivity disorders	6	4	5	0
F91 – Conduct disorders	2	0	0	0
F93 – Emotional disorders with onset specific to childhood	0	2	0	0
F95 – Tic disorder	0	1	0	0
F99 – Unspecified mental disorder	10	0	1	0
Total	**461**	**228**	**71**	**9**

Process Evaluation Question 3: How closely did implementation match the plan?

The planning phase of the AHCCCS ECOVID project was conducted and completed as outlined in the implementation plan. The identified service gaps, barriers, and overlaps helped AHCCCS identify and outline program requirements in the allocation letters sent to the RBHAs and the contracts established with local service providers.

Outreach services were identified as a crucial component to the AHCCCS ECOVID project in the implementation plan. Providers experienced some initial challenges with identifying individuals who were not eligible for Arizona's Medicare program or Title XIX services. The RBHAs addressed this challenge by integrating grant eligibility into the providers' existing decision tree matrix used to trigger GPRA intakes. A tribal provider expanded their outreach activities to individuals in correctional facilities who are not eligible for Medicare. Providers created outreach materials specific to their local program, which were distributed across their communities.

Supplemental funding allowed AHCCCS to expand outreach activities by contracting with the Arizona Department of Veterans Services (AZDVS) for outreach, screening, and referral services to veterans, active service members, and their dependents. Between April 2021 and July 2021, protocols for service delivery were developed and enhancements were made to the web portal for data collection and emailing referrals. Three AZDVS outreach positions in northern, southern, and central Arizona were staffed by August 9, 2021, with outreach activities focused on zip codes with high incident rates of veteran suicide and events catering to veterans and their families.

The strategies implemented by providers contributed to an increase in the average number of GPRA completed each month. Between September and December 2020, the monthly average was 31 GPRA a month. After the new and expanded outreach strategies were implemented between January and September 2021, the average number of GPRA intakes rose to 42, a 35% increase.

Process Evaluation Question 4: What types of changes were made to the original plan?

The implementation plan for the AHCCCS ECOVID project required providers to complete the GPRA tool with eligible clients. One RBHA encountered reluctance from local service providers on adding COVID services and administering the GPRA to their existing services and processes. The RBHA responded to providers' concerns with an innovative approach. The RBHA hired program coordinators responsible for conducting intake, follow-up, and discharge GPRA. This action removed the burden from providers and increased service coordination and care between the RBHA, local providers, and the individuals receiving services.

RBHAs and service providers struggled with recruiting healthcare professionals due to the stigma associated with seeking behavioral health treatment. AHCCCS altered the implementation plan to allow healthcare providers to receive single encounter services under the AHCCCS ECOVID project. With permission from SAMHSA, the GPRA intake process was modified for healthcare professionals to reduce stigma and increase anonymity.

Another strategy utilized to increase healthcare provider participation in the AHCCCS ECOVID project was the expansion of employee assistance program (EAP) services. One tribe contracted with Jorgensen Brook to provide counseling services, coaching, and therapeutic services to employees. Additional EAP services included self-paced online learning classes, Applied Suicide Intervention Skills Training, and information on crisis services, the importance of self-care and self-care strategies, and exercise to help manage stress.

Process Evaluation Question 5: What effect did the changes have on the planned intervention and performance assessment?

The program coordinators began providing services and completing GPRA interviews in late August 2021. During the first month, the program coordinators completed four GPRA intakes. These four clients were the first to receive AHCCCS ECOVID services through this RBHA and the local providers.

The modifications implemented for healthcare professionals have also demonstrated results. Between September and December 2020, four health care professionals completed a GPRA intake interview. An additional 11 health care providers completed the Intake GPRA between January and September 2021.

The EAP services did not contribute to a completed Intake GPRA with healthcare providers by September 30, 2021. The EAP services provided and GPRA completion will continue to be documented through August 19, 2022.

Outcome Evaluation Results

Outcome Evaluation Question 1: What was the effect of intervention on key outcome goals?

The following tables compare matched participant data from intake to the six-month follow-up interview and from intake to discharge for key outcome goals. The percent change between the specified time intervals is documented in each table. The six-month follow-up GPRA was completed by 106 individuals and 11 clients completed the discharge GPRA interview. Clients

with "missing" or "unknown" at one time interval (intake, follow-up, or discharge) were removed from data analysis.

Risk factor variable: Employment

Employment status was reported at intake, follow-up, and discharge. Table 11 compares 106 participant responses at intake and at the six-month follow-up. The positive percent change reported for full time (23%) was the desired outcome indicating more individuals were employed after receiving services through AHCCCS ECOVID project. Overall, there was a 19% increase in employment and a 4% reduction in unemployment among participants six months after intake. At follow-up, participants also had a positive percent change for individuals who were unemployed and retired (36%) and unemployed individuals and doing volunteer work (100%). The increases seen in the unemployed individuals doing volunteer work reflected the small number of people selecting this option, rising from zero to one. The larger number of individuals who indicated they were unemployed and retired at intake (15) and follow-up (20) reflected the older average age of clients who completed the follow-up interview. The average age for all AHCCCS ECOVID participants is 40.9, as documented previously in Table 3, while the average age for clients who completed the follow-up GPRA was 52.5 (ranging from 20 to 84).

11. Current employment status (%)	**Intake (n = 106)**	**Follow-up (n = 106)**	**Percent Change**
Employed, Full Time	24%	31%	23%
Employed, Part Time	6%	4%	-33%
Unemployed, looking for work	6%	4%	-33%
Unemployed, disabled	40%	37%	-7%
Unemployed, volunteer work	0%	1%	100%
Unemployed, retired	14%	19%	36%
Unemployed, not looking for work	6%	2%	-67%
Other	4%	2%	-50%
On medical leave (Intake: n=2)			
Jail (Intake: n=1 and Follow-up: n=1)			
Furlough (Intake: n=1)			
Self-employed (Follow-up: n=1)			

The employment data at discharge indicated mixed results. The 11 clients who completed the discharge GPRA interview reported a 39% reduction in full-time employment and a 100% increase in part-time employment compared to intake. No changes were reported for the percent of clients who were unemployed and looking for work or unemployed and retired. A 33% decrease was reported for clients who were unemployed and disabled, and individuals who were unemployed and not looking for work increase by 100%. The results in Table 12 should be interpreted with caution due to the small N value.

12. Current employment status (%)	**Intake (n = 11)**	**Discharge (n = 11)**	**Percent Change**
Employed, Full Time	46%	28%	-39%
Employed, Part Time	9%	18%	100%

12. Current employment status (%)	Intake (n = 11)	Discharge (n = 11)	Percent Change
Unemployed, looking for work	9%	9%	0%
Unemployed, disabled	27%	18%	-33%
Unemployed, retired	9%	9%	0%
Unemployed, not looking for work	0%	18%	100%

Risk factor variable: Housing

Table 13 presents the housing data at intake and follow-up. Clients reported a 100% reduction in living on the street or in an automobile at follow-up. A 100% increase was also reported for clients living in an institution. No change was reported for the percent of individuals living in permanent housing, but some changes were reported in the type of permanent housing. Clients had a 7% increase in living in an apartment, room, or house that 23% increase in housing at the six-month follow-up with individuals who owned or rented an apartment, room, or house they owned or rented.

13. In the past 30 days, where have lived most of the time? (%)	Intake (n = 106)	Follow-up (n = 106)	Percent Change
On Street/Automobile	1%	0%	-100%
Institution	1%	2%	100%
Permanent Housing	98%	98%	0%
Permanent Housing: Own/Rent apartment, room, or house	*84%*	*90%*	*7%*
Permanent Housing: Someone else's apartment, room, or house	*11%*	*8%*	*-27%*
Permanent Housing: Halfway house	*2%*	*1%*	*-50%*
Permanent Housing: Residential treatment	*3%*	*0%*	*-100%*
Permanent Housing: Other – Oxford House	*0%*	*1%*	*100%*

All clients who completed the discharge GPRA interview reported living in permanent housing. No changes were reported between intake and discharge in the type of permanent housing where these individuals lived.

14. In the past 30 days, where have lived most of the time? (%)	Intake (n = 11)	Discharge (n = 11)	Percent Change
Permanent Housing	100%	100%	0%
Permanent Housing: Own/Ren apartment, room, or house	*82%*	*82%*	*0%*
Permanent Housing: Someone else's apartment, room, or house	*18%*	*18%*	*0%*

Risk factor variable: Past 30-day substance use

A reduction in client's substance use was an intended outcome of the AHCCCS ECOVID project. The intake interview established clients' baseline use of alcohol and illegal drugs. Tables 15 and 16 compare the baseline use with client's use six-months after enrollment in the AHCCCS ECOVID project. The number of clients responding to each question is shown as the N value beside each substance. The N value is smaller for some questions, such as five or more alcoholic

drinks in one sitting, because only clients who reported using alcohol in the past 30 days responded to this question. Missing or unknown data at one data collection interval also contributed to changes in the N value for each substance as matched data was utilized to compare past 30-day substance use.

Table 15 summarizes the data for clients who reported using alcohol and/or illegal drugs at intake. A reduction in alcohol and illegal drug use at follow-up was seen across all items with clients reporting reductions in both the percent of users and the average number of days of use. The smallest reductions were documented for any alcohol use with a 3% reduction in the percent of clients using alcohol and a 14% reduction in the average number of days. The largest reductions were reported among clients who had four or fewer drinks of alcohol a day. These clients showed a 69% reduction in the percent of clients who had four or fewer drinks a day and an 81% decrease in the average number of days of use.

15. Individuals who reported substance use at intake: In past 30 days	**Intake**		**Follow-up**		**Percent Change**	
	% Yes	**Average # of Days**	**% Yes**	**Average # of Days**	**% Change**	**% Change # Days**
Any alcohol use (n=97)	32%	8.5	31%	7.3	-3%	-14%
Use of alcohol for intoxication (5+ drinks in 1 sitting) (n=31)	39%	3.1	16%	4.8	-59%	-55%
Use of alcohol for intoxication (4 or fewer) and felt high (n=33)	42%	6.8	13%	1.3	-69%	-81%
Used illegal drugs (n=99)	15%	19.5	8%	10.1	-47%	-49%
Used both alcohol and drugs (n=8)	50%	4.0	20%	2.0	-60%	-50%

A few individuals did not report using alcohol or illegal drugs during the past 30 days at intake but reported use of the specified substance during the six-month follow-up interview. These clients reported an average of 7.1 days of alcohol use and 15.0 days of illegal drug use at follow-up. It is not possible to determine if the increased substance use seen in Table 16 indicated new behavior or if clients failed to disclose their use at intake. Results should be interpreted with caution due to the small N values.

16. Individuals who first reported substance use at follow-up: In past 30 days	**Intake**		**Follow-up**		**Percent Change**
	% Yes	**Average # of Days**	**% Yes**	**Average # of Days**	
Any alcohol use (n=8)	0%	0	100%	7.1	100%
Use of alcohol for intoxication (5+ drinks in 1 sitting) (n=4)	0%	0	100%	4.8	100%
Use of alcohol for intoxication (4 or fewer) and felt high (n=4)	0%	0	100%	10.0	100%
Used illegal drugs (n=5)	0%	0	100%	15.0	100%
Used both alcohol and drugs (n=2)	0%	0	100%	6.0	100%

Table 17 documents the change in illegal drug use by individual substance between intake and follow-up. A small percentage of the clients who completed the intake and follow-up GPRA interviews reported using any illegal drugs. Marijuana/hashish had the highest percent of users at intake (13%) and at follow-up (8%), which may reflect the legality of medical marijuana use since November 2010 and recreational marijuana use in November 2020. Clients documented a 38% decline in the percent of clients using marijuana and a 31% decrease in the average number of days of use. Clients reported abstaining from oxycontin/oxycodone at follow-up.

17. Individuals who reported illegal drug use at intake: In past 30 days (n=99)	Intake		Follow-up		Percent Change	
	% Yes	Average # of Days	% Yes	Average # of Days	% Change	% Change # Days
Marijuana/Hashish	13%	17.5	8%	12.0	-38%	-31%
Oxycontin/Oxycodone	1%	30.0	0%	0	-100%	-100%
Benzodiazepines	2%	25.0	1%	15.0	-50%	-40%

Five individuals reported using a specific substance during follow-up that was not reported at intake. Marijuana had the largest number of individuals who reported use only at follow-up with the highest average of 10.5 days of use. Table 18 should be interpreted with caution due to the small N values.

18. Individuals who first reported illegal drug use at follow-up: In past 30 days	Intake		Follow-up		Percent Change
	% Yes	Average # of Days	% Yes	Average # of Days	
Marijuana/Hashish (n=4)	0%	0	100%	10.5	100%
Methamphetamine (n=1)	0%	0	100%	3.0	100%

Tables 19 and 20 compare baseline use with clients' use at discharge. The N value for each question indicates number of clients who responded. The N value changed for questions because only clients who reported using alcohol or illegal drugs in the past 30 days responded to the subsequent questions. For this matched comparison, missing or unknown data at one data collection interval also contributed to the N value changing.

Table 19 summarizes the data for clients who reported using alcohol and/or illegal drugs at intake compared to discharge. A reduction in alcohol and illegal drug use at follow-up was seen in both the percent of users and the average number of days of use. All individuals reported abstaining from illegal drugs and stopped drinking four or fewer drinks at discharge. There was a 34% reduction in the percent of individuals using any alcohol at discharge and a 52% decrease in the average number of days of alcohol use.

19. Individuals who reported substance use at intake: In past 30 days	Intake		Discharge		Percent Change	
	% Yes	Average # of Days	% Yes	Average # of Days	% Change	% Change # Days
Any alcohol use (n=8)	38%	12.0	25%	5.7	-34%	-52%
Use of alcohol for intoxication (5+ drinks in 1 sitting) (n=3)	0%	0	0%	0	0%	0%
Use of alcohol for intoxication (4 or fewer) and felt high (n=3)	33%	1.0	0%	0	-100%	-100%
Used illegal drugs (n=9)	11%	20.0	0%	0	-100%	-100%
Used both alcohol and drugs (n=0)	0%	0	0%	0	0%	0%

Six individuals did not report using alcohol or illegal drugs during the past 30 days at intake and then documented substance use in the past 30 days at discharge. These clients reported an average of 6.7 days of alcohol use and 17.0 days of illegal drug use at discharge. The increased substance use documented in Table 20 could indicate new behavior or cases where clients failed to disclose substance use at intake. The results shown in Table 20 should be interpreted with caution due to the small N values.

20. Individuals who first reported substance use at discharge: In past 30 days	Intake		Discharge		Percent Change
	% Yes	Average # of Days	% Yes	Average # of Days	
Any alcohol use (n=3)	0%	0	100%	6.7	100%
Use of alcohol for intoxication (5+ drinks in 1 sitting) (n=1)	0%	0	100%	14.0	100%
Use of alcohol for intoxication (4 or fewer) and felt high (n=2)	0%	0	100%	1.5	100%
Used illegal drugs (n=2)	0%	0	100%	17.0	100%
Used both alcohol and drugs (n=1)	0%	0	100%	4.0	100%

Table 21 compares illegal drug use in the past 30 days at intake and at discharge. At discharge, clients reported abstaining from all illegal substances.

21. Individuals who reported illegal drug use at intake: (n=9)	Intake		Discharge		Percent Change	
	% Yes	Average # of Days	% Yes	Average # of Days	% Change	% Change # Days
Marijuana/Hashish	11%	15.0	0%	0	-100%	-100%
Benzodiazepines	10%	20.0	0%	0	-100%	-100%

Among the substances individuals reported using at discharge but did not report at intake, benzodiazepines had the highest average number of days of use (30 days). Data in Table 22 should be interpreted with caution due to the small N.

22. Individuals who first reported substance use at discharge: In past 30 days	Intake		Discharge		Percent Change
	% Yes	Average # of Days	% Yes	Average # of Days	
Marijuana/Hashish (n=2)	0%	0	100%	4.0	100%
Benzodiazepines (n=1)	0%	0	100%	30.0	100%

Risk factor variable: Impact of substance use

Participants were also asked to rate the impact of their use of alcohol or other drugs on a scale from 1 to 4 with "1" being "Not at all" to "4" being "Extremely". Table 23 shows intake and follow-up ratings of clients who reported alcohol or drug use at intake and completed the follow-up interview. The negative percent change values indicate movement in the desired direction as participants reported that substance us had less impact on their lives. Clients reported the largest reduction (5%) in emotional problems caused by alcohol and other drug use.

23. In the past 30 days	Intake Mean (n=104)	Follow-up Mean (n=104)	Percent Change
How stressful have things been for you because of your use of alcohol or other drugs?	3.7	3.6	-3%
Has your use of alcohol or other drugs caused you to reduce or give up important activities?	3.7	3.6	-3%
Has your use of alcohol or other drugs caused you to have emotional problems?	3.7	3.5	-5%

Table 24 shows ratings from clients with alcohol or drug use at intake who completed a discharge interview. The negative percent change seen for all three items is the desired outcome. Clients reported the largest decreases (18%) for stress and emotional problems caused by using alcohol and drugs.

24. In the past 30 days	Intake Mean (n=11)	Discharge Mean (n=11)	Percent Change
How stressful have things been for you because of your use of alcohol or other drugs?	3.4	2.8	-18%
Has your use of alcohol or other drugs caused you to reduce or give up important activities?	3.2	2.8	-12%
Has your use of alcohol or other drugs caused you to have emotional problems?	3.4	2.8	-18%

Risk factor variable: Mental and Behavioral Health

The baseline for mental and behavioral health issues was established for clients on the intake GPRA and matched with follow-up interview responses. The N value changed due to missing or unknown data. All seven items in Table 25 showed the intended outcome with negative percent

changes, indicating clients reported fewer days of the specified mental and behavioral health issue at follow-up. No clients reported attempted suicide in the past 30 days at follow-up. The percent of clients who reported experiencing trouble controlling violent behavior declined by more than 70%. The average number of days clients experienced serious depression or had trouble controlling violent behavior declined by more than a third (36% and 34% respectively).

25. Individuals who reported mental and behavioral health issues at intake: In the past 30 days	**Intake**		**Follow-up**		**Percent Change**	
	% Yes	**Avg. # Days**	**% Yes**	**Avg. # Days**	**% Change**	**% Change # Days**
Experienced serious depression (n=91)	80%	15.6	61%	9.9	-24%	-36%
Experienced anxiety (n=97)	87%	18.9	77%	15.5	-11%	-18%
Experienced hallucinations (n=100)	12%	16.2	7%	12.2	-42%	-25%
Experienced and/or had trouble understanding, concentrating, or remembering (n=95)	71%	21.1	54%	17.9	-24%	-15%
Experienced and/or had trouble controlling violent behavior (n=100)	7%	6.7	2%	4.4	-71%	-34%
Attempted suicide (n=106)	1%	1.0	0%	0	-100%	-100%
Were prescribed medications for psychological/emotional problems (n=96)	58%	28.2	46%	22.7	-21%	-19%

A few clients reported experiencing a mental or behavioral health issue in the past 30 days on the follow-up interview after reporting no experiences at intake. Table 26 shows that 11 people reported experiencing serious depression at follow-up with an average of 5.9 days of depression. The highest average number of days was seen for clients who experienced hallucinations (18.0) in the past 30 days at follow-up. Due to the small N values, the results in Table 26 should be interpreted with caution.

26. Individuals who first reported mental and behavioral health issues at follow-up: In the past 30 days	**Intake**		**Follow-up**		**Percent Change**
	% Yes	**Avg. # Days**	**% Yes**	**Avg. # Days**	
Experienced serious depression (n=11)	0%	0	100%	5.9	100%
Experienced anxiety (n=8)	0%	0	100%	8.4	100%
Experienced hallucinations (n=4)	0%	0	100%	18.0	100%
Experienced and/or had trouble understanding, concentrating, or remembering (n=8)	0%	0	100%	9.3	100%
Experienced and/or had trouble controlling violent behavior (n=5)	0%	0	100%	5.0	100%
Were prescribed medications for psychological/emotional problems (n=6)	0%	0	100%	30.0	100%

Table 27 compares the baseline with matched responses from the discharge interview. Missing and unknown data contributed to changes in the N value. For all but one of the seven items, participants reported a decline in the percent of clients experiencing the issue and the average number of days, which is the intended outcome. Although there was a decrease in the percent of individuals who experienced trouble understanding, concentrating, or remembering, there was an increase of 14% in the number of days clients reported experiencing this challenge. Clients reported no experiences of hallucinations at discharge. Caution should be used when interpreting the results in Table 27 due to the small N value.

27. Individuals who reported mental and behavioral health at intake: In the past 30 days	Intake		Discharge		Percent Change	
	% Yes	Avg. # Days	% Yes	Avg. # Days	% Change	% Change # Days
Experienced serious depression (n=8)	75%	11.2	25%	3.2	-67%	-71%
Experienced anxiety (n=9)	78%	20.6	55%	12.7	-29%	-38%
Experienced hallucinations (n=10)	100%	2.0	0%	0	-100%	-100%
Experienced and/or had trouble understanding, concentrating, or remembering (n=9)	67%	13.2	33%	15.0	-51%	14%
Were prescribed medications for psychological/emotional problems (n=8)	50%	28.0	25%	15.0	-50%	-46%

A small number of clients reported experiencing a mental or behavioral health issue in the past 30 days on the discharge interview after reporting no experiences at intake. Table 28 shows a few clients reported experiencing serious depression and hallucinations at discharge with an average of 30.0 days each. Clients also reported prescribed medication for psychological/emotional problems for an average of 30.0 days, which may reflect clients who began receiving medication following their participation in the AHCCCS ECOVID project. Table 28 should be interpreted with caution due to the small N values.

28. Individuals who reported mental and behavioral health for the first time at discharge: In the past 30 days	Intake		Discharge		Percent Change
	% Yes	Avg. # Days	% Yes	Avg. # Days	
Experienced serious depression (n=3)	0%	0	100%	30.0	100%
Experienced anxiety (n=2)	0%	0	100%	22.5	100%
Experienced hallucinations (n=1)	0%	0	100%	30.0	100%
Experienced and/or had trouble understanding, concentrating, or remembering (n=2)	0%	0	100%	17.5	100%
Were prescribed medications for psychological/emotional problems (n=3)	0%	0	100%	30.0	100%

Risk factor variable: Crime and Recidivism

Matched data on criminal activity from clients who completed the intake and follow-up interview is presented in Table 29. No change was documented in the number of nights spent in jail, both the percent of clients and the average number of nights remained consistent at intake and follow-up. Reductions were reported for the number of times clients committed a crime. The percent of clients who committed a crime decreased by 47% and the average number of crimes declined by 48%.

29. Individuals who reported criminal activity at intake: In past 30 days	**Intake (n=99)**		**Follow-up (n=99)**		**Percent Change**	
	% Yes	**Avg. # Times/ Days**	**% Yes**	**Avg. # Times/ Days**	**% Change**	**% Change # Time/ Days**
Number of nights spent in jail and/or prison	1%	30.0	1%	30.0	0%	0%
Number of times committed a crime	15%	19.5	8%	10.1	-47%	-48%

At the six-month follow-up, a few individuals reported criminal activity in the past 30 days after reporting no criminal activity at intake. The N value for the number of people who reported being arrested is one. Five individuals reported committing at least one crime in the past 30 days at follow-up after reporting no criminal activity at intake. The average number of crimes these five individuals committed ranged from three to 30 with an average of 15.0 crimes. The results in Table 30 should be interpreted with caution due to the small N values.

30. Individuals who first reported criminal activity at follow-up: In past 30 days	**Intake**		**Follow-up**		**Percent Change**
	% Yes	**Avg. #**	**% Yes**	**Avg. #**	
Number of times arrested (n=1)	0%	0	100%	1.0	100%
Number of times committed a crime (n=5)	0%	0	100%	15.0	100%

Clients who completed the discharge interview also showed the anticipated change of a reduction in criminal activity. There was a 100% decline in the percent of people who committed a crime in the past 30 days.

31. Individuals who reported criminal activity at intake: In past 30 days	**Intake (n=9)**		**Discharge (n=9)**		**Percent Change**	
	% Yes	**Avg. # Times/ Days**	**% Yes**	**Avg. # Times/ Days**	**% Change**	**% Change # Time/ Days**
Number of times committed a crime	11%	20.0	0%	0	-100%	-100%

Two individuals reported criminal activity at discharge after reporting no criminal activity at intake. The average number of crimes committed at discharge was 17.0, ranging between four and

30. The increases reported in Table 32 may indicate new criminal activity or ongoing behavior that clients did not disclose at intake. The small N values mean results in Table 32 should be interpreted with caution.

32. Individuals who first reported criminal activity at discharge: In past 30 days	Intake		Discharge		Percent Change
	% Yes	Avg. #	% Yes	Avg. #	
Number of times committed a crime (n=2)	0%	0	100%	17.0	100%

Protective factor variables

Social connectedness was measured by attendance at self-help groups and interaction with family/friends as support for recovery. The percentage of participants who identified attending a self-help group or support group at intake and at follow-up was low, ranging from 7% to 13% of clients at intake and 3% to 11% at follow-up. Attendance at self-help and support groups declined across all categories with other support groups having the largest decreases, a 60% reduction in the percent of clients and a 92% reduction in the average number of times clients attended. The COVID pandemic and the measures taken to reduce transmission, such as social distancing and restrictions on group meetings, may have impacted clients' ability to find and attend self-help and support groups. Participants did report a small increase in their interactions with friends and family that are supportive of recovery. At follow-up, 85% of clients reported interactions with friends and family, a four percent increase from intake. The GPRA interview did not include a question to measure the average number of times a client interacted with friends and family.

Protective factor variables	Intake (n=106)		Follow-up (n=106)		Percent Change	
33. Social Connectedness: In past 30 days	% "yes"	Average # of Times	% "yes"	Average # of Times	% Change	% Change # Times
Attended voluntary self-help groups	13%	1.7	11%	0.7	-19%	-59%
Attended religious/faith-based self-help groups	7%	0.5	3%	0.1	-57%	-80%
Attended any other support groups	10%	1.3	4%	0.1	-60%	-92%
Interacted with any family/friends that are supportive of recovery	82%		85%		4%	

The discharge data on protective factors presented mixed results. While attendance at voluntary self-help groups and religious/faith-based self-help groups showed increases in the percent of clients and the average number of times (100% for both), a decline was reported in the average number of times clients attended other support groups. A decrease was also reported for the percent of individuals who interacted with family and friends supportive of recovery, a 27% drop. The data presented in Table 34 should be interpreted with caution due to the small N values.

Protective factor variables	Intake (n=11)		Discharge (n=11)		Percent Change	
34. Social Connectedness: In past 30 days	% "yes"	Average # of Times	% "yes"	Average # of Times	% Change	% Change # Times
Attended voluntary self-help groups	0%	0	9%	0.9	100%	100%
Attended religious/faith-based self-help groups	0%	0	9%	0.3	100%	100%
Attended any other support groups	18%	1.3	18%	0.9	0%	-31%
Interacted with any family/friends that are supportive of recovery	100%		73%		-27%	

Mental and Physical Health Outcome Variables

The first mental and physical health outcome measured self-report of health status. The 106 clients who completed the intake and follow-up interview reported an improvement in their health status with a 35% increase in the percent of people who said their health status was "Good" and a reduction in the percent of people who selected "Fair" (-25%) and "Poor" (-14%). These changes indicated movement in the desired direction.

35. Self-reported health status	Intake (n=106)	Follow-up (n=106)	Percent Change
Excellent	5%	5%	0%
Very Good	14%	14%	0%
Good	31%	42%	35%
Fair	36%	27%	-25%
Poor	14%	12%	-14%

Clients who completed both the intake and discharge interview did not demonstrate the anticipated improvement in their health status. There was a reduction in the percentage of clients who selected "Very Good" (-5%) and "Good" (-19%) at discharge and an increase in the selection of "Fair" (5%) and "Poor" (100%). Caution should be utilized when interpreting the results shown in Table 36 due to the small N values.

36. Self-reported health status	Intake (n=11)	Discharge (n=11)	Percent Change
Excellent	9%	9%	0%
Very Good	18%	9%	-5%
Good	46%	37%	-19%
Fair	18%	27%	5%
Poor	9%	18%	100%

The second item to address mental health and physical health outcomes measured whether treatment was received in the past 30 days. Clients' treatment service utilization was limited with 40% of individuals receiving at least one treatment type at intake or follow-up. Table 37 shows increases for multiple forms of treatment, a few decreases, and no change in others. The largest increases were reported for inpatient mental treatment with a 200% increase in the percent of clients receiving this service and a 186% increase in the average number of nights. At intake and follow-up, outpatient mental treatment had the highest percent of clients (38% at intake and 40%

at follow-up) and the largest average number of times clients received this treatment (1.2 times at intake and 1.8 times at follow-up). No change between intake and follow-up was reported for inpatient physical, and the percent of clients accessing outpatient alcohol or substance abuse treatment also remained consistent. Clients reported declines in inpatient alcohol or substance abuse treatment and emergency room physical treatment.

	Intake (n=106)		Follow-up (n=106)		Percent Change	
37. Received treatment in past 30 days	**% Yes**	**Average # of nights/ times**	**% Yes**	**Average # of nights/ times**	**% Change**	**% Change # nights/ times**
Inpatient Physical	3%	0.2	3%	0.2	0%	0%
Inpatient Mental	1%	0.07	3%	0.2	200%	186%
Inpatient Alcohol or Substance Abuse	3%	0.6	2%	0.1	-33%	-83%
Outpatient Physical	21%	0.4	23%	0.7	9%	75%
Outpatient Mental	38%	1.2	40%	1.8	5%	50%
Outpatient Alcohol or Substance Abuse	6%	0.3	6%	0.6	0%	100%
ER Physical	4%	0.04	2%	0.02	-50%	-50%
ER Alcohol or Substance Abuse	0%	0	1%	0.01	100%	100%

Table 38 compares the treatment clients received in the past 30 days at intake and discharge. Overall, less than 30% of clients reported receiving treatment in the past 30 days at intake or discharge. Increases in the percent of clients and the average number of nights or times of treatment were reported for all but one item. Clients reported no change in the percent of individuals who received outpatient alcohol or substance abuse and a 63% reduction in the average number of times they received this treatment. The largest increases were reported for outpatient physical treatment, which had a 100% increase in the percent of clients and a 260% increase in the average number of times clients received this treatment.

	Intake (n=11)		Discharge (n=11)		Percent Change	
38. Received treatment in past 30 days	**% Yes**	**Average # of times**	**% Yes**	**Average # of nights/ times**	**% Change**	**% Change # times**
Outpatient Physical	9%	0.1	18%	0.36	100%	260%
Outpatient Mental	18%	0.6	27%	1.9	50%	217%
Outpatient Alcohol or Substance Abuse	9%	1.1	9%	0.4	0%	-63%
ER Physical	0%	0	9%	0.1	100%	100%
ER Mental	0%	0	9%	0.2	100%	100%

AHCCCS ECOVID project participants were asked to rate their perception of several components of their mental and physical health on a scale from "1" to "5" with "5" being the preferred response. Clients reported higher means at follow-up for all five items. The largest increase was reported

for clients feeling satisfied with themselves with a ten percent increase rising from 3.1 at intake to 3.4 at follow-up. Clients reported the highest mean score at follow-up for quality of life, which rose nine percent to 3.6.

39. Ratings of Mental and Physical Health (Scale 1 to 5–Mean 5.0 preferred)	**Intake Mean (n=106)**	**Follow-up Mean (n=106)**	**Percent Change**
Quality of life	3.3	3.6	9%
Satisfaction with health	3.1	3.2	3%
Enough energy for everyday life	2.9	3.1	7%
Satisfaction with ability to perform daily activities	3.2	3.5	9%
Satisfied with yourself	3.1	3.4	10%

Table 40 shows changes in clients' mental and physical health between intake and discharge. Clients reported higher means for three items at discharge: satisfaction with health, satisfaction with ability to perform daily activities, and satisfaction with themselves. No change was documented for having enough energy for everyday life. For quality of life, clients reported a 13% reduction at discharge with the mean score dropping from 3.7 at intake to 3.2 at discharge. The data presented in Table 40 should be interpreted with caution due to the small N values.

40. Ratings of Mental and Physical Health (Scale 1 to 5–Mean 5.0 preferred)	**Intake Mean (n=11)**	**Discharge Mean (n=11)**	**Percent Change**
Quality of life	3.7	3.2	-13%
Satisfaction with health	3.4	3.6	6%
Enough energy for everyday life	3.0	3.0	0%
Satisfaction with ability to perform daily activities	3.3	3.6	9%
Satisfied with yourself	3.4	3.7	9%

Outcome Evaluation Question 2: Was the intervention effective in maintaining the project outcomes at the six-month follow-up?

The six-month follow-up interviews and discharge interviews revealed important trends with maintaining project outcomes. At the six-month follow-up, the percent of employed clients rose by 19%. Decreases in alcohol and substance use were consistent at discharge and follow-up. At discharge, clients reported abstaining from all illegal drugs and consuming alcohol to intoxication. They also reported reductions in criminal activity with no criminal activity reported at discharge. Improvements in their mental and physical health were documented at follow-up and discharge with reductions in all seven mental and behavioral health issues.

Planned and Received Services

The services clients received through the AHCCCS ECOVID project provided insight into clients' needs and the treatment and recovery services delivered to clients. Positive changes, such as a reduced substance use and criminal activity, and negative outcomes, like decreased social

connectedness, emerged from the type and frequency of services clients received through the AHCCCS ECOVID project.

The intake interview identified services planned for the client and the services received, with a count of how often the service was provided, were documented at discharge. Fifty clients were discharged from the AHCCCS ECOVID project by September 30, 2021. Table 41 presents the percent of clients with a planned service, the percent of clients who received specified services, and the average number of days/sessions clients received the service. The GPRA interview lists 44 service options and seven "Other" options where providers and document additional services not listed. Providers working on the AHCCCS ECOVID project planned or provided services in all but five categories between September 2020 and September 2021. The five service categories not utilized by the AHCCCS ECOVID providers were: methadone, detoxification – ambulatory detoxification, HIV/AIDS counseling, childcare, and HIV/AIDS medical support and testing. Providers planned to provide nearly all clients with case management services (98%) and nearly 60% with individual counseling. Screening (56%), assessment (52%), and individual services coordination (46%) conclude the top five planned services for the AHCCCS ECOVID clients.

The discharge interviews showed that nearly 90% of the clients received case management (88%). The high percent of clients who received case management services indicated that providers followed the implementation plan which specified that case management services would be utilized to manage all aspects of a client's care. Only six individuals at discharge have no documentation of receiving case management. Four clients terminated from the program and two completed services. Case management services also had the highest average number of days at 8.0 with clients receiving between one and 90 days of services. Assessment and screening services were provided to more clients than planned at intake. Over 70% of clients received assessment services and 64% of clients received screening services. Individual services coordination was provided as planned with 44% of clients receiving this service. Outpatient services was provided to more clients than planned with 44% of clients receiving an average of 6.0 days (ranging from one to 64 days).

Knowing which services clients did not receive is equally as important as understanding which services were provided. The intake GPRA indicate that at least ten percent of clients had the following planned services: relapse prevention, recovery coaching, employment service – employment coaching, and alcohol- and drug-free social activities. The other planned services not received by clients were identified for less than four clients at intake.

41. Planned/Received Services	**% of Clients Planned Service at Intake (n = 50)**	**% of Clients Received Service at Discharge (n = 50)**	**Average # of Days/Sessions**
Case Management	98%	88%	8.0
Day Treatment	6%	0%	0
Inpatient/Hospital (Other Than Detox)	0%	6%	0.4
Outpatient	28%	44%	6.0
Outreach	32%	42%	2.5
Intensive Outpatient	10%	2%	0.06
Methadone	0%	0%	0
Residential/Rehabilitation	2%	2%	0.1

41. Planned/Received Services	% of Clients Planned Service at Intake (n = 50)	% of Clients Received Service at Discharge (n = 50)	Average # of Days/Sessions
Detoxification – Hospital Inpatient	2%	2%	0.1
Detoxification – Free-Standing Residential	2%	0%	0
Detoxification – Ambulatory Detoxification	0%	0%	0
After Care	16%	4%	0.04
Recovery Support	38%	6%	0.4
Other Modality – Specified:	2%	0%	0
Counseling	*100%*	*0%*	*0*
Screening	56%	64%	0.7
Brief Intervention	20%	6%	0.06
Brief Treatment	6%	0%	0
Referral to Treatment	28%	12%	0.1
Assessment	52%	72%	0.9
Treatment/Recovery Planning	32%	38%	0.4
Individual Counseling	58%	40%	2.5
Group Counseling	38%	32%	2.5
Family/Marriage Counseling	0%	2%	0.02
Co-Occurring Treatment/ Recovery Services	8%	8%	0.7
Pharmacological Interventions	20%	6%	0.3
HIV/AIDS Counseling	0%	0%	0
Other Clinical Services – Specified:	2%	0%	0
Anger management education	*100%*	*0%*	*0*
Family Services (Including Marriage Education, Parenting, Child Development Services)	6%	2%	0.02
Child Care	0%	0%	0
Employment Service – Pre-Employment	10%	8%	0.1
Employment Service – Employment Coaching	10%	0%	0
Individual Services Coordination	46%	44%	0.8
Transportation	38%	4%	0.1
HIV/AIDS Service	2%	0%	0
Supportive Transitional Drug-Free Housing Services	2%	0%	0
Other Case Management Services – Specify:	16%	14%	0.4
Coordination with legal system	*62.5%*	*72%*	*2.3*
Food box	*12.5%*	*14%*	*1.0*

41. Planned/Received Services	% of Clients Planned Service at Intake (n = 50)	% of Clients Received Service at Discharge (n = 50)	Average # of Days/Sessions
Resume	*12.5%*	*0%*	*0*
Remote learning support	*12.5%*	*0%*	*0*
Walk-in, same day service	*0%*	*14%*	*1.0*
Medical Care	26%	6%	0.1
Alcohol/Drug Testing	2%	0%	0
HIV/AIDS Medical Support and Testing	0%	0%	0
Other Medical Services – Specify:	0%	0%	0
Continuing Care	24%	8%	0.1
Relapse Prevention	18%	0%	0
Recovery Coaching	12%	0%	0
Self-Help and Support Groups	16%	4%	0.04
Spiritual Support	10%	2%	0.02
Other After Care Services – Specify:	2%	0%	0
Grief support/counseling	*100%*	*0%*	*0*
Substance Abuse Education	28%	22%	1.7
HIV/AIDS Education	4%	2%	0.04
Other Education Services – Specify:	12%	0%	0
Budgeting	*17%*	*0%*	*0*
Medication management	*66%*	*0%*	*0*
Remote learning support	*17%*	*0%*	*0*
Peer Coaching or Mentoring	42%	18%	0.3
Housing Support	18%	2%	0.02
Alcohol- and Drug-Free Social Activities	10%	0%	0
Information and Referral	24%	2%	0.02
Other Peer-to-Peer Recovery Support Services – Specify:	2%	0%	0
Organizational help	*100%*	*0%*	*0*

<u>Outcome Evaluation Question 3:</u> What factors were associated with outcomes?

One factor associated with the outcomes presented above is the success AHCCCS ECOVID providers have had with completing follow-up GPRA interviews. Out of the 141 follow-ups submitted by September 30, 2021, 75% were completed GPRA interviews. Thirty-five follow-up GPRAs interviews were not completed for the reasons presented in Table 42. "Unable to locate, other" accounted for more than 60% of the administrative follow-up GPRAs with "Client did not respond to outreach" accounting for 46% of the "other" responses.

42. Reason Follow-up Interview Not Completed	Number	Percent
Deceased at time of due date	2	6%
Located, but refused, unspecified	2	6%

42. Reason Follow-up Interview Not Completed	Number	Percent
Located, but unable to gain institutional access	3	8%
Located, but otherwise unable to gain access	4	11%
Located, but withdrawn from project	1	3%
Unable to locate, moved	1	3%
Unable to locate, other	22	63%
Incorrect contact information	*1*	*4%*
No response to outreach	*10*	*46%*
Contact information no longer valid	*2*	*10%*
Unable to locate/contact client	*5*	*24%*
Phone disconnected	*1*	*4%*
Incarcerated	*1*	*4%*
Closed out from services with agency	*1*	*4%*
Lack of contact with the program	*1*	*4%*

The high success rate for completing follow-up interviews stemmed from 91% of clients continuing to receive services when they entered the data collection window. Program staff knew where and how to locate clients receiving services, and the relationship established between the provider and client over six months encouraged clients to complete the interview. Nine clients completed the follow-up GPRA interview when they were no longer receiving services. Out of the nine, discharge GPRAs were submitted for seven clients with four clients completing/ graduating from the program and three clients terminating. A discharge GPRA was not submitted for two additional clients as of September 30, 2021.

Providers have strived to maintain accurate contact information and to discuss the follow-up interview process with clients prior to the completion or termination from the program. Their efforts to engage participants in completing GPRA interviews has been crucial to documenting the successes and challenges encountered in the AHCCCS ECOVID project.

Outcome Evaluation Question 4: What program factors were associated with increased access to and enrollment in treatment services?

The established and well-maintained connections between the AHCCCS ECOVID providers and their communities facilitated their ability to identify and enroll clients in appropriate services. The comprehensive recovery support and case management services ensured appropriate services were delivered to clients who needed direct substance abuse, mental health and crisis services, and those who needed general assistance with challenges caused by the COVID pandemic, such as housing, food assistance or utility assistance. Providers recognized addressing clients' basic needs removed challenges and barriers preventing clients from engaging in behavioral health services.

Providers were given the flexibility to implement marketing and outreach strategies developed for their communities. One provider collaborated with local school districts while another focused on providing flexible services virtually or in the home during and after normal business hours. Innovative strategies were also implemented to target specific populations such as healthcare providers. Some providers implemented single encounter services and modified GPRA data collection while others utilized employee assistance program services to provide self-paced online learning and self-care strategies.

The partnership with AZDVS initiated targeted outreach and referral services for veterans, service members and family members with unmet treatment needs. This partnership was designed to increase referrals to treatment services from local providers. During the first month of implementation, seven referrals were emailed to AHCCCS ECOVID providers.

Outcome Evaluation Question 5: What was the effect of the AHCCCS ECOVID project on the level of collaboration between integrated care system, recovery support services, and healthcare system on key outcome goals?

Collaboration between the local service providers, RBHAs, and other community partners was fundamental to achieving key outcomes. Providers identified and collaborated with unique partners to best meet the needs of their communities. The result of these collaborations was diversified outreach and marketing strategies to recruit and enroll participants and distinct services to address client needs during the COVID pandemic. Collaborative partners ranged from local school districts to agencies specializing in employee assistance programs to the Arizona Department of Veterans Services. Services offered with the support of collaborative partners include outreach specialist who provided in-person or virtual check-ins, transportation, care coordination, recovery support services, and referrals to additional services. These connections ensured clients with complex needs had access to comprehensive wellness services and could focus on improving their overall quality of life.

Conclusion

At the end of this reporting period, the AHCCCS ECOVID project completed the planning period and provided a year of direct client services. A total of 500 individuals enrolled in the project and completed the intake GPRA interview, and 106 clients completed a six-month follow-up GPRA interview. The follow-up completion rate of 44% was below the minimum 80% completion rate established by SAMHSA. The project is positioned to improve its follow-up completion rate as the established procedures resulted in completed follow-up interviews accounting for 75% of all submitted follow-up GPRA.

Completing follow-up interviews is vital for monitoring the long-term impacts of the AHCCCS ECOVID project. Program participants who completed the six-month follow-up interview achieved several important outcomes.

- Clients reported reductions in the impact of alcohol and other drugs on their lives.
- Fewer clients experienced mental and behavioral health issues at follow-up with an 11% decrease in anxiety and a 71% reduction in controlling violent behavior.
- The average number of days clients reported experiencing seven mental and behavioral health issues declined, ranging between 18% for anxiety and 36% decrease in depression.
- Clients reported improved mental and physical health.
- There was a 19% increase in employment and a 4% reduction in unemployment.
- Reductions in alcohol and drug use.
- Reductions in criminal activity.

The follow-up interviews also revealed areas where AHCCCS ECOVID participants did not achieve the intended outcome. A small group of participants disclosed behaviors on the follow-up interview that were not reported at intake. These behaviors occurred in key measures such as alcohol and illegal drug use, mental and behavioral health issues, and criminal activity. It is

unclear if the information reported at follow-up indicated new behavior or ongoing behaviors the client did not previously disclose. Both scenarios are disconcerting as they indicate the client engaged in new behaviors after receiving services or did not feel comfortable with the provider staff to disclose this information.

Participants' use of self-help and support groups declined at follow-up. Reductions were reported for both the percent of clients utilizing these services, ranging from 19% to 60% decline, and the average number of days they attended with a 59% to 92% decrease.

The discharge interview was completed by 11 of the 50 individuals (22%) with discharge GPRA forms. The discharge results should be interpreted with caution due to the small N value. Clients who completed the discharge interview demonstrated several strengths.

- More than a 50% reduction in the average number of days clients used alcohol.
- All clients reported abstaining from illegal drugs at discharge.
- Alcohol and drugs had a reduced impact on clients' lives.
- Fewer clients experienced mental and behavioral health issues with no clients reporting experiencing hallucinations.
- No criminal activity reported at discharge.
- Increased attendance at voluntary self-help and support groups.

The discharge interviews identified a few areas where clients did not achieve the intended outcomes. Clients reported lower levels of employment and higher levels of unemployment at discharge. Participants also reported a 27% reduction in interacting with family and friends supportive of their recovery. Similar decreases were documented in the clients' self-reported health status where fewer clients indicated their health was "Very Good" (5% reduction) or "Good" (19% decrease) at discharge. Again, the small N value used to calculate the discharge data indicates results should be interpreted with caution.

Recommendations

The outreach and recruitment strategies implemented by providers have increased enrollment in the AHCCCS ECOVID project during the reporting period. The first recommendation is for providers to maintain the procedures that have facilitated the completion of the six-month follow-up interviews. The high percentage of completed follow-up interviews submitted for this project indicates providers have successfully integrated reporting requirements into their procedures and interactions with clients.

The second recommendation is to review "what's working" with the strategies and procedures utilized for completing follow-up interviews and to identify approaches that can be implemented to increase discharge GPRA interviews. The current completion rate for discharge interviews is half of the follow-up completion rate. Improving the completion of discharge interviews will improve the project's ability to report fully on a client's participation in the AHCCCS ECOIVD project and subsequent outcomes.

Attachment 2:

AHCCCS Emergency COVID-19 Data Infographics

December 20, 2021

AHCCCS
Arizona Health Care Cost Containment System

Outcome Data for AHCCCS ECOVID-19 Clients
APRIL 20, 2020 TO SEPTEMBER 30, 2021

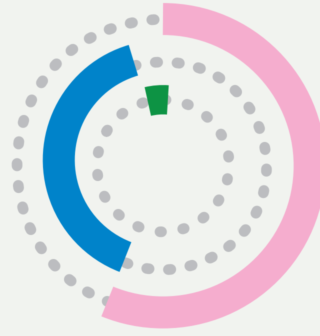
The AHCCCS Emergency COVID-19 (ECOVID-19) program provides crisis intervention, behavioral health treatment, and recovery support for adults impacted by the pandemic. The program specifically addresses the needs of individuals with serious mental illness, substance use disorders, and/or co-occurring disorders, and behavioral disorders less severe than serious mental illness. The program also specifically serves healthcare professionals.

YEAR TO DATE DEMOGRAPHIC SNAPSHOT OF CLIENTS SERVED

The AHCCCS ECOVID-19 has a 73.4% Intake Coverage Rate.

500
clients enrolled between 4/20/20 and 9/30/21

GENDER



57% OF CLIENTS WERE FEMALE

42% OF CLIENTS WERE MALE

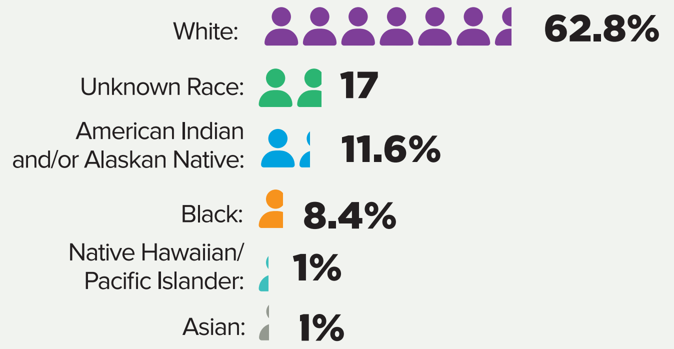
1% of clients were unknown.
The majority of clients were female.

AGE GROUP

The majority of clients are between the ages of **25-44**

Average age: 40.9 years old

RACE/ETHNICITY



53% Non-Hispanic

46% Hispanic

1% of clients were unknown.

EDUCATION

17% of clients did not finish High School

30% had a High School diploma or GED

53% attended Post Secondary education

YEAR TO DATE SNAPSHOT ENROLLMENT & DISCHARGE

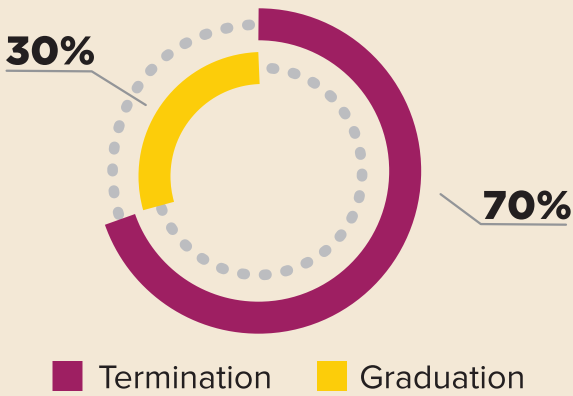
106 Successful follow-up interviews completed out of **240** follow-ups due

44% FOLLOW-UP RATE AS OF 9/30/21

500 clients enrolled and **50** DISCHARGED between 4/20/21 and 9/30/21

The AZ COVID-19 project is required to collect outcome data for clients at enrollment, 6-months, and at discharge. The program's follow-up rate includes the number of individuals providing data at intake and again at 6-months. As of 9/30/21, ECOVID-19 had a 44% follow-up rate, meaning the program successfully collected 106 six-month follow-up interviews out of 240 follow-ups due.

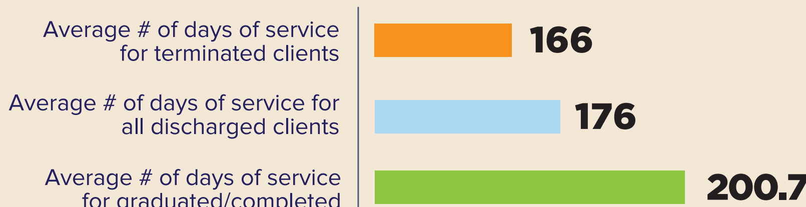
REASONS FOR TERMINATION



37% Terminated for Nonparticipation

The most common reason clients were discharged was failure to participate in program services (e.g. clients did not show up for regularly scheduled services and could not be contacted by the provider).

Average Number of Days of Services for All Discharged Clients
(N = 50)



This publication was made possible by grant number FG000250 from SAMHSA. The views expressed in the report do not necessarily reflect the official policies of the Department of Health and Human Services nor does mention of trade names, commercial practices or organizations imply endorsement by the U.S. Government.

Outcome Data for AHCCCS ECOVID-19 Clients

APRIL 20, 2020 TO SEPTEMBER 30, 2021

The AHCCCS Emergency COVID-19 (ECOVID-19) project uses the Center for Substance Use Treatment Government Performance and Results Act (GPRA) data collection tool at specific time points to collect baseline and outcome data for enrolled clients. GPRA data collection occurs as part of the client's enrollment in the program with a second data collection point occurring six months later. The third data collection interval occurs when the client is discharged from the program. The "N" is the number of individuals responding to the GPRA question at intake and follow-up interviews.

MENTAL HEALTH & BEHAVIORAL HEALTH OUTCOMES

The ECOVID-19 program tracks mental and behavioral health of clients. The data represent a matched sample of clients who completed behavioral health questions at intake and 6-month follow-up interviews.

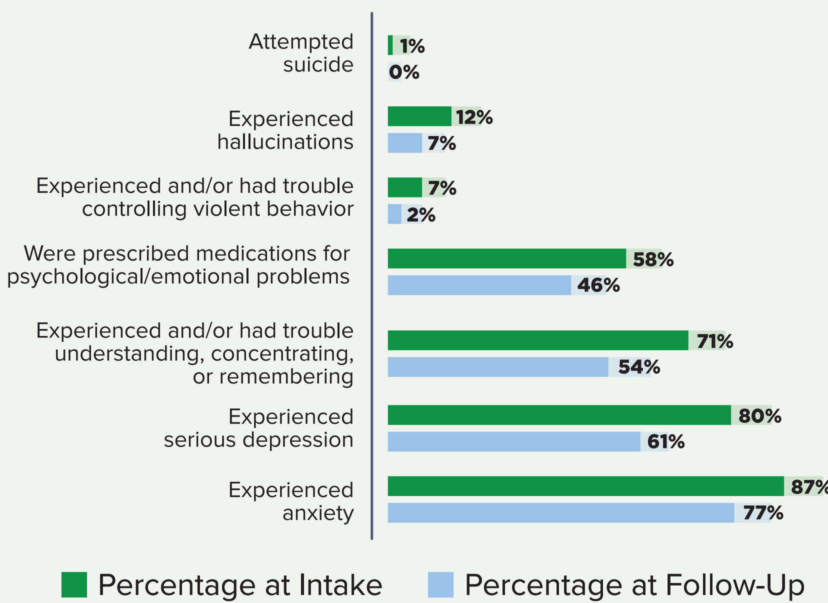
At Intake, clients most frequently reported experiencing

87% ANXIETY

80% DEPRESSION

71% TROUBLE UNDERSTANDING CONCENTRATING OR REMEMBERING THINGS

Percent of Individuals Reporting Past 30 Day Mental and Behavioral Health

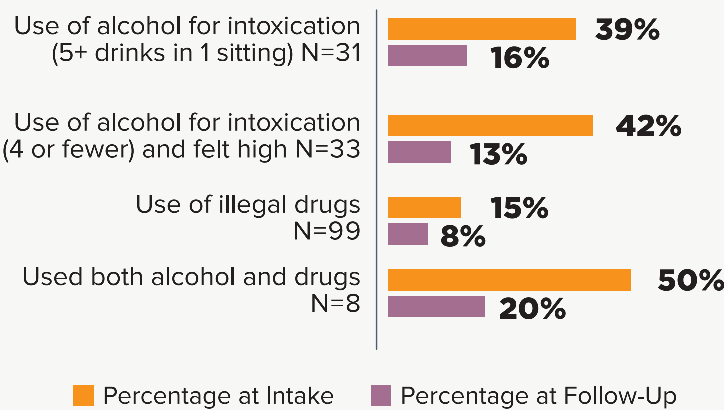


The number of clients reporting these experiences in the past 30 days at 6-month post intake decreased across all categories. It should be noted that a client could report experiencing more than one mental and behavioral health issue.

SUBSTANCE USE OUTCOMES

The ECOVID-19 program tracks substance use in the past 30 days clients. The data represent a matched sample of clients who reporting substance use at intake and 6-month follow-up interviews.

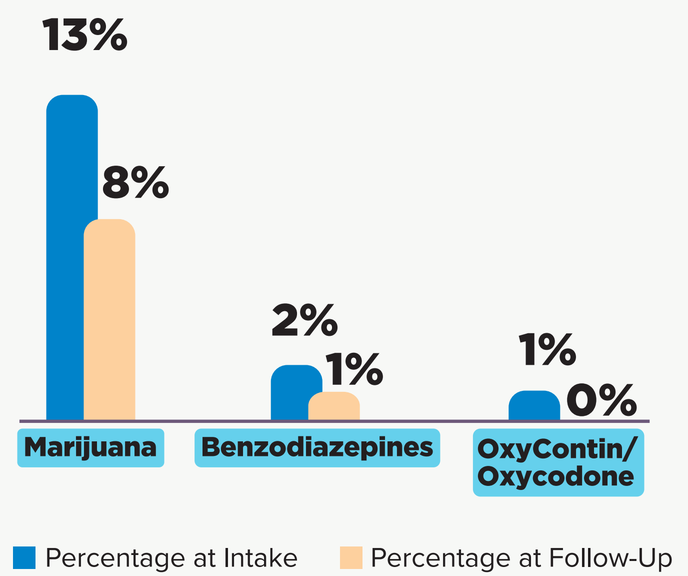
Individuals Reporting Substance Use In the Past 30 Days



The number of clients reporting using alcohol for intoxication and illegal drugs in the past 30 days at 6-month post intake decreased across all categories.

Percent of Individuals Reporting Past 30 Day Use of Illegal Drugs

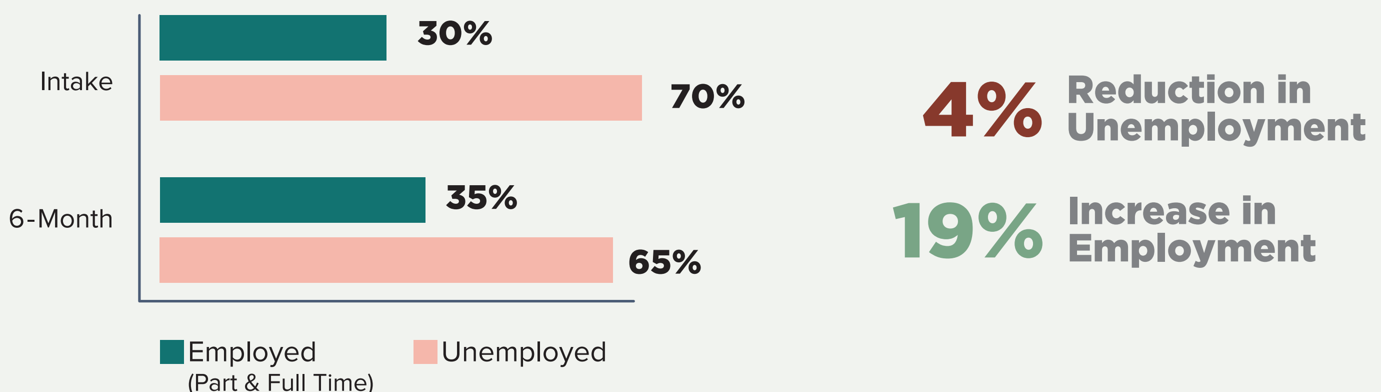
The highest percentage of ECOVID-19 clients reporting past 30 day use of illegal drugs at intake used marijuana/hashish (13%), benzodiazepines (2%), and oxycontin/oxycodone (1%). The numbers of clients reporting substance use in the past 30 days at 6-month post intake decreased across all substances. It should be noted that a client could report use of more than one substance.



EMPLOYMENT OUTCOMES

The ECOVID-19 program tracks employment outcomes of clients. The data represent a matched sample of 106 clients who completed employment questions at intake and 6-month follow-up interviews.

Percent of Individuals Employed at Intake Compared to 6-month Follow-up



Employed (Part & Full Time) Unemployed

SERVICE OUTCOMES

The ECOVID-19 program tracks services provided to enrolled clients. The data represent a sample of 50 clients who discharged from the program.

88% Received Case Management

44% Received Outpatient Mental Health Services

40% Received Individual Counseling

32% Received Group Counseling

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