Mercer

Government Human Services Consulting

Case File Review Findings FY 2021

Substance Abuse Prevention and Treatment

Arizona Health Care Cost Containment System
Division of Grants Administration

June 30, 2022

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A business of Marsh McLennan

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Section 1

Executive Summary

The State of Arizona (Arizona or State), Arizona Health Care Cost Containment System (AHCCCS) engaged Mercer Government Human Services Consulting (Mercer) to implement an independent case file review (ICR) for persons who received substance abuse treatment services through federal Substance Abuse Block Grant (SABG) funds between July 1, 2020–June 30, 2021. This report represents the most recent in an annual series of ICRs and the second conducted by Mercer.

The purpose of the annual review is to review the quality, appropriateness, and efficacy of treatment services as documented in the client records; the intent of the independent peer review process is to continuously improve the treatment services provided to individuals diagnosed with substance use disorder within the State (see 45 CFR § 96.136) in order to ultimately improve client outcomes and recovery.

Consistent with statute, Mercer licensed clinicians (i.e., Licensed Clinical Social Worker, Doctor of Philosophy [PhD], Registered Nurse, Certified Alcohol and Drug Counselor) examined the following aspects of the treatment records as part of the review process:

- Admission criteria/intake process
- Assessments and ongoing criteria
- Treatment planning, including appropriate referral, (e.g., prenatal care, tuberculosis [TB], and HIV services)
- Documentation of implementation of treatment services
- Engagement and re-engagement
- Discharge and continuing care planning
- Indications of treatment and national (e.g., employment, education, law enforcement involvement) outcomes

In addition to these statutorily required review components, Mercer also examined aspects of the treatment records related to Social Determinants of Health (SDoH), evidence-based treatment practices, peer support services, women's services, and opioid specific services.

Mercer reviewed a total of 200 treatment records, provided by AHCCCS, from across the State. The files included in this review sample represented 89% of the providers in the State who receive SABG funds, which exceeds the minimum statutory requirement for this review (5%).

Overview of Key Findings

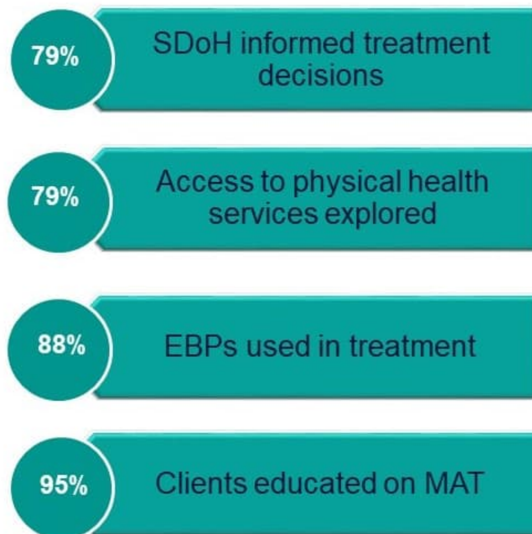
Specific findings from the ICR are presented in the body of the report in aggregate and broken down by Regional Behavioral Health Authority (RBHA): Arizona Complete Health

(AzCH) (Southern Arizona), Health Choice (HC) Arizona (Northern Arizona), and Mercy Care (MC) (Central Arizona). Key findings identify how the documentation demonstrates the overall effectiveness and quality of the SABG service delivery system in Arizona. This includes how providers are performing in the identification, engagement, and response to client needs through the provision of Substance Use Disorder (SUD) treatment services. The following bulleted list represents a summary of the major themes found across the system.

Strengths

- This is the second year the ICR has evaluated an item examining the providers' inclusion of SDoH in the initial assessment. Last year 81% of providers were already using this important information to inform treatment decisions. This number declined slightly this year to 79%, but still remains a strength in review of cases. Such a high percentage continues to bode well for future outcomes and suggests providers are continuing to incorporate emerging areas of research into current treatment approaches. Specific areas assessed include housing, employment, and education. The slight decline may be due to COVID-19 and the inability to do in-person case management, but still remains a significant positive inclusion of assessment of need and treatment planning.

- In 79% of cases, the individual's access to physical health services were also explored as part of treatment. This is a strength as it increases the opportunity for integrated care. Many cases had consent forms and made contact with primary care providers (PCPs) to inform them that the individual was in treatment and to coordinate care, an important part of ensuring full person treatment of the individual, which was also reflected in many of the treatment plans. Adoption of the American Society of Addiction Medicine (ASAM) criteria in determining the appropriate level of care (LOC) appears to continue to be a strength, with 92% of cases documenting its use during the initial assessment, an increase from 86% last year.

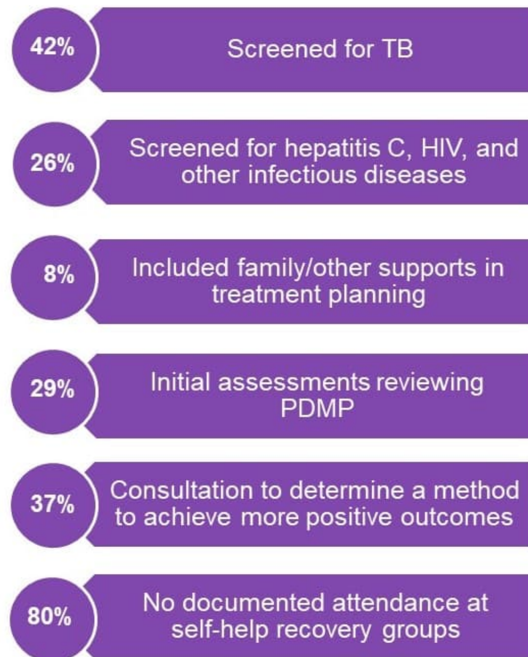


- In 88% of cases reviewed, the providers documented the use of evidenced-based practices (EBPs) in the treatment of SUD clients, a 1% increase from 87% last year. The most frequently used EBPs include Cognitive Behavioral Therapy (CBT) and Motivational Interviewing. Although this is a strength, it is also an area of opportunity for the State and the RHBAs to promote other evidence-based modalities, such as Beyond Trauma: A Healing Journey for Women or Moral Re-conation Therapy (MRT).

- For those clients diagnosed with an Opioid Use Disorder (OUD), 95% were educated on the benefits of Medication Assisted Treatment (MAT) and offered this intervention, an increase from 84% last year.

Opportunities

- Documented screening for required medical conditions continues to remain an area of needed improvement in the aggregate data. Screening for TB was documented in only 42% of cases, a decline from last year's result of screening in 57% of cases, and screening for hepatitis C, HIV, and other infectious diseases declined more significantly from 45% of cases last year to 26% in this year's findings. Although this finding may in part be due to COVID-19 and the reduction of in-person services, these results represent an area with opportunities for improvement as they were also low the previous year when COVID-19 was not a factor.



- Utilization of natural supports in the development of individual service plans (ISPs) was another area of significant decline, going from 14% of cases documenting the inclusion of family or other supports in treatment planning last year to 8% this year. Another significant area of opportunity is in the provider utilization of the Prescription Drug Monitoring Program (PDMP). This measure declined from 55% last year to 29% this year, a significant decrease that likely cannot be attributed to COVID-19 and may be an opportunity for the State to provide updated training to providers on the system and the role it plays in addressing the monitoring of opioid and other prescription use.

- Family and other supports were included only 8% of the time. This is a reduction from 14% last year. The decline may be due to COVID-19 as many assessments were conducted virtually, but still represents an opportunity to encourage providers and consumers to engage family and other supports in treatment planning as engaging natural supports can lead to significant improved treatment outcomes.

- Although 98 cases presented with a lack of progress, only 36 cases (37%) had a consultation to determine a method to achieve more positive outcomes. This result suggests a need for providers to be more active in case consultation with their peers and intervention with their clients to facilitate more positive outcomes. The majority of cases (80%) failed to provide any documentation as to whether the client was attending self-help recovery groups (e.g., Alcoholics Anonymous or Narcotics Anonymous). This is an increase from 66% reported last year and suggests an area of opportunity for improvement.

- Of all the charts reviewed, 80% lacked any documentation of whether an individual had attended a self-help recovery group. This marks a 46% decline from the previous year. This measure simply defines whether a consumer was asked if they attended a group, not a specific number of groups or no attendance at all. The decline in asking consumers

about this number may be another opportunity for technical assistance to encourage providers to again ask this question about another important resource that appears to have a reduction in interest from providers as a part of assessment.

Recommendations

The following recommendations are presented as potential areas of improvement to round out the evaluation of SABG programming and services, impact practice and outcomes for clients based upon the results of the ICR, and associated analysis of findings. A more detailed outline of recommendations can be found in Section 6 of this report.

1. **Inclusion of a mechanism for feedback to individual providers** remains one suggested opportunity for utilizing the findings from the ICR review for improvement of quality in the system.

2. **Formal statistical validation of the tool** could allow for more thorough review of the system and allow for development of validated system wide change efforts.

3. **Sub-stratification of populations** would also be a valuable enhancement, allowing for more focus on individual groups such as women, the criminal justice population, and the elderly to have a more meaningful sample size to understand the treatment arc for these populations.

4. **Adding key informant interviews to the process** could also increase the usefulness of the review process, bringing to light qualitative strengths and opportunities that are not as available from only doing a desk/record review.

Several suggestions for improving quality can also be found in Section 6. They include opportunities for encouraging the use of self-help groups, training on EBPs, and training on peer support services as well as individualized treatment plans. Other suggestions include more flexibility in hours of available treatment to accommodate individuals who are employed and increased training on the importance of solid relapse prevention plan development with the individuals in treatment.

Section 2
Background and Introduction

AHCCCS serves as the single State authority to provide coordination, planning, administration, regulation, and monitoring of all facets of the State public behavioral health (BH) system. AHCCCS contracts with managed care organizations, known as RBHAs, to administer integrated physical health (to select populations) and BH services, including SUD treatment, throughout the State. The current RBHAs are AzCH (Southern Arizona), HC Arizona (Northern Arizona), and MC (Central Arizona). Effective July 1, 2016, AHCCCS began to administer and oversee the full spectrum of services to support integration efforts at the health plan, provider, and client levels.[1]

Consistent with the requirements of 45 CFR § 96.136, AHCCCS contracted with Mercer as the independent review contractor to perform the annual SABG ICR for State Fiscal Year (SFY) 2021. Mercer also completed the independent review the previous year (SFY 2020). Mercer does not have any reviewers who are employed as treatment providers with, or who have administrative oversight for, the programs under review. Further, Mercer's peer review personnel performed this review independent (i.e., separate) from SABG funding decision makers. The Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded a SABG to AHCCCS each year since the current program was established in 1993; the block grant requires that AHCCCS produce an independent review of the treatment services provided with SABG funds on an annual basis. For the current year, AHCCCS program goals for the SABG include[2]:

- Increase the availability and service utilization of MAT options for members with a SUD.
- Ensure women have ease of access to all specialty population related SUD treatment and recovery support services.
- Increase the number of TB screenings for members entering substance abuse treatment.
- Increase the percent of older adults (aged 55 and older) who receive treatment in the BH system who are diagnosed as having a SUD.

Below are results from the SABG chart review relating to each of the above AHCCCS program goals.

Increase the availability and service utilization of MAT options for members with a SUD

Offering MAT services promotes a "whole-patient" approach to the provision of substance use services.[3] Overall, 31% of sampled BH case files (62 individuals) contained

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[1] State of Arizona. AHCCCS. (2020). Quality Service Review 2020.

[2] AHCCCS. (n.d.). *Substance Abuse Prevention and Treatment Block Grant (SABG).* Available at: https://www.azahcccs.gov/Resources/Grants/SABG/

[3] SAMHSA, *Medication-Assisted Treatment (MAT)*, updated January 1, 2021. Available at: https://www.samhsa.gov/medication-assisted-treatment

documentation that MAT was incorporated into treatment. This is a decrease of 11% from last year.

However, for members with a documented OUD, MAT education as a treatment option as well as referral to a MAT provider as a result of MAT education remains fairly stable at 81% (3% decrease) and 95% (1% decrease) respectively.

Figure 1-1 — Percentages of Members Receiving Medication Assisted Treatment

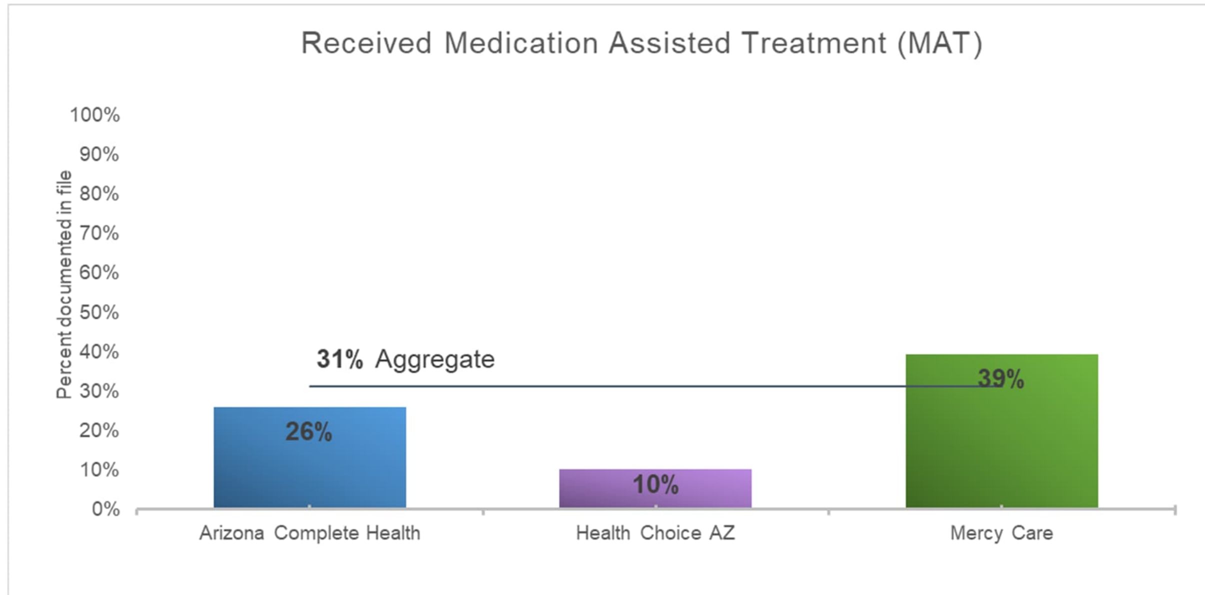


Figure 1-2 — Percentages of Members with an OUD Who Were Provided MAT Education as a Treatment Option

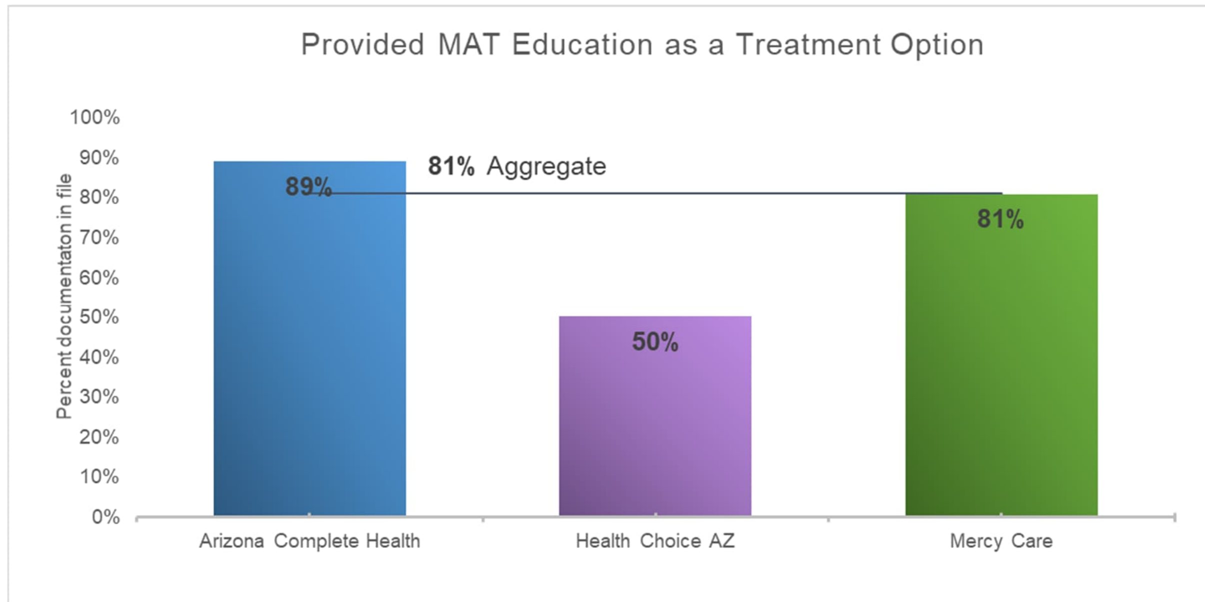
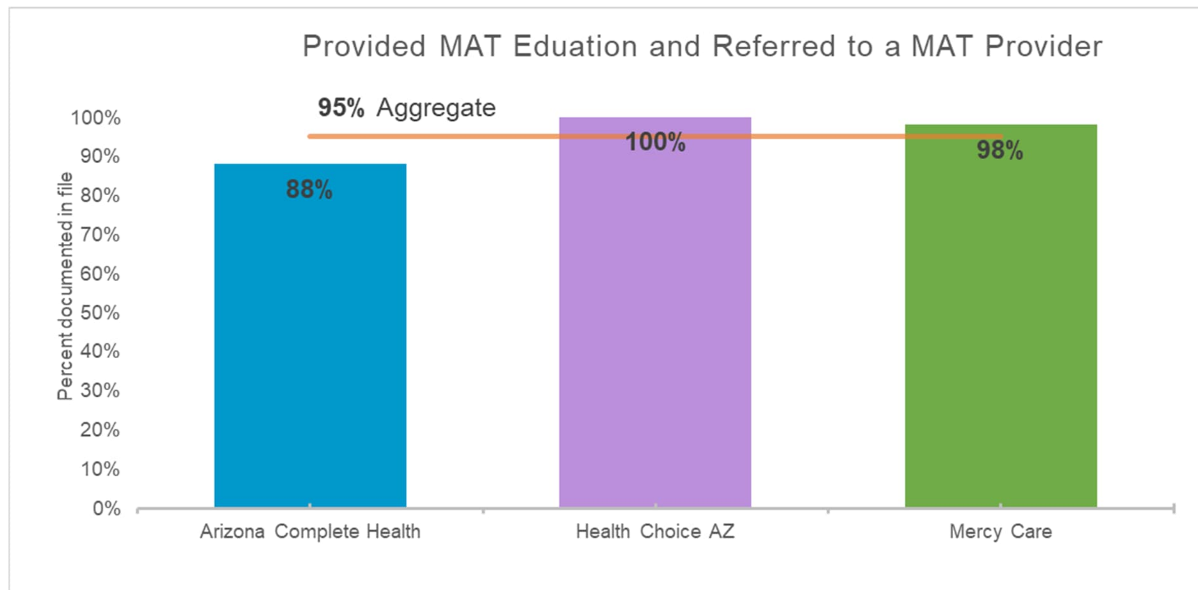


Figure 1-3 — Percentages of Members with an OUD Provided MAT Education who were Referred to a Treatment Provider



Ensure women have ease of access to all specialty population related SUD treatment and recovery support services

Women have different circumstances and experiences in regard to SUDs and treatment.[4] Allowing access to appropriate gender-based treatment can produce more favorable outcomes. One SABG metric, *Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?,* showed that only 18% of females in the aggregate sample had documented access to gender-specific services. This is a 10% decrease in performance on this metric compared to fiscal year (FY) 2020. A second metric, *If the female had dependent children, was there documentation to show that childcare was addressed?*, showed a higher percentage (91%) of mothers had childcare addressed by the provider. Although this is only a 1% increase from the previous year, this is still relevant for women as addressing childcare removes one possible obstacle to treatment.

Overall, outreach and engagement efforts for pregnant women and women with dependent children have been successful for this specialty population as noted in the SABG progress report highlighting the second-year target/outcome measurement being met. Fifty-two percent (11 out of 21) of women who disclosed they had a domestic violence history had a safety plan in the clinical record while 50% of pregnant women received education regarding substance use effects on the fetus. Examining internal organizational procedures and processes may be one opportunity to ensure domestic violence safety plans and education on the negative effects substance use has on the fetus is a priority while women are receiving treatment and recovery support services.

[4] National Institute on Drug Abuse, *What are the unique needs of women with substance use disorders?*, January 2018. Available at: https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/what-are-unique-needs-women-substance-use-disorders

Figure 1-4 — Percentages of Gender-Specific Treatment Services Available (e.g., Women's-Only Group Therapy Sessions)

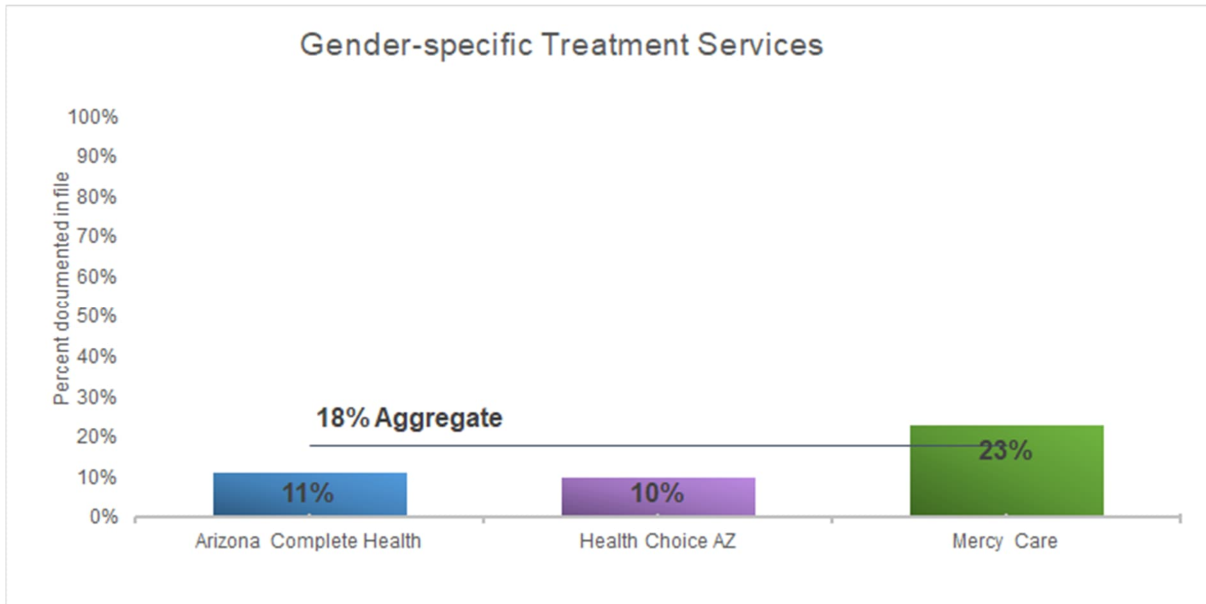
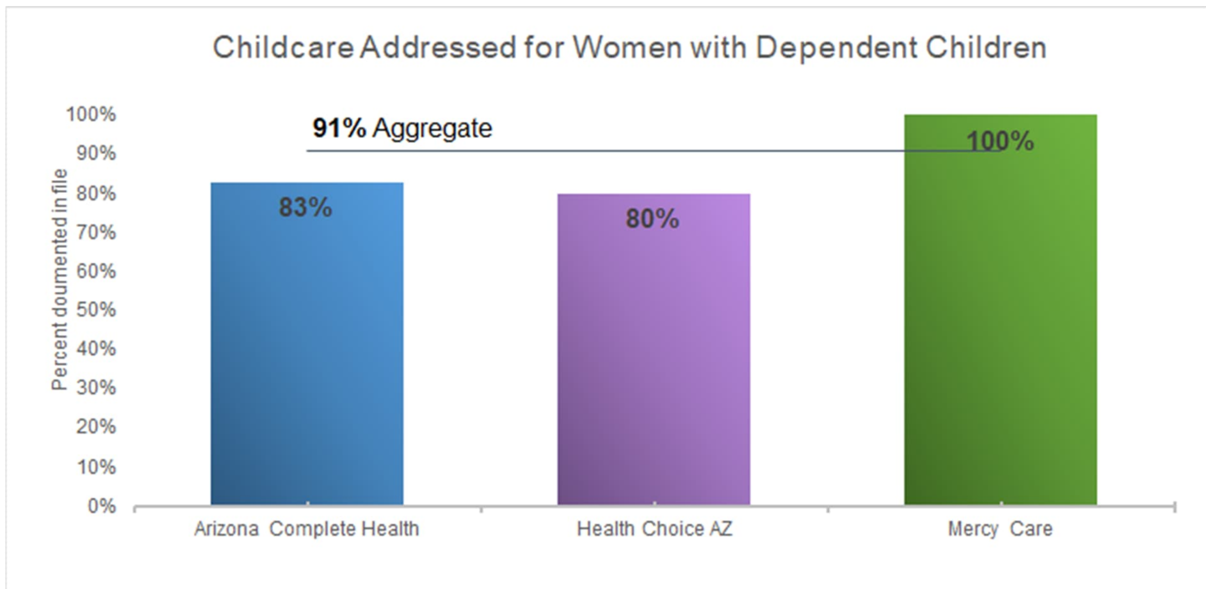


Figure 1-5 — Percentages of Women with Dependent Children Who Had Childcare Needs Addressed During Treatment



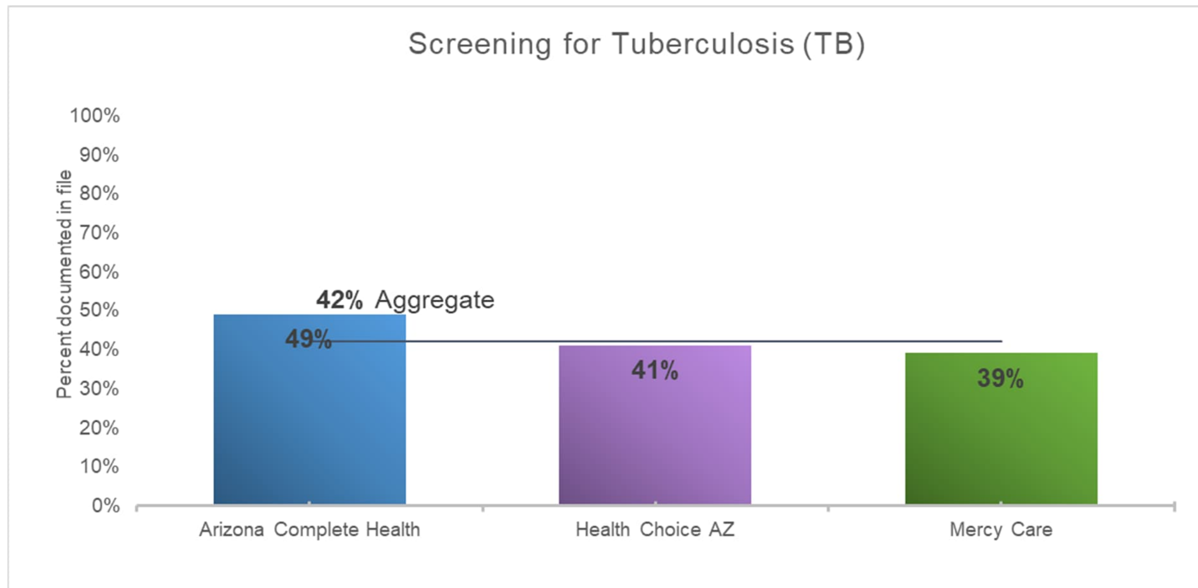
Increase the number of TB screenings for members entering substance abuse treatment

A third program goal and requirement of the Code of Federal Regulations 45 CFR § 96.127[5], requires entities providing substance use treatment to provide TB screening of individuals in

[5] eCFR, *Title 45 Section 96.127 — 96.127 Requirements regarding tuberculosis.* Available at: https://ecfr.io/Title-45/Section-96.127

order to prevent TB transmission. Forty-two percent of sampled charts documented providing TB screening for members. This was a 15 % decrease in performance from FY 2020. It was noted that the most successful documentation of TB screening was found in residential levels of care or in MAT programs. This was less evident in outpatient programs, which may have been more directly impacted by COVID-19 pandemic and virtual nature of service delivery.

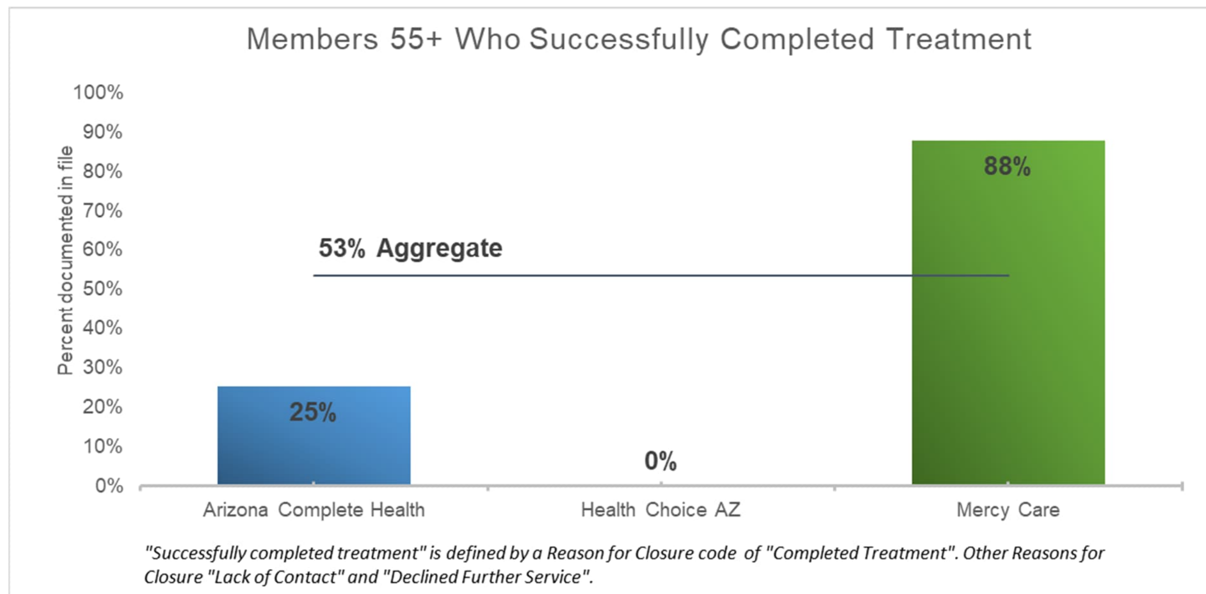
Figure 1-6 — Percentages of Members who were Screened for Tuberculosis



Increase the percent of older adults (aged 55 and older) who receive treatment in the BH system who are diagnosed as having a SUD

New from the FY 2020 ICR, the data was analyzed to assess the older adult population and how they are accessing and receiving care. Of the 200 records reviewed, 15 individuals are age 55 or older and were represented mostly by MC and AzCH One individual was identified as having a physical concern related to pain, and for this individual, alternative pain management options were addressed. Based on the documented reason for closure, of the 15 individuals, 53% successfully received and completed their SUD treatment. Although Health Choice AZ has a result of zero individuals completing treatment, it is important to remember that the number of individuals this represents is three, a very small sample size that should not be used to draw conclusions about the treatment outcomes of this population. Reasons considered not successfully completing treatment include "Lack of contact" and "Member declined further service".

Figure 1-7 — Percentages of Members (aged 55 and older) who Successfully Completed Treatment



Goals of the Independent Case Review

The primary objective of this review is to determine the level of quality and appropriateness of care being provided through the use of SABG funds in accordance with federal SABG requirements noted in 45 CFR § 96.136. According to State guidance, *quality* is the provision of treatment services which, within the constraints of technology, resources, and patient/client circumstances, will meet accepted standards and practices, which will improve patient/client health and safety status in the context of recovery. *Appropriateness* means the provision of treatment services consistent with the individual's identified clinical needs and level of functioning.[6]

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

The following domains were examined to determine the level of treatment quality and appropriateness (see Appendix A for specific review items in each domain):

- Intake and Treatment Planning
- Placement Criteria and Assessment

[6] AHCCCS. (n.d.). *Substance Abuse Prevention and Treatment Block Grant (SABG). Available at:* https://www.azahcccs.gov/Resources/Grants/SABG/

- Best Practices
- Treatment, Support Services, and Rehabilitation Services
- Gender Specific (Female Only)
- Opioid Specific
- Discharge and Continuing Care Planning (Only for successful treatment completions or decline of further services)
- Re-engagement (Only for decline of further services or chose not to appear for services)
- National Outcome Measures (NOM)

Content of Records Reviewed

Based upon the requirements of the annual ICR report to SAMHSA, AHCCCS sampled treatment records provided by the RBHAs. BH records vary from provider to provider, but typically include the following key documents and captured data elements:

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

Mercer used these documents, and any others contained in the individual records, to assess the level to which providers that receive SABG funds in Arizona are providing high quality engagement, planning, treatment, and discharge services to SUD clients.

Section 3

Methodology

The review team from Mercer consisted of licensed clinicians and certified counselors (one registered nurse, two master's level BH providers, one clinical psychologist, and one certified alcohol and drug counselor). A sixth member of the team provided data analytic services and ensured consistency in the application of project standards. Finally, Mercer included a Certified Peer as part of the team to review the findings and analysis through the peer lens. All feedback resulting from this additional review have been incorporated throughout the body of this report. The files reviewed by the evaluation team during the ICR were provided by AHCCCS and were stored and accessed on the State's Secure File Transfer Protocol site. Each Mercer reviewer received a secured sign in to ensure all file protected health information was protected. Due to the COVID-19 pandemic, and consistent with public health best practices, Mercer completed all ICR activities virtually, with no onsite reviews or in-person team meetings.

Sampling

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

- Substance abuse clients with a substance abuse treatment service and episode of care (EOC) during SFY 2021: July 1, 2020, through June 30, 2021.
- Disenrolled/EOC end date before or on June 30, 2021.
- At least 18 years of age during the treatment episode.
- Were not diagnosed with a serious mental illness.
- Disenrolled due to completing treatment, declining further service, or lack of contact.
- Clients must have received substance abuse treatment during the treatment period.
- Clients must have received counseling treatment during the treatment period.
- Clients must have been enrolled in a treatment center for at least 30 days.
- Clients must not be enrolled in a Tribal Behavioral Health Authority.

The sampling methodology used by AHCCCS excluded individuals who:

- Did not have any service encounters during the treatment episode.
- Only had assessment services during the treatment episode.
- Did not have any counseling encounters during the treatment episode.
- Only had a detoxification hospitalization encounter during the treatment episode.
- Only had services provided by an individual private provider.

Based upon these inclusion and exclusion criteria, AHCCCS supplied 274 treatment records to Mercer. Upon receipt of the review sample, Mercer randomly selected 200 files to be used in the initial review, with the remainder being held as an oversample. In 55 instances, files determined to be unusable for review purposes (e.g., an exclusion criterion was found in the file or the treatment dates were out of range) were removed from the original 200 records and replaced from the oversample.

File Review Tool

AHCCCS collaboratively reviewed the existing State tool with Mercer. During the previous review (FY 2020) there were new and updated items incorporated into the tool. These items are listed below for reference, however additional changes or updates were not made to the review tool for the current FY 2021 ICR. Therefore, the review tool in its entirety allows for a comparison of performance to that last review period on all metrics.

New Tool Items

- Added an item to assess whether the service provider reviewed the PDMP website during the course of the treatment.
- Added an item to assess whether SDoHs were evaluated as part of the initial assessment.
- Added an item to assess whether the service provider explored the client's access to a PCP or other medical provider.

Updated Tool Items

- Changed, for clarity, the wording of items related to application of the ASAM criteria. Specifically, "revised/updated" was changed to "reassessed" when reviewing for ongoing use of ASAM criteria during the course of treatment.
- Changed, for specificity, the wording of two items related to peer support services. Specifically, added the word "certified" to the term peer support to differentiate therapeutic peer support from social-support-based offerings.
- Changed, for clarity, the wording of an item related to pain management for individuals receiving treatment for an OUD. Specifically, identified chronic pain as the health issue of concern when assessing whether providers offered alternative interventions.
- Edited, for consistency, the wording and syntax of multiple items throughout the tool. For example, made the capitalization of medications more consistent, made changes for verb/tense agreement, etc.

For this review period, the Mercer team used the previously updated ICR tool as the source for development of an electronic format of the tool. The e-version of the tool, which was developed in Microsoft Access, allowed the review team to record review results in a format more conducive to analyzing the data and producing useful tables for presentation.

Inter-rater Reliability

To ensure consistency in the use of the file review tool, the Mercer review team participated in an inter-rater reliability (IRR) training session followed by an IRR test prior to initiation of the review process. The test consisted of a vignette that approximated the information included in a SUD treatment record. Participants had the opportunity to review the clinical vignette and were then asked to use the ICR tool to score the record consistent with the ICR Tool Instructions (Appendix A).

The Mercer project lead in partnership with the project licensed psychologist and subject matter expert facilitated the IRR and recorded the answers from each individual reviewer and then discussed with the team any items that yielded inconsistent results. As a result of this discussion, the team reached a consensus decision on how items would be scored. The initial review of the vignette yielded an IRR average score of 95%, while the team reached 100% agreement following discussion and consensus building.

Throughout the evaluation, which occurred during April 2022 and May 2022, the project lead maintained frequent contact with individual reviewers, answered questions regarding the application of the ICR Tool Instructions, and assured consistent application of the consensus methods for scoring. Additionally, in order to ensure fidelity to the scoring approach, the team met biweekly during the review process for group debriefs and problem solving related to the application of the ICR Tool Instructions.

Data Analysis

Mercer selected sample data from the chart listing provided by AHCCCS. Each chart included in the sample was assigned a sample ID and uploaded into a customized, password-protected Microsoft Access review tool. After each reviewer finalized his or her assigned reviews, the data was exported and aggregated into a final dataset for analysis purposes in Microsoft Excel. Data checks were performed to ensure consistent and complete data was received; results were updated as necessary. Data tables reflecting required output tables were programmed with formulas reflecting the instructions for data entry (Appendix B). Results were technically peer reviewed for accuracy and reasonableness.

Limitations

Mercer applied best practices in training and testing to foster optimal review findings for the ICR results. However, Mercer did not design the original ICR tool used in the file review process (although some modifications were made), nor did Mercer complete a separate and independent validation of the tool. Therefore, Mercer cannot attest to the reliability and validity of the tool.

Additionally, the period of review for this project (July 1, 2020–June 30, 2021) includes the advent of the worldwide COVID-19 pandemic (March 2020–present), which introduced multiple complicating factors into the SUD treatment landscape (e.g., loss of in-person treatment, rapid implementation of telehealth practices, etc.). Although the review team was aware of these complicating factors, there is no reliable way to account fully for COVID-19's multiple impacts upon individual choices (e.g., reactions to the shift to telehealth interventions, treatment efficacy of virtual SUD treatment and the resultant treatment outcomes).

Given these considerations, year-to-year results may include variability due to updates in the tool, which may have impacted validity or reliability. Further, orthogonal variables, such as the pandemic driven shift from in-person treatment to telehealth, introduced unknown impacts on treatment outcomes that would not have been seen in any prior year ICRs. Therefore, Mercer advises caution against the comparison of ICR findings across years without further validation and evaluation of the results.

Section 4

Aggregate Case File Review Findings

The SABG independent chart review findings are organized throughout this section in aggregate, by RBHA and by individual evaluation measure. This also includes sample demographics, records reviewed (broken down by RBHA), and gender and age of population sampled. Additionally, statistics on the reasons for case closure, referral to the program, and SABG-funded providers sampled are included for comparison purposes, as in past year's reports.

Sample Demographics

The State provided a universe of 274 charts for the ICR review. Out of this number, a sample of 200 charts were reviewed for the ICR. Mercer's record review represented 88% of the Arizona Complete Health charts, 61% of the HC Arizona charts, and 70% of the MC charts of the respective charts provided (see Table 1-1 below).

The sample of charts reviewed closely mirrors the percentages of members enrolled in each RBHA.[7] This reflects a comparably sufficient sample for each of the RBHAs, based upon the records that were made available at the time of the review.

Table 1-1 — Distribution of Case File Review Sample by RBHA

RBHA	Universe of Charts Received for ICR Review	Number of ICR Charts Reviewed	ICR Sample Charts Reviewed as a Percent of Universe	Percent of ICR Charts Reviewed	Percent of Total Members Who are Both Title XIX and SMI Enrolled in a RBHA
AzCH	66	58	88%	29%	30%
HC Arizona	49	30	61%	15%	13%
MC	159	112	70%	56%	57%
Total	**274**	**200**	**73%**	**100%**	**100%**

AHCCCS requires that at least 5% of the providers delivering SABG services are reviewed for quality and appropriateness of treatment services. This review ensured that over 5% of SABG providers from each RBHA were reviewed (distribution included in the table below).[8]

[7] AHCCCS (n.d). Behavioral Health. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/behavioralhealth.html

[8] AHCCCS. (n.d.). Substance Abuse Prevention and Treatment Block Grant (SABG). Available at: https://www.azahcccs.gov/Resources/Grants/SABG

Table 1-2 — SABG-Funded Treatment Providers Included In Independent Case Review

RBHA	SABG-funded Treatment Providers by RBHA	SABG-Funded Treatment Providers included in the ICR Review	Percentage of SABG Treatment Providers included in the ICR Review
AzCH	19	11	58%
HC Arizona	12	7	42%
MC	21	6	29%
Total	52	**24**	42%

Table 1-3 shows the gender and age distribution by RBHA. Overall, the mean age served in the sample was 36.9 years, with a median of 33.7. Almost 26% percent of the sample identified as female, 74% male, and one member identified as “Other”.

Table 1-3 — Distribution of Case File Review Sample by Gender and Age

RBHA	Sample Cases	Percent of Sample	Gender						Age (Years)	
			Female		Male		Other			
			N	%	N	%	N	%	Mean	Median
AzCH	58	29%	9	16%	49	84%	0	0%	38.0	48.4
HC Arizona	30	15%	10	33%	20	67%	0	0%	38.3	35.4
MC	112	56%	32	29%	79	71%	1	1%	35.9	28.9
Total	**200**	**100.0%**	**51**	**25.5%**	**148**	**74.0%**	**1**	**0.5%**	**36.9**	**33.7**

Sample Characteristics

Clients chosen for the sample must have been disenrolled or have had an EOC with a closure date within FY 2021 (July 1, 2020 to June 30, 2021) with a final case closure date no later than June 30, 2021. Closure reasons include *Client Declined Further Service*, *Lack of Con*tact, *Treatment Completion*, and *Transfer* (individual was incarcerated, moved, or no longer on Medicaid). Consistent with the previous review period, the most frequent reason for case closure during this period was *Lack of Contact* (49%), followed closely by *Treatment Completion* (34%).

Table 1-4 — Distribution Based on Case Closure Reason

		Client Declined Further Treatment		Lack of Contact		Treatment Completion		Transfer	
RBHA	**Sample Cases**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
AzCH	58	11	19%	24	41%	13	22%	10	17%
HC Arizona	30	2	7%	20	67%	8	27%	0	0%
MC	112	12	11%	53	47%	47	42%	0	0%
Total*	**200**	**25**	**13%**	**97**	**49%**	**68**	**34%**	**10**	**5%**

*Total percentage reflects 101% due to rounding.

The rates for the most frequent source of referral to SUD treatment are shown in Table 1-5 below. “Criminal Justice/Correctional” includes Administrative Office of the Courts, Arizona Department of Corrections, Arizona Department of Juvenile Corrections, Jail/Prison, and Probation. “Other” includes physical health providers, State agencies, crisis, and unknown sources. Overwhelmingly, self-referral or referral by family or friends was the most frequent referral source (58%, 1% higher than the previous period).

Table 1-5 — Source for Referral

		Criminal Justice/ Correctional		Other BH Provider		Self/Family/ Friend		Other		Total
RBHA	**Sample Cases**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**
AzCH	58	10	17%	18	31%	24	41%	6	10%	58
HC Arizona	30	15	50%	1	3%	10	33%	4	13%	30
MC	112	11	10%	9	8%	82	73%	3	3%	105*
Total	**200**	**36**	**18%**	**28**	**14%**	**116**	**58%**	**13**	**7%**	**193**

*Seven MC charts were missing referral source.

Aggregate Review Findings

The tables (2-1 through 2-9) below represent the aggregate chart review findings. As noted in the Methodology section, measures remain the same as those used in the previous year. The denominators primarily consisted of the sum of “Yes” and “No” responses and, as such, differ across the measures. The denominators of certain indicators were based on the number of “Yes” responses from a prior question when applicable. For example, the denominators for I.A.1 through 9 equate to the numerator for *I.A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?* Certain measures allowed for a response of “Not Applicable” (N/A); N/As are not included in any denominator,

consistent with prior years' analyses. Measures marked with an asterisk in the "N/A" column indicate that "N/A" was not a valid response option for that particular measure. Additionally, certain measures included an option for missing documentation. Narrative information was also collected on the following measures (See full set and description of measures in Appendix A) and is incorporated into the Findings section prior to the table.

- II.D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?
- III.A.1. The following evidence-based practices were used in treatment.
- VIII.C. Were other attempts made to re-engage the individual?

Measure I — Intake/Treatment Planning Key Findings

Initial Behavioral Health Assessment

Mercer reviewed 200 total records for the State, as a whole, and found 95% of the charts contained evidence that an initial BH assessment was completed within 45 days of the initial appointment. As part of the initial assessment, providers successfully documented compliance with the required components of the assessment (Items A1–9) with a range of 26% to 100%. The areas of lowest performance were hepatitis C, HIV, and other infectious disease screening (26%, down from 45% in FY 2020), documentation of review of the PDMP (29%, down from 55% in FY 2020), and TB screening (42%, down from 57% in FY 2020). Although the low performance area metrics were the same as the previous period, there was a significant decrease in performance. As mentioned earlier, movement to virtual services may have had an effect on the completion of screenings for TB, hepatitis C, HIV, and other infectious diseases, however a negative impact on review PDPM was not expected.

Individual Service Plan (ISP)

Providers developed an ISP for the client's treatment (within 90 days of the initial appointment) in 98% of the reviewed cases. In 98% of these cases, the providers developed the ISP in congruence with the presenting concerns. This represents a 1% and 2% improvement respectively over the last period. However, related to documenting family support and engagement there was a decrease to 8% of ISPs were developed with the participation of the client's family or other supports (when the client consented to allow participation from these sources). Twenty-four percent of clients declined participation from family and other supports or supports did not exist.

Table 2-1 — Assessment and Individual Service Plan

	Denominator	# of Yes	% of Yes	# of N/A
Intake/Treatment Planning				
A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	200	189	95%	0
Did the behavioral health assessment:				
1. **Address substance-related disorder(s)?**	189	189	100%	*
2. **Describe the intensity/frequency of substance use?**	189	181	96%	*
3. **Include the effect of substance use on daily functioning?**	189	181	96%	*
4. **Include the effect of substance use on interpersonal relationships?**	189	171	90%	*
5. **Was a risk assessment completed?**	189	187	99%	*
6. **Document screening for tuberculosis (TB)?**	189	80	42%	*
7. **Document screening for Hepatitis C, HIV and other infectious diseases?**	189	49	26%	*
8. **Document screening for emotional and/or physical abuse/trauma issues?**	189	184	97%	*
9. **Document that review of the Prescription Drug Monitoring Program (PDMP) was completed?**	121	35	29%	68
B. Was there documentation that charitable choice requirements were followed, if applicable?	20	15	75%	169
C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	189	185	98%	0
Was the ISP:				
1. **Developed with participation of the family/support network?**	185	14	8%	44
2. **Congruent with the diagnosis(es) and presenting concern(s)?**	185	181	98%	*

	Denominator	# of Yes	% of Yes	# of N/A
3. **Measurable objectives and timeframes to address the identified needs?**	185	177	96%	*
4. **Addressing the unique cultural preferences of the individual?**	185	155	84%	*
5. **Were social determinants of health issues considered as part of, and incorporated into, the ISP?**	185	147	79%	*

Measure II — Placement Criteria/Assessment Key Findings

ASAM Patient Placement Criteria were used at intake to determine the appropriate level of service in 92% of the cases reviewed demonstrating a 6% increase from FY 2020. Of these cases, documentation showed that 93% (3% increase) received the LOC identified by the ASAM criteria. Providers documented the use of the ASAM criteria to reassess the proper LOC during treatment in 50% of cases, which was a 7% improvement on the last period. In FY 2021 providers documented performance doubled to 42% on the use of other (or additional) assessment tools during the course of treatment. Additional Assessment Tools Utilized are follows:

- Cut, Annoyed, Guilty, and Eye (CAGE) Substance Abuse Screening Tool (Used five times)
- Clinical Institute Withdrawal Assessment (CIWA) (Used four times)
- Clinical Opioid Withdrawal Scale (COWS) (Used once)
- Daily Living Activities–20 (DLA-20) (Used eight times)
- DMAST (Used once)
- DSM 5 (Used once)
- National Institute on Drug Abuse (NIDA) Assist/Modified ASSIST/ASSIST V.3 (Used five times)
- Protocol for Responding to and Assessing Patient Asset, Risk and Experience (PRAPARE) (Used three times)
- UNCOPE Screening Instrument for Substance Abuse (Used eight times)

Table 2-2 — Placement Criteria/Assessment

	Denominator	# of Yes	% of Yes	# of N/A
A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?	200	183	92%	*
1. **If the ASAM Patient Placement Criteria were used, the level of service identified was:**				
Level 0.5: Early Intervention	183	2	1%	*
OMT: Opioid Maintenance Therapy	183	35	19%	*
Level I: Outpatient Treatment	183	115	63%	*
Level II: Intensive Outpatient Treatment/Partial Hospitalization	183	18	10%	*
Level III: Residential/Inpatient Treatment	183	44	24%	*
Level IV: Medically Managed Intensive Inpatient Treatment	183	2	1%	*
B. Did the member receive the level of services identified by the placement criteria/assessment?	183	171	93%	*
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	183	92	50%	*
D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	200	82	41%	*

Measure III — Best Practices Key Findings

Eighty-eight percent of sampled BH case files contained documentation that EBPs were used in treatment. Of these, CBT was the most widely used EBP (56%). MAT was documented in 31% of the BH case files. Of the 62 individuals who received MAT, methadone was the most frequently used medication (73%). Four interventions were not documented as having been used during this review period: Adolescent Community Reinforcement Approach (ACRA), Beyond Trauma: A Healing Journey for Women, Contingency Management, and Trauma Recovery and Empowerment Model (TREM). It should be noted that ACRA not being utilized is not a cause for concern as very few adolescents were included in the overall sample.

The EBPs listed in the master tool were compiled based on the most commonly utilized practices in the field, but was not meant to be all inclusive. A review of the EBPs chosen next year should be done in order to ensure they continue to be appropriate to capture the most commonly used methodologies. Providers are most likely to have only utilized one of the curricula, such as the Matrix model in their training program, which may cause other options to be lower due to a preference of providers for a certain model.

In addition to the EPBs noted in the tool, providers noted other EBPs used under an option marked “Other” with a free text box to denote the EBP delivered. Thus, the findings are complete for the universe of charts reviewed as all EPBs were able to be captured. Additional interventions (27%) used by providers included:

- Acceptance and Commitment Therapy (Used four times)
- Addictive Thinking (Used two times)
- Alcohol and Other Drugs (AOD) Treatment Focused Diversion (Used once)
- Accelerated Resolution Therapy (ART) (Used two times)
- Building Bridges (Used once)
- Helping Men Recover (Used once)
- Living in Balance (Used five times)
- Prime for Life (Used once)
- Psycho-Education (Used once)
- Rational Emotional Behavior Therapy (REBT) (Used five times)
- Wellness Program (Used three times)
- Women's Self Recovery Groups (Used once)

In 26% of cases, providers offered peer support services and, in 52% of those cases, the services were provided as part of treatment. Sixteen individuals declined peer support services when the provider offered (Including these cases would bring the offered peer support services performance percentage to 34%). The EBP of screening for ongoing substance use during treatment occurred in 55% of the reviewed cases. This is another area potentially impacted by COVID-19 and the delivery of outpatient services via telehealth modalities. Representation of screenings were more consistent in the inpatient and residential LOCs.

Table 2-3 — Best Practices

	Denominator	# of Yes	% of Yes	# of N/A
A. Were evidence-based practices used in treatment?	200	175	88%	*
1. The following evidence-based practices were used in treatment:				
Adolescent Community Reinforcement Approach (ACRA)	175	0	0%	*
Beyond Trauma: A Healing Journey for Women	175	0	0%	*
Cognitive Behavioral Therapy (CBT)	175	98	56%	*
Contingency management	175	0	0%	*
Dialectal Behavioral Therapy (DBT)	175	19	11%	*
Helping Women Recover	175	3	2%	*
Matrix	175	28	16%	*
Moral Re-conation Therapy (MRT)	175	5	3%	*
Motivational Enhancement/Interviewing Therapy (MET/MI)	175	47	27%	*
Relapse Prevention Therapy (RPT)	175	27	15%	*
Seeking Safety	175	8	5%	*
SMART Recovery	175	18	10%	*
Thinking for a Change	175	2	1%	*
Trauma Recovery and Empowerment Model (TREM)	175	0	0%	*
Trauma-Informed Care (TIC)	175	3	2%	*
Wellness Recovery Action Plan (WRAP)	175	1	1%	*
Other Practices or Program	175	47	27%	*
B. Medication Assisted Treatment (MAT)	200	62	31%	–
1. The following medication was used in treatment:				
❖ Alcohol-related				
Acamprosate (Campral)	62	0	0%	*
Disulfiram (Antabuse)	62	2	3%	*

	Denominator	# of Yes	% of Yes	# of N/A
❖ Opioid-related				
Subutex (buprenorphine)	62	2	3%	*
Methadone/Levo-Alpha-Acetylmethadol (LAAM)	62	45	73%	*
Narcan (naloxone)	62	3	5%	*
Vivitrol (long-acting naltrexone)	62	3	5%	*
Suboxone (buprenorphine-naloxone)	62	11	18%	*
C. Was screening for substance use/abuse conducted during the course of treatment?	200	109	55%	*
D. Was certified peer support offered as part of treatment?	200	52	26%	16
If yes to III.I.D, were certified peer support services used as a part of treatment?	52	27	52%	*

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

Providers used case management as the most common service provided in the sample (78%), followed by group therapy (75%) and individual therapy (63%). During this FY 2021 review period, family counseling was not documented in any of the charts. This correlates to the low number of individuals engaging family or other supports in the treatment planning process, which was only 8%. For those individuals who received counseling, 49% (increase from FY 2020) attended more than 11 sessions; 36% (decrease from FY 2020) attended five or fewer sessions.

Eighty percent of BH case files did not contain documentation regarding the number of self-help or recovery group sessions completed during treatment. This is a significant negative performance impact of 14% from the previous review. Of those that did document this metric (20%), 5% of cases documented zero attendance at the self-help or recovery group sessions while 15% documented attending some number of sessions.

Table 2-4 — Treatment/Support Services/Rehabilitation Services

	Denominator	# of Yes	% of Yes	# of N/A
A. The following services were used in treatment:				
Individual counseling/therapy	200	125	63%	*
Group counseling/therapy	200	149	75%	*
Family counseling/therapy	200	0	0%	*
Case management	200	156	78%	*
B. Was there clear documentation of progress or lack of progress toward the identified ISP goals?	200	170	85%	9
C. The number of completed counseling/therapy sessions during treatment was:				
0–5 sessions	199	71	36%	*
6–10 sessions	199	31	16%	*
11 sessions or more	199	97	49%	*
D. Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:				
No documentation	200	160	80%	*
0 times during treatment	200	10	5%	*
1–4 times during treatment	200	12	6%	*
5–12 times during treatment	200	5	3%	*
13–20 times during treatment	200	4	2%	*
21 or more times during treatment	200	9	5%	*
E. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?	98	36	37%	102
F. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	107	80	75%	93

	Denominator	# of Yes	% of Yes	# of N/A
G. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	101	38	38%	99
H. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	136	56	41%	64
I. Does the documentation reflect that substance abuse services were provided?	200	189	95%	*
J. Was member's access to a primary care physician (PCP) or other medical provider explored?	200	157	79%	11

Measure V — Gender Specific Key Findings

Providers documented 21 women's case files with a history of domestic violence; of these, 52% contained a safety plan. This will be an area for follow-up and review as this metric decreased by 20% from the previous period. Providers documented four pregnant women in this sample; coordination of care with the PCP or obstetrician occurred in three cases (75%) and education on the effects of substance use on fetal development occurred in two cases (50%). This sample contained four women who had given birth in the past year of which half documented screening for postpartum depression/psychosis. Of the case files for women who had dependent children, 91% documented an examination of childcare. Gender-specific services were documented in 18% (10% lower than FY 2020) of cases.

Table 2-5 — Gender Specific (Female Only)

	Denominator	#of Yes	% of Yes	#of N/A
A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	21	11	52%	30
B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	4	3	75%	47
C. If the female was pregnant; did documentation show evidence of education	4	2	50%	47

	Denominator	#of Yes	% of Yes	#of N/A
on the effects of substance use on fetal development?				
D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?	4	2	50%	47
E. If the female had dependent children, was there documentation to show that childcare was addressed?	22	20	91%	29
F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	49	9	18%	2

Measure VI — Opioid Specific Key Findings

For this sample, providers documented OUD diagnosis in 40% of the cases. Of these cases, providers educated 81% of the clients on MAT as a treatment option, and 95% of those were referred to a MAT provider. Documentation showed MAT providers educated the client on overdose, naloxone, and steps to take in the event of an overdose in 52% of the cases. Education on the effects of polysubstance abuse with opioids was provided in 47% of the cases. In 89% of cases, providers referred clients with withdrawal symptoms to a medical provider

Table 2-6 — Opioid Specific

	Denominator	#of Yes	% of Yes	#of N/A
A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?	200	79	40%	*
B. Was there documentation that the member was provided MAT education as a treatment option?	79	64	81%	*
C. If yes to VI B, were they referred to a MAT provider?	64	61	95%	7
D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	47	42	89%	31
E. If a physical health concern related to pain was identified, were alternative pain management options addressed?	18	10	56%	61

	Denominator	#of Yes	% of Yes	#of N/A
F. If member is a pregnant female; did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?	3	1	33%	75
G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?	79	41	52%	*
H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	79	37	47%	*

Measure VII — Discharge and Continuing Care Planning Key Findings

With a slight improvement from FY 2020, 58% of the reviewed cases, providers documented completion of a relapse prevention plan for clients who completed treatment or declined further services. Providers documented offering resources pertaining to community supports in 63% of these cases. For those clients engaged with other agencies, providers actively coordinated with these agencies at the time of discharge in 71% of the cases.

Table 2-7 — Discharge and Continuing Care Planning (completed only if member completed treatment or declined further services)

	Denominator	#of Yes	% of Yes	#of N/A
A. Was there documentation present that a relapse prevention plan completed?	160	93	58%	*
B. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g., crisis line)?	160	100	63%	*
C. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?	132	94	71%	28

Measure VIII — Re-engagement Key Findings

In 83% (20% improvement over the last review period) of cases where the client declined further services or chose not to appear for scheduled services, providers followed up with a

phone call at times when the member was expected to be available. In 71% (15% increase from FY 2020) of these cases, providers mailed a letter to the client requesting contact. Other activities taken by providers to make contact included contacting other involved agencies (46%), visiting the client's home (31%), and calling the client's emergency contact (27%). Other methods of outreach were documented in 19% of cases reviewed and include:

Table 2-8 — Re-engagement (completed only if member declined further services or chose not to appear for scheduled services)

	Denominator	#of Yes	% of Yes	#of N/A
A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?	127	106	83%	*
B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	104	74	71%	19
C. Were other attempts made to re-engage the individual, such as:				
Home visit?	26	8	31%	0
Call emergency contact(s)?	26	7	27%	0
Contacting other involved agencies?	26	12	46%	0
Street Outreach?	26	0	0%	0
Other	26	5	19%	0

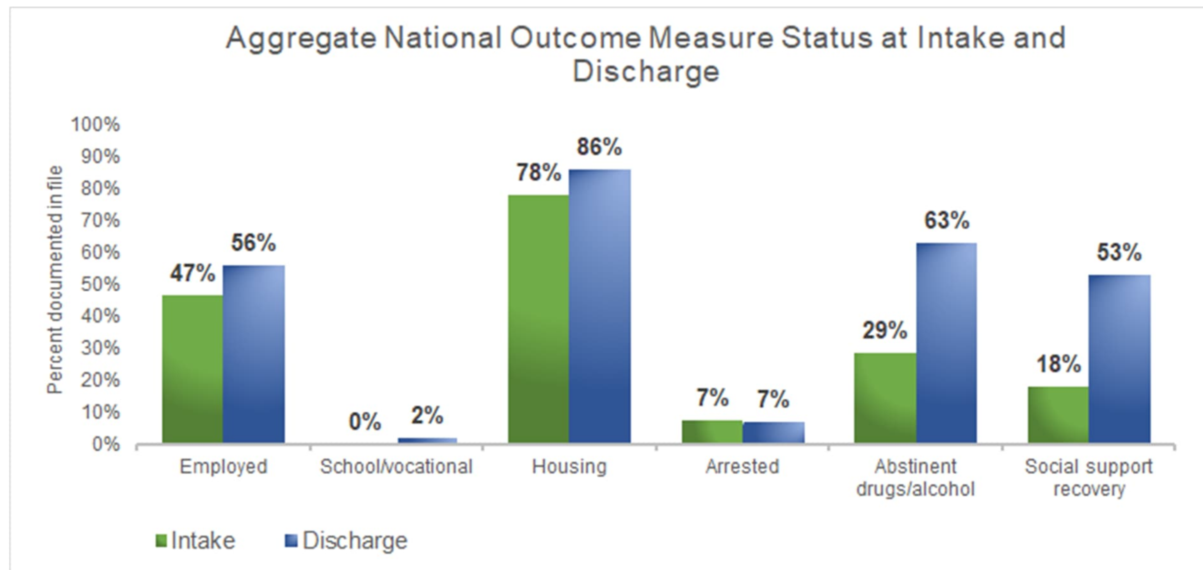
Measure IX — National Outcome Measures Key Findings

Each of the six NOMs for Measure IX are depicted in Table 2-9. Fluctuation in denominators reflect missing documentation of status at intake and discharge, if applicable. In general, documentation on NOM status was more likely to be contained in the file at intake as opposed to discharge. On average this domain was absent in 63% (ranging 27% to 94% missing depending on the specific metric) of the files at discharge. However, in the cases where the NOMs were documented at intake and discharge improvement in each metric was noted. The only exception was *Arrested in the preceding 30 days?* , which stayed stable. Note that a lower number and percentage are desired for the NOM *Arrested in the preceding 30 days?* measure. The graph below shows the results for each NOM at intake and discharge. Results for each RBHA for each NOM improved at discharge. The number of individuals enrolled in school or vocational educational program was zero at intake and 2% at discharge, but these low numbers do not necessarily reflect a poor outcome, as most of the individual charts reviewed were for adults who were either working or whose primary focus was on returning to work. It is also important to note that members were screened for interest in school or vocational educational programs 38% of the time, so interest was explored although very few individuals chose to pursue an educational activity.

Table 2-9 — National Outcome Measures

	At Intake			At Discharge		
	Denominator	# Yes	% Yes	Denominator	# Yes	% Yes
A. Employed?	189	88	47%	90	70	56%
B. Enrolled in school or vocational educational program?	178	0	0%	3	129	2%
C. Lived in a stable housing environment (e.g., not homeless)?	192	150	78%	141	23	86%
D. Arrested in the preceding 30 days?	189	14	7%	11	148	7%
E. Abstinent from drugs and/or alcohol?	189	54	29%	85	50	63%
F. Participated in social support recovery in the preceding 30 days?	200	36	18%	62	55	53%

Figure 2-1 — National Outcome Measures



Section 5

Case File Review Findings by RBHA

The narratives and tables (3-1 through 5-9) below represents the chart review findings for each RBHA. The methodology is identical to Section 4, Aggregate Findings and is repeated here. As noted in the Methodology Section, the measures remain the same as those used in the previous year. The denominators primarily consisted of the sum of “Yes” and “No” responses and, as such, differ across the measures. The denominators of certain indicators were based on the number of “Yes” responses from a prior question when applicable. For example, the denominators for I.A.1 through 9 equate to the numerator for *I.A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?* Certain measures allowed for a response of “Not Applicable” (N/A); N/As are not included in any denominator, consistent with prior years’ analyses. Measures marked with an asterisk in the “N/A” column indicate that “N/A” was not a valid response option for that particular measure. Additionally, certain measures included an option for missing documentation. Additional narrative information was collected on the following measures and is incorporated into the findings narrative prior to the table.

- II.D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?
- III.A.1. The following evidence-based practices were used in treatment…Other Practices or Programs (please list in box below).
- VIII.C. Were other attempts made to re-engage the individual, such as…Other, please list other identified outreach efforts in the box below.

Arizona Complete Health (AzCH)

AzCH has responsibility for AHCCCS clients in the southern region of the State. Mercer reviewed provider treatment records from 11 separate clinics under AzCH’s area of responsibility. The following highlights were observed within the data collected from these cases.

- Providers addressed SDoH issues during the initial assessment in 88% of the cases that contained an ISP, which was well above average for the State (79%).
- Providers used ASAM dimensions to determine the proper level of care at intake 95% of the time, slightly above the State average of 92%.
- Screening for TB within this region, which was documented in 49% of cases, was above the average for the State (42%).
- There was documentation that charitable choice requirements were followed, if applicable, 100% of the time, well above the State average of 75%.

- When there was evidence of lack of progress in an individual's treatment, providers in AzCH sought consultation to improve outcomes 55% of the time, much higher than the State average of 37%.

Measure I — Intake/Treatment Planning Key Findings

Initial Behavioral Health Assessment

Mercer reviewed 58 total records for AzCH and found 98% of the charts contained evidence that an initial BH assessment was completed within 45 days of the initial appointment. As part of the initial assessment, providers successfully documented compliance with the required components of the assessment (Items A1–9) with a range of 23% to 100%. The areas of lowest performance were documentation of review of the PDMP (23%); hepatitis C, HIV, and other infectious disease screening (33%); and TB screening (49%). These were the same three low performing areas in FY 2020, however performance for the current period dropped since then.

Individual Service Plan (ISP)

Providers developed an ISP for the client's treatment (within 90 days of the initial appointment) in 98% (nearly a 10% improvement from FY 2020) of the reviewed cases. In 96% of these cases, the providers developed the ISP in congruence with the presenting concerns. Nine percent of ISPs were developed with the participation of the client's family or other supports (when the client consented to allow participation from these sources). Twenty clients declined participation from family and other supports, or supports did not exist.

Table 3-1 — AzCH Assessment and Individual Treatment Plan

	Denominator	# of Yes	% of Yes	# of N/A
Intake/Treatment Planning				
A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	58	57	98%	0
Did the behavioral health assessment:				
1. **Address substance-related disorder(s)?**	57	57	100%	*
2. **Describe the intensity/frequency of substance use?**	57	54	95%	*
3. **Include the effect of substance use on daily functioning?**	57	51	89%	*
4. **Include the effect of substance use on interpersonal relationships?**	57	44	77%	*
5. **Was a risk assessment completed?**	57	56	98%	*
6. **Document screening for tuberculosis (TB)?**	57	28	49%	*

	Denominator	# of Yes	% of Yes	# of N/A
7. **Document screening for Hepatitis C, HIV and other infectious diseases?**	57	19	33%	*
8. **Document screening for emotional and/or physical abuse/trauma issues?**	57	54	95%	*
9. **Document that review of the Prescription Drug Monitoring Program (PDMP) was completed?**	39	9	23%	18
B. Was there documentation that charitable choice requirements were followed, if applicable?	1	1	100%	56
C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	57	56	98%	0
Was the ISP:				
1. **Developed with participation of the family/support network?**	56	5	9%	20
2. **Congruent with the diagnosis(es) and presenting concern(s)?**	56	54	96%	*
3. **Measurable objectives and timeframes to address the identified needs?**	56	54	96%	*
4. **Addressing the unique cultural preferences of the individual?**	56	46	82%	*
5. **Were social determinants of health issues considered as part of, and incorporated into, the ISP?**	56	49	88%	*

Measure II — Placement Criteria/Assessment Key Findings

ASAM Patient Placement Criteria were used at intake to determine the appropriate level of service in 95% of the cases reviewed. Of these cases, documentation showed that 93% received the LOC identified by the ASAM criteria. Providers documented the use of the ASAM criteria to reassess the proper LOC during treatment in 44% of cases. In 43% of the reviewed case files, providers documented the use of other (or additional) assessment tools during the course of treatment. These tools included:

- CIWA (Used two times)
- DLA-20 (Used eight times)
- DMAST (Used once)
- PRAPARE (Used once)

Table 3-2 — AzCH Assessment and Individual Treatment Plan

	Denominator	# of Yes	% of Yes	# of N/A
A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?	58	55	95%	*
1. If the ASAM Patient Placement Criteria were used, the level of service identified was:				
Level 0.5: Early Intervention	55	2	4%	*
OMT: Opioid Maintenance Therapy	55	3	5%	*
Level I: Outpatient Treatment	55	30	55%	*
Level II: Intensive Outpatient Treatment/Partial Hospitalization	55	9	16%	*
Level III: Residential/Inpatient Treatment	55	13	24%	*
Level IV: Medically Managed Intensive Inpatient Treatment	55	1	2%	*
B. Did the member receive the level of services identified by the placement criteria/assessment?	55	51	93%	*
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	55	24	44%	*
D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	58	25	43%	*

Measure III — Best Practices Key Findings

Eighty-three percent of sampled BH case files contained documentation that EBPs were used in treatment. Of these, CBT was the most widely used EBP (60%). MAT was documented in 26% of the BH case files. Of the 15 individuals who received MAT, methadone was the most frequently used medication (53%). Five interventions were not documented as having been used during this review period: ACRA, Beyond Trauma: A Healing Journey for Women, Contingency Management, Helping Women Recover, and TREM. It is important to note that only five women were included in the sample, making a finding of zero services not statistically significant or representative of the entire population. Additional interventions used by providers included:

- Acceptance and Commitment Therapy (Used three times)
- Addictive Thinking (Used two times)

- AOD Treatment Focused Diversion (Used once)
- ART (Used two times)
- Building Bridges (Used once)
- Living in Balance (Used four times)
- Psycho-Education (Used once)
- REBT (Used three times)

In 26% (significant decrease from FY 2020 performance of 82%) of cases, providers offered certified peer support services and, in 40% of those cases, the services were provided as part of treatment. Eight individuals declined peer support services when the provider offered. The EBP of screening for ongoing substance use during treatment occurred in 50% of the reviewed cases.

Table 3-3 — AzCH Best Practices

	Denominator	# of Yes	% of Yes	# of N/A
A. Were evidence-based practices used in treatment?*	58	48	83%	*
1. **The following evidence-based practices were used in treatment:**				
Adolescent Community Reinforcement Approach (ACRA)	48	0	0%	*
Beyond Trauma: A Healing Journey for Women	48	0	0%	*
Cognitive Behavioral Therapy (CBT)	48	29	60%	*
Contingency management	48	0	0%	*
Dialectal Behavioral Therapy (DBT)	48	1	2%	*
Helping Women Recover	48	0	0%	*
Matrix	48	11	23%	*
Moral Re-conation Therapy (MRT)	48	2	4%	*
Motivational Enhancement/Interviewing Therapy (MET/MI)	48	6	13%	*
Relapse Prevention Therapy (RPT)	48	6	13%	*
Seeking Safety	48	6	13%	*
SMART Recovery	48	5	10%	*

	Denominator	# of Yes	% of Yes	# of N/A
Thinking for a Change	48	1	2%	*
Trauma Recovery and Empowerment Model (TREM)	48	0	0%	*
Trauma-Informed Care (TIC)	48	2	4%	*
Wellness Recovery Action Plan (WRAP)	48	1	2%	*
Other Practices or Programs	48	16	33%	*
A. Medication Assisted Treatment (MAT)	58	15	26%	*
1. The following medication was used in treatment:				
❖ Alcohol-related				
Acamprosate (Campral)	15	0	0%	*
Disulfiram (Antabuse)	15	0	0%	*
❖ Opioid-related				
Subutex (buprenorphine)	15	1	7%	*
Methadone/Levo-Alpha-Acetylmethadol (LAAM)	15	8	53%	*
Narcan (naloxone)	15	1	7%	*
Vivitrol (long-acting naltrexone)	15	2	13%	*
Suboxone (buprenorphine-naloxone)	15	4	27%	*
C. Was screening for substance use/abuse conducted during the course of treatment?	58	29	50%	*
D. Was certified peer support offered as part of treatment?	58	15	26%	8
If yes to III.I.D, were certified peer support services used as a part of treatment?	15	6	40%	*

*Eight records did not document EBPs.

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

Providers used case management as the most common service provided in the sample (83%), followed by group therapy (66%) and individual therapy (50%). Providers did not document the provision of family counseling in any of the reviewed cases (0%). For those individuals who received counseling, 46% attended more than 11 sessions; 40% attended five or fewer sessions. Seventy-eight percent of BH case files did not contain documentation

regarding the number of self-help or recovery group sessions completed during treatment. Of those that did document this metric, 10% of cases documented zero attendance at the self-help or recovery group sessions while 12% attended some combination of sessions.

Table 3-4 — AzCH Treatment/Support Services/Rehabilitation Services

	Denominator	# of Yes	% of Yes	# of N/A
A. The following services were used in treatment:				
Individual counseling/therapy	58	29	50%	*
Group counseling/therapy	58	38	66%	*
Family counseling/therapy	58	0	0%	*
Case management	58	50	86%	*
B. Was there clear documentation of progress or lack of progress toward the identified ISP goals?	58	48	83%	5
C. The number of completed counseling/therapy sessions during treatment was:				
0–5 sessions	57	23	40%	*
6–10 sessions	57	8	14%	*
11 sessions or more	57	26	46%	*
D. Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:				
No documentation	58	45	78%	*
0 times during treatment	58	6	10%	*
1–4 times during treatment	58	1	2%	*
5–12 times during treatment	58	1	2%	*
13–20 times during treatment	58	1	2%	*
21 or more times during treatment	58	4	7%	*
E. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?	22	12	55%	36

	Denominator	# of Yes	% of Yes	# of N/A
F. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	32	24	75%	26
G. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	39	11	28%	19
H. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	48	15	31%	10
I. Does the documentation reflect that substance abuse services were provided?	58	53	91%	*
J. Was member's access to a primary care physician (PCP) or other medical provider explored?	58	49	84%	4

Measure V — Gender Specific Key Findings

Providers documented five women's case files with a history of domestic violence; of these, 80% contained a safety plan. This sample contained one pregnant women or women who had given birth in the past year. However documented evidence as outlined in the metric was not found. Of the case files for women who had dependent children, 83% documented an examination of childcare. Gender-specific services were documented in 11% of cases.

Table 3-5 — AzCH Gender Specific (Female Only)

	Denominator	# of Yes	%of Yes	# of N/A
A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	5	4	80%	4
B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	1	0	0%	8

	Denominator	# of Yes	%of Yes	# of N/A
C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?	1	0	0%	8
D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?	1	0	0%	8
E. If the female had dependent children, was there documentation to show that childcare was addressed?	6	5	83%	3
F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	9	1	11%	0

Measure VI — Opioid Specific Key Findings

For this sub-sample, providers documented OUD diagnosis in 31% of the cases. Of these cases, providers educated 89% of the clients on MAT as a treatment option, and 88% of those were referred to a MAT provider. Documentation showed MAT providers educated the client on overdose, naloxone, and steps to take in the event of an overdose in 39% of the cases. Education on the effects of polysubstance abuse with opioids was provided in 44% of the cases. Both metrics have dropped over 10% since the previous review period. In 90% of cases, providers referred clients with withdrawal symptoms to a medical provider. There were no pregnant women in the sample size, leading to the finding of zero for documentation of education about the safety of methadone and/or buprenorphine during the course of pregnancy.

Table 3-6 — AzCH Opioid Specific

	Denominator	# of Yes	% of Yes	# of N/A
A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?	58	18	31%	*
B. Was there documentation that the member was provided MAT education as a treatment option?	18	16	89%	*
C. If yes to VI B, were they referred to a MAT provider?	16	14	88%	3

	Denominator	# of Yes	% of Yes	# of N/A
D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	10	9	90%	8
E. If a physical health concern related to pain was identified, were alternative pain management options addressed?	6	3	50%	12
F. If member is a pregnant female; did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?	N/A	0	N/A	18
G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?	18	7	39%	*
H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	18	8	44%	*

Measure VII — Discharge and Continuing Care Planning Key Findings

In 57% of the reviewed cases, providers documented completion of a relapse prevention plan for clients who completed treatment or declined further services. Providers documented offered resources pertaining to community supports in 62% of these cases. For those clients engaged with other agencies, providers actively coordinated with these agencies at the time of discharge in 66% of the cases.

Table 3-7 — AzCH Discharge and Continuing Care Planning (completed only if member completed treatment or declined further services)

	Denominator	# of Yes	% of Yes	# of N/A
A. Was there documentation present that a relapse prevention plan completed?	53	30	57%	*
B. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g., crisis line)?	53	33	62%	*

	Denominator	# of Yes	% of Yes	# of N/A
C. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?	45	34	76%	8

Measure VIII — Re-engagement Key Findings

In 75% of cases where the client declined further services or chose not to appear for scheduled services, providers followed up with a phone call at times when the member was expected to be available. In 71% of these cases, providers mailed a letter to the client requesting contact. Other activities taken by providers to make contact included visiting the client's home (46%), contacting other involved agencies (31%), and calling the client's emergency contact (23%). Other outreach activities included checking jails to see if beneficiary was incarcerated, contacted hospital to check for admission, contacting old boss, and spoke to Mother, who the member lived with.

Table 3-8 — AzCH Re-Engagement (completed only if member declined further services or chose not to appear for scheduled services)

	Denominator	# of Yes	% of Yes	# of N/A
A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?	44	33	75%	*
B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	28	20	71%	14
C. Were other attempts made to re-engage the individual, such as:				
Home visit?	13	6	46%	0
Call emergency contact(s)?	13	3	23%	0
Contacting other involved agencies?	13	4	31%	0
Street Outreach?	13	0	0%	0
Other	13	4	31%	0

Measure IX — NOMs Key Findings

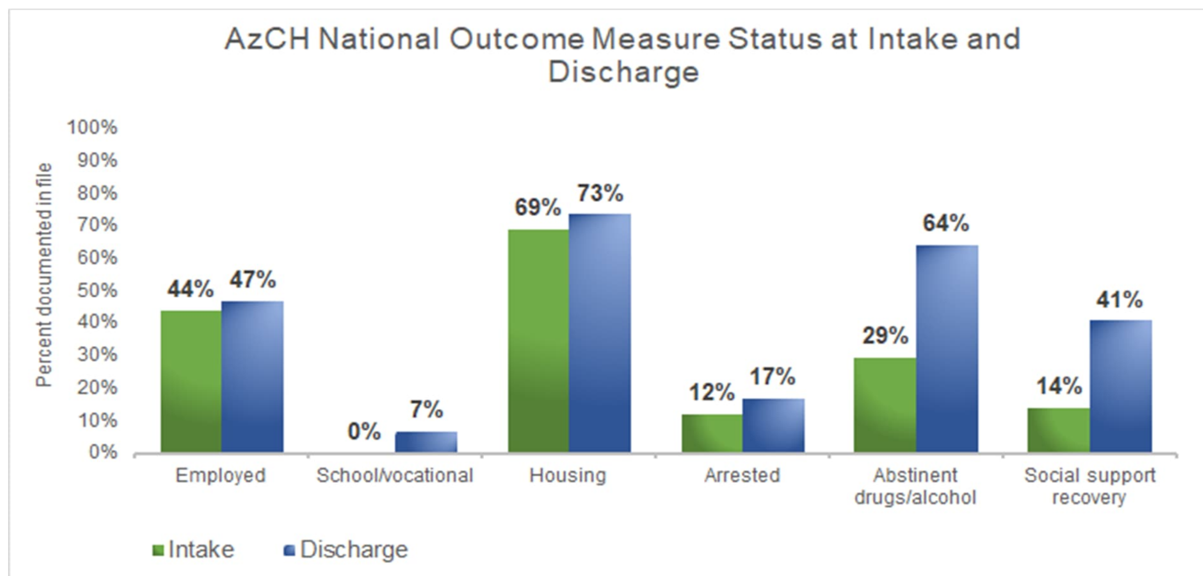
Each of the six AzCH NOMs for Measure IX are depicted in Table 3-9. Denominators are impacted by missing documentation of status at intake and discharge if applicable. Across all NOMs documentation was nearly complete at intake versus discharge. The graphs below show the client's status for each NOM at intake and discharge. Results for AzHC for each

NOM improved at discharge with the exception of *Arrested in the preceding 30 days? (a lower number at discharge denotes improvement*.

Table 3-9 — AzCH National Outcome Measures

	At Intake			At Discharge		
	Denominator	# Yes	% Yes	Denominator	# Yes	% Yes
A. Employed?	57	25	44%	47	22	47%
B. Enrolled in school or vocational educational program?	54	0	0%	45	3	7%
C. Lived in a stable housing environment (e.g., not homeless)?	58	40	69%	49	36	73%
D. Arrested in the preceding 30 days?	58	7	12%	48	8	17%
E. Abstinent from drugs and/or alcohol?	58	17	29%	39	25	64%
F. Participated in social support recovery in the preceding 30 days?	58	8	14%	32	13	41%

Figure 3-1 — AzCH National Outcome Measures



Health Choice (HC) Arizona

HC has responsibility for AHCCCS clients in the northern region of the State. Mercer reviewed provider treatment records from seven separate clinics under HC Arizona's area of responsibility. The following highlights were observed within the data collected from these cases.

- Certified peer support was offered 37% of the time in treatment, higher than the State average of 26%.
- Members were provided MAT services 100% of the time compared to the State average of 95%.
- Referral to a medical provider for clients with withdrawal symptoms occurred in 100% of the cases reviewed within this region as compared with the State average of 89%.
- Re-engagement attempts via home visits were attempted 50% of the time, well above the State average of 31%.

Measure I — Intake/Treatment Planning Key Findings

Initial Behavioral Health Assessment

Mercer reviewed 30 total records for HC Arizona and found 73% (a decrease from 100% of 33 records in FY 2020) of the charts contained evidence that an initial BH assessment was completed within 45 days of the initial appointment. As part of the initial assessment, providers successfully documented compliance with the required components of the assessment (Items A1–9) with a range of 11% to 100%. The areas of lowest performance were documentation of review of the PDMP (17%), hepatitis C, HIV, and other infectious disease screening (18%), and TB screening (41%).

Individual Service Plan (ISP)

Providers developed an ISP for the client's treatment (within 90 days of the initial appointment) in 95% of the reviewed cases. In 100% of these cases, the providers developed the ISP in congruence with the presenting concerns. Zero percent of ISPs were developed with the participation of the client's family or other supports. Eight clients declined participation from family and other supports, or supports did not exist.

Table 4-1 — HC Arizona Assessment and Individual Service Plan

	Denominator	# of Yes	% of Yes	# of N/A
Intake/Treatment Planning				
A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	30	22	73%	0
Did the behavioral health assessment:				

	Denominator	# of Yes	% of Yes	# of N/A
1. Address substance-related disorder(s)?	22	22	100%	*
2. Describe the intensity/frequency of substance use?	22	20	91%	*
3. Include the effect of substance use on daily functioning?	22	21	95%	*
4. Include the effect of substance use on interpersonal relationships?	22	18	82%	*
5. Was a risk assessment completed?	22	21	95%	*
6. Document screening for tuberculosis (TB)?	22	9	41%	*
7. Document screening for Hepatitis C, HIV and other infectious diseases?	22	4	18%	*
8. Document screening for emotional and/or physical abuse/trauma issues?	22	21	95%	*
9. Document that review of the Prescription Drug Monitoring Program (PDMP) was completed?	6	1	17%	16
B. Was there documentation that charitable choice requirements were followed, if applicable?	1	1	100%	21
C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	22	21	95%	0
Was the ISP:				
1. Developed with participation of the family/support network?	21	0	0%	8
2. Congruent with the diagnosis(es) and presenting concern(s)?	21	21	100%	*
3. Measurable objectives and timeframes to address the identified needs?	21	20	95%	*
4. Addressing the unique cultural preferences of the individual?	21	15	71%	*
5. Were social determinants of health issues considered as part of, and incorporated into, the ISP?	21	14	67%	*

Measure II — Placement Criteria/Assessment Key Findings

ASAM Patient Placement Criteria were used at intake to determine the appropriate level of service in 73% of the cases reviewed. Of these cases, documentation showed that 82% received the LOC identified by the ASAM criteria. Providers documented the use of the ASAM criteria to reassess the proper LOC during treatment in 50% of cases. In 23% of the reviewed case files, providers documented the use of other (or additional) assessment tools during the course of treatment. These tools included:

- CIWA (Used once)
- NIDA Assist/Modified ASSIST/ASSIST V.3 (Used five times)
- PRAPARE (Used two times)

Table 4-2 — HC Arizona Placement Criteria/Assessment

	Denominator	# of Yes	% of Yes	# of N/A
A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?	30	22	73%	*
1. If the ASAM Patient Placement Criteria were used, the level of service identified was:				
Level 0.5: Early Intervention	22	0	0%	*
OMT: Opioid Maintenance Therapy	22	1	5%	*
Level I: Outpatient Treatment	22	15	68%	*
Level II: Intensive Outpatient Treatment/Partial Hospitalization	22	3	14%	*
Level III: Residential/Inpatient Treatment	22	3	14%	*
Level IV: Medically Managed Intensive Inpatient Treatment	22	1	5%	*
B. Did the member receive the level of services identified by the placement criteria/assessment?	22	18	82%	*
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	22	11	50%	*
D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	30	7	23%	*

Measure III — Best Practices Key Findings

Seventy-seven percent of sampled BH case files contained documentation that EBPs were used in treatment. Of these, CBT was the most widely used EBP (39%). MAT was documented in 10% percent of the BH case files. Of the three individuals who received MAT, one received disulfiram, one methadone, and one suboxone. Eight interventions were not documented as having been used during this review period: ACRA, Beyond Trauma: A Healing Journey for Women, Contingency Management, Helping Women Recover, Thinking for a Change, TREM, Trauma Informed Care, and Wellness Recovery Action Plan (WRAP). Only seven women were represented in the sample size, indicating that the lack of women specific interventions is not statistically significant. Additional interventions used by providers included:

- Helping Men Recover (Used once)
- Prime for Life (Used once)
- REBT (Used two times)
- Women's Self Recovery Groups (Used once)

In 37% of cases, providers offered certified peer support services and, in 27% of those cases, the services were provided as part of treatment. One individual declined peer support services when the provider offered. The EBP of screening for ongoing substance use during treatment occurred in 43% of the reviewed cases.

Table 4-3 — HC Arizona Best Practices

	Denominator	# of Yes	% of Yes	# of N/A
A. Were evidence-based practices used in treatment?*	30	23	77%	*
1. **The following evidence-based practices were used in treatment:**				
Adolescent Community Reinforcement Approach (ACRA)	23	0	0%	*
Beyond Trauma: A Healing Journey for Women	23	0	0%	*
Cognitive Behavioral Therapy (CBT)	23	9	39%	*
Contingency management	23	0	0%	*
Dialectal Behavioral Therapy (DBT)	23	6	26%	*
Helping Women Recover	23	0	0%	*
Matrix	23	6	26%	*
Moral Re-conation Therapy (MRT)	23	3	13%	*

	Denominator	# of Yes	% of Yes	# of N/A
Motivational Enhancement/Interviewing Therapy (MET/MI)	23	3	13%	*
Relapse Prevention Therapy (RPT)	23	4	17%	*
Seeking Safety	23	2	9%	*
SMART Recovery	23	2	9%	*
Thinking for a Change	23	0	0%	*
Trauma Recovery and Empowerment Model (TREM)	23	0	0%	*
Trauma-Informed Care (TIC)	23	0	0%	*
Wellness Recovery Action Plan (WRAP)	23	0	0%	*
Other Practices or Programs	23	3	13%	*
B. Medication Assisted Treatment (MAT)	30	3	10%	*
1. The following medication was used in treatment:				
❖ Alcohol-related				
Acamprosate (Campral)	3	0	0%	*
Disulfiram (Antabuse)	3	1	33%	*
❖ Opioid-related				
Subutex (buprenorphine)	3	0	0%	*
Methadone/Levo-Alpha-Acetylmethadol (LAAM)	3	1	33%	*
Narcan (naloxone)	3	0	0%	*
Vivitrol (long-acting naltrexone)	3	0	0%	*
Suboxone (buprenorphine-naloxone)	3	1	33%	*
C. Was screening for substance use/abuse conducted during the course of treatment?	30	13	43%	*
D. Was certified peer support offered as part of treatment?	30	11	37%	1
If yes to III.I.D, were certified peer support services used as a part of treatment?	11	3	27%	*

*Four records did not document EBPs.

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

Providers used group therapy (70%) and case management (77%) as the most common followed by individual therapy (57%). Family counseling was not documented in any of the records. For those individuals who received counseling, 40% attended more than 11 sessions; 50% attended five or fewer sessions. Eighty-seven percent of BH case files did not contain documentation regarding the number of self-help or recovery group sessions completed during treatment. Of those that did document this metric, 3% of cases documented zero attendance at the self-help or recovery group sessions while 10% attended some combination of sessions.

Table 4-4 — HC Arizona Treatment/Support Services/Rehabilitation Services

	Denominator	# of Yes	% of Yes	# of N/A
A. The following services were used in treatment:				
Individual counseling/therapy	30	17	57%	*
Group counseling/therapy	30	21	70%	*
Family counseling/therapy	30	0	0%	*
Case management	30	23	77%	*
B. Was there clear documentation of progress or lack of progress toward the identified ISP goals?	30	20	67%	4
C. The number of completed counseling/therapy sessions during treatment was:				
0–5 sessions	30	15	50%	*
6–10 sessions	30	3	10%	*
11 sessions or more	30	12	40%	*
D. Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:				
No documentation	30	26	87%	*
0 times during treatment	30	1	3%	*
1–4 times during treatment	30	1	3%	*
5–12 times during treatment	30	1	3%	*
13–20 times during treatment	30	0	0%	*
21 or more times during treatment	30	1	3%	*

	Denominator	# of Yes	% of Yes	# of N/A
E. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?	15	6	40%	15
F. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	18	9	50%	12
G. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	18	3	17%	12
H. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	24	3	13%	6
I. Does the documentation reflect that substance abuse services were provided?	30	27	90%	*
J. Was member's access to a primary care physician (PCP) or other medical provider explored?	30	16	53%	0

Measure V — Gender Specific Key Findings

Providers documented seven women's case files with a history of domestic violence; of these, 29% contained a safety plan. This sample did not contain any pregnant women or women who had given birth in the past year. Of the case files for women who had dependent children, 80% documented an examination of childcare. Gender-specific services were documented in 10% of cases.

Table 4-5 — HC Arizona Gender Specific (Female Only)

	Denominator	# of Yes	% of Yes	# of N/A
A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	7	2	29%	3
B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	N/A	0	N/A	10
C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?	N/A	0	N/A	10
D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?	N/A	0	N/A	10
E. If the female had dependent children, was there documentation to show that childcare was addressed?	5	4	80%	5
F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	10	1	10%	0

Measure VI — Opioid Specific Key Findings

For this sub-sample, providers documented OUD diagnosis in 13% of the cases. Of these cases, providers educated 50% of the clients on MAT as a treatment option, and 100% of those were referred to a MAT provider. Documentation showed MAT providers educated the client on overdose, naloxone, and steps to take in the event of an overdose in 25% of the cases. Education on the effects of polysubstance abuse with opioids was provided in 50% of the cases. In 100% of cases, providers referred clients with withdrawal symptoms to a medical provider. In this domain HC Arizona remained consistent or improved performance since the last review period.

Table 4-6 — HC Arizona Opioid Specific

	Denominator	# of Yes	% of Yes	# of N/A
A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?	30	4	13%	*
B. Was there documentation that the member was provided MAT education as a treatment option?	4	2	50%	*

	Denominator	# of Yes	% of Yes	# of N/A
C. If yes to VI B, were they referred to a MAT provider?	2	2	100%	1
D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	1	1	100%	3
E. If a physical health concern related to pain was identified, were alternative pain management options addressed?	1	0	0%	3
F. If member is a pregnant female; did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?	N/A	0	N/A	4
G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?	4	1	25%	*
H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	4	2	50%	*

Measure VII — Discharge and Continuing Care Planning Key Findings

In 27% of the reviewed cases, providers documented completion of a relapse prevention plan for clients who completed treatment or declined further services. Providers documented offered resources pertaining to community supports in 23% of these cases. For those clients engaged with other agencies, providers actively coordinated with these agencies at the time of discharge in 24% of the cases. In this domain, HC Arizona decreased performance by more than half.

Table 4-7 — HC Arizona Discharge and Continuing Care Planning (completed only if member completed treatment or declined further services)

	Denominator	# of Yes	% of Yes	# of N/A
A. Was there documentation present that a relapse prevention plan completed?	26	7	27%	*
B. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g., crisis line)?	26	6	23%	*
C. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?	17	4	24%	9

Measure VIII — Re-engagement Key Findings

In 86% of cases where the client declined further services or chose not to appear for scheduled services, providers followed up with a phone call at times when the member was expected to be available. In 58% of these cases, providers mailed a letter to the client requesting contact. Other activities taken by providers to make contact included calling the client's emergency contact (50%), visiting the client's home (50%), and contacting other involved agencies (25%). In one case, the provider contacted the member's wife.

Table 4-8 — HC Arizona Re-engagement (completed only if member declined further services or chose not to appear for scheduled services)

	Denominator	# of Yes	% of Yes	# of N/A
A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?	21	18	86%	*
B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	19	11	58%	2
C. Were other attempts made to re-engage the individual, such as:				
Home visit?	4	2	50%	0
Call emergency contact(s)?	4	2	50%	0
Contacting other involved agencies?	4	1	25%	0
Street Outreach?	4	0	0%	0
Other	4	1	25%	0

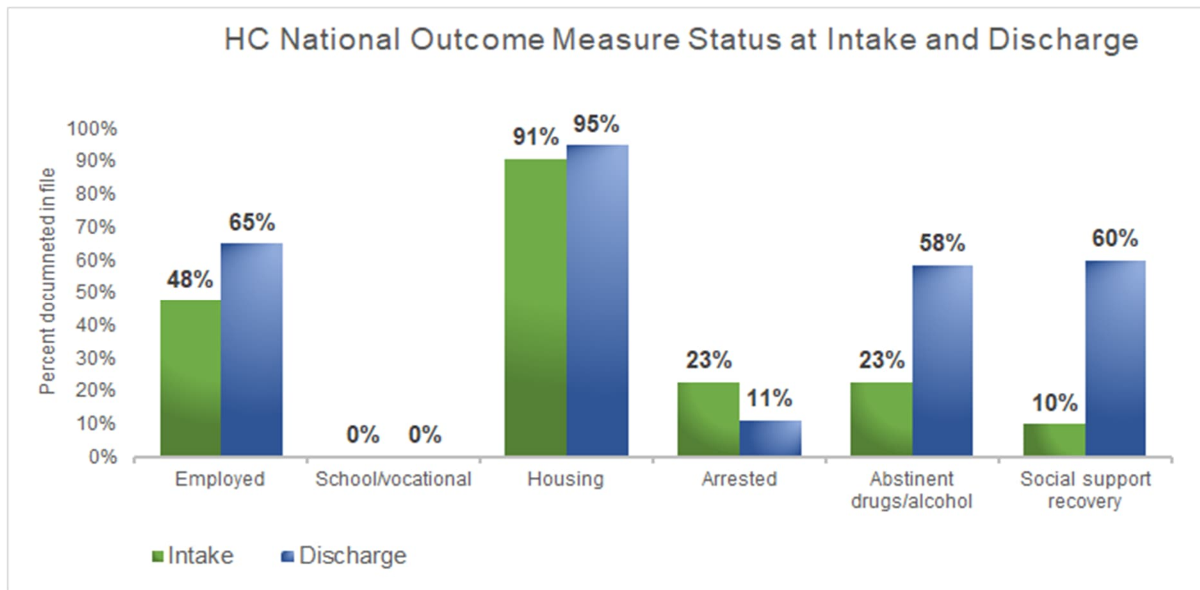
Measure IX — NOMs Key Findings

Each of the six HC Arizona NOMs for Measure IX are depicted in Table 4-9. Denominators are impacted by missing documentation of status at intake and discharge if applicable. Although HC Arizona documented more of the metrics at intake versus discharge, they were more consistent compared to the other RBHAs. The graph below show the client's status for each NOM at intake and discharge. Results for HC Arizona for each NOM improved at discharge for almost every measure and the RBHA to demonstrate the most improvement for *Arrested in the preceding 30 days?.*

Table 4-9 — HC Arizona National Outcome Measures

	At Intake			At Discharge		
	Denominator	# Yes	% Yes	Denominator	# Yes	% Yes
A. Employed?	21	10	48%	20	13	65%
B. Enrolled in school or vocational educational program?	19	0	0%	16	0	0%
C. Lived in a stable housing environment (e.g., not homeless)?	22	20	91%	20	19	95%
D. Arrested in the preceding 30 days?	22	5	23%	18	2	11%
E. Abstinent from drugs and/or alcohol?	22	5	23%	12	7	58%
F. Participated in social support recovery in the preceding 30 days?	30	3	10%	10	6	60%

Figure 4-1 — HC Arizona National Outcome Measures



Mercy Care (MC)

Measure I — Intake/Treatment Planning

MC has responsibility for AHCCCS clients in the central region of the State. Mercer reviewed provider treatment records from eight separate clinics under MC's area of responsibility. The following highlights were observed within the data collected from these cases.

- EBPs were used in treatment 93% of the time as compared with the State average of 88%.
- Certified peer support services were utilized as part of the treatment process 69% of the time, as opposed to the State average of 52%.
- Individual counseling services were utilized 71% of the time as compared with the State average of 63% of the time.
- For the three pregnant women in the sample, care was coordinated with the obstetrician 100% of the time as compared to the State average of 75%.

Initial Behavioral Health Assessment

Mercer reviewed 112 total records for MC and found 98% of the charts contained evidence that an initial BH assessment was completed within 45 days of the initial appointment. As part of the initial assessment, providers successfully documented compliance with the required components of the assessment (Items A1–9) with a range of 24% to 100%. The areas of lowest performance were consistent with the FY 2020 review and had a decrease in each metric for documentation of hepatitis C, HIV, and other infectious disease screening (24%), review of the PDMP (33%), and TB screening (39%).

Individual Service Plan (ISP)

Providers developed an ISP for the client's treatment (within 90 days of the initial appointment) in 98% of the reviewed cases. In 98% of these cases, the providers developed the ISP in congruence with the presenting concerns. Eight percent of ISPs were developed with the participation of the client's family or other supports (when the client consented to allow participation from these sources). Sixteen clients declined participation from family and other supports, or supports did not exist.

Table 5-1 — MC Assessment and Individual Service Plan

	Denominator	# of Yes	% of Yes	# of N/A
Intake/Treatment Planning				
A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	112	110	98%	0
Did the behavioral health assessment:				
1. **Address substance-related disorder(s)?**	110	110	100%	*
2. **Describe the intensity/frequency of substance use?**	110	107	97%	*
3. **Include the effect of substance use on daily functioning?**	110	109	99%	*
4. **Include the effect of substance use on interpersonal relationships?**	110	109	99%	*
5. **Was a risk assessment completed?**	110	110	100%	*
6. **Document screening for tuberculosis (TB)?**	110	43	39%	*
7. **Document screening for Hepatitis C, HIV and other infectious diseases?**	110	26	24%	*
8. **Document screening for emotional and/or physical abuse/trauma issues?**	110	109	99%	*
9. **Document that review of the Prescription Drug Monitoring Program (PDMP) was completed?**	76	25	33%	34
B. Was there documentation that charitable choice requirements were followed, if applicable?	18	13	72%	92
C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	110	108	98%	0

	Denominator	# of Yes	% of Yes	# of N/A
Was the ISP:				
1. **Developed with participation of the family/support network?**	108	9	8%	16
2. **Congruent with the diagnosis(es) and presenting concern(s)?**	108	106	98%	*
3. **Measurable objectives and timeframes to address the identified needs?**	108	103	95%	*
4. **Addressing the unique cultural preferences of the individual?**	108	94	87%	*
5. **Were social determinants of health issues considered as part of, and incorporated into, the ISP?**	108	84	78%	*

Measure II — Placement Criteria/Assessment Key Findings

ASAM Patient Placement Criteria were used at intake to determine the appropriate level of service in 95% of the cases reviewed. Of these cases, documentation showed that 96% received the LOC identified by the ASAM criteria. Providers documented the use of the ASAM criteria to reassess the proper LOC during treatment in 54% of cases. In 45% of the reviewed case files, providers documented the use of other (or additional) assessment tools during the course of treatment. These tools included:

- CAGE Substance Abuse Screening Tool (Used five times)
- CIWA (Used once)
- COWS (Used once)
- DSM 5 (Used once)
- UNCOPE Screening Instrument for Substance Abuse (Used eight times)

Table 5-2 — MC Placement Criteria/Assessment

	Denominator	# of Yes	% of Yes	# of N/A
A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?	112	106	95%	*
1. If the ASAM Patient Placement Criteria were used, the level of service identified was:				
Level 0.5: Early Intervention	106	0	0%	*
OMT: Opioid Maintenance Therapy	106	31	29%	*
Level I: Outpatient Treatment	106	70	66%	*
Level II: Intensive Outpatient Treatment/Partial Hospitalization	106	6	6%	*
Level III: Residential/Inpatient Treatment	106	28	26%	*
Level IV: Medically Managed Intensive Inpatient Treatment	106	0	0%	*
B. Did the member receive the level of services identified by the placement criteria/assessment?	106	102	96%	*
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	106	57	54%	*
D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	112	50	45%	*

Measure III — Best Practices Key Findings

MC increased from 89% to 93% of sampled BH case files contained documentation that EBPs were used in treatment. Of these, CBT was the most widely used EBP (58%). MAT was documented in 39% percent of the BH case files. Of the 44 individuals who received MAT, methadone was the most frequently used medication (82%). Seven interventions were not documented as having been used during this review period: ACRA, Beyond Trauma: A Healing Journey for Women, Contingency Management, MRT, Seeking Safety, TREM, and WRAP. Additional interventions used by providers included:

- ACT (Used once)
- Living in Balance (Used once)
- Wellness Program (Used three times)

In 23% of cases, providers offered certified peer support services and, in 69% (up from 53% in FY 2020) of those cases, the services were provided as part of treatment. Twelve clients declined the use of peer support services when providers offered. The EBP of screening for ongoing substance use during treatment occurred in 60% of the reviewed cases.

Table 5-3 — MC Best Practices

	Denominator	# of Yes	% of Yes	# of N/A
A. Were evidence-based practices used in treatment?*	112	104	93%	*
1. The following evidence-based practices were used in treatment:				
Adolescent Community Reinforcement Approach (ACRA)	104	0	0%	*
Beyond Trauma: A Healing Journey for Women	104	0	0%	*
Cognitive Behavioral Therapy (CBT)	104	60	58%	*
Contingency management	104	0	0%	*
Dialectal Behavioral Therapy (DBT)	104	12	12%	*
Helping Women Recover	104	3	3%	*
Matrix	104	11	11%	*
Moral Re-conation Therapy (MRT)	104	0	0%	*
Motivational Enhancement/Interviewing Therapy (MET/MI)	104	38	37%	*
Relapse Prevention Therapy (RPT)	104	17	16%	*
Seeking Safety	104	0	0%	*
SMART Recovery	104	11	11%	*
Thinking for a Change	104	1	1%	*
Trauma Recovery and Empowerment Model (TREM)	104	0	0%	*
Trauma-Informed Care (TIC)	104	1	1%	*
Wellness Recovery Action Plan (WRAP)	104	0	0%	*
Other Practices or Programs	104	28	27%	*
B. Medication Assisted Treatment (MAT)	112	44	39%	*
1. The following medication was used in treatment:				

	Denominator	# of Yes	% of Yes	# of N/A
❖ Alcohol-related				
Acamprosate (Campral)	44	0	0%	*
Disulfiram (Antabuse)	44	1	2%	*
❖ Opioid-related				
Subutex (buprenorphine)	44	1	2%	*
Methadone/Levo-Alpha-Acetylmethadol (LAAM)	44	36	82%	*
Narcan (naloxone)	44	2	5%	*
Vivitrol (long-acting naltrexone)	44	1	2%	*
Suboxone (buprenorphine-naloxone)	44	6	14%	*
C. Was screening for substance use/abuse conducted during the course of treatment?	112	67	60%	*
D. Was certified peer support offered as part of treatment?	112	26	23%	7
If yes to III.I.D, were certified peer support services used as a part of treatment?	26	18	69%	*

*Eight records did not document EBPs.

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

Providers used group therapy as the most common service provided in the sample (80%), followed by case management (74%) and individual therapy (71%). Family counseling was not documented in any of the charts reviewed. For those individuals who received counseling, 53% attended more than 11 sessions; 29% attended five or fewer sessions. Seventy-nine percent of BH case files did not contain documentation regarding the number of self-help or recovery group sessions completed during treatment. Of those that did document this metric, 3% of cases documented zero attendance at the self-help or recovery group sessions while 18% attended some combination of sessions. When there was a documented lack of progress in treatment, providers sought consultation or changed the treatment approach in 91% of the cases reviewed.

Table 5-4 — MC Treatment/Support Services/Rehabilitation Services

	Denominator	# of Yes	% of Yes	# of N/A
A. The following services were used in treatment:				
Individual counseling/therapy	112	79	71%	*
Group counseling/therapy	112	90	80%	*
Family counseling/therapy	112	0	0%	*
Case management	112	83	74%	*
B. Was there clear documentation of progress or lack of progress toward the identified ISP goals?	112	102	91%	0
C. The number of completed counseling/therapy sessions during treatment was:				
0–5 sessions	112	33	29%	*
6–10 sessions	112	20	18%	*
11 sessions or more	112	59	53%	*
D. Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:				
No documentation	112	89	79%	*
0 times during treatment	112	3	3%	*
1–4 times during treatment	112	10	9%	*
5–12 times during treatment	112	3	3%	*
13–20 times during treatment	112	3	3%	*
21 or more times during treatment	112	4	4%	*
E. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?	61	18	30%	51
F. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	57	47	82%	55

	Denominator	# of Yes	% of Yes	# of N/A
G. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	44	24	55%	68
H. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	64	38	59%	48
I. Does the documentation reflect that substance abuse services were provided?	112	109	97%	*
J. Was member's access to a primary care physician (PCP) or other medical provider explored?	112	92	82%	7

Measure V — Gender Specific Key Findings

Providers documented nine women's case files with a history of domestic violence; of these, 56% contained a safety plan. Providers documented three pregnant women in this sample; coordination of care with the PCP or obstetrician occurred in all cases (100%) and education on the effects of substance use on fetal development occurred in two cases (67%). This sample contained three women who had given birth in the past year of which 67% showed documentation of screening for postpartum depression/psychosis. Of the 11 case files for women who had dependent children, 100% documented an examination of childcare. Gender-specific services were documented in 23% of cases.

Table 5-5 — MC Gender Specific (Female Only)

	Denominator	# of Yes	% of Yes	# of N/A
A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	9	5	56%	23
B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	3	3	100%	29
C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?	3	2	67%	29

	Denominator	# of Yes	% of Yes	# of N/A
D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?	3	2	67%	29
E. If the female had dependent children, was there documentation to show that childcare was addressed?	11	11	100%	21
F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	30	7	23%	2

Measure VI — Opioid Specific Key Findings

For this sub-sample, providers documented OUD diagnosis in 51% of the cases. Of these cases, providers educated 81% of the clients on MAT as a treatment option, and 98% of those were referred to a MAT provider. Documentation showed MAT providers educated the client on overdose, naloxone, and steps to take in the event of an overdose in 58% of the cases. Education on the effects of polysubstance abuse with opioids was provided in 47% of the cases. In 89% of cases, providers referred clients with withdrawal symptoms to a medical provider.

Table 5-6 — MC Opioid Specific

	Denominator	# of Yes	% of Yes	# of N/A
A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?	112	57	51%	*
B. Was there documentation that the member was provided MAT education as a treatment option?	57	46	81%	*
C. If yes to VI B, were they referred to a MAT provider?	46	45	98%	3
D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	36	32	89%	20
E. If a physical health concern related to pain was identified, were alternative pain management options addressed?	11	7	64%	46
F. If member is a pregnant female; did documentation show evidence of education about the safety of methadone and/or	3	1	33%	53

	Denominator	# of Yes	% of Yes	# of N/A
buprenorphine during the course of pregnancy?				
G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?	57	33	58%	*
H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	57	27	47%	*

Measure VII — Discharge and Continuing Care Planning Key Findings

In 69% (increase of 14% from FY 2020) of the reviewed cases, providers documented completion of a relapse prevention plan for clients who completed treatment or declined further services. Providers documented offered resources pertaining to community supports in 75% of these cases. For those clients engaged with other agencies, providers actively coordinated with these agencies at the time of discharge in 80% (improvement of 15% from the previous review period) of the cases.

Table 5-7 — MC Discharge and Continuing Care Planning (completed only if member completed treatment or declined further services)

	Denominator	# of Yes	% of Yes	# of N/A
A. Was there documentation present that a relapse prevention plan completed?	81	56	69%	*
B. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g., crisis line)?	81	61	75%	*
C. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?	70	56	80%	11

Measure VIII — Re-engagement Key Findings

In 89% of cases where the client declined further services or chose not to appear for scheduled services, providers followed up with a phone call at times when the member was expected to be available. In 75% of these cases, providers mailed a letter to the client requesting contact. Other activities taken by providers to make contact included contacting other involved agencies (78%) and calling the client's emergency contact (22%).

Table 5-8 — MC Re-engagement (completed only if member declined further services or chose not to appear for scheduled services)

The following efforts were documented:	Denominator	# of Yes	% of Yes	# of N/A
A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?	62	55	89%	*
B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	57	43	75%	3
C. Were other attempts made to re-engage the individual, such as:				
Home visit?	9	0	0%	0
Call emergency contact(s)?	9	2	22%	0
Contacting other involved agencies?	9	7	78%	0
Street Outreach?	9	0	0%	0
Other	9	0	0%	0

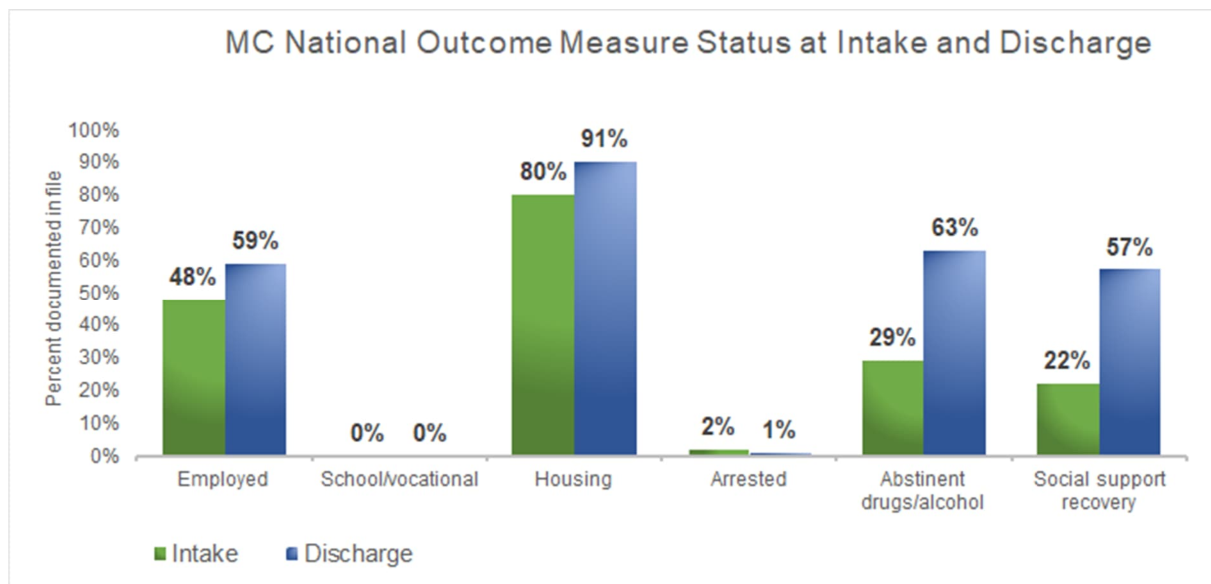
Measure IX — NOMs Key Findings

Each of the six MC NOMs for Measure IX are depicted in Table 5-9. The denominator is determined and compared for both intake and discharge. Denominators are impacted by missing documentation of status at intake and discharge. Across all NOMs documentation was nearly complete at intake versus discharge. The table and graph below show the client's status for each NOM at intake and discharge. Results for MC for each NOM improved at discharge for every measure with the exception of *Enrolled in school or vocational educational program?.*

Table 5-9 — MC National Outcome Measures

	At Intake			At Discharge		
	Denominator	# Yes	% Yes	Denominator	# Yes	% Yes
A. Employed?	111	53	48%	93	55	59%
B. Enrolled in school or vocational educational program?	105	0	0%	71	0	0%
C. Lived in a stable housing environment (e.g., not homeless)?	112	90	80%	95	86	91%
D. Arrested in the preceding 30 days?	109	2	2%	93	1	1%
E. Abstinent from drugs and/or alcohol?	109	32	29%	84	53	63%
F. Participated in social support recovery in the preceding 30 days?	112	25	22%	75	43	57%

Figure 5-1 — MC National Outcome Measures



Section 6
Recommendations

Based upon the results of the ICR and associated analysis of findings, Mercer recommends the following areas of improvement for AHCCCS' consideration.

Carryover Recommendations from FY 2020 and FY 2021 ICRs

1. **Develop a mechanism for feedback to providers.** Although all SABG SUD providers have access to the findings of the ICR, the Mercer review team noted several instances where it would be beneficial to provide feedback to a specific provider (e.g., treatment concerns, missed opportunities for intervention, etc.). The ICR, in its present form, does not allow for provider-specific feedback to the RBHAs; such feedback could be provided with the intention of having that information passed along to the provider in question. AHCCCS should consider amending the ICR process to include a feedback mechanism that would allow for "lessons learned" to be disseminated to specific providers.

   A potential vehicle for this feedback could be the ICR tool. AHCCCS could amend the ICR tool to include an additional section that would allow reviewers to identify important information related to the documented care in the record (e.g., treatment issues, missed opportunities, quality of care concerns, etc.). At the conclusion of the ICR, the comments could be compiled (by each individual provider) and given to the RBHAs to pass along to the individual agencies, with the intent of having the providers make necessary adjustments in practices and procedures. When feedback is provided with specific examples, which are relevant to the receiver of the feedback, the recommendation is more likely to lead to improvements in behavior.[9] Additionally, AHCCCS could ask for bullet points outlining more universal improvement activities for implementation such as protocols for TB testing that can be submitted to the RBHAs for more general training for all providers.

   The addition of a comment and feedback process would likely add to the ICR timeline, but such additional time could lead to desired improvements in provider treatment to the SUD population. Mercer suggests the benefits of this additional work may be worth the added effort.

2. **Consider the inclusion of interviews in future ICRs.** The ICR currently reveals useful information related to the use of best practices and procedures by SUD treatment providers. However, a file review only conveys the information as it is documented. By incorporating live interviews with the RBHAs, clients, and providers, AHCCCS could collect additional, valuable information that would round-out its understanding of what works and what needs to be improved in SUD treatment services within the State. For example, interviews could shed light on the impact each provider is seeing as a result of the COVID-19 pandemic. Other AHCCCS-sponsored projects that focus on the

[9] Westberg, J. & Jason, H. (2001). Fostering Reflection and Providing Feedback. New York, NY: Springer Publishing Company.

improvement of BH care service delivery have used live interviews to great effect. The Quality Services Review, which focuses on BH care service delivery to the Serious Mental Illness population, has included individual interviews with service recipients and other stakeholders for the past nine years. This project could serve as a model for the ICR and provide valuable insight into potential areas of improvement for the SUD treatment system.

3. **Consider formal statistical validation of the ICR Tool for future independent reviews.** As the use of SABG funds continues, and additional ICRs are undertaken, AHCCCS could benefit from improved information that allows for year-to-year comparisons of ICR findings. Such comparisons can only be appropriately made when a statistically validated tool is used that increases confidence in the comparability of the different years' results. AHCCCS would have the option of performing such validation in-house, or leveraging the expertise of consultants trained in the validation of clinical review tools. As an additional option, AHCCCS could consider maintaining consistency in the independent review team that performs the ICR. Such consistency, together with the use of a statistically validated tool, would decrease variability from year-to-year, and increase the State's ability to compare results and assess large-scale trends within the SUD service system.

4. **Consider changes to sampling methodology for future reviews.** As an option in future reviews, AHCCCS should consider increasing validity and reliability by using a more randomized sampling methodology. One method for achieving this would be to have the independent reviewer randomly select the sample cases to be reviewed (from the entire population of files that meet inclusion criteria) and then ask the RBHAs to supply those specific records. This would add some time to the process (when compared to having the RBHAs select files to provide), but it would increase confidence in the results and contribute to overall project validity. Mercer has used this sampling methodology in support of the Priority Mental Health Services review, which is conducted annually for AHCCCS. An additional benefit of using this sampling methodology is that the independent reviewer would have the opportunity to stratify the sample and increase the number of cases from small sub-populations that are reviewed (e.g., women, older adults, transition age youth). For example, this year's review only captured one additional pregnant woman (three versus last year's two). This small representation within the sample makes it difficult to draw conclusions for this group. By using appropriate sampling methodology, the independent reviewer could increase the representation of sub-populations in the sample while maintaining the randomness necessary for increased validity and reliability.

New Recommendations from FY 2021 ICR

1. **Monitor and review for impact of COVID-19 pandemic.** As noted throughout the report, there is not a definitive way to directly link the impact of COVID-19 to the results. There are some assumptions that can be made, most directly tied to providers and RBHAs having to operate largely in a virtual telehealth environment, however those assumptions will need to be tested as we progress out of the pandemic in the coming ICR periods. Some metrics that appear to have had a potential impact include, but are not limited to, largely the outpatient LOCs for medical screenings, alcohol and drug

screening, and engagement and participation in services via telehealth accompanied with technology challenges.

2. **Clinical consideration for improved quality of care include the following considerations:**

   - **Training and technical assistance on the importance and development of relapse plans at every LOC.** There were several instances where upon discharge from one LOC to the next the relapse plan was listed as an activity for the next provider. Relapse plans along an individual's full course of treatment is essential in their recovery.

   - **Training and technical assistance on the importance of and development of safety plans in cases of domestic violence.** The findings reflected that just over 50% of the women who shared being involved in a domestic violence situation had a documented safety plan. This is a missed opportunity by the treatment team that could have an impact on that member's level engagement and success in recovery.

   - **Expand the focus of ICR next year to also target the older adult (aged 55 and older) population.** With that added goal to increase the percent of older adults (aged 55 and older) who receive treatment in the BH system who are diagnosed as having a SUD, gathering feedback from the RBHAs and providers on the needs, strengths and challenges for this age group would be advantageous in crafting specific questions and area of focus. This feedback could then be utilized to update the ICR tool and process for the next review in order to better assess performance toward this goal.

   - **Training and technical assistance on the importance of and development of individualized service plans.** This builds off the recommendation from FY 2020 to encourage the ongoing focus on SDoH into treatment. Providers continue to document SDoH needs in the assessment. However, the SDoH findings are still lagging in the incorporation into treatment in order to actively work to address individual obstacles to recovery. Missed opportunities included goals and measurable strategies to address unemployment, housing, transportation, and in light of COVID-19, technology needs. In addition to SDoH, service plans within a residential treatment program were close to exact for each enrolled member and lacked the individualization for each member's diagnosis, stage of recovery, personal circumstance, and associated needs.

   - **Encourage the use of peer support services as well as social support recovery such as 12-step programs.** Out of the 200 charts reviewed only 23 (12%) had documentation on peer support services being offered. Although the numbers for social support recovery were better out of 200 records only 25 (13%) charts had documentation at the point of intake and 43 (22%) at the point of discharge. Interventions such as these can also be incorporated into a member's relapse and recovery plan to support building healthy relationships in the community.

   - **Training and technical assistance to improve knowledge and skills for work with the justice-involved population.** This could also include an additional focus of the ICR targeted to management of issues and interventions for justice-involved

members with the added goal to decrease recidivism and improve resocialization post release to support recovery.

3. **Consider increasing available hours of services to allow for individuals to work and still receive treatment.** Allowing for flexible hours to accommodate work schedules could result in improved engagement in some cases. Several of the charts that were closed due to lack of engagement reflected that the reason for loss of contact was due to conflicting work commitments.

4. **Consider additional subcategories in the NOMs to reflect individuals who are retired or receiving disability.** In several cases, the individual was not employed but this was not a negative outcome as they had a source of support through disability income, Social Security, or other resources as they had a condition that prevented them from seeking work or employment. Not capturing this information skews the outcomes of the NOMs for employment and education negatively as these individuals should at least be pulled from the denominator when calculating this measure.

5. **Consider additional training in EBPs for substance abuse treatment.** Fifty-six percent of cases utilized CBT, and while an effective treatment modality, other options more specific to substance use may be more efficacious, especially specific options for other groups such as women, pregnant women, the elderly, or those that are LGBTQ+.

Appendix A
Case File Review Tool

Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	# of Yes	% of Yes	# of N/A	# of No Documentation
I	Intake/Treatment Planning					
	A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?					
	Did the behavioral health assessment:					
	1. Address substance-related disorder(s)?					
	2. Describe the intensity/frequency of substance use?					
	3. Include the effect of substance use on daily functioning?					
	4. Include the effect of substance use on interpersonal relationships?					
	5. Was a risk assessment completed?					
	6. Document screening for tuberculosis (TB)?					
	7. Document screening for Hepatitis C, HIV and other infectious diseases?					
	8. Document screening for emotional and/or physical abuse/trauma issues?					
	9. Documentation that review of the Prescription Drug Monitoring Program (PDMP) was completed?					
	B. Was there documentation that charitable choice					

Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**	**# of No Documentation**
	requirements were followed, if applicable?					
	C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?					
	Was the ISP:					
	1. Developed with participation of the family/support network?					
	2. Congruent with the diagnosis(es) and presenting concern(s)?					
	3. Measurable objectives and timeframes to address the identified needs?					
	4. Addressing the unique cultural preferences of the individual?					
	5. Were social determinants of health issues considered as part of, and incorporated into, the ISP?					
II	**Placement Criteria/Assessment**					
	A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?					
	1. If the ASAM Patient Placement Criteria were used, the level of service identified was:					
	Level 0.5: Early Intervention					
	OMT: Opioid Maintenance Therapy					
	Level I: Outpatient Treatment					
	Level II: Intensive Outpatient Treatment/Partial Hospitalization					

Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**	**# of No Documentation**
	Level III: Residential/Inpatient Treatment					
	Level IV: Medically Managed Intensive Inpatient Treatment					
	B. Did the member receive the level of services identified by the placement criteria/assessment?					
	C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?					
	D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment? If yes, please list in box below:					
III	**Best Practices**					
	A. Were evidence-based practices used in treatment?					
	1. The following evidence-based practices were used in treatment:					
	Adolescent Community Reinforcement Approach (ACRA)					
	Beyond Trauma: A Healing Journey for Women					
	Cognitive Behavioral Therapy (CBT)					
	Contingency management					
	Dialectal Behavioral Therapy (DBT)					
	Helping Women Recover					
	Matrix					
	Moral Re-conation Therapy (MRT)					
	Motivational Enhancement/					

Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	# of Yes	% of Yes	# of N/A	# of No Documentation
	Interviewing Therapy (MET/MI)					
	Relapse Prevention Therapy (RPT)					
	Seeking Safety					
	SMART Recovery					
	Thinking for a Change					
	Trauma Recovery and Empowerment Model (TREM)					
	Trauma-Informed Care (TIC)					
	Wellness Recovery Action Plan (WRAP)					
	Other Practices or Programs (please list in box below):					
	B. Medication Assisted Treatment (MAT)					
	1. The following medication was used in treatment:					
	❖ Alcohol-related					
	Acamprosate (Campral)					
	Disulfiram (Antabuse)					
	❖ Opioid-related					
	Subutex (buprenorphine)					
	Methadone/Levo-Alpha-Acetylmethadol (LAAM)					
	Narcan (naloxone)					
	Vivitrol (long-acting naltrexone)					
	Suboxone (buprenorphine-naloxone)					
	C. Was screening for substance use/abuse conducted during the course of treatment?					

Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	# of Yes	% of Yes	# of N/A	# of No Documentation
	D. Was certified peer support offered as part of treatment?					
	If yes to III.I.D, were certified peer support services used as a part of treatment?					
IV	Treatment/Support Services/Rehabilitation Services					
	A. The following services were used in treatment:					
	Individual counseling/therapy					
	Group counseling/therapy					
	Family counseling/therapy					
	Case management					
	B. Was there clear documentation of progress or lack of progress toward the identified ISP goals?					
	C. The number of completed counseling/therapy sessions during treatment was:					
	0–5 sessions					
	6–10 sessions					
	11 sessions or more					
	D. Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:					
	No documentation					
	0 times during treatment					
	1–4 times during treatment					
	5–12 times during treatment					
	13–20 times during treatment					
	21 or more times during treatment					
	E. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?					
	F. If the member was unemployed during intake, was there evidence that the					

Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	# of Yes	% of Yes	# of N/A	# of No Documentation
	individual's interest in finding employment was explored?					
	G. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?					
	H. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?					
	I. Does the documentation reflect that substance abuse services were provided?					
	J. Was member's access to a primary care physician (PCP) or other medical provider explored?					
V	Gender Specific (female only)					
	A. If there was a history of domestic violence, was there evidence that a safety plan was completed?					
	B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?					
	C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?					
	D. If the female had a child less than one year of age, was there evidence that a screening was completed for					

Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	# of Yes	% of Yes	# of N/A	# of No Documentation
	postpartum depression/psychosis?					
	E. If the female had dependent children, was there documentation to show that childcare was addressed?					
	F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?					
VI	Opioid Specific					
	A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?					
	B. Was there documentation that the member was provided MAT education as a treatment option?					
	C. If yes to VI B, were they referred to a MAT provider?					
	D. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?					
	E. If a physical health concern related to pain was identified, were alternative pain management options addressed?					
	F. If member is a pregnant female; did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?					
	G. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to					

Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	# of Yes	% of Yes	# of N/A	# of No Documentation
	take in the event of an opioid overdose?					
	H. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?					
VII	Discharge and Continuing Care Planning					
	(completed only if member completed treatment or declined further services)					
	A. Was there documentation present that a relapse prevention plan completed?					
	B. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g. crisis line)?					
	C. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?					
VIII	Re-engagement					
	(completed only if member declined further services or chose not to appear for scheduled services)					
	The following efforts were documented:					
	A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?					
	B. If telephone contact was unsuccessful, was a letter mailed requesting contact?					
	C. Were other attempts made to re-engage the individual, such as:					
	Home visit?					
	Call emergency contact(s)?					

Substance Abuse Prevention and Treatment						
Case File Review Findings for Measure I-IX						
		Denominator	**# of Yes**	**% of Yes**	**# of N/A**	**# of No Documentation**
	Contacting other involved agencies?					
	Street Outreach?					
	Other (please list other identified outreach efforts in the box below)					
IX	**National Outcome Measures**					

	At Intake			At Discharge		
	Yes	No	Missing	Yes	No	Missing
A. Employed?						
B. Enrolled in school or vocational educational program?						
C. Lived in a stable housing environment (e.g., not homeless)?						
D. Arrested in the preceding 30 days?						
E. Abstinent from drugs and/or alcohol?						
F. Participated in social support recovery in the preceding 30 days?						

Appendix B

Case File Review Methodology

The methodology for making review determinations is comparable to prior years to promote consistency over the continuum of the SABG periods. Methodology was slightly updated based on consultation with AHCCCS. Review team members used this methodology to perform the primary IRR and review process. This methodology was also used to program the formulas used for the analysis.

Indicator	Instructions
I. Intake/Treatment Planning	
A. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?	Yes: A comprehensive behavioral health assessment has been performed within 45 days of the initial appointment. No: No comprehensive behavioral health assessment has been performed within 45 days of the initial appointment. No: A behavioral health assessment has been performed within 45 days of the initial appointment but is not present in the file. N/A: No comprehensive behavioral health assessment is present in the file and the case
Did the behavioral health assessment:	
1. Address substance-related disorder(s)	Yes: The assessment addressed substance-related disorder(s) within 45 days of the initial appointment. No: The assessment addressed substance-related disorder(s) within 45 days of the initial appointment.
2. Describe the intensity/frequency of substance use?	Yes: The assessment described the intensity/frequency of substance use within 45 days of the initial appointment. No: The assessment did not describe the intensity/frequency of substance use within 45 days of the initial appointment.
3. Include the effect of substance use on daily functioning?	Yes: The assessment included the effect of substance use on daily functioning within 45 days of the initial appointment. No: The assessment did not include the effect of substance use on daily functioning within 45 days of the initial appointment.
4. Include the effect of substance use on interpersonal relationships?	Yes: The assessment addressed the intensity/frequency of substance use within 45 days of the initial appointment. No: The assessment did not address the intensity/frequency of substance use within 45 days of the initial appointment.
5. Was a risk assessment completed?	Yes: The assessment included a completed risk assessment. The risk assessment may be part of the behavioral health assessment or exist on separate RBHA- or provider-specific forms. The risk assessment must be completed within the first 45 days of the initial appointment. No: The assessment or file did not include a completed risk assessment or the risk assessment was not completed within 45 days of the initial appointment.

Indicator	Instructions
6. Document screening for tuberculosis (TB)?	Yes: The assessment included documentation of screening for TB. Acceptable documentation includes information on testing, education, referrals for screening and services, follow-up counseling addressing identified services, or an evaluation of history, risk factors, and/or screening tools. The screening must be completed within the first 45 days of the initial appointment. No: The assessment did not include documentation for screening of TB or the documentation was not completed within 45 days of the initial appointment.
7. Document screening for Hepatitis C, HIV and other infectious diseases?	Yes: The assessment included documentation of screening for Hepatitis C, HIV, and other infectious diseases. Acceptable documentation includes information on testing, education, referrals for screening and services, follow-up counseling addressing identified services, an evaluation of history, risk factors, and/or screening tools. No: The assessment did not include documentation of screening for Hepatitis C, HIV, and other infectious diseases.
8. Document screening for emotional and/or physical abuse/trauma issues?	Yes: The assessment documented screening for emotional and/or physical abuse/trauma issues within 45 days of the initial appointment. No: The assessment did not document screening for emotional and/or physical abuse/trauma issues within 45 days of the initial appointment.
9. Document that review of the Prescription Drug Monitoring Program (PDMP) was completed?	Yes: The assessment documented that a review of the PDMP was completed for those clients receiving MAT or other medication services. No: The assessment did not document that a review of the PDMP was completed for those clients receiving MAT or other medication services. N/A: The client was not receiving MAT or other medications as part of SUD treatment services.
B. Was there documentation that charitable choice requirements were followed, if applicable?	Yes: The assessment documented within 45 days of the initial appointment that charitable choice requirements were followed and applicable. No: The assessment did not include documentation that charitable choice requirements were followed when applicable or were not followed within 45 days of the initial appointment. N/A: Charitable choice requirements were not applicable for the provider.
C. Was an Individual Service Plan (ISP) completed within 90 days of the initial appointment?	Yes: An ISP was completed within 90 days of the initial appointment and in the file. Note: an interim ISP is not acceptable documentation for this measure. No: An ISP was not completed within 90 days of the initial appointment or was not contained in the file. N/A: No ISP was completed and the case was closed within 90 days of the initial appointment.

Indicator	Instructions
Was the ISP:	Measures below apply only if there is an ISP completed within 90 days of the initial appointment.
1. Developed with participation of the family/support network?	Yes: There is documentation that the ISP was developed with active input of the client's family/support network. Documentation may include verbal or written efforts to solicit their input. No: There is no documentation that staff tried to seek input from the client's family/support network. N/A: There is no family/support network and/or the client chose not to engage others in the process.
2. Congruent with the diagnosis(es) and presenting concern(s)?	Yes: The scope, intensity, and duration of services offered are congruent with the diagnosis(es). No: The scope, intensity, and duration of services offered are not congruent with the diagnosis(es).
3. Measurable objectives and timeframes to address the identified needs?	Yes: The objectives and timeframes on the ISP are measurable and address the identified needs. No: The objectives and timeframes on the ISP are not measurable and do not address the identified needs.
4. Addressing the unique cultural preferences of the individual?	Yes: The ISP addresses one or more unique cultural preferences of the individual including language, customs, traditions, family, age, gender identity, ethnicity, race, sexual orientation, and socioeconomic class. No: The ISP does not address any cultural preferences of the individual.
5. Were social determinants of health issues considered as part of, and incorporated into, the ISP?	Yes: The ISP addresses one or more social determinants of health issues (e.g., housing, employment, health, etc.). No: The ISP does not address social determinants of health issues.
II. Placement Criteria/Assessment	
A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?	Yes: An ASAM tool was completed to determine the level of care at intake. A provider-created tool is acceptable. No: No ASAM tool or evidence of an ASAM tool was completed at intake or found in the file.

Indicator	Instructions
1. If the ASAM Patient Placement Criteria were used, the level of service identified was:	If an ASAM tool was completed at intake, choose the level of service identified by the tool. At least one level must be chosen. Level 0.5: Early Intervention OMT: Opioid Maintenance Therapy Level I: Outpatient Treatment Level II: Intensive Outpatient Treatment/Partial Hospitalization Level III: Residential/Inpatient Treatment Level IV: Medically Managed Intensive Inpatient Treatment
B. Did the member receive the level of services identified by the placement criteria/ assessment?	Yes: An ASAM tool was completed at intake and the member received the level of services identified by the placement criteria/assessment. No: An ASAM tool was completed at intake but the member did not receive the level of services identified by the placement criteria/assessment.
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	Yes: An ASAM tool was updated and the dimensions reassessed after intake and during the course of treatment. The tool results (level of care) may remain the same as long as it has been reassessed. No: An ASAM tool was not updated after intake/during the course of treatment.
D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	Yes: One or more non-ASAM multi-dimensional placement criteria were used after intake and during treatment. No: No other assessment tool was used after intake/during the course of treatment.
If yes, please list in box below:	List the name(s) of the other assessment tool(s) used during the course of treatment.
III. Best Practices	
A. Were evidence-based practices used in treatment?	Yes: Documentation exists that evidence-based practices were incorporated into treatment. No: No documentation exists that evidence-based practices were used in treatment. No documentation: There is indication that evidence-based practices were used in treatment but not enough documentation available to confirm. For example, the specific treatment intervention was not mentioned in progress notes.

Indicator	Instructions
1. The following evidence-based practices were used in treatment:	Select which evidence-based practice were used in treatment. Choose all that apply. Adolescent Community Reinforcement Approach (ACRA) Beyond Trauma: A Healing Journey for Women Cognitive Behavioral Therapy (CBT) Contingency management Dialectal Behavioral Therapy (DBT) Helping Women Recover Matrix Moral Re-conation Therapy (MRT) Motivational Enhancement/Interviewing Therapy (MET/MI) Relapse Prevention Therapy (RPT) Seeking Safety SMART Recovery Thinking for a Change Trauma Recovery and Empowerment Model (TREM) Trauma-Informed Care (TIC) Wellness Recovery Action Plan (WRAP)
Other Practices or Programs (please list in box below):	Yes: An evidence-based practice not listed in the above question was incorporated into treatment. No: No other evidence-based practice other than those listed above were incorporated into treatment.
Listed other practices/programs	List the name(s) of the other evidence-based practice(s) indicated in the question above.
B. Medication Assisted Treatment (MAT)	Yes: For individuals undergoing substance abuse treatment, documentation exists that MAT was incorporated into treatment. No: No documentation exists that MAT was incorporated into treatment.
1. The following medication was used in treatment:	If MAT was used in treatment, select which alcohol-related medication(s) were used in treatment. Choose all that apply. Acamprosate (Campral) Disulfiram (Antabuse)
	If MAT was used in treatment, select which opioid-related medication(s) were used in treatment. Choose all that apply. Subutex (buprenorphine) Methadone/Levo-Alpha-Acetylmethadol (LAAM) Narcan (naloxone) Vivitrol (long-acting naltrexone) Suboxone (buprenorphine-naloxone)
C. Was screening for substance use/abuse conducted during the course of treatment?	Yes: Documentation exists that screening for substance use/abuse occurred during the course of treatment. No: No documentation exists that screening for substance use/abuse occurred during the course of treatment.

Indicator		Instructions	
D.	Was certified peer support offered as part of treatment?	Yes:	Documentation exists that certified peer support (e.g., coaches, peer specialists) was offered as part of treatment. Evidence of certification is not required but the peer support offered should be more formal and less of a social support group.
		No:	No documentation exists that certified peer support (e.g., coaches, peer specialists) was offered as part of treatment.
		N/A:	Peer support was offered to the client and the client declined.
	If yes to above, were certified peer support services used as a part of treatment?	Yes:	Certified peer support services were offered and were accepted and used.
		No:	Certified peer support services were offered and accepted, but not used.
IV. Treatment/Support Services/Rehabilitation Services			
A.	The following services were used in treatment:	Select which service(s) were used in treatment. Choose all that apply. Individual counseling/therapy Group counseling/therapy Family counseling/therapy Case management	
B.	Was there clear documentation of progress or lack of progress toward the identified ISP goals?	Yes:	Documentation of progress or lack of progress toward the identified ISP goals exists in the record.
		No:	No documentation exists that screening for substance use/abuse occurred during the course of treatment.
		N/A:	No ISP exists or services provided are recent but no change in progress is indicated.
C.	The number of completed counseling/therapy sessions during treatment was:	Select the number of completed counseling/therapy sessions during treatment. Choose one response only. 0–5 sessions 6–10 sessions 11 sessions or more	
D.	Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:	Select the number of instances the client reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.). Choose No Documentation when the client was referred to a group but did not attend. 0 times during treatment 1–4 times during treatment 5–12 times during treatment 13–20 times during treatment 21 or more times during treatment	

Indicator		Instructions	
E.	If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation in order to facilitate positive outcomes?	Yes:	The chart showed documentation of lack of progress towards the identified goal and evidence that the provider revised the treatment approach and/or sought consultation in order to enact symptomatic improvement.
		No:	The chart showed documentation of lack of progress towards the identified goal but no evidence that the provider revised the treatment approach and/or sought consultation in order to enact symptomatic improvement.
		N/A:	Documentation of symptomatic improvement exists in the file.
F.	If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?	Yes:	The client was unemployed at intake and the chart showed documentation of employment opportunity discussion(s).
		No:	The client was unemployed at intake and the chart did not show documentation of employment opportunity discussions(s).
		N/A:	The client was employed at intake or unemployed but an employment discussion was irrelevant (i.e. client participates in a vocational program or is retired).
G.	If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?	Yes:	The client was not involved in an educational or vocational training program at intake but involvement in such a program was explored.
		No:	The client was not involved in an educational or vocational training program at intake and the chart did not show documentation of such a discussions.
		N/A:	The client was involved in an educational or vocational training program at intake or not involved but a discussion was irrelevant (i.e. client is employed).
H.	If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?	Yes:	The client was not involved in a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation) at intake but involvement in such a program was explored.
		No:	The client was not involved in a meaningful community activity at intake and involvement in such a program was not discussed with the client.
		N/A:	The client was involved in a community activity at intake or not involved but a discussion was irrelevant (i.e. client is employed).
I.	Does the documentation reflect that substance abuse services were provided?	Yes:	Documentation exists that substance abuse services were provided.
		No:	No documentation exists of the provision of substance abuse services.
J.	Was member's access to a primary care physician (PCP) or other medical provider explored?	Yes:	A discussion about the client's access to a PCP or other medical provider(s) was documented.
		No:	No documentation exists about whether the client's access to a PCP or other medical provider(s) was discussed.
V. Gender Specific (female only)			

Indicator	Instructions
A. If there was a history of domestic violence, was there evidence that a safety plan was completed?	Yes: Client is female, a history of domestic violence exists, and documentation of a safety plan is contained in the file. No: Client is female, a history of domestic violence exists, but no documentation of a safety plan is contained in the file. N/A: Client is female but a history of domestic violence does not exist.
B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	Yes: Client is a pregnant female and documentation exists showing efforts at coordination with the client's PCP and/or obstetrician. No: Client is a pregnant female and documentation does not exist showing coordination with the client's PCP and/or obstetrician. N/A: Client is female but not pregnant.
C. If the female was pregnant; did documentation show evidence of education on the effects of substance use on fetal development?	Yes: Client is a pregnant female and documentation exists showing client was educated on the effects of substance use on fetal development. No: Client is a pregnant female and documentation does not exist showing client was educated on the effects of substance use on fetal development. N/A: Client is female but not pregnant.
D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?	Yes: Client is a female with a child less than one year of age and documentation exists showing a screening was completed for postpartum depression/psychosis. No: Client is a female with a child less than one year of age and no documentation exists showing a screening was completed for postpartum depression/psychosis. N/A: Client is female but does not have a child less than one year of age.
E. If the female had dependent children, was there documentation to show that childcare was addressed?	Yes: Client is a female with dependent children and documentation exists showing that childcare was addressed. No: Client is a female with dependent children but no documentation exists showing that childcare was addressed. N/A: Client is female with no dependent children.
F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	Yes: Client is a female and documentation exists showing female-specific treatment services were offered and/or provided (i.e. women's-only group therapy sessions, female peer support). No: Client is a female but no documentation exists showing female-specific treatment services were offered and/or provided. N/A: Client is female and turned down female-specific services.
VI. Opioid Specific	
A. Was there documentation of a diagnosed Opioid Use Disorder (OUD)?	Yes: Documentation exists showing client had an OUD diagnosis. No: No documentation exists showing an OUD diagnosis.

Indicator		Instructions	
B.	Was there documentation that the member was provided MAT education as a treatment option?	Yes:	Client has a documented OUD diagnosis and documentation exists showing client was offered MAT education.
		No:	Client has a documented OUD diagnosis but no documentation exists showing client was offered MAT education.
C.	If yes to VI B, were they referred to a MAT provider?	Yes:	Client has a documented OUD diagnosis and documentation exists showing client was offered MAT and referred to a MAT provider.
		No:	Client has a documented OUD diagnosis and documentation exists showing client was offered MAT but was not referred to a MAT provider.
		N/A:	Client has a documented OUD diagnosis and documentation exists showing client was not offered MAT.
D.	If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	Yes	Client has a documented OUD diagnosis and documentation exists showing client had withdrawal symptoms that were addressed by referral and/or intervention by a medical provider.
		No:	Client has a documented OUD diagnosis but no documentation exists showing client's withdrawal symptoms were addressed by referral and/or intervention by a medical provider.
		N/A:	Client has a documented OUD diagnosis but no withdrawal symptoms.
E.	If a physical health concern related to pain was identified, were alternative pain management options addressed?	Yes:	Client has a documented OUD diagnosis and documentation exists showing client received alternative pain management options for an identified physical health concern related to pain.
		No:	Client has a documented OUD diagnosis and documentation exists showing client had an identified physical health concern related to pain but did not receive alternative pain management options.
		N/A:	Client has a documented OUD diagnosis but no pain-related physical health concerns.
F.	If member is a pregnant female; did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?	Yes:	Client is a pregnant female with a documented OUD diagnosis and documentation exists showing client received education about the safety of methadone and/or buprenorphine during the course of pregnancy.
		No:	Client is a pregnant female with a documented OUD diagnosis but no documentation exists showing client received education about the safety of methadone and/or buprenorphine during the course of pregnancy.
		N/A:	Client has a documented OUD diagnosis but is not a pregnant female.

Indicator		Instructions	
G.	Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?	Yes:	Client has a documented OUD diagnosis and documentation exists showing client received relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose.
		No:	Client has a documented OUD diagnosis but no documentation exists showing client received relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose.
H.	Was there documentation that the member was provided education on the effects of polysubstance use with opioids?	Yes:	Client has a documented OUD diagnosis and documentation exists showing client received information on the effects of polysubstance use with opioids.
		No:	Client has a documented OUD diagnosis but no documentation exists showing client received information on the effects of polysubstance use with opioids.
VII. Discharge and Continuing Care Planning			
A.	Was there documentation present that a relapse prevention plan completed?	Yes:	Client completed treatment or declined further services and documentation of a completed relapse prevention plan exists.
		No:	Client completed treatment or declined further services but no documentation of a completed relapse prevention plan exists.
B.	Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g. crisis line)?	Yes:	Client completed treatment or declined further services and documentation exists that staff offered at least one resource pertaining to community supports, including recovery self-help, and/or other individualized support services (e.g. crisis line).
		No:	Client completed treatment or declined further services but no documentation exists that staff offered at least one resource pertaining to community supports, including recovery self-help, and/or other individualized support services (e.g. crisis line).
C.	Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?	Yes:	Client completed treatment or declined further services and documentation exists that staff actively coordinated with other involved agencies at the time of discharge.
		No:	Client completed treatment or declined further services but no documentation exists that staff actively coordinated with other involved agencies at the time of discharge.
		N/A:	Client completed treatment or declined further services and there were no other involved agencies at the time of discharge.
VIII. Re-engagement			

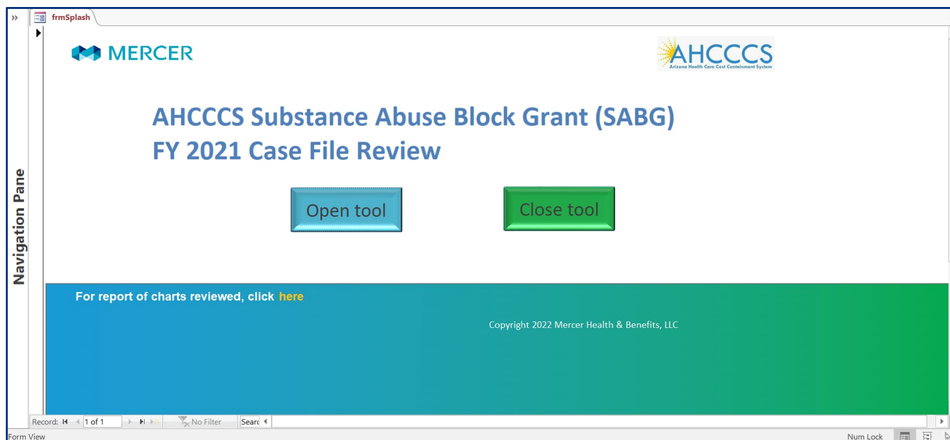
Indicator	Instructions
A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?	Yes: Client declined further services or chose not to appear for scheduled services and documentation exists that the client (or legal guardian) was contacted by telephone at times when the client was expected to be available (e.g., after work or school). No: Client declined further services or chose not to appear for scheduled services but was not contacted by telephone at times when the client was expected to be available (e.g., after work or school).
B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	Yes: Client declined further services or chose not to appear for scheduled services and documentation exists that telephone contact was unsuccessful but a letter was mailed requesting contact. No: Client declined further services or chose not to appear for scheduled services and documentation exists that although telephone contact was unsuccessful, no letter was mailed requesting contact. N/A: Client declined further services or chose not to appear for scheduled services and documentation exists that client was contacted successfully through means other than a telephone call or letter.
C. Were other attempts made to re-engage the individual, such as:	Yes: Client declined further services or chose not to appear for scheduled services and documentation exists that the following attempts at re-engaging were made. Select all that apply. - Home visit - Call emergency contact(s) - Contacting other involved agencies - Street Outreach - Other N/A: Other means of re-engagement not listed above were successful or not applicable to the client.
Other, please list other identified outreach efforts in the box below	List other identified outreach efforts.
IX. National Outcome Measures (NOMs)	
A. Status at Intake	Yes: For each NOM, client's status at intake. - Employed? - Enrolled in school or vocational educational program? - Lived in a stable housing environment (e.g., not homeless)? - Arrested in the preceding 30 days? - Abstinent from drugs and/or alcohol? - Participated in social support recovery in the preceding 30 days? Missing: No documentation of the NOM at intake

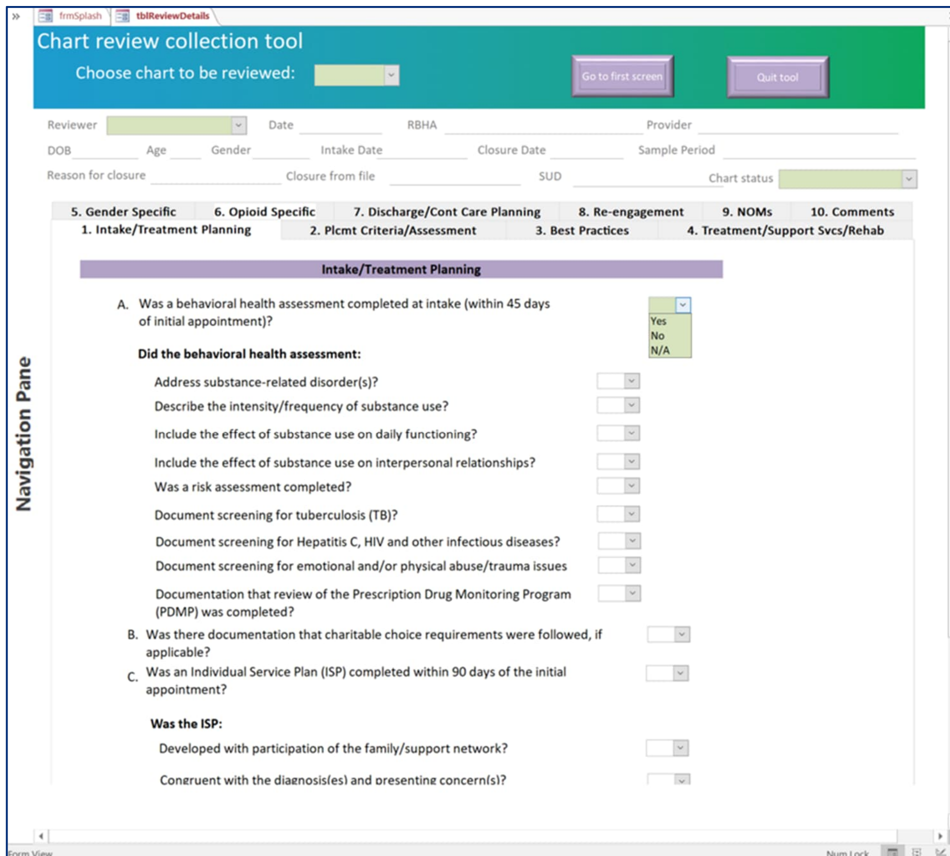
Indicator	Instructions
B. Status at Discharge	Yes: For each NOM, client's status at discharge. - Employed? - Enrolled in school or vocational educational program? - Lived in a stable housing environment (e.g., not homeless)? - Arrested in the preceding 30 days? - Abstinent from drugs and/or alcohol? - Participated in social support recovery in the preceding 30 days? Missing: No documentation of the NOM at discharge.

Appendix C

Case File Electronic Review Tool

Reviewers used an Access review tool pre-populated with relevant chart data. Below are sample screen shots of the tool.





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