Mercer

Government Human Services Consulting

Independent Case File Review Findings

State Fiscal Year 2024

Substance Use Block Grant

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

August 1, 2025

Contents

Section 1

Executive Summary

The State of Arizona (Arizona or State), Arizona Health Care Cost Containment System (AHCCCS), engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop and implement an independent peer review for members who received substance use treatment services through federal Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) funds between July 1, 2023, and June 30, 2024. To ensure compliance with 45 CFR § 96.136, Mercer uses an independent case review (ICR) process. Mercer completed ICRs for the State in state fiscal year (SFY) 2020, SFY 2021, SFY 2022, and SFY 2023 for AHCCCS, with this report representing the fifth year, allowing identification of year-over-year trends in continuous improvement of services.

Building upon the last two years of seeking member and provider feedback, this current ICR process included a qualitative data collection component using focus groups. Focus groups were conducted with providers and members. Previous years included a focus group with AHCCCS Complete Care Contractors with Regional Behavioral Health Agreements (ACC-RBHAs). This year, an additional member focus group was added, as AHCCCS has more continuous direct interaction with the ACC-RBHAs throughout the year. Findings from the ICRs helped frame a guided interview format to use with focus group participants, creating a collaborative environment to help enhance program application and practice. As with the quantitative data, any trends from the focus groups are noted below and in Appendix D.

The core dimensions and elements of the ICR tool have remained substantively the same for SFY 2020–SFY 2023, predating the involvement of Mercer. Mercer worked with AHCCCS to refine the tool from year to year, to review the data elements collected, ensuring they are still relevant. Annually, Mercer performed interrater reliability testing to measure the degree of consistency among the review team's findings. In calendar year 2024, AHCCCS decided to incorporate formal validation activities that include face, construct, and content validity of the review tool. The purpose of this validation is to evaluate the degree to which the survey measures what it intends to measure. The results of the validation have been provided to AHCCCS in a separate report. Changes to the tool were not incorporated into the SFY 2023 ICR but were incorporated into this year's tool.

The purpose of the annual review is to examine the compliance of participating Medicaid-enrolled agencies serving persons who received substance use services through the Block Grant against treatment standards, including quality, appropriateness, and efficacy

of treatment services, as documented in the member records. The ICR also provides a process to continuously improve the treatment services provided to members diagnosed with substance use disorder within the state (see 45 CFR § 96.136 for ICR requirements) to improve member outcomes and recovery.

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

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

In addition to the statutorily required treatment, Mercer also examined aspects of the treatment records related to assessment and addressing social determinants of health, evidence-based treatment practices, peer support services, gender-specific services for women[1], and opioid-specific services.

The State provided a universe of 259 records for the ICR. Of those 259 records, 56 were deemed unusable due to reasons such as the record not being complete, the member not returning after their initial assessment, or the treatment episode being for a service other than substance use such as anger management. Additionally, three records were determined to be an oversample, leading Mercer to analyze the data from a total of 200 usable records for the ICR. The files included in this review sample represented 63% of the provider

[1] Gender-specific services for women included female and female-identified individuals.

agencies in Arizona who receive SUBG funds, which exceeds the minimum statutory requirement of 5% for this review.

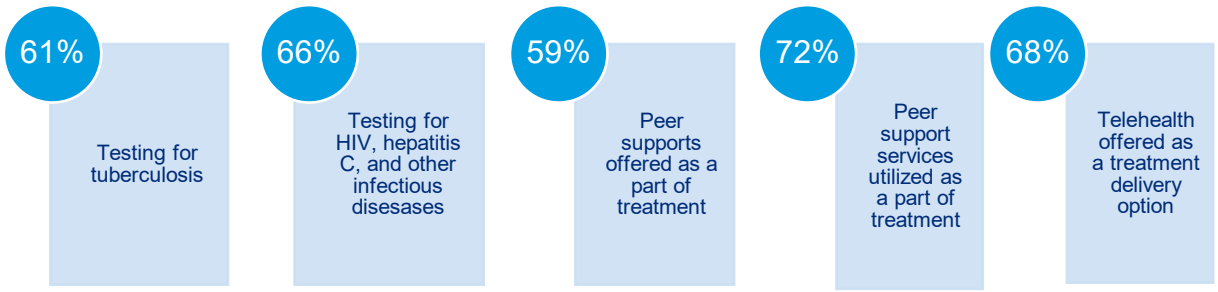
Overview of Key Findings

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

- Arizona Complete Health (Southern Arizona)
- Care1st (Northern Arizona)
- Mercy Care (Central Arizona)

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

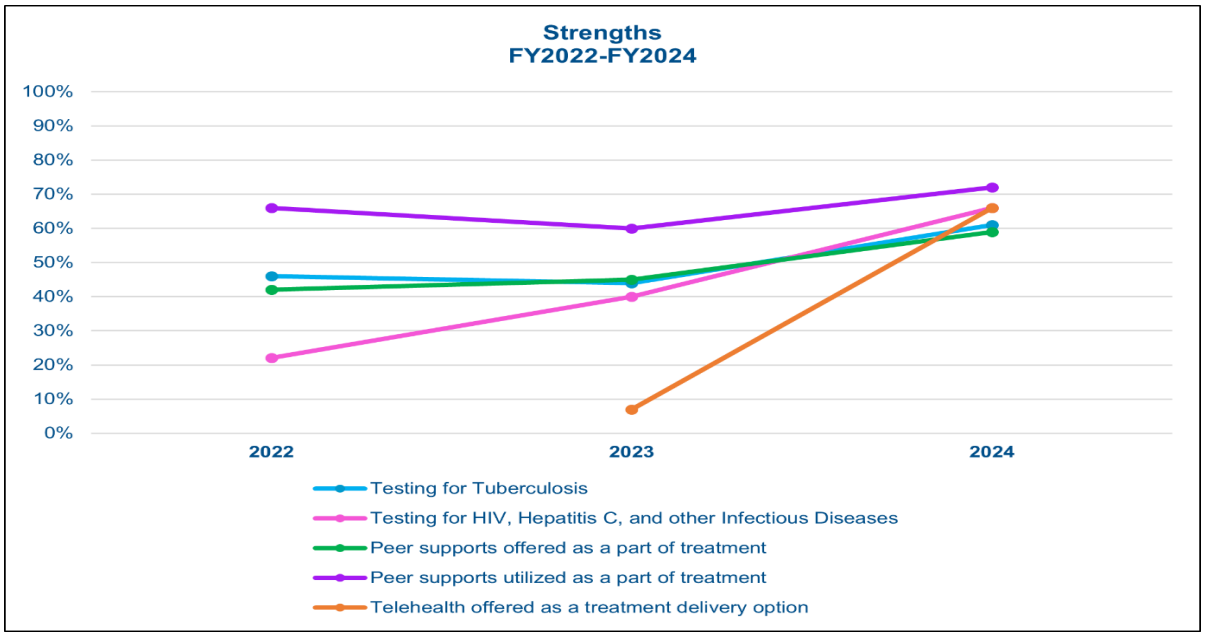
Strengths



In the review of the SFY 2024 statewide aggregate data, there were several areas of strength identified that have demonstrated improvement each year over the periods of SFY 2022, SFY 2023, and SFY 2024 (reflected in Graph 1 below). Of note, there was an increase in cases in which there was documentation of testing for tuberculosis, which occurred in 61% of cases in SFY 2024, a significant increase from SFY 2023 and SFY 2022, which were 44% and 46%, respectively. Documentation of testing for human

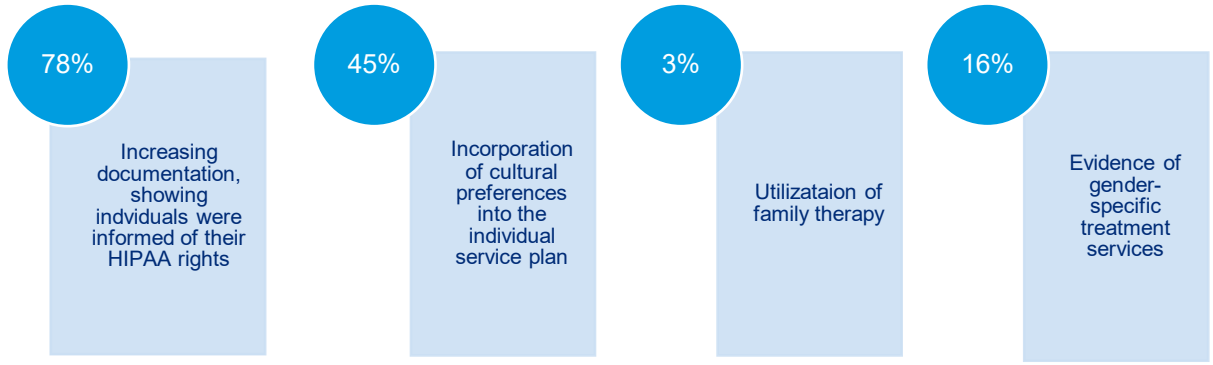
immunodeficiency virus, hepatitis C, and other infectious diseases also showed improvement, as results increased from 40% in SFY 2023 to 66% in SFY 2024. This is also an improvement over SFY 2022, which was 22%. Two other areas of improvement were the use of peer support services and the availability of telehealth. Peer support services were offered in 59% of cases in SFY 2024, an increase from 45% in SFY 2023 and 42% in SFY 2022. Peer support services were also utilized more often when offered in 72% of cases in SFY 2024, as compared with 60% of cases in SFY 2023 and 66% of cases in SFY 2022. Telehealth was offered as an option in 68% of cases, an increase of 7% over last year.[2]

Graph 1: Year-Over-Year Aggregate Strengths



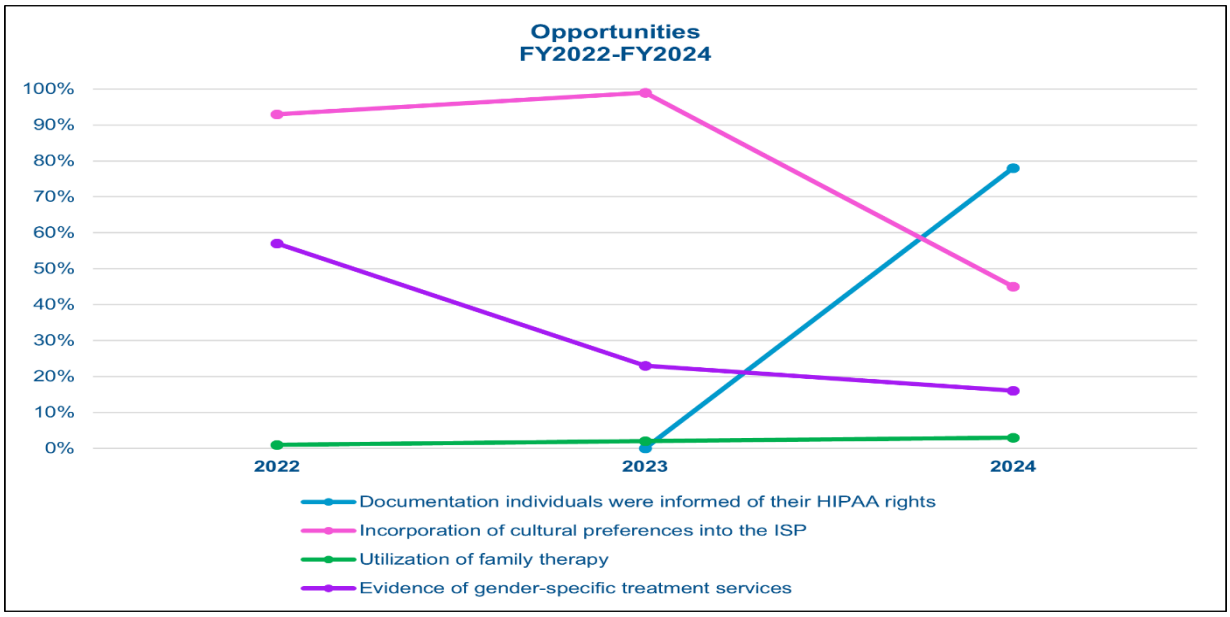
[2]SFY 2023 was the first year this information was collected.

Opportunities



Opportunities identified (see Graph 2 below) because of the 2024 ICR potentially include increasing documentation that the member was informed of their Health Insurance Portability & Accountability Act (HIPAA) rights. This is the first year this information has been collected, but the result of 78% suggests an area for opportunity. Additionally, the number of individual service plans incorporating the cultural preferences of the member dropped significantly in SFY 2024 to 45%. The results for this measure were 99% in SFY 2023 and 93% in SFY 2022, indicating a significant decline. Utilization of family therapy is another area of opportunity. Although utilization has increased from 1% in SFY 2022 to 2% in SFY 2023, and 3% in SFY 2024, the low overall utilization presents an area for potential growth, as positive family and community systems help with recovery and stability. Additionally, gender-specific services for women are an area of opportunity, as this finding has steadily declined from 57% in SFY 2022, to 23% in SFY 2023, and 16% in SFY 2024.

Graph 2: Year-Over-Year Aggregate Opportunities



Recommendations

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

Education and technical assistance for providers would assist in ensuring all regulatory requirements are met, including documentation of informed consent, HIPAA notification, and charitable choice. Other areas of potential training and technical assistance could be additional training on the use of American Society of Addiction Medicines (ASAM) criteria in determining level of care, as this year's ICR found a 4% decline in this area, down to 79% from 83% in the previous two years.

An additional recommendation continues to be on specific population and evidence-based practices. In general, as noted above, there was a decline in incorporating cultural preferences into treatment planning. Gender-based services would benefit from a focus on increased evidence-based practices, such as trauma-informed care, and assessment for co-occurring conditions such as eating disorders.[3]

AHCCCS currently utilizes the ASAM 3rd Edition criteria in treatment and in determining level of care. ASAM 4th Edition criteria were recently released, and both sets of criteria are

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

currently acceptable. AHCCCS should consider a timeframe and process, including provider and staff training, for transition to the updated ASAM 4th Edition criteria. The ASAM 4th Edition criteria also emphasize co-occurring mental health conditions, and a focus on this population will align Arizona with best practices in the substance use treatment field.

A final area of recommendation focuses on reengagement efforts for members who have left treatment before completion. There was a decline, from 97% in the previous year to 60% in the current ICR review, of outreach phone calls to members not attending treatment. There were a few instances of utilizing texts and emails to attempt to reengage members due to the member's preference, showing some evidence of person-centered outreach but, in general, efforts in outreach have declined.

Section 2

Background and Introduction

Arizona Health Care Cost Containment System (AHCCCS) serves as the single State authority to provide coordination, planning, administration, regulation, and monitoring of all facets of the State public behavioral health (BH) system. AHCCCS contracts with managed care organizations, known as AHCCCS Complete Care (ACC) plans to administer the Medicaid and Kids Care (Title XIX/XXI) programs. Three of the ACC plans are plans with Regional Behavioral Health Authorities (RBHAs), known as ACC-RBHAs, which administer Non-Title XIX/XXI BH programs, including the Substance Use Block Grant (SUBG). The current ACC-RBHAs are Arizona Complete Health (AzCH) in Southern Arizona, Care1st in Northern Arizona, and Mercy Care (MC) in Central Arizona.

Consistent with the requirements of 45 CFR § 96.136, AHCCCS contracted with Mercer as the independent peer review contractor to perform the annual SUBG independent case review (ICR) for state fiscal year (SFY) 2024. Mercer also completed the independent review of the four previous years (SFY 2020, SFY 2021, SFY 2022, and SFY 2023). Mercer does not have any reviewers employed as treatment providers or who have administrative oversight for any programs under review. Further, Mercer's peer review personnel performed this review independently (i.e., separately) from SUBG funding decision makers. The Substance Abuse and Mental Health Services Administration (SAMHSA) awarded the SUBG to AHCCCS each year since the current program was established in 1993. The block grant requires AHCCCS to produce, on an annual basis, an independent peer review of the treatment services provided with SUBG funds.

Goals of the Independent Case Review

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

For the current year, SFY 2024, AHCCCS program goals for the SUBG include:[4]

- Identify and address known health disparities related to SUD, and ensure access to a comprehensive system of care, including employment, housing services, case management, rehabilitation, dental services, and health services as well as SUD services and supports
- Improve direct service provision among SUD treatment providers, including use of standardized treatment planning and placement such as ASAM 3rd Edition criteria, screening for infectious diseases (including tuberculosis and human immunodeficiency virus [HIV]), and increasing the use of scientifically based outreach strategies and low-barrier programming to engage and reengage members, especially those who disengage early from treatment.
- Improve access to SUD treatment services, particularly for underserved and high-risk populations, increasing the access of digital therapeutics in treatment such as telehealth.
- Improve gender-specific services, including services for pregnant and parenting women, addressing healthy relationships, sexual and physical abuse, reproductive wellness, and other culturally responsive treatment services.
- Increase the capacity of the service-delivery system to meet the evolving needs of members served such as increasing the access to outpatient clinics by expanding the hours of operation to evenings and weekends.
- Expand and enhance a range of recovery support services to include access and engagement with peer support services.

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

[4] FY2024_2025_BlockGrantApplication.pdf

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

- Intake and treatment planning, to include identification of Social Determinants of Health (SDoH)[5] needs
- Placement criteria and assessment
- Best practices
- Treatment, support services, and rehabilitation services
- Gender-specific treatment services for women
- Opioid-specific treatment services
- Discharge and continuing care planning (only for successful treatment completions or decline of further services)
- Reengagement (only for members who declined further services or chose not to appear for services)
- National Outcome Measures (NOMs) at intake and discharge

Content of Records Reviewed

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

- Demographic information
- Initial assessment
- Risk assessment and safety plan
- Crisis plan
- Individual service plan (ISP)
- ASAM patient placement criteria (initial and ongoing)

[5] Updated terminology for next year's ICR should reflect current federal language, such as social drivers of health or health-related social needs. Social Drivers of Health and Health-Related Social Needs | CMS

- Medication record
- Medical screenings
- Results of diagnostic testing, including illicit substance use testing
- Progress notes (e.g., therapy [individual and group], case management, etc.)
- Medication-assisted treatment (MAT) documentation
- Evidence of outreach, engagement, and reengagement efforts
- Discharge or termination of treatment summary

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

Section 3
Methodology

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

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

Sampling

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

- Substance use members with a substance use treatment service and an episode of care (EOC) funded by the SUBG during SFY 2024: July 1, 2023, through June 30, 2024
- Disenrolled/EOC end date before or on June 30, 2024
- At least 18 years of age during the treatment episode
- Disenrolled due to completing treatment, declining further service, or lack of contact
- Must have received substance use treatment and counseling during the treatment period. Treatment was defined by identifying members having at least one paid claim for a substance use service during SFY 2024 for any ASAM 3rd Edition level of care (LOC)
- Must have been enrolled in a treatment center for at least 30 days
- Must not be enrolled in a Tribal Regional Behavioral Health Authority
- The sampling methodology used by AHCCCS excluded members who:
  - Did not have any service encounters during the treatment episode

- Only had a crisis encounter 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 a member private provider

Based on these inclusion and exclusion criteria, AHCCCS supplied 259 treatment records for the ICR. Mercer randomly selected 200 files to be used in the initial review, with the remainder being held as an oversample. Fifty-six files were determined to be unusable for review purposes (e.g., an exclusion criterion was found in the file or the treatment dates were out of range) and were replaced from the oversample.

File Tool Review

The Mercer team used the tool validated during the SFY 2023 review for development of the SFY 2024 ICR tool. The validation approach employed activities to evaluate the tool, including content and face validity. Content validity concerns the adequacy of a tool or survey content being measured, how questions represent the topic under consideration, and what the questions aim to measure. Face validity addresses the suitability of the tool or instrument content used. Mercer used the Delphi Method to determine face and content validity and engaged subject matter specialists in the area of substance use, who have not been involved in the Arizona SUBG Independent Case Review process, to conduct a content and face validity review.

As a result of the validation activities, the following updates were made to the previous tool.

- The “Behavioral Health Assessment” referenced in the previous tool of sub-items appeared to indicate a more comprehensive psychosocial and medical assessment, rather than just a “Behavioral Health Assessment.” Additionally, the question included two aspects: the assessment's importance and the importance of completing the assessment within 45 days, noting that both the completion of the assessment and its timeliness should be captured. A third discovery regarding the item was that, in its current form, it did not appear to contribute to the identification of SDoH, which needs to be addressed in the individual treatment plan.

  The tool was updated to split the behavioral health assessment into two questions, one to determine whether the assessment was completed and a second to determine whether it was completed within 45 days. Additionally, SDoH items were added to the

assessment section to reflect areas of SDoH need scored in previous years as a part of the ISP. A link to a definition of an assessment was also included.

- Importance of charitable choice requirements: The specialist panelists identified this as a regulatory component and not an item reviewing program effectiveness regarding program completion rate, abstinence post-discharge, and addressing SDoH.

  A regulatory section was, therefore, added under the "Intake/Treatment Planning" domain. Two other items were also added to the regulatory section: documentation of whether members were provided with information about HIPAA rights and whether members were provided with information on informed consent.

- Similar to the behavioral health assessment question, ISP completion included two aspects: the importance of the ISP and the importance of completion of the ISP within 90 days.

  The tool was updated to split the ISP into two questions: one to determine whether the ISP was completed and a second to determine whether it was completed within 90 days.

- Certified peer support offered as part of treatment: This item raised questions related to the term "certified." The question includes two aspects: the importance of offering peer support and the importance of offering "certified" peer support.

- The tool was updated to split up the question to determine whether peer support in any form was provided and, if so, whether the peer support provided is from a "certified" peer support specialist.

The e-version of the tool, which was developed in Microsoft Access, allowed the review team to record review results in a format more conducive to analyzing the data and producing year-over-year trending, with useful tables to present areas that were not updated as a part of validation.

Medication-Assisted Treatment

In addition to updates to validate the tool, AHCCCS requested that Mercer also review the current best practices in MAT. Previous independent case reviews included the following medications:

- Alcohol use disorder:
  - Acamprosate (Campral)
  - Disulfiram (Antabuse)

- Opioid use disorder:
  - Subutex (buprenorphine)
  - Methadone/Levo-Alpha-Acetylmethadol (LAAM)
  - Narcan (naloxone)
  - Vivitrol (long-acting naltrexone)
  - Suboxone (buprenorphine-naloxone)
- Nicotine replacement therapy – reviewed, in general, as an informational measure

Medications for Alcohol Use Disorder[6]

According to the 2023 National Survey on Drug Use and Health (NSDUH), only 1.9% of the 28.9 million people aged 12 years and older, with an alcohol use disorder in the past year, received MAT for their alcohol use. Evidence-based treatment and supports for alcohol use disorder may include US Food and Drug Administration-approved medications, although they are not as commonly used as those for opioid use disorder (OUD). A common barrier to medication for alcohol use disorder utilization includes lack of education for providers and beneficiaries on MAT for alcohol use disorder.[7] In addition to the medications previously reviewed, the tool was updated to reflect all evidence-based medications available for the treatment of alcohol use disorder:

- Acamprosate calcium (Campral): Maintenance of abstinence from alcohol in patients dependent on alcohol, who are abstinent at treatment initiation
- Disulfiram (Antabuse): Management of selected patients who want to remain in a state of enforced sobriety so that supportive and psychotherapeutic treatment may be applied to best advantage
- Oral naltrexone (Vivitrol®, Revia) (naltrexone hydrochloride tablet): Treatment of alcohol dependence
- Extended-release injectable naltrexone: Treatment of alcohol dependence in patients who have been able to abstain from alcohol in an outpatient setting

[6] Medication for the Treatment of Alcohol Use Disorder: A Brief Guide | SAMHSA Publications and Digital Products

[7] SAMHSA. (2024). Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-021, NSDUH Series H-59). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration

Medications for Opioid Use Disorder[8]

- The 2023 NSDUH report found that of the 5.7 million people aged 12 years or older with a past year OUD, 18% (1.0 million people) received MAT in the past year for their opioid use. MAT continues to be an evidence-based treatment option used in addressing OUD.[9] The tool has been updated to reflect current best practice medication options.
- Buprenorphine (Brixadi®, Sublocade®): Continuous release of the medicine buprenorphine all month, at sustained levels, for moderate to severe opioid addiction (dependence) to opioid drugs (prescription or illegal).
- Buprenorphine and naloxone (Suboxone, Zubsolv®): Combination of buprenorphine and naloxone used to reduce withdrawal symptoms and cravings associated with stopping opioid use.
- Methadone: Long-acting opioid medication used to reduce withdrawal symptoms in people addicted to heroin or other narcotic drugs, and it can also be used as a pain reliever.
- Naltrexone (Vivitrol®, Revia): Reduces cravings and helps control physiological dependence by blocking the effects of opioid medications, preventing the euphoria and intoxication as well as helping reduce the urge or cravings to use opioids.

Medication for Smoking Cessation[10]

Tobacco use and cessation has been of interest to the funders of the SUBG, with the Tobacco Regulations for Substance Use Prevention, Treatment, and Recovery Services Block Grant; Final Rule, 61 Federal Register 1492 (PDF |259 KB) published on January 19, 1996. One of the targeted populations and service areas of the SUBG is primary prevention services. Primary prevention strategies of interest include problem identification and referral to identify members who have indulged in illegal or age-inappropriate use of tobacco or alcohol and members who have indulged in the first use of illicit drugs. Although not a main focus of the ICR, part of the review does look for whether smoking cessation and associated MAT interventions have been provided for informational purposes. Specific MAT options have been added to this year's iteration of the ICR tool.

[8] 23.04.06_CCBHC-Evidence-Based-Practice-Reference-Guide_v2.pdf

[9] SAMHSA. (2024). Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-021, NSDUH Series H-59). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration

[10] Clinical Interventions to Treat Tobacco Use and Dependence Among Adults | Smoking and Tobacco Use | CDC

- **Nicotine replacement therapy:**
  - Over-the-counter patch, gum, or lozenge
  - Prescription inhaler or nasal spray
- **Varenicline** prescription (Chantix®): Reduction of nicotine withdrawal symptoms by blocking nicotinic receptors
- **Bupropion** prescription (Wellbutrin, Aplezin®, Forfivo®, Zyban®): Dopamine and norepinephrine re-uptake inhibitor, with nicotine receptor antagonist properties

Inter-Rater Reliability

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

To ensure consistency in the use of the file review tool, the Mercer review team participated in an inter-rater reliability (IRR) training session, followed by an IRR test, prior to the initiation of the review process. The test consisted of reviewing two unique live records. Participants used the ICR tool to score the live records, consistent with the review training session provided by the senior engagement advisor, who is a licensed clinical social worker, and the ICR Tool Instructions (Appendix B).

The Mercer senior engagement advisor facilitated the IRR and recorded the answers from each individual reviewer. Any items yielding inconsistent results were discussed with each reviewer. As a result of this discussion, the team reached a consensus decision on how items would be scored. The initial review of the live records yielded an IRR average score of 95%, exceeding the 90% threshold requirements; the team reached 100% agreement following discussion and consensus building.

Throughout the evaluation, which occurred during March and April 2025, the senior engagement manager maintained frequent contact with individual reviewers, answered questions regarding the application of the ICR Tool Instructions, and ensured the consistent application of the tool's scoring methodology. Additionally, to ensure fidelity to the scoring approach, the team met biweekly during the review process for group debriefs and problem solving related to the application of the ICR Tool Instructions

Data Analysis

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

Limitations

Although IRR methodology, tool training, and reviewer coaching facilitate accurate review findings for the ICR results, individual experience, as well as discipline-specific education in substance use treatment, may still result in some irregularities in interpretation of case review contents. A validated tool was used as a part of this year's ICR process, reducing the potential for variance due to a tool that has not been determined as reliable and valid.

The data collection period of review for this project (July 1, 2023–June 30, 2024) is after the federal unwinding of the Public Health Emergency that occurred March 31, 2023, and there should no longer be any further impact from the pandemic in next year's ICR. There is no reliable way to fully account for COVID-19's multiple impacts on individual member choices (e.g., reactions to the shift to telehealth interventions, treatment efficacy of virtual SUD treatment, and the resultant treatment outcomes). Many providers have maintained a hybrid model, allowing members to receive services both in-person and virtually, which has been of benefit for SDoH concerns, such as transportation and lack of childcare, which may have prevented access to services in the past. Use of telehealth services continues to be captured in the *Best Practice* section of the tool, and digital therapeutics have been identified as a goal of AHCCCS for the SUBG.

Section 4

Aggregate Case File Review Findings

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

Sample Demographics

The State provided a universe of 259 records for the ICR. Of those 259 records, 56 were deemed unusable due to such reasons as the record not being complete, the member not returning after their initial assessment, or the treatment being for a different service such as anger management. Also, three records were determined to be an oversample, leading Mercer to analyze the data from 200 usable records for the ICR. The 56 records that were unusable represent an exceptionally high number compared to previous years and may reflect a quality concern with some of the charts, as many unusable charts were excluded due to missing information. Mercer's record review represented 26% of the AzCH records, 11% of the Care1st records, and 64% of the MC records, of the respective records provided (see Table 4-1 below).

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

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

ACC-RBHA	Universe of Records Received for ICR Review (including oversample)	Number of Usable ICR Records Reviewed	Number of ICR Records Reviewed but Unusable	Unusable ICR Records Reviewed as a Percent of Universe	ICR Sample Records Reviewed as a Percent of Universe	Percent of ICR Records Reviewed
AzCH	64	61	3	5%	95%	31%
Care1st	41	37	4	10%	90%	19%

MC	154	102	49	32%	66%	51%
Total	**259**	**200**	**56**	**22%**	**77%**	**100%**

Table 4-2 shows the gender and age distribution by ACC-RBHA. Overall, the mean age served in the sample was 38.5 years, with a median of 36.0 years. Thirty three percent of the sample identified as female, 68% male, and no members (0%) identified as "Other." The youngest age represented in the total sample was 19 years of age. The age of the oldest represented was 76 years.

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

ACC-RBHA	Sample Cases	Percent of Sample	Gender						Age (Years)	
			Female		Male		Other			
			N	%	N	%	N	%	Mean	Median
AzCH	61	31%	14	23%	47	77%	0	0%	39.6	36.0
Care1st	37	19%	17	46%	20	54%	0	0%	39.1	38.0
MC	102	51%	34	33%	68	67%	0	0%	37.7	36.0
Total	**200**	**100%**	**65**	**33%**	**135**	**68%**	**0**	**0%**	**38.5**	**36.0**

Sample Characteristics

Members chosen for the sample must have been disenrolled or have had an EOC with a closure date within SFY 2024 (July 1, 2023, to June 30, 2024), with a final case closure date no later than June 30, 2024. Any documentation included in records that was outside of this date range was not considered for this review. Closure reasons include member declined further service, lack of contact, treatment completion, and transfer (member was incarcerated, moved, or no longer on Medicaid). The most frequent reason for case closure during this period was treatment completion (41%), followed by lack of contact (36%). This represents a reversal over last year's findings, as lack of contact was the most common reason for case closure.

Table 4-3: Distribution Based on Case Closure Reason

ACC-RBHA	Number of Sample Cases	Client Declined Further Treatment		Lack of Contact		Treatment Completion		Transfer	
	N	N	%	N	%	N	%	N	%
AzCH	61	18	30%	22	36%	21	34%	0	0%
Care1st	37	8	22%	13	35%	15	41%	1	3%
MC	102	18	18%	36	35%	45	44%	3	3%
Total	**200**	**44**	**22%**	**71**	**36%**	**81**	**41%**	**4**	**2%**

The rates for the most frequent source of referral to SUD treatment are shown in Table 4-4 below. "Criminal Justice/Correctional" includes the Administrative Office of the Courts, Arizona Department of Corrections, Arizona Department of Juvenile Corrections, jail/prison, and probation. "Other" includes physical health providers, State agencies, crisis, and unknown sources. Overwhelmingly, self-referral or referral by family or friends was the most frequent referral source at 53%. This is 6% lower than the previous period of 59%. It should also be noted that Criminal Justice/Correctional referrals increased to 33% in this year's sample compared to last year's sample, which was 25%.

Table 4-4: Source for Referral

ACC-RBHA	Sample Cases	Criminal Justice/ Correctional		Other BH Provider		Self/Family/ Friend		Other	
		N	%	N	%	N	%	N	%
AzCH	61	30	49%	4	7%	23	38%	4	7%
Care1st	37	18	49%	1	3%	18	49%	0	0%
MC	102	18	17%	7	7%	64	63%	13	13%
Total	**200**	**66**	**33%**	**12**	**6%**	**105**	**53%**	**17**	**9%**

Aggregate Review Findings

The tables below (4-5 through 4-15) contain the aggregate record of review findings. As noted in the Methodology section, most measures remain the same as those used in the

previous year. Tables reflecting new measures do not have a comparison to previous years' findings, and the new measure is flagged in the previous years' findings column. The denominators primarily consisted of the sum of "Yes" or "No" responses and, as such, differentiates across the measures. The denominators of certain indicators were based on the number of "Yes" responses from a prior question when applicable. For example, the denominators for I.C.1 through 9 equate to the numerator for *I.C. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?*

Certain measures allowed for a response of "Not Applicable" (N/A); N/As are not included in any denominator, consistent with prior years' analyses. Measures marked with an asterisk indicate that "N/A" was not a valid response option for that measure, and a dash was used instead of a number in the "N/A" column. Additionally, certain measures included an option for missing documentation.

Narrative information was also collected on the following measures (see full set and description of measures in Appendix A) and incorporated into the Findings section prior to the respective table. Throughout each table, improvements (green) and declines (pink) have been color coded to reflect the comparison of findings from the previous year's review period. **In some cases, a number may be higher than the previous year but is coded pink because the outcome is a negative trend**. For example, a question about whether documentation was present may have a higher number of responses but is a negative finding, as the documentation should have been present. **These items are noted with a double asterisk**. For findings in which the results are the same from one year to the next, results have been shaded in grey to indicate no change.

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

Although these findings represent an aggregation of data from record reviews and an underlying root cause analysis for trends has not been conducted, additional qualitative information on the potential reasons for the findings in different areas can be found in Appendix D, under focus group summary discussions. These discussions point to strengths and areas of opportunities and concerns, as noted by providers and ACC-RBHAs, that could have an impact on results from record reviews.

Measure I — Intake/Treatment Planning Key Findings

Initial Behavioral Health Assessment

Mercer reviewed 200 total records for the State and found the most commonly used substances were alcohol, at 37%, followed by opioids, at 30%. This is a 12% decline in opioid

use from SFY 2023. Two substances identified under the category of "Other" included one instance of Xanax and one of psilocybin. Smoking was the most common method of ingestion, at 47%, followed by oral consumption, at 41%. In one case, the method of ingestion was unidentified.

There was a slight decrease in the number of behavioral health assessments completed. Assessments were completed 96% of the time, a 1% drop from both SFY 2023 and SFY 2022. The new measure of whether an assessment was completed within 45 days was 95%, as one assessment was not completed within the 45-day timeframe. The completion of a risk assessment continues to be an area of strength, with a result of 100% over the current period as well as the previous two fiscal years. There was a noticeable improvement in screening for tuberculosis, from 44% to 61%, in this year's cycle, an area of priority for AHCCCS. Screening for hepatitis C, HIV, and other infectious diseases also significantly improved, increasing from 40% to 66%.

SDoH were added to the assessment process this year. Further discussion below summarized findings of the assessment that are also included in the ISP. Other determinants listed under the option of "Other" include difficulty with finances, not practicing safe sex, having legal concerns, difficulty paying for utilities, lack of adequate clothing, dental concerns, and lack of childcare.

Regulatory Requirements

Charitable choice regulation compliance remained consistent over the past three years, with a slight increase to 89% from 85%. Both of the two new regulatory requirements reviewed this year could represent areas of opportunity for RHBAs to provide technical assistance to substance use providers. Members were provided with information on informed consent in 85% of cases reviewed. Documentation was present, showing members were informed of their HIPAA rights in 78% of cases reviewed.

Individual Service Plan

An ISP was completed in 97% of cases, a slight increase from the previous year's result of 94%. The ISP was completed within 90 days in 98% of cases. Participation of the family or support network in development of the ISP declined from 13% in the previous two reviews to 9%. A more significant finding was a reduction in the number of cases incorporating the cultural preferences of the member, from 99% to 45%, indicating another area in which providers may benefit from ACC-RHBA technical assistance. There was a slight drop in the number of ISPs incorporating SDoH, from 45% to 37%. Unemployment is the highest area of SDoH need addressed in ISPs, at 21%, followed by access to medical care at 20%. These findings align with assessment determinations of SDoH need, with unemployment at 87%

and access to medical care at 67%. Although housing was identified to be a need in 83% of assessments, it was only addressed in 14% of ISPs. Members of the provider focus group identified training on inclusion of SDoH in ISPs as a potential area for additional staff training.

Table 4-5: Assessment and Individual Service Plan

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes 2023	% of Yes 2023
A. What was the primary substance used?[11]*						
• Opioids	200	59	30%	-	84	42%
• Marijuana	200	28	14%	-	34	17%
• Alcohol	200	73	37%	-	82	41%
• Amphetamines	200	47	24%	-	50	25%
• Cocaine	200	15	8%	-	21	11%
• Other (please list)	200	2	1%	-	8	4%
B. What was the method of ingestion?[9]*						
• Smoking	200	93	47%	-	94	47%
• Oral	200	82	41%	-	88	44%
• Inhalation	200	22	11%	-	22	11%
• Injection	200	8	4%	-	13	7%
• Transdermal	200	0	0%	-	0	0%
• Other (please list)	200	1	1%	-	15	8%
Behavioral Health Assessment						

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

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes 2023	% of Yes 2023
C. Was a behavioral health assessment completed?[12]*	200	191	96%	-	97%	97%
i. Was the behavioral health assessment completed within 45 days of the initial appointment?	200	190	95%	0	New measure	New measure
D. Did the behavioral health assessment:*						
Address substance-related disorder(s)?	191	167	87%	-	87%	99%
ii. Describe the intensity/frequency of substance use?	191	183	96%	-	95%	93%
iii. Include the effect of substance use on daily functioning?	191	179	94%	-	96%	93%
iv. Include the effect of substance use on interpersonal relationships?	191	170	89%	-	94%	95%
v. Include a completed risk assessment?	191	191	100%	-	100%	100%
vi. Document screening for tuberculosis?	191	116	61%	-	44%	46%
vii. Document screening for hepatitis C, HIV, and other infectious diseases?	191	126	66%	-	40%	53%
viii. Document screening for emotional and/or physical abuse/trauma issues?	191	189	99%	-	96%	95%
ix. Document that review of the Prescription Drug Monitoring Program (PDMP) was completed?	175	22	13%	-	18%	22%

[12] Item C and C.1. were split into two questions for the 2024 review due to tool validation.

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes 2023	% of Yes 2023
E. Were SDoHs documented as a part of the assessment?*	191	184	96%	-	New measure	New measure
Access to medical care?	191	145	76%	-	New measure	New measure
x. Housing?	191	158	83%	-	New measure	New measure
xi. Food insecurity?	191	100	52%	-	New measure	New measure
xii. Domestic violence?	191	128	67%	-	New measure	New measure
xiii. Unemployment?	191	166	87%	-	New measure	New measure
xiv. Transportation?	191	137	72%	-	New measure	New measure
xv. Other?	191	17	9%	-	New measure	New measure
F. Regulatory requirements:						
Was there documentation that charitable choice requirements were followed, if applicable?	27	24	89%	168	85%	69%
xvi. Was there documentation that individuals were informed of their HIPAA rights?*	196	152	78%	-	New measure	New measure
xvii. Was there documentation that individuals were given information on informed consent?*	196	167	85%	-	New measure	New measure

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes 2023	% of Yes 2023
G. Was an ISP completed?*[13]	197	191	97%	-	94%	99%
Was the ISP completed within 90 days of the initial appointment?	191	188	88%	0	New measure	New measure
H. Was the ISP:						
Developed with participation of the family/support network?	188	17	9%	151	13%	13%
xviii. Congruent with the diagnosis(es) and presenting concern(s)?*	188	185	98%	-	100%	98%
xix. Containing measurable objectives and timeframes to address the identified needs?*	188	186	99%	-	100%	96%
xx. Addressing the unique cultural preferences of the individual?*	188	84	45%	-	99%	93%
xxi. Considering SDoH issues as part of, and incorporated into, the ISP?	188	69	37%	0	45%	53%
If yes, which domains?*						
• Access to medical care	188	37	20%	-	20%	23%
• Housing	188	26	14%	-	21%	39%
• Food insecurity	188	3	2%	-	4%	4%
• Domestic violence	188	4	2%	-	3%	5%
• Unemployment	188	40	21%	-	24%	41%
• Transportation	188	13	7%	-	11%	New Measure

[13] Items G and G.i. were split into two questions for the 2024 review due to tool validation.

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes 2023	% of Yes 2023
• Other	188	9	5%	-	12%	7%

Measure II — Placement Criteria/Assessment Key Findings

ASAM 3rd Edition criteria was used in determining the appropriate LOC in 79% of cases, a slight decrease from 83% in the past two preceding reviews. Provider training on utilization of ASAM criteria in determining LOC continues to be an identified area of opportunity. Level 1 Outpatient Treatment remains the most common LOC, at 51%, followed by Level 2.1 Intensive Outpatient at 27%. Members received the LOC indicated in their assessment in 99% of cases, an improvement over last year's result of 87%, and the member was reassessed against ASAM criteria during the course of treatment more often, increasing from 43% last year to 59% this year. Additional assessment tools were used in 63% of cases and included:

- Patient Health Questionnaire: 9 (37 cases)
- Generalized Anxiety Disorder: 7 (32 cases)
- Adverse Childhood Experiences Questionnaire: (23 cases)
- Protocol for Responding To & Assessing Patients' Assets, Risks & Experiences: (18 cases)
- Columbia Suicide Severity Rating Scale: (16 cases)
- Drug Abuse Screening Test: (13 cases)
- Diagnostic and Statistical Manual of Mental Disorders 5: (10 cases)
- Michigan Alcohol Screening Test: (10 cases)
- Alcohol Use Disorders Identification Test – Consumption: (6 cases)
- Child and Adolescent Level of Care Utilization System: (6 cases)

Table 4-6: Placement Criteria/Assessment

Question	Denominator	# of Yes 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation that ASAM dimensions were used to determine the proper level of care at intake?	200	158	79%	83%	83%
If the ASAM Placement Criteria were used, the level of service identified was:					
Level 0.5: Early Intervention	158	1	1%	1%	1%
OMT: Opioid Maintenance Therapy	158	24	15%	27%	16%
Level 1: Outpatient Treatment	158	80	51%	42%	45%
Level 2: Intensive Outpatient Treatment/Partial Hospitalization	158	43	27%	19%	12%
Level 3: Residential/Inpatient Treatment	158	24	15%	20%	42%
Level 4: Medically Managed Intensive Inpatient Treatment	158	1	1%	0%	1%
B. Did the member receive the level of services identified by the placement criteria/assessment?	158	156	99%	87%	96%
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	158	94	59%	43%	54%
D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	200	125	63%	58%	50%

Measure III — Best Practices Key Findings

Evidence-based practices (EBPs) were found to be used in treatment 84% of the time, an increase from 74% in SFY 2023 and 77% in SFY 2022. Relapse prevention therapy was the

most commonly used, at 64%, a marked increase from the previous year's finding of 27%, followed by motivational enhancement/interviewing therapy at 45%, and cognitive behavioral therapy at 36%. Additional interventions (17%) used by providers included:

- Living In Balance (10 cases)
- Rational Emotive Behavior Therapy (8 cases)
- Thinking for Good (3 cases)
- Relaxation Therapy (2 cases)
- Eye Movement Desensitization and Reprocessing (3 cases)
- Mindfulness (2 cases)
- Community Reinforcement Approach (2 cases)

The use of MAT declined in SFY 2024, from 37% last year to 26% this year. Campral was used in one alcohol use disorder case, and oral naltrexone was used in nine. For OUD cases, methadone was used 40% of the time, a decrease from 74%. Suboxone was used in 31% of cases.

Certified peer support services were used 72% of the time, an increase from 60% the previous year. Eighty-six percent (86%) of peer support personnel utilized were credentialed. In addition, telehealth services increased from 61% to 68%. Both outcomes align with AHCCCS goals.

Table 4-7: Best Practices

Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
Were EBPs used in treatment?	200	168	84%	74%	77%
• Cognitive Behavioral Therapy	168	60	36%	44%	82%
• Dialectal Behavioral Therapy	168	18	11%	13%	12%
• Helping Women Recover	168	0	0%	1%	0%
• Matrix	168	15	9%	9%	10%
• Moral Re-conation Therapy	168	11	7%	0%	1%

Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
• Motivational Enhancement/ Interviewing Therapy	168	75	45%	53%	44%
• Relapse Prevention Therapy	168	108	64%	27%	54%
• Seeking Safety	168	11	7%	1%	11%
• SMART Recovery	168	14	8%	8%	18%
• Thinking for a Change	168	0	0%	0%	1%
• Trauma Recovery and Empowerment Model	168	0	0%	1%	1%
• Trauma-Informed Care	168	6	4%	1%	11%
• Wellness Recovery Action Plan	168	1	1%	2%	0%
• Other Practices or Program	168	28	17%	7%	24%

Table 4-8: Medication Assisted Treatment, Peer Support, and Telehealth

Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
MAT[14]	200	52	26%	37%	41%
A. The following medication was used in treatment:					
Alcohol-Related					
• Acamprosate (Campral)	52	1	2%	1%	0%
• Disulfiram (Antabuse)	52	0	0%	1%	1%

[14] MAT options updated from 2023 to current evidence-based best practices

Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
• Oral naltrexone (Vivitrol®, Revia) (naltrexone hydrochloride tablet)	52	9	17%	New measure	New measure
Opioid-Related					
• Buprenorphine and naloxone (Suboxone, Zubsolv®)	52	16	31%	12%	22%
• Subutex (buprenorphine)	52	1	2%	3%	4%
• Methadone/ LAAM	52	21	40%	74%	69%
• Naltrexone (Vivitrol®, Revia)	52	6	12%	4%	5%
Nicotine-Related (Information Only)					
• Use of nicotine replacement therapy •	52	2	1%	4%	New measure
• Over-the-counter patch, gum, or lozenge	52	2	4%	New measure	New measure
• Prescription inhaler or nasal spray	52	0	0%	New measure	New measure
• Varenicline prescription (Chantix®)	52	0	0%	New measure	New measure
• Bupropion prescription (Wellbutrin, Aplezin®, Forfivo®, Zyban®)	52	0	0%	New measure	New measure
B. Was screening for substance use/abuse conducted during the course of treatment?	200	101	51%	55%	66%
C. Was certified peer support offered as part of treatment?	200	117	59%	45%	42%

Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
xxii. If yes to C, were certified peer support services used as a part of treatment?	117	84	72%	60%	66%
xxiii. If peer support services were used, were the peer support specialists credentialed?	84	72	86%	New measure	New measure
D. Was telehealth offered as an option to receive treatment?	200	135	68%	61%	New measure

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

The types of treatment services used remained fairly consistent over the past three years. Case management remains the most common service at 91%, followed by group therapy at 75%. There was a 1% increase in family counseling, from 2% to 3%. Family counseling continues to be a potential area for improvement. Most members continue to complete 11 sessions or more at a fairly consistent percentage, 55% in this year's cycle and 51% and 57% in the previous two years, respectively. Lack of documentation of information provided on self-help groups also continues to be consistent, with 63% reported this year, 66% last year, and 57% the year before. This may represent an area of lacking documentation, rather than a lack of education and referral, and may be an opportunity for technical assistance to be offered to providers. Documentation that substance use services have been provided has been consistently increasing, with 97% this year, from 96% in SFY 2023, and 91% in SFY 2022.

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

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. The following services were used in treatment:*						
• Individual counseling/ therapy	200	145	73%	-	75%	79%

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
• Group counseling/ therapy	200	149	75%	-	69%	80%
• Family counseling/ therapy	200	5	3%	-	2%	1%
• Case management	200	181	91%	-	92%	82%
B. Was there clear documentation of progress or lack of progress towards the identified ISP goals?*	200	180	90%	-	92%	89%
The number of completed counseling/ therapy sessions during treatment was:*						
• 0–5 sessions	199	65	33%	-	34%	32%
• 6–10 sessions	199	24	12%	-	15%	11%
• 11 sessions or more	199	110	55%	-	51%	57%
C. Was the individual given any education on self-help or recovery groups?	199	126	63%	_	66%	74%
D. Documentation showed the member reported attending self-help or recovery groups the following number of times:*						
• No documentation	200	126	63%	-	66%	57%
• 0 times during treatment	200	27	14%	-	10%	4%
• 1–4 times during treatment	200	13	7%	-	4%	6%
• 5–12 times during treatment	200	12	6%	-	7%	6%
• 13–20 times during treatment	200	4	2%	-	2%	6%
• 21 or more times during treatment	200	18	9%	-	13%	23%
E. If there was evidence of lack of progress towards the identified goal, did the provider revise the treatment approach	100	69	69%	98	66%	60%

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
and/or seek consultation to facilitate positive outcomes?						
F. If the member was unemployed during intake, was there evidence the individual's interest in finding employment was explored?	98	75	77%	100	81%	84%
G. If the member was not involved in an educational or vocational training program, was there evidence the individual's interest in becoming involved in such a program explored?	71	42	59%	127	71%	64%
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 the individual's interest in such an activity was explored?	82	55	67%	116	72%	64%
I. Does the documentation reflect that substance abuse services were provided?*	200	193	97%	_	96%	91%
J. Was member's access to a primary care physician (PCP) or other medical provider explored?	200	166	83%	12	81%	79%

Measure V — Gender-Specific Key Findings

There were 65 women in the state sample, representing 33% of all cases. There was a significant increase in domestic violence safety plans completed in cases in which there was a history of domestic violence, with 29% completed in SFY 2023 and 57% completed in SFY 2024. In the one case in which the female was pregnant, there was documentation of coordination of care with the PCP or obstetrician. There has been an overall decline in gender-specific services, from 57% in SFY 2022 to 23% in SFY 2023 and 16% in

SFY 2024. One identified goal of AHCCCS is to increase services for women, and increasing gender-specific programming is one opportunity to do so.

Table 4-10: Gender-Specific for Women

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. If there was a history of domestic violence, was there evidence a safety plan was completed?	21	12	57%	44	29%	45%
B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	1	1	100%	64	0%	50%
C. If the female was pregnant, did documentation show evidence of education on the effects of substance use on fetal development?	1	0	0%	64	0%	50%
D. If the female had a child less than one year of age, was there evidence a screening was completed for postpartum depression/ psychosis?	4	3	75%	61	33%	67%
E. If the female had dependent children, was there documentation to show childcare was addressed?	21	15	71%	44	81%	83%
F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	49	8	16%	16	23%	57%

Measure VI — Opioid-Specific Key Findings

There has been a year-over-year decline in opioid use diagnoses, from 54% in SFY 2022 to 45% in SFY 2023 and 32% in SFY 2024. There was a decline in documentation that members were provided with education about MAT as a treatment option, dropping from 81% last year to 77% this year. There has also been a decline in providing members with education on naloxone, dropping from 67% last year to 53% this year.

Table 4-11: Opioid-Specific Key Findings

Question	Denominator	# of Yes 2024	%of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation of a diagnosed OUD?*	200	64	32%	-	45%	54%
B. Was there documentation the member was provided MAT education as a treatment option?*	64	49	77%	-	81%	85%
If yes, were they referred to a MAT provider?	49	45	92%	8	97%	93%
C. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	27	26	96%	38	97%	98%
D. If a physical health concern related to pain was identified, were alternative pain management options addressed?	16	13	81%	49	72%	76%
E. 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	0%	-	0%	33%
F. Was there documentation the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?*	64	34	53%	-	67%	47%
G. Was the individual provided with naloxone or information on how to obtain naloxone?*	64	35	55%	-	66%	48%
H. Were family members/ natural supports provided information on how to obtain naloxone/provided naloxone, and actions to take in the event of an opioid overdose, if applicable?	64	0	0%	0	57%	New measure

Question	Denominator	# of Yes 2024	%of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
I. Was there documentation the member was provided education on the effects of polysubstance use with opioids?	64	32	50%	0	68%	54%

Measure VII — Discharge and Continuing Care Planning Key Findings

There was a significant decrease in documentation of completion of relapse prevention plans. Relapse prevention plans were present in 70% of cases in SFY 2022 and 2023 but dropped to 54% in SFY 2024. Other findings in discharge and continuing care findings included an increase in the reassessment of ASAM at the time of discharge, increasing 11% from SFY 2023 to 39% in SFY 2024, although there was a decrease in referrals to the ASAM-indicated LOC, from 98% in SFY 2023 to 87% in SFY 2024.

Other methods of outreach used by providers included:

- Internal staffing discussions to determine reengagement strategies
- Email communication

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

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation present that a relapse prevention plan was completed?*	177	95	54%	-	70%	70%
B. Was the individual reassessed at the time of discharge using ASAM criteria to determine an appropriate LOC?*	178	70	39%	-	28%	48%
C. Was the individual referred to the appropriate LOC based on the ASAM determination?	60	52	87%	39	98%	95%

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
D. Was there documentation staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g., crisis line)?*	177	104	59%	-	58%	67%
E. Was there documentation staff actively coordinated with other involved agencies at the time of discharge?	110	75	68%	68	68%	61%

Measure VIII — Reengagement Key Findings

Telephonic reengagement efforts decreased 8% in SFY 2024, dropping to 76% from 84% in both SFY 2023 and SFY 2022. If telephone contact was unsuccessful, outreach letters sent also decreased, from 65% in SFY 2023 to 60% in SFY 2024. Some other efforts did include sending emails or texts, as that was the preferred method indicated by the individual. Increased efforts toward reengagement could lead to increased retention and completion of treatment.

Table 4-13: Reengagement Key Findings (completed only if members decline further services or choose not to appear for scheduled services)

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
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)?*	115	87	76%	_	84%	84%
B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	94	56	60%	20	65%	59%
C. Were other attempts made to reengage the individual such as*:						
• Home visit?	21	5	24%	-	43%	31%

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
• Call emergency contact(s)?	21	8	38%	-	10%	25%
• Contact other involved agencies?	21	7	33%	-	3%	31%
• Street outreach?	21	0	0%	-	0%	0%

Measure IX — National Outcome Measures Key Findings

National outcome measures showed improvement from intake in most categories in SFY 2024. The greatest increases were in abstinence, which increased from 37% to 83%, and participation in social support, which increased from 25% to 80%. These areas of improvement were also the biggest areas of improvement in SFY 2023, with 65% of cases demonstrating abstinence and 64% participation in social support at the time of discharge. Improvements (green) versus decreases or negative outcomes (pink), such as arrests, from intake to discharge are reflected at the point of discharge in Tables 4-14 (2024) and 4-15 (2023).

Table 4-14: 2024 National Outcome Measures

2024	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
A. Employed?	195	91	47%	4	105	60	57%	94
B. Enrolled in school or vocational educational program?	178	9	5%	21	91	8	9%	108
C. On disability or retired?	155	21	14%	44	88	14	16%	111
D. Lived in a stable housing environment	194	162	84%	5	98	95	97%	101

2024	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
(e.g., not homeless)?								
E. Arrested in the preceding 30 days?**	182	27	15%	17	94	5	5%	105
F. Abstinent from drugs and/or alcohol?	194	71	37%	5	93	77	83%	106
G. Participated in social support recovery in the preceding 30 days?	198	50	25%	37	95	76	80%	103

Table 4-15: 2023 National Outcome Measures

2023	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
Employed?	193	103	53%	7	132	78	59%	68
B. Enrolled in school or vocational educational program?	177	4	2%	23	130	6	5%	70
C. On disability or retired?	161	20	12%	39	126	13	10%	74
D. Lived in a stable housing environment (e.g., not homeless)?	193	154	80%	7	130	111	85%	70
E. Arrested in the preceding 30 days?**	184	15	8%	16	131	3	2%	69

2023	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
F. Abstinent from drugs and/or alcohol?	189	56	30%	11	119	77	65%	81
G. Participated in social support recovery in the preceding 30 days?	200	42	21%	28	122	78	64%	78

Section 5
Case File Review Findings by ACC-RBHA

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

Arizona Complete Health (AzCH)

AzCH has responsibility for AHCCCS members in the southern region of the state. AzCH is assigned to members living in Greenlee, Graham, Cochise, Santa Cruz, Pima, Yuma, and La Paz counties. Mercer reviewed 61 provider treatment records from nine separate clinics under AzCH's area of responsibility. In the previous review, the AzCH sample performed better than the state across multiple metrics.

Measure I — Intake/Treatment Planning Key Findings

Initial Behavioral Health Assessment

Similar to the statewide findings, alcohol was the primary substance of choice, at 31%, followed by opioids at 26%. The primary method of ingestion was smoking, at 48%, followed by oral at 36%.

The behavioral health assessment findings have been consistent over SFY 2022, SFY 2023, and SFY 2024, with a 100% completion rate. The new separate measure of whether the assessment was completed within 45 days of intake was also 100%. There has been a decline in the assessment, including the effect of substance use on personal relationships, from 100% in SFY 2022 to 96% in SFY 2023 and 87% in SFY 2024. A positive finding of note is a significant increase in the number of assessments, reflecting a screening for tuberculosis, increasing from 33% in the previous year to 73% in SFY 2024. There was a similar significant

increase in the screenings for hepatitis C, HIV, and other infectious diseases, with an increase of 52% from SFY 2023 to SFY 2024. Regarding the new measure of SDoH in the assessment, unemployment and housing were both the areas of highest identified need, with a result of 88% of cases identifying these areas. Determinants listed under the option of "Other" include difficulty with finances, not practicing safe sex, having legal concerns, difficulty paying for utilities, lacking adequate clothing, dental concerns, and lack of childcare.

Regulatory Requirements

AzCH performed better than the state average on the new measures collected, with 88% of cases being informed of their HIPAA rights and 95% having documentation that members were given information regarding informed consent. There was also a positive increase in compliance with charitable choice requirements, as applicable, from 67% in the previous year to 83% in SFY 2024.

Individual Service Plan

There was a slight decline in ISPs completed in SFY 2024, dropping from 100% in SFY 2023 to 97%. The new measure of plan completion within 90 days was also 97%. There was also a decline in family participation in the development of the ISP, from 15% in SFY 2022 to 14% in SFY 2023 to 7% in SFY 2024. Another similarity to overall state findings was a significant drop in the incorporation of individual cultural preferences in the ISP, dropping from 98% last year to 41% in SFY 2024. Unemployment was the most common SDoH addressed, in alignment with assessment findings, at 27%, followed by access to care at 24% and housing at 19%. This may be an opportunity for technical assistance to providers to ensure ISPs are created, both with the cultural preferences of the members and addressing identified SDoH, as indicated by the assessment.

Table 5-1: AzCH Assessment and Individual Service Plan

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes FY 2023	% of Yes FY 2023
A. What was the primary substance used?[15]*						
• Opioids	61	16	26%	-	16	31%

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

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes FY 2023	% of Yes FY 2023
• Marijuana	61	13	21%	-	9	18%
• Alcohol	61	19	31%	-	22	43%
• Amphetamines	61	13	21%	-	18	35%
• Cocaine	61	7	11%	-	12	24%
• Other (please list)	61	1	2%	-	1	2%
B. What was the method of ingestion?*						
• Smoking	61	29	48%	-	27	53%
• Oral	61	22	36%	-	22	43%
• Inhalation	61	8	13%	-	11	22%
• Injection	61	3	5%	-	2	4%
• Transdermal	61	0	0%	-	0	0%
• Other (please list)	61	0	0%	-	3	6%

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
Behavioral Health Assessment						
C. Was a behavioral health assessment completed?[16]*	61	61	100%	-	100%	100%
i. Was the behavioral health assessment completed within 45 days of the initial appointment?	61	61	100%	0	New measure	New measure
D. Did the behavioral health assessment:*						

[16] Item C and C.1. were split into two questions for the 2024 review due to tool validation

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
i. Address substance-related disorder(s)?	61	61	100%	-	100%	100%
ii. Describe the intensity/ frequency of substance use?	61	57	93%	-	100%	93%
iii. Include the effect of substance use on daily functioning?	61	56	92%	-	98%	98%
iv. Include the effect of substance use on interpersonal relationships?	61	53	87%	-	96%	100%
v. Was a risk assessment completed?	61	60	98%	-	100%	100%
vi. Document screening for tuberculosis?	61	46	75%	-	33%	51%
vii. Document screening for hepatitis C, HIV, and other infectious diseases?	61	44	72%	-	20%	44%
viii. Document screening for emotional and/or physical abuse/ trauma issues?	61	60	98%	-	94%	98%
ix. Document that review of the PDMP was completed?	53	6	11%	-	13%	8%
E. Were social determinants of health documented as a part of the assessment?*						
i. Access to medical care?	60	46	77%	-	New measure	New measure
ii. Housing?	60	53	88%	-	New measure	New measure
iii. Food insecurity?	60	33	55%	-	New measure	New measure

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
iv. Domestic violence?	60	38	63%	-	New measure	New measure
v. Unemployment?	60	53	88%	-	New measure	New measure
vi. Transportation?	60	44	73%	-	New measure	New measure
vii. Other?	60	9	15%	-	New measure	New measure
F. Regulatory requirements:						
i. Was there documentation that charitable choice requirements were followed, if applicable?	6	5	83%	53	67%	0%
ii. Was there documentation that individuals were informed of their HIPAA rights?*	60	53	88%	-	New measure	New measure
iii. Was there documentation that individuals were given information on informed consent?*	60	57	95%	-	New measure	New measure
G. Was an ISP completed?[17]*	61	59	97%	-	100%	95%
i. Was the ISP completed within 90 days of the initial appointment?	61	59	97%	0	New measure	New measure
H. Was the ISP:						
i. Developed with participation of the family/support network?	59	4	7%	49	14%	15%
ii. Congruent with the diagnosis(es) and presenting concern(s)?*	59	57	97%	-	100%	97%

[17] Item G was split into two measures, G and G.i., for the 2024 review due to tool validation.

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
iii. Measurable objectives and timeframes to address the identified needs?*	59	58	98%	-	98%	95%
iv. Addressing the unique cultural preferences of the individual?*	59	24	41%	-	98%	95%
v. Were SDoH issues considered as part of, and incorporated into, the ISP?	59	22	37%	17	45%	85%
If yes, which domains?*						
• Access to medical care	59	14	24%	-	16%	33%
• Housing	59	11	19%	-	8%	72%
• Food insecurity	59	0	0%	-	6%	8%
• Domestic violence	59	0	0%	-	4%	10%
• Unemployment	59	16	27%	-	27%	69%
• Transportation	59	2	3%	-	10%	New Measure
• Other	59	2	3%	-	3%	2%

Measure II — Placement Criteria/Assessment Key Findings

There has been a decline in the use of ASAM 3rd Edition criteria to determine LOC, dropping from 93% in SFY 2022 to 90% in SFY 2023, and to a low of 69% in SFY 2024, a 21% decrease from the previous year. These tools included:

- Patient Health Questionnaire: 9 (16 cases)
- Generalized Anxiety Disorder: 7 (14 cases)
- Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences: (9 cases)

- Drug Abuse Screening Test: (6 cases)
- Alcohol Use Disorders Identification Test – Consumption: (2 cases)
- Adverse Childhood Experiences Questionnaire: (5 cases)
- Columbia Suicide Severity Rating Scale: (1 case)
- Diagnostic and Statistical Manual of Mental Disorders 5: (1 case)
- Michigan Alcohol Screening Test: (1 Case)
- Level 1 Outpatient Treatment remained the most common level of care, at 57%, followed by Level 2.1 Intensive Outpatient Treatment/Partial Hospitalization at 31%. There was a 26% increase in the number of individuals receiving the LOC indicated in their assessment, from 74% in SFY 2023 to 100% in SFY 2024. When ASAM dimensions were used, there was an increase in reassessment during treatment, from 24% in the previous year to 31% in SFY 2024.

Table 5-2: AzCH Placement Criteria/Assessment

Question	Denominator	# of Yes 2024	% of Yes 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation that ASAM dimensions were used to determine the proper level of care at intake?	61	42	69%	90%	93%
If the ASAM Placement Criteria were used, the level of service identified was:					
Level 0.5: Early Intervention	42	0	0%	0%	3%
OMT: Opioid Maintenance Therapy	42	5	12%	20%	8%
Level 1: Outpatient Treatment	42	24	57%	46%	24%
Level 2: Intensive Outpatient Treatment/Partial Hospitalization	42	13	31%	30%	11%
Level 3: Residential/Inpatient Treatment	42	2	5%	11%	68%

Question	Denominator	# of Yes 2024	% of Yes 2024	% of Yes FY 2023	% of Yes FY 2022
Level 4: Medically Managed Intensive Inpatient Treatment	42	0	0%	0%	0%
B. Did the member receive the level of services identified by the placement criteria/assessment?	42	42	100%	74%	89%
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	42	13	31%	24%	34%
D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	61	45	74%	57%	20%

Measure III — Best Practices Key Findings

There was an increase in the use of EBPs in AzCH, increasing from 76% in SFY 2023 to 89% in SFY 2024. Modalities used were reflective of overall State findings, with relapse prevention as the primary EBP, used at 61%, and motivational enhancement/interviewing therapy at 43%. Additional interventions used by providers included:

- Rational Emotive Behavior Therapy (4 cases)
- Thinking for Good (3 cases)
- Living in Balance (3 cases)
- Community Reinforcement Approach (2 cases)

MAT for alcohol was used in only one instance, despite alcohol being the primary drug of choice for the AzCH cases reviewed. Suboxone remains the primary MAT for OUDs at 50%, followed by methadone at 40%. There was no MAT utilized for nicotine, although this was a measure reviewed for information only. Peer support services were offered in 71% of cases, an increase from last year's finding of 61%, and 85% of cases utilized peer support services, an increase from last year's result of 65%. Telehealth was offered in 64% of cases, an increase from the previous year's finding of 53%. The findings in peer support and telehealth align with AHCCCS goals for the SUBG.

Table 5-3: AzCH Best Practices

Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
A. Were EBPs used in treatment?	61	54	89%	76%	90%
• Cognitive Behavioral Therapy	54	18	33%	41%	70%
• Dialectal Behavioral Therapy	54	3	6%	13%	24%
• Helping Women Recover	54	0	0%	3%	0%
• Matrix	54	9	17%	13%	3%
• Moral Re-conation Therapy	54	8	15%	0%	3%
• Motivational Enhancement/ Interviewing Therapy	54	23	43%	41%	35%
• Relapse Prevention Therapy	54	33	61%	33%	51%
• Seeking Safety	54	3	6%	0%	27%
• SMART Recovery	54	5	9%	13%	41%
• Thinking for a Change	54	0	0%	0%	3%
• Trauma Recovery and Empowerment Model	54	0	0%	3%	3%
• Trauma-Informed Care	54	0	0%	3%	11%
• Wellness Recovery Action Plan	54	1	2%	5%	0%
• Other Practices or Program	54	11	20%	10%	32%

Table 5-4: AzCH Medication-Assisted Treatment, Peer Support, and Telehealth

Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
MAT[18]	61	10	16%	25%	24%
A. The following medication was used in treatment:					
Alcohol-Related					
• Acamprosate (Campral)	10	0	0%	0%	0%
• Disulfiram (Antabuse)	10	0	0%	0%	0%
• Oral naltrexone (Vivitrol®, Revia) (naltrexone hydrochloride tablet)	10	1	10%	New measure	New measure
Opioid-Related					
• Buprenorphine and naloxone (Suboxone, Zubsolv®)	10	5	50%	54%	33%
• Subutex (buprenorphine)	10	0	0%	0%	10%
• Methadone/Levo-Alpha-Acetylmethadol (LAAM)	10	4	40%	38%	60%
• Naltrexone (Vivitrol®, Revia)	10	1	10%	0%	0%
Nicotine-Related (Information Only)					
• Use of nicotine replacement therapy •	10	0	0%	8%	New measure

[18] MAT options updated from 2023 to current EBPs

Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
• Over-the-counter patch, gum, or lozenge	10	0	0%	New measure	New measure
• Prescription inhaler or nasal spray	10	0	0%	New measure	New measure
• Varenicline prescription (Chantix®)	10	0	0%	New measure	New measure
• Bupropion prescription (Wellbutrin, Aplezin®, Forfivo®, Zyban®)	10	0	0%	New measure	New measure
B. Was screening for substance use/abuse conducted during the course of treatment?	61	19	31%	47%	76%
C. Was certified peer support offered as part of treatment?	61	47	77%	61%	54%
If yes to C, were certified peer support services used as a part of treatment?	47	40	85%	65%	86%
If peer support services were used, were the peer support specialists credentialed?	40	39	98%	New measure	New measure
D. Was telehealth offered as an option to receive treatment?	61	39	64%	53%	New measure

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

Case management was the primary service modality at 90%, a reduction from last year, which was at 96%. Group therapy was the second most utilized delivery method, at 85%, an increase from last year, which was 67%. There was a slight increase in family counseling, with one member receiving family therapy. There was an increase in members receiving 11 sessions or more, from 42% last year to 67% in SFY 2024, indicating members engaged in treatment do receive an appropriate number of services for outpatient and intensive outpatient, the most commonly used levels of care. Education about self-

help groups continues to remain an area of opportunity, with a finding of 58%, the same as the previous year. There was a 14% increase in exploring the member's need for a PCP, from 75% in SFY 2023 to 89% in SFY 2024.

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

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. The following services were used in treatment:*						
• Individual counseling/ therapy	61	32	52%	-	53%	93%
• Group counseling/ therapy	61	52	85%	-	67%	95%
• Family counseling/ therapy	61	1	2%	-	0%	0%
• Case management	61	55	90%	-	96%	80%
B. Was there clear documentation of progress or lack of progress towards the identified ISP goals?*	61	54	89%	-	94%	100%
C. The number of completed counseling/therapy sessions during treatment was:*						
• 0–5 sessions	60	13	22%	-	42%	10%
• 6–10 sessions	60	7	12%	-	16%	2%
• 11 sessions or more	60	40	67%	-	42%	88%
D. Was the individual given any education on self-help or recovery groups?*	60	35	58%	-	58%	85%
E. Documentation showed the member reported attending self-help or recovery groups the following number of times:*						
• No documentation	61	42	69%	-	73%	41%
• 0 times during treatment	61	7	11%	-	8%	0%
• 1–4 times during treatment	61	5	8%	-	2%	5%
• 5–12 times during treatment	61	3	5%	-	6%	5%

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
• 13–20 times during treatment	61	1	2%	-	0%	17%
• 21 or more times during treatment	61	3	5%	-	12%	32%
F. If there was evidence of lack of progress towards the identified goal, did the provider revise the treatment approach and/or seek consultation to facilitate positive outcomes?	30	21	70%	29	68%	88%
G. If the member was unemployed during intake, was there evidence the individual's interest in finding employment was explored?	29	22	76%	30	84%	88%
H. If the member was not involved in an educational or vocational training program, was there evidence the individual's interest in becoming involved in such a program was explored?	24	15	63%	35	67%	69%
I. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence the individual's interest in such an activity was explored?	20	13	65%	39	61%	84%
J. Does the documentation reflect substance abuse services were provided?*	61	56	92%	-	92%	93%
K. Was member's access to a PCP or other medical provider explored?	61	54	89%	2	75%	85%

Measure V — Gender-Specific Key Findings

There were 14 females in the AzCH sample. There were five cases with a history of domestic violence documented, and one case had a safety plan completed in SFY 2024, for a finding of 20%. There were no pregnant women in the sample.

Gender-specific treatment services continue to remain an area of opportunity, with a decline from 76% in SFY 2022, to 38% in SFY 2023, to 30% in SFY 2024.

Table 5-6: AzCH Gender-Specific for Women

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. If there was a history of domestic violence, was there evidence a safety plan was completed?	5	1	20%	9	0%	67%
B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	N/A	0	-	14	N/A	0%
C. If the female was pregnant, did documentation show evidence of education on the effects of substance use on fetal development?	N/A	0	-	14	N/A	0%
D. If the female had a child less than one year of age, was there evidence a screening was completed for postpartum depression/ psychosis?	1	1	100%	13	N/A	100%
E. If the female had dependent children, was there documentation to show childcare was addressed?	3	3	100%	11	100%	100%
F. Was there evidence of gender-specific treatment services (e.g., women's only group therapy sessions)?	10	3	30%	4	38%	76%

Measure VI — Opioid-Specific Key Findings

There continues to be a decline in the percentage of cases with an opioid use diagnosis, from 49% in SFY 2022, to 35% in SFY 2023, to 26% in SFY 2024. There was a decrease in the

number of cases referred to a MAT provider, from 100% the previous year to 82% in SFY 2024. There was also a decrease in withdrawal symptoms being addressed, if present, to 83% in SFY 2024, from 100% in the previous two years. The referral to MAT and follow up for withdrawal symptoms might be areas in which AzCH may want to provide technical assistance to providers, as these are potential areas of medical concern, especially the follow up on withdrawal symptoms. There was a positive increase in education and provision of naloxone to members, from 44% in the previous year to 56% in SFY 2024.

Table 5-7: AzCH Opioid-Specific Key Findings

Question	Denominator	# of Yes 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation of a diagnosed OUD?*	61	16	26%	-	35%	49%
B. Was there documentation the member was provided MAT education as a treatment option?*	16	11	69%	-	67%	80%
If yes to B, were they referred to a MAT provider?	11	9	82%	5	100%	88%
C. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	6	5	83%	11	100%	100%
D. If a physical health concern related to pain was identified, were alternative pain management options addressed?	2	1	50%	15	0%	50%
E. 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	0%
F. Was there documentation the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?*	16	9	56%	-	44%	25%

Question	Denominator	# of Yes 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
G. Was the individual provided with naloxone or information on how to obtain naloxone?*	16	9	56%	-	44%	30%
H. Were family members/ natural supports provided information on how to obtain naloxone/provided naloxone, and actions to take in the event of an opioid overdose, if applicable?	16	0	0%	3	6%	New measure
I. Was there documentation the member was provided education on the effects of polysubstance use with opioids?	16	6	38%	0	39%	35%

Measure VII — Discharge and Continuing Care Planning Key Findings

There was a significant decline of 29% in documentation that a relapse prevention plan was completed, dropping from 83% in SFY 2023 to 52% in SFY 2024. There was an increase in members being reassessed using ASAM at the time of discharge, from 15% in the previous year to 25% in SFY 2024. Of those reassessed, there was a significant decline in referral to the identified LOC, from 100% in SFY 2023 to 67% in SFY 2024. Continuing care planning may be another area for AzCH to provide technical assistance to providers, as relapse prevention planning and referral are important parts of ongoing stabilization in the recovery process.

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

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation present a relapse prevention plan was completed?*	61	32	52%	-	83%	80%
B. Was the individual reassessed at the time of discharge using ASAM criteria to determine an appropriate LOC?*	61	15	25%	-	15%	40%

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
C. Was the individual referred to the appropriate LOC based on the ASAM determination?	9	6	67%	18	100%	94%
D. Was there documentation staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g., crisis line)?*	61	27	44%	-	43%	84%
E. Was there documentation staff actively coordinated with other involved agencies at the time of discharge?	35	23	66%	26	75%	69%

Measure VIII — Reengagement Key Findings

Reengagement findings also saw a decline, from SFY 2023 to SFY 2024, with telephone outreach dropping from 97% to 60% and follow-up letter contact dropping from 83% to 59%. Other activities taken by providers to make contact include visiting the member's home (57%) and calling the member's emergency contact (57%). Increased reengagement efforts could lead to increased retention, better treatment outcomes, and might be an additional potential area for AzCH to provide technical assistance to providers.

Table 5-9: AzCH Reengagement Key Findings

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
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)?*	35	21	60%	-	97%	94%
B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	27	16	59%	7	83%	69%
C. Were other attempts made to reengage the individual, such as*:						

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
• Home visit?	7	4	57%	-	63%	63%
• Call emergency contact(s)?	7	4	57%	-	11%	25%
• Contacting other involved agencies?	7	0	0%	-	0%	13%
• Street Outreach?	7	0	0%	-	0%	0%

Measure IX — NOMs Key Findings

Each of the six AzCH NOMs for Measure IX are depicted in Table 5-10. Denominators are impacted by missing documentation of status at intake and discharge, if applicable. The graphs below show the members' status for each NOM at intake and discharge. For the NOMs in which data was available at discharge, there was a positive trend in all measures, with 96% of members living in stable housing, 90% participating in social support, and 86% reporting at least 30 days of abstinence. There was also improvement in discharge findings, from SFY 2023 to SFY 2024, with an 8% improvement in employment, a 24% improvement in abstinence, and a 31% improvement in participation in social supports. These numbers may be higher due to a higher volume of available discharge information in SFY 2024, as each measure had more responses.

Table 5-10: 2024 and 2023 AzCH National Outcome Measures

2024	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
A. Employed?	61	30	49%	0	32	21	66%	29
B. Enrolled in school or vocational educational program?	55	3	5%	6	26	3	12%	35

2024	At Intake				At Discharge			
C. On disability or retired?	48	6	13%	13	29	5	17%	32
D. Lived in a stable housing environment (e.g., not homeless)?	61	48	79%	0	27	26	96%	34
E. Arrested in the preceding 30 days?**	58	14	24%	3	30	3	10%	31
F. Abstinent from drugs and/or alcohol?	61	32	52%	0	28	24	86%	33
G. Participated in social support recovery in the preceding 30 days?	61	20	33%	12	29	26	90%	32

2023	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
A. Employed?	50	25	50%	1	24	14	58%	27
B. Enrolled in school or vocational educational program?	44	0	0%	7	24	0	0%	27

2023	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
C. On disability or retired?	34	4	12%	17	22	1	5%	29
D. Lived in a stable housing environment (e.g., not homeless)?	51	42	82%	0	24	22	92%	27
E. Arrested in the preceding 30 days?**	49	4	8%	2	25	0	0%	26
F. Abstinent from drugs and/or alcohol?	48	22	46%	3	26	16	62%	25
G. Participated in social support recovery in the preceding 30 days?	51	13	25%	5	22	13	59%	29

Care1st Health Plan

Care1st Health Plan has responsibility for AHCCCS members in the northern region of the state and is part of Arizona Complete Care. Care1st is assigned to members living in Apache, Coconino, Maricopa, Mohave, Navajo, and Yavapai counties. Mercer reviewed provider treatment records from six separate clinics under Care1st's area of responsibility.

Measure I — Intake/Treatment Planning Key Findings

Initial Behavioral Health Assessment

The initial behavioral health assessment concluded that alcohol was the primary substance of choice, at 46%, followed by amphetamines at 27%. The primary method of ingestion for substances was oral, at 54%, and smoking at 49%.

The behavioral health assessment findings improved for SFY 2024 to 100%, with SFY 2023 and SFY 2022 both being at 95%. The new separate measure of whether the assessment was completed within 45 days of intake was also 100%. There has been a decline in the assessment, including the effect of substance use on personal relationships, which in SFY 2022 and SFY 2023, was 95% and in SFY 2024, the percentage decreased to 89%. A positive finding of note is a significant increase in the number of assessments reflecting a screening for tuberculosis, increasing from 20% in SFY 2023 to 51% in SFY 2024. There was a similar significant increase in the screenings for hepatitis C, HIV, and other infectious diseases, with an increase to 52% in SFY 2024 from 10% in SFY 2023. Regarding the new measure of SDoH in the assessment, unemployment was the highest need identified, at 84%, with both housing and access to medical care being very close to identified needs. Housing was identified at 78%, and access to medical care was close behind, at 76%, as an identified need.

Regulatory Requirements

New measures in the regulatory requirements included HIPAA, informed consent, and ISP completed within 90 days of appointment. Informed consent indicated an 86% compliance, and HIPAA was at 78% compliance. It should be noted that charitable choice was 100% for SFY 2024.

Individual Service Plan

Care1st completed the ISP within 90 days of an appointment, with a result of 97%. As mentioned above, this is a new measure. Completing the ISP for members saw an increase, from 85% for SFY 2023 to 97% for SFY 2024. There was a marked decline in addressing cultural differences for the members, from SFY 2023 (88%) and SFY 2022 (86%) to SFY 2024 (47%). An additional decline in SFY 2024 was seen in family participation in the development of the ISP, from 29% in SFY 2022, to 14% in SFY 2023, to 17% in SFY 2024. Access to medical care was the most identified need addressed in the ISP, at 28%, followed by unemployment, at 19%, for SFY 2024. Other domains include food insecurity, domestic violence, and a new measure of transportation. Transportation was noted in 14% of documentation for SFY 2024.

Table 5-12: Care1st Health Plan Assessment and ISP

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes FY 2023	% of Yes FY 2023
A. What was the primary substance used?*[19]						
• Opioids	37	7	19%	-	7	33%
• Marijuana	37	7	19%	-	4	19%
• Alcohol	37	17	46%	-	12	57%
• Amphetamines	37	10	27%	-	8	38%
• Cocaine	37	0	0%	-	0	0%
• Other (please list)	37	1	3%	-	1	5%
What was the method of ingestion?*						
• Smoking	37	18	49%	-	7	33%
• Oral	37	20	54%	-	12	57%
• Inhalation	37	2	5%	-	2	10%
• Injection	37	2	5%	-	5	24%
• Transdermal	37	0	0%	-	0	0%
• Other (please list)	37	0	0%	-	1	5%

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
Behavioral Health Assessment						

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

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
C. Was a behavioral health assessment completed?*	37	37	100%	-	95%	95%
i. Was the behavioral health assessment completed within 45 days of the initial appointment? [20]	37	37	100%	0	New measure	New measure
D. Did the behavioral health assessment:*						
i. Address substance- related disorder(s)?	37	37	100%	-	100%	100%
ii. Describe the intensity/frequency of substance use?	37	36	97%	-	95%	100%
iii. Include the effect of substance use on daily functioning?	37	35	95%	-	95%	95%
iv. Include the effect of substance use on interpersonal relationships?	37	33	89%	-	95%	95%
v. Was a risk assessment completed?	37	37	100%	-	100%	100%
vi. Document screening for tuberculosis?	37	19	51%	-	20%	38%
vii. Document screening for hepatitis C, HIV, and other infectious diseases?	37	21	57%	-	10%	33%
viii. Document screening for emotional and/or physical abuse/ trauma issues?	37	37	100%	-	100%	86%
ix. Document that review of the PDMP was completed?	37	4	11%	-	5%	11%
Were SDoHs documented as a part of the assessment?*						
i. Access to medical care?	37	28	76%	-	New measure	New measure

[20] Items B and B.i. were split into two questions for the 2024 review due to tool validation.

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
ii. Housing?	37	29	78%	-	New measure	New measure
iii. Food insecurity?	37	22	59%	-	New measure	New measure
iv. Domestic violence?	37	27	73%	-	New measure	New measure
v. Unemployment?	37	31	84%	-	New measure	New measure
vi. Transportation?	37	26	70%	-	New measure	New measure
vii. Other?	37	3	8%	-	New measure	New measure
Regulatory requirements:						
i. Was there documentation charitable choice requirements were followed, if applicable?	1	1	100%	36	19%	0%
ii. Was there documentation individuals were informed of their HIPAA rights?*	37	29	78%	-	New measure	New measure
iii. Was there documentation individuals were given information on informed consent?*	37	32	86%	-	New measure	New measure
G. Was an ISP completed?*[21]	37	36	97%	-	85%	100%
Was the ISP completed within 90 days of the initial appointment?	37	36	97%	0	New measure	New measure
H. Was the ISP:						

[21] Item G was split into two measures, G and G.i. for the 2024 review due to tool validation.

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
i. Developed with participation of the family/support network?	36	6	17%	25	12%	29%
ii. Congruent with the diagnosis(es) and presenting concern(s)?*	36	35	97%	-	100%	100%
iii. Measurable objectives and timeframes to address the identified needs?*	36	36	100%	-	100%	95%
iv. Addressing the unique cultural preferences of the individual?*	36	17	47%	-	88%	86%
Were SDoH issues considered part of, and incorporated into, the ISP?	36	17	47%	15	29%	67%
If yes, which domains?*						
• Access to medical care?	36	10	28%	-	24%	10%
• Housing?	36	4	11%	-	6%	24%
• Food insecurity?	36	1	3%	-	0%	0%
• Domestic violence?	36	3	8%	-	0%	10%
• Unemployment?	36	7	19%	-	6%	38%
• Transportation?	36	5	14%	-	0%	New Measure
• Other	36	1	3%	-	2%	3%

Measure II — Placement Criteria/Assessment Key Findings

ASAM criteria was used in determining the appropriate LOC in 86% of cases, an increase from SFY 2023, at 67%, and SFY 2022 at 73%. Level 1 Outpatient Treatment remains the most common LOC, at 63%, followed by Level 2.1 Intensive Outpatient and Level 3 Residential, both at 19%. Members received the LOC indicated in their assessment in 97% of cases, an improvement over last year's result of 86%, and the member was reassessed against ASAM

criteria during the course of treatment more often, increasing from 57% last year to 59% this year. Additional assessment tools were used in 49% of cases and included:

- PHQ-9, AASE (4 cases)
- GAD-7 (3 cases)
- Columbia Suicide Scale (3 cases)
- CIWA (one case)

Table 5-13: Care1st Placement Criteria/Assessment

Question	Denominator	# of Yes 2024	% of Yes 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation ASAM dimensions were used to determine the proper level of care at intake?	37	32	86%	67%	73%
If the ASAM Placement Criteria were used, the level of service identified was:					
Level 0.5: Early Intervention	32	0	0%	0%	0%
OMT: Opioid Maintenance Therapy	32	3	9%	0%	0%
Level 1: Outpatient Treatment	32	20	63%	50%	44%
Level 2: Intensive Outpatient Treatment/ Partial Hospitalization	32	6	19%	7%	13%
Level 3: Residential/Inpatient Treatment	32	6	19%	57%	44%
Level 4: Medically Managed Intensive Inpatient Treatment	32	0	0%	0%	0%
B. Did the member receive the level of services identified by the placement criteria/assessment?	32	31	97%	86%	94%

Question	Denominator	# of Yes 2024	% of Yes 2024	% of Yes FY 2023	% of Yes FY 2022
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	32	19	59%	57%	38%
D. Were additional assessment tools (in addition to ASAM or in lieu of) used during the course of treatment?	37	18	49%	67%	50%

Measure III — Best Practices Key Findings

There was an increase in the use of EBPs in Care1st, increasing from 76% in SFY 2023 to 84% in SFY 2024. Modalities used were reflective of overall state findings, with relapse prevention as the primary EBP used, at 55%, and motivational enhancement/interviewing therapy and cognitive behavior therapy, both at 39%. It is noteworthy that in SFY 2022, cognitive behavior therapy was 74%. Additional interventions used by providers included:

- Living in Balance (3 cases)
- Rational Emotive Behavior Therapy (2 cases)
- Relaxation Therapy (2 cases)

MAT for alcohol was utilized at 19%, despite alcohol being the primary drug of choice for the Care1st cases reviewed. Suboxone remains the primary MAT for OUDs, at 43%, followed by Methadone and Naltrexone, both at 29%. There was one member MAT used for nicotine, although this was a measure reviewed for information purposes only. Peer support services were offered in 51% of cases, an increase from last year's finding of 38%, and 42% of cases utilized peer support services, an increase from last year's result of 25%. Telehealth was offered in 78% of cases, an increase from the previous year's finding of 64%. The findings in the areas of peer support and telehealth services are in alignment with AHCCCS goals for the SUBG.

Table 5-14: Care1st Best Practices — EBPs

Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
A. Were EBPs used in treatment?	37	31	84%	76%	86%
• Cognitive Behavioral Therapy	31	12	39%	50%	74%
• Dialectal Behavioral Therapy	31	9	29%	6%	11%
• Helping Women Recover	31	0	0%	0%	0%
• Matrix	31	2	6%	6%	16%
• Moral Re-conation Therapy	31	2	6%	0%	0%
• Motivational Enhancement /Interviewing Therapy	31	12	39%	56%	21%
• Relapse Prevention Therapy	31	17	55%	19%	58%
• Seeking Safety	31	1	3%	1%	11%
• SMART Recovery	31	0	0%	0%	5%
• Thinking for a Change	31	0	0%	0%	5%
• Trauma Recovery and Empowerment Model	31	0	0%	0%	9%
• Trauma-Informed Care	31	2	6%	0%	11%
• Wellness Recovery Action Plan	31	0	0%	0%	0%
• Other Practices or Program	31	7	23%	1%	0%

Table 5-15: Care1st Best Practices — Medication Assisted Treatment, Peer Support, and Telehealth

Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
• MAT [22]	37	7	19%	10%	18%
The following medication was used in treatment:					
Alcohol-Related					
• Acamprosate (Campral)	7	1	14%	0%	0%
• Disulfiram (Antabuse)	7	0	0%	0%	0%
• Oral naltrexone (Vivitrol®, Revia) (naltrexone hydrochloride tablet)	7	1	14%	New measure	New measure
Opioid-Related					
• Buprenorphine and naloxone (Suboxone, Zubsolv®)	7	3	43%	50%	25%
• Subutex (buprenorphine)	7	0	0%	0%	0%
• Methadone/LAAM	7	2	29%	50%	50%
• Naltrexone (Vivitrol®, Revia)	7	2	29%	50%	25%
Nicotine-Related (Information Only)					
• Use of nicotine replacement therapy	7	1	14%	0%	New measure
• Over-the-counter patch, gum, or lozenge	7	1	14%	New measure	New measure
• Prescription inhaler or nasal	7	0	0%	New	New

[22] MAT options updated from 2023 to current evidence-based best practices

Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
spray				measure	measure
• Varenicline prescription (Chantix®)	7	0	0%	New measure	New measure
• Bupropion prescription (Wellbutrin, Aplezin®, Forfivo®, Zyban®)	7	0	0%	New measure	New measure
B. Was screening for substance use/abuse conducted during the course of treatment?	37	15	41%	14%	41%
C. Was certified peer support offered as part of treatment?	37	19	51%	38%	45%
If yes to C, were certified peer support services used as a part of treatment?	19	8	42%	25%	80%
If peer support services were utilized, were the peer support specialists credentialed?	8	6	75%	New measure	New measure
D. Was telehealth offered as an option to receive treatment?	37	29	78%	64%	New measure

Table 5-16: Care1st Treatment/Support Services/Rehabilitation Services

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
The following services were used in treatment:*						
• Individual counseling/ therapy	37	30	81%	-	62%	86%
• Group counseling/ therapy	37	26	70%	-	62%	91%

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
• Family counseling/ therapy	37	1	3%	-	0%	5%
• Case management	37	34	92%	-	76%	86%
A. Was there clear documentation of progress or lack of progress towards the identified ISP goals?	37	35	95%	-	90%	91%
The number of completed counseling/therapy sessions during treatment was:*						
• 0–5 sessions	37	13	35%	-	33%	27%
• 6–10 sessions	37	7	19%	-	14%	23%
• 11 sessions or more	37	17	46%	-	52%	50%
B. Was the individual given any education on self-help or recovery groups?	37	22	59%	-	62%	82%
C. Documentation showed the member reported attending self-help or recovery groups the following number of times:*						
• No documentation	37	24	65%	-	57%	27%
• 0 times during treatment	37	4	11%	-	5%	5%
• 1–4 times during treatment	37	4	11%	-	5%	23%
• 5–12 times during treatment	37	2	5%	-	14%	14%
• 13–20 times during treatment	37	2	5%	-	10%	5%
• 21 or more times during treatment	37	1	3%	-	10%	27%
D. If there was evidence of lack of progress towards the identified goal, did the provider revise the treatment approach	22	15	68%	7	44%	64%

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
and/or seek consultation to facilitate positive outcomes?						
E. If the member was unemployed during intake, was there evidence the individual's interest in finding employment was explored?	18	12	67%	19	25%	55%
F. If the member was not involved in an educational or vocational training program, was there evidence the individual's interest in becoming involved in such a program was explored?	13	6	46%	24	20%	44%
G. 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 the individual's interest in such an activity was explored?	16	11	69%	21	14%	46%
H. Does the documentation reflect that substance abuse services were provided?*	37	36	97%	-	100%	86%
I. Was member's access to a PCP or other medical provider explored?	37	31	84%	4	76%	68%

Measure V — Gender-Specific Key Findings

The total sample size of female members for Care1st was 17. There were seven cases with a history of domestic violence documented, and five cases had a safety plan completed in SFY 2024, for a finding of 71%. There were no pregnant women in the sample. Gender-specific treatment services continue to remain an area of opportunity, with 0% for SFY 2024 and SFY 2023.

Table 5-17: Care1st Gender-Specific for Women

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. If there was a history of domestic violence, was there evidence a safety plan was completed?	7	5	71%	10	50%	50%
B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	N/A	0	-	17	N/A	0%
C. If the female was pregnant, did documentation show evidence of education on the effects of substance use on fetal development?	N/A	0	-	17	N/A	0%
D. If the female had a child less than one year of age, was there evidence a screening was completed for postpartum depression/ psychosis?	N/A	0	-	17	N/A	0%
E. If the female had dependent children, was there documentation to show childcare was addressed?	3	2	67%	14	100%	0%
F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	13	0	0%	4	0%	14%

Measure VI — Opioid-Specific Key Findings

Care1st saw an increase, from SFY 2023 of 10% to SFY 2024 of 22%, of cases with an opioid use diagnosis. All cases identified as OUD were referred to a MAT provider. This has been consistent since SFY 2022. There were also 100% of all cases that were referred to a provider if withdrawal symptoms were present. There was a positive increase in naloxone education, including overdose and actions to take for an overdose. This increased from 50% in the previous year to 63% in SFY 2024. The measure of natural supports/family members being provided education on how to obtain naloxone and actions to take in case of overdose was

0%. This would substantiate the information of low incidences of natural supports/family being involved in treatment from earlier than the measure.

Table 5-18: Care1st Opioid-Specific

Question	Denominator	# of Yes 2024	%of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation of a diagnosed OUD?*	37	8	22%	-	10%	18%
B. Was there documentation the member was provided MAT education as a treatment option?*	8	6	75%	-	50%	100%
If yes, were they referred to a MAT provider?	6	6	100%	1	100%	100%
C. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	4	4	100%	4	100%	100%
D. If a physical health concern related to pain was identified, were alternative pain management options addressed?	4	4	100%	4	N/A	0%
E. 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	N/A
F. Was there documentation the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?*	8	5	63%	-	50%	25%

Question	Denominator	# of Yes 2024	%of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
G. Was the individual provided with naloxone or information on how to obtain naloxone?*	8	6	75%	-	0%	25%
H. Were family members/ natural supports provided information on how to obtain naloxone/provided naloxone, and actions to take in the event of an opioid overdose, if applicable?	8	0	0%	4	0%	New measure
I. Was there documentation the member was provided education on the effects of polysubstance use with opioids?	8	4	50%	0	50%	50%

Measure VII — Discharge and Continuing Care Planning Key Findings

There was a decrease, from SFY 2023 of 56% to 49% in SFY 2024, when a relapse prevention plan was completed. There was a slight increase in members being reassessed using ASAM at the time of discharge, from 31% in the previous year to 34% in SFY 2024. Of those reassessed, there was a slight increase in referral to the identified LOC of 31% in SFY 2023 to 34% in SFY 2024. There was an increase in coordination with other agencies, from 42% in SFY 2023 to 65% in SFY 2024.

Table 5-19: Care1st Discharge and Continuing Care Planning (completed only if member completed treatment or declined further services)

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation present that a relapse prevention plan completed?*	35	17	49%	-	56%	61%

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
B. Was the individual reassessed at the time of discharge using ASAM criteria to determine an appropriate LOC?*	35	12	34%	-	31%	39%
C. Was the individual referred to the appropriate LOC based on the ASAM determination?	11	9	82%	8	80%	100%
D. Was there documentation staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g., crisis line)?*	35	24	69%	-	63%	72%
E. Was there documentation staff actively coordinated with other involved agencies at the time of discharge?	23	15	65%	12	42%	65%

Measure VIII — Reengagement Key Findings

Reengagement findings also saw a decline from SFY 2023 to SFY 2024, with telephone outreach dropping from 80% to 71% and follow-up letter contact dropping from 67% to 56%. Other activities taken by providers to make contact included calling the member's emergency contact (75%). There were no home visits or street outreach. Increased reengagement efforts could lead to increased retention and better treatment outcomes and may be an additional potential area for Care1st to provide technical assistance to providers.

Table 5-20: Care1st Reengagement (completed only if member declined further services or chose not to appear for scheduled services)

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
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)?*	24	17	71%	-	80%	82%
B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	18	10	56%	6	67%	67%
C. Were there other attempts made to reengage the individual, such as:	D.	E.	F.	G.	H.	I.
• Home visit?	4	0	0%	-	0%	0%
• Call emergency contact(s)?	4	3	75%	-	50%	0%
• Contacting other involved agencies?	4	1	25%	-	0%	100%
• Street Outreach?	4	0	0%	-	0%	0%

Measure IX — NOMs Key Findings

The tables below illustrate both intake and discharge comparisons for NOMs. There was information missing in both categories, reflecting the fluctuations in denominators. Employment information at intake saw a significant decrease, from 75% in SFY 2023 to 47% in SFY 2024. Employment information at discharge also saw a decrease, with SFY 2023 discharge information of 90% while SFY 2024 was 53%. For SFY 2023 documentation of abstinence from drugs and/or alcohol, SFY 2023 was 25%, with SFY 2024 at 30%. The number of members arrested within 30 days at discharge in SFY 2024 was 17%, while SFY 2023 was 22%.

Table 5-21: 2024 Care1st National Outcome Measures

2024	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
A. Employed?	36	17	47%	1	19	10	53%	18
B. Enrolled in school or vocational educational program?	33	2	6%	4	14	2	14%	23
C. On disability or retired?	25	5	20%	12	16	3	19%	21
D. Lived in a stable housing environment (e.g., not homeless)?	37	34	92%	0	19	18	95%	18
E. Arrested in the preceding 30 days?**	35	6	17%	2	18	2	11%	19
F. Abstinent from drugs and/or alcohol?	37	11	30%	0	16	12	75%	21
G. Participated in social support recovery in the preceding 30 days?	37	8	22%	5	16	12	75%	21

Table 5-22: 2023 Care1st National Outcome Measures

2023	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
A. Employed?	20	15	75%	1	10	9	90%	11
B. Enrolled in school or vocational educational program?	18	0	0%	3	11	0	0%	10
C. On disability or retired?	19	2	11%	2	11	1	9%	10
D. Lived in a stable housing environment (e.g., not homeless)?	21	18	86%	0	11	11	100%	10
E. Arrested in the preceding 30 days?**	18	4	22%	3	11	0	0%	10
F. Abstinent from drugs and/or alcohol?	20	5	25%	1	11	11	100%	10
G. Participated in social support recovery in the preceding 30 days?	21	4	19%	6	11	8	73%	10

Mercy Care

Measure I — Intake/Treatment Planning Key Findings

Mercy Care is a not-for-profit health plan having responsibility for AHCCCS members in the central and south-central regions of Arizona. MC is assigned to members living in Gila, Maricopa, and Pinal counties.

Initial Behavioral Health Assessment

Alcohol, opioids, and amphetamines were the top three substances most frequently used during this reporting period, respectively. In the previous reporting period, opioids were the most frequently used substance, followed by alcohol and amphetamines. Use of opioids and marijuana both decreased from SFY 2023; opioid use decreased from 48% to 35%, and marijuana use decreased from 16% to 8%. Amphetamine use increased from 19% in SFY 2023 to 24% in SFY 2024.

The three most used methods of ingestion remained the same from the previous reporting period to this reporting period. Forty-five percent (45%) of members reported smoking as their preference, followed by oral (39%) and inhalation (11%) in SFY 2024.

Ninety-one percent (91%) of the records had a behavioral health assessment completed within 45 days of intake. This metric continued to decline over the last few reporting periods. In SFY 2022, 96% of the records had a completed behavioral health assessment. In SFY 2023, there was a three-point decrease, from 96% to 93%. There was another slight decrease from SFY 2023 (93%) to SFY 2024 (91%).

One hundred percent (100%) of the behavioral health assessments addressed substance-related disorders, showing improvement from the previous year (95%). Describing the intensity and frequency of substance use increased across years (SFY 2022 at 91%, SFY 2023 at 93%, and SFY 2024 at 97%). There was a 38% and 47% increase, respectively, for including the effect of substance use on interpersonal relationships and the completion of a risk assessment. Conversely, there was a 41% and 27% decrease, respectively, in the documentation of tuberculosis and screening for hepatitis C, HIV, and other infectious diseases. Further, there has been a steady decline in the documentation of the PDMP. In SFY 2022, 28% of the charts reviewed the PDMP, followed by 22% in SFY 2023 and 14% in SFY 2024.

A new measure for this reporting period included assessing whether SDoHs were documented as part of the assessment. The top three SDoHs identified in the assessment were:

- Unemployment (85%)
- Housing (78%)
- Access to medical care (73%)

Regulatory Requirements

Regulatory requirements, such as documentation following charitable choice requirements, decreased, from 100% in SFY 2023 to 90% in SFY 2024. There were two additional regulatory metrics added this reporting year related to HIPAA and informed consent. Seventy-one percent (71%) of the records included evidence of members being informed of their HIPAA rights, and 79% included evidence that members were given information on informed consent.

Individual Service Plan

One hundred percent (100%) of the charts reviewed had a completed ISP, and 100% of the ISPs were completed within 90 days of the initial appointment (new measure). All other components of the ISP reflected decreases, with the exception of one metric: "Was the ISP congruent with the diagnosis and presenting concerns?" This metric remained unchanged for SFY 2024, at 100%. All other metrics decreased, with the largest decrease (from 100% to 46%) occurring for addressing the unique cultural preferences of the member.

Table 5-24: MC Assessment and Individual Service Plan

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes FY 2023	% of Yes FY 2023
A. What was the primary substance used?*[23]						
• Opioids	102	36	35%	-	61	48%
• Marijuana	102	8	8%	-	21	16%
• Alcohol	102	37	36%	-	43	34%
• Amphetamines	102	24	24%	-	24	19%

[23] [23] Substance used and method of ingestion represent information on preferred substances. In some cases, multiple substances were reported as the primary substance for members with polysubstance use conditions because it was hard to discern in the record.

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes FY 2023	% of Yes FY 2023
• Cocaine	102	8	8%	-	9	7%
• Other (please list)	102	0	0%	-	6	5%
B. What was the method of ingestion?*						
• Smoking	102	46	45%	-	60	47%
• Oral	102	40	39%	-	49	38%
• Inhalation	102	11	11%	-	9	7%
• Injection	102	3	3%	-	6	5%
• Transdermal	102	0	0%	-	0	0%
• Other (please list)	102	1	1%	-	11	9%

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
Behavioral Health Assessment						
C. Was a behavioral health assessment completed?*	102	93	91%	-	93%	96%
i. Was the behavioral health assessment completed within 45 days of the initial appointment? [24]	102	92	90%	0	New measure	New measure
D. Did the behavioral health assessment:*						
i. Address substance related disorder(s)?	93	93	100%	-	95%	97%
ii. Describe the intensity/ frequency of substance use?	93	90	97%	-	93%	91%

[24] Item C and C.i. was split into two questions for the 2024 review due to tool validation.

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
iii. Include the effect of substance use on daily functioning?	93	88	95%	-	99%	89%
iv. Include the effect of substance use on interpersonal relationships?	93	84	90%	-	52%	91%
v. Was a risk assessment completed?	93	93	100%	-	53%	91%
vi. Document screening for tuberculosis?	93	51	55%	-	96%	45%
vii. Document screening for hepatitis C, HIV, and other infectious diseases?	93	61	66%	-	93%	58%
viii. Document screening for emotional and/or physical abuse/trauma issues?	93	92	99%	-	95%	93%
ix. Document that review of the PDMP was completed?	85	12	14%	-	22%	28%
E. Were SDoHs documented as a part of the assessment?*						
i. Access to medical care?	97	71	73%	-	New measure	New measure
ii. Housing?	97	76	78%	-	New measure	New measure
iii. Food Insecurity?	97	45	46%	-	New measure	New measure
iv. Domestic Violence?	97	63	65%	-	New measure	New measure
v. Unemployment?	97	82	85%	-	New measure	New measure
vi. Transportation?	97	67	69%	-	New measure	New measure

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
vii. Other?	97	5	5%	-	New measure	New measure
F. Regulatory requirements:						
i. Was there documentation charitable choice requirements were followed, if applicable?	20	18	90%	79	100%	73%
ii. Was there documentation individuals were informed of their HIPAA rights?*	99	70	71%	-	New measure	New measure
iii. Was there documentation individuals were given information on informed consent?*	99	78	79%	-	New measure	New measure
G. Was an ISP completed?*[25]	93	93	100%	-	93%	98%
i. Was the ISP completed within 90 days of the initial appointment?	93	93	100%	0	New measure	New measure
H. Was the ISP:						
i. Developed with participation of the family/support network?	93	7	8%	77	13%	9%
ii. Congruent with the diagnosis(es) and presenting concern(s)?*	93	93	100%	-	100%	97%
iii. Showing measurable objectives and timeframes to address the identified needs?*	93	92	99%	-	100%	96%
iv. Addressing the unique cultural preferences of the individual?*	93	43	46%	-	100%	93%
v. Showing SDoH issues were considered as part of, and incorporated into, the ISP?	93	30	32%	34	48%	77%

[25] Item G and G.i. were split into two questions for the 2024 review due to tool validation.

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
I. If yes, which domains?*						
• Access to medical care?	93	13	14%	-	21%	22%
• Housing?	93	11	12%	-	29%	31%
• Food insecurity?	93	2	2%	-	4%	4%
• Domestic violence?	93	1	1%	-	3%	3%
• Unemployment?	93	17	18%	-	25%	33%
• Transportation?	93	6	6%	-	13%	New Measure
• Other	93	3	2%	-	4%	5%

Measure II — Placement Criteria/Assessment Key Findings

Eighty-two percent (82%) — a 1% decrease from the previous year — of the charts reviewed included documentation that ASAM dimensions were used to determine the proper LOC at intake. Forty-three percent (43%) of members received Level 1 outpatient treatment, and 29% of members received Level 2 intensive outpatient treatment/partial hospitalization. Nineteen percent (19%) of members received opioid maintenance therapy and residential/inpatient treatment. Compared to the previous year, there was a decrease in opioid maintenance therapy (from 34% in SFY 2023 to 19% in SFY 2024) and an increase in intensive outpatient treatment/partial hospitalization (from 16% in SFY 2023 to 29% in SFY 2024). Ninety-eight percent (98%) of members received the level of services identified by the placement criteria/assessment. During the course of treatment, 74% of the ASAM dimensions were reassessed compared to 50% the previous reporting period.

Additional assessment tools were used to identify clinical needs in 61% of the records reviewed. Some of the tools providers used are the following:

- PHQ-9 (22 cases)
- UNCOPE (one case)

- Columbia Suicide Severity Scale (six cases)
- GAD-7 (27 cases)
- PHQ-2 (two cases)
- PRAPARE (three cases)
- DAST (three cases)
- CRAFFT (three cases)
- ACES (five cases)
- CAGE (two cases)

Table 5-25: MC Placement Criteria/Assessment

Question	Denominator	# of Yes 2024	% of Yes 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation ASAM dimensions were used to determine the proper level of care at intake?	102	84	82%	83%	80%
If the ASAM Placement Criteria were used, the level of service identified was:					
Level 0.5: Early Intervention	84	1	1%	2%	1%
OMT: Opioid Maintenance Therapy	84	16	19%	34%	21%
Level 1: Outpatient Treatment	84	36	43%	40%	52%
Level 2: Intensive Outpatient Treatment/Partial Hospitalization	84	24	29%	16%	13%
Level 3: Residential/Inpatient Treatment	84	16	19%	20%	32%
Level 4: Medically Managed Intensive Inpatient Treatment	84	1	1%	0%	1%
B. Did the member receive the level of services identified by the placement criteria/ assessment?	84	82	98%	92%	97%

Question	Denominator	# of Yes 2024	% of Yes 2024	% of Yes FY 2023	% of Yes FY 2022
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	84	62	74%	50%	63%
D. Were additional assessment tools (in addition to ASAM or in lieu of) used during the course of treatment?	102	62	61%	56%	60%

Measure III — Best Practices Key Findings

EBPs were used 81% of the time during treatment; this is an 8% increase from SFY 2023. Relapse prevention therapy was used 70% of the time during treatment, followed by motivational enhancement/interviewing therapy (48%) and cognitive behavioral therapy (36%). Relapse prevention therapy increased 44% in SFY 2024 (from 26% in SFY 2023 to 70% in SFY 2024). Although seeking safety was used 8% in SFY 2024 during treatment, this modality was not used in either SFY 2023 or SFY 2022. Other EBPs included:

- Living in Balance (4 cases)
- Eye Movement Desensitization and Reprocessing (EMDR) (3 cases)
- Rational Emotive Behavior Therapy (2 cases)
- Mindfulness (2 cases)

MAT was used 34% of the time during treatment. There has been a steady decrease in MAT across review years (47% in SFY 2022; 45% in SFY 2023; 34% in SFY 2024). In SFY 2024, 20% of members received oral naltrexone for alcohol-related addiction (which was a new measure this year). Buprenorphine and naloxone, Subutex, methadone, and naltrexone were used by members 29%, 3%, 43%, and 9%, respectively. There was a 27% increase in buprenorphine and naloxone and a 40% decrease in methadone.

Screening for substance use/abuse was conducted during the course of treatment 66% of the time, a 2% increase from the previous year. Since 2022, there has been a steady increase in certified peer support services being offered as part of treatment (36% in SFY 2022; 40% in SFY 2023; 50% in SFY 2024) and deployed as a member of the treatment team (56% in SFY 2022; 63% in SFY 2023; 71% in SFY 2024). Seventy-five percent (75%) of

peer specialists utilized were credentialed (new measure). Telehealth was offered as an option for treatment 66% of the time in SFY 2024, a 3% increase from the previous year.

Table 5-26: MC Best Practices — EBPs

Questions	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
Were EBPs used in treatment?	102	83	81%	73%	71%
• Cognitive Behavioral Therapy	83	30	36%	44%	88%
• Dialectal Behavioral Therapy	83	6	7%	14%	8%
• Helping Women Recover	83	0	0%	1%	0%
• Matrix	83	4	5%	9%	12%
• Moral Re-conation Therapy	83	1	1%	0%	0%
• Motivational Enhancement/ Interviewing Therapy	83	40	48%	57%	52%
• Relapse Prevention Therapy	83	58	70%	26%	55%
• Seeking Safety	83	7	8%	0%	0%
• SMART Recovery	83	9	11%	8%	12%
• Thinking for a Change	83	0	0%	0%	0%
• Trauma Recovery and Empowerment Model	83	0	0%	0%	0%
• Trauma-Informed Care	83	4	5%	1%	11%
• Wellness Recovery Action Plan	83	0	0%	0%	0%
• Other Practices or Program	83	10	12%	7%	24%

Table 5-27: MC Best Practices — Medication Assisted Treatment, Peer Supports, and Telehealth

Questions	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
MAT[26]	102	35	34%	45%	47%
The following medication was used in treatment:					
Alcohol-Related					
• Acamprosate (Campral)	35	0	0%	2%	0%
• Disulfiram (Antabuse)	35	0	0%	2%	2%
• Oral naltrexone (Vivitrol®, Revia) (naltrexone hydrochloride tablet)	35	7	20%	New measure	New measure
Opioid-Related					
• Buprenorphine and naloxone (Suboxone, Zubsolv®)	35	10	29%	2%	22%
• Subutex (buprenorphine)	35	1	3%	3%	3%
• Methadone/Levo-Alpha-Acetylmethadol (LAAM)	35	15	43%	83%	74%
• Naltrexone (Vivitrol®, Revia)	35	3	9%	3%	5%
Nicotine-Related (Information Only)					
Use of nicotine replacement therapy: •	35	1	3%	3%	New measure
• Over-the-counter patch, gum, or lozenge	35	1	3%	New measure	New measure
• Prescription inhaler or nasal spray	35	0	0%	New measure	New measure

[26] MAT options updated from 2023 to current evidence-based best practices

Questions	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
• Varenicline prescription (Chantix®)	35	0	0%	New measure	New measure
• Bupropion prescription (Wellbutrin, Aplezin®, Forfivo®, Zyban®)	35	0	0%	New measure	New measure
H. Was screening for substance use/abuse conducted during the course of treatment?	102	67	66%	64%	65%
I. Was certified peer support offered as part of treatment?	102	51	50%	40%	36%
i. If yes to C, were certified peer support services used as a part of treatment?	51	36	71%	63%	56%
J. If peer support services were utilized, were the peer support specialists credentialed?	36	27	75%	New measure	New measure
K. Was telehealth offered as an option to receive treatment?	102	67	66%	63%	New measure

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

Case management services were documented in 90% of records, a slight decrease from 91% in SFY 2023. Eighty-one percent (81%) of members received individual therapy, and 70% of members received group therapy, with a 4% decrease individual services and a 1% drop in group services. Family therapy increased by 1%, from 2% in SFY 2023 to 3% in SFY 2024. There was clear documentation of progress or lack of progress towards the ISP goals in 89% of charts. This is lower than SFY 2023 (91%) but higher than SFY 2022 (85%). Fifty-two percent (52%) of members received 11 sessions or more, compared to 10% of members who received six to 10 sessions and 38% of members who received zero to five sessions.

Fifty-nine percent (59%) of records had no documentation of members reporting they attended self-help or recovery groups. Sixteen percent (16%) of charts documented members attended zero self-help or recovery groups; a 5% increase from SFY 2023 and 11% increase from SFY 2022. Four percent (4%) of members reported attending self-help groups one to four times during treatment, 7% of members attended five to 12 times during treatment, and 1% attended 13–20 times during treatment.

When there was evidence of lack of progress towards identified goals, providers revised the treatment plan or sought consultation to facilitate positive outcomes 69% of the time. This occurred 68% of the time in SFY 2023 and 54% of the time in SFY 2022. When members were unemployed during intake, 80% of charts showed evidence that finding employment was explored. This is a 3% decline from SFY 2023 and a 10% decline from SFY 2022. Sixty-two percent of charts had evidence that an educational or vocational training program was explored when members were not involved in any such activities, compared to 79% in SFY 2023 and 67% in SFY 2022. Sixty-seven percent (67%) of charts had evidence that meaningful community activities were explored, a 16% decrease from SFY 2023, yet a 9% increase from SFY 2022. The documentation reflected that substance abuse services were provided 99% of the time, an increase from SFY 2023 (97%) and SFY 2022 (90%). Seventy-nine percent (79%) of charts had evidence that a PCP or other medical provider was explored; a 5% decrease from SFY 2023 and 1% increase from SFY 2022.

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

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. The following services were used in treatment:*						
• Individual counseling/ therapy	102	83	81%	-	85%	72%
• Group counseling/ therapy	102	71	70%	-	71%	73%
• Family counseling/ therapy	102	3	3%	-	2%	0%
• Case management	102	92	90%	-	93%	81%
B. Was there clear documentation of progress or lack of progress towards the identified ISP goals?*	102	91	89%	-	91%	85%
C. The number of completed counseling/therapy sessions during treatment was:*						

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
• 0–5 sessions	102	39	38%	-	31%	41%
• 6–10 sessions	102	10	10%	-	14%	11%
• 11 sessions or more	102	53	52%	-	55%	48%
D. Was the individual given any education on self-help or recovery groups?*	102	69	68%	-	70%	70%
E. Documentation showed the member reported attending self-help or recovery groups the following number of times:*						
• No documentation	102	60	59%	-	65%	66%
• 0 times during treatment	102	16	16%	-	11%	5%
• 1–4 times during treatment	102	4	4%	-	4%	3%
• 5–12 times during treatment	102	7	7%	-	5%	4%
• 13–20 times during treatment	102	1	1%	-	2%	3%
• 21 or more times during treatment	102	14	14%	-	13%	19%
F. If there was evidence of lack of progress towards the identified goal, did the provider revise the treatment approach and/or seek consultation to facilitate positive outcomes?	48	33	69%	54	68%	54%
G. If the member was unemployed during intake, was there evidence the individual's interest in finding employment was explored?	51	41	80%	51	83%	90%
H. If the member was not involved in an educational or vocational training program, was there evidence the individual's interest in becoming involved in such a program was explored?	34	21	62%	68	79%	67%

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
I. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence the individual's interest in such an activity was explored?	46	31	67%	56	83%	58%
J. Does the documentation reflect substance abuse services were provided?*	102	101	99%	-	97%	90%
K. Was member's access to a PCP or other medical provider explored?	102	81	79%	6	84%	78%

Measure V — Gender-Specific Key Findings

There were 34 members in the MC sample that were women. There were notable increases for three of the gender-specific metrics (domestic violence, coordination of care with PCP/obstetrician, and postpartum depression/psychosis screening). Sixty-seven percent (67%) of MC providers had documentation of a safety plan when there was a history of domestic violence, a 34% increase from SFY 2023 and 29% increase from SFY 2022. For pregnant women, 100% of the charts reflected documentation of coordination of care efforts with PCP and/or obstetricians in SFY 2024 compared to zero percent in SFY 2023 and 50% in SFY 2022. If a female had a child less than one year of age, there was evidence of postpartum depression/psychosis screening 67% of the time, up from 33% in SFY 2023 and 60% in SFY 2022. Childcare was addressed when the female had dependent children 67% of the time in SFY 2024, a decrease from 73% and 86% in SFY 2023 and SFY 2022, respectively.

Table 5-29: MC Gender-Specific for Women

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. If there was a history of domestic violence, was there evidence a safety	9	6	67%	25	33%	38%

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
plan was completed?						
B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	1	1	100%	33	0%	50%
C. If the female was pregnant, did documentation show evidence of education on the effects of substance use on fetal development?	1	0	0%	33	0%	50%
D. If the female had a child less than one year of age, was there evidence a screening was completed for postpartum depression/ psychosis?	3	2	67%	31	33%	60%
E. If the female had dependent children, was there documentation to show childcare was addressed?	15	10	67%	19	73%	86%
F. Was there evidence of gender-specific treatment services (e.g., women's only group therapy sessions)?	26	5	19%	8	23%	57%

Measure VI — Opioid-Specific Key Findings

Eighty percent (80%) of charts had documentation of a diagnosed OUD in SFY 2024; this is a 6% decrease from SFY 2023 but a 20% increase from SFY 2022. Ninety-four percent (94%) of charts had documentation that the members were provided with MAT education as a treatment option, and 100% of those members were referred to a MAT provider. Pregnant females were educated about the safety of methadone and/or buprenorphine during the course of pregnancy 50% of the time compared to 33% in SFY 2022. There was documentation the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose 50% of the time, a 23% decrease from SFY 2023 and 4% decrease from SFY 2022. Fifty-five percent (55%) of the charts included documentation that family members/natural supports were provided information on how to obtain naloxone/provided naloxone and actions to take in the event of an opioid overdose (new measure). There was documentation (80% of the time) that the

member was provided education on the effects of polysubstance use with opioids. This is a 4% increase from SFY 2023 and a 21% increase from SFY 2022.

Table 5-30: MC Opioid-Specific

Questions	Denominator	# of Yes 2024	%of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation of a diagnosed OUD?*	40	32	80%	-	86%	60%
B. Was there documentation the member was provided MAT education as a treatment option?*	32	30	94%	-	97%	85%
If yes to B, were they referred to a MAT provider?	17	17	100%	23	97%	94%
C. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	10	8	80%	30	81%	98%
D. If a physical health concern related to pain was identified, were alternative pain management options addressed?	N/A	0	--	40	86%	79%
E. 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?*	40	20	50%	-	N/A	33%
F. Was there documentation the member was provided with relevant information related to overdose, naloxone education, and	40	20	50%	-	73%	54%

Questions	Denominator	# of Yes 2024	%of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
actions to take in the event of an opioid overdose?*						
G. Was the individual provided with naloxone or information on how to obtain naloxone?*	40	0	0%	-	73%	54%
H. Were family members/natural supports provided information on how to obtain naloxone/provided naloxone, and actions to take in the event of an opioid overdose, if applicable?	40	22	55%	0	0%	New measure
I. Was there documentation the member was provided education on the effects of polysubstance use with opioids?	40	32	80%	0	76%	59%

Measure VII — Discharge and Continuing Care Planning Key Findings

Case review found that 57% of records contained a relapse prevention plan that was done for members who completed treatment or declined further services. This is a 10% decrease from SFY 2023 (67%) and a 12% decrease from SFY 2022 (69%). Sixty-five percent (65%) of cases had documentation supporting resources for community support, including recovery, self-help, and other services that were offered.

This review found that MC providers referred to the appropriate LOC based on ASAM determination in 93% of cases in which a discharge ASAM assessment was documented (compared to 100% of the cases in SFY 2023). In SFY 2024, there was an increase in the number of members being referred to community resources (65%, up from 63% in SFY 2023, and up from 61% in SFY 2022). Staff are actively coordinating with other relevant agencies (71% in SFY 2024 and SFY 2023, up from 59% in SFY 2022). It should be noted that there was an increase in discharge reassessments using ASAM criteria to determine appropriate LOC (52% in SFY 2024 compared to 33% in SFY 2023).

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

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation present a relapse prevention plan completed?*	81	46	57%	-	67%	69%
B. Was the individual reassessed at the time of discharge using ASAM criteria to determine an appropriate LOC?*	82	43	52%	-	33%	55%
C. Was the individual referred to the appropriate LOC based on the ASAM determination?	40	37	93%	13	100%	94%
D. Was there documentation staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g., crisis line)?*	81	53	65%	-	63%	61%
E. Was there documentation staff actively coordinated with other involved agencies at the time of discharge?	52	37	71%	30	71%	59%

Measure VIII — Reengagement Key Findings

Members (or legal guardian if applicable) were contacted by telephone at times when the member was expected to be available (e.g., after work or school) 88% of the time (up from 78% in SFY 2023). When telephone contact was unsuccessful, a letter requesting contact was mailed 61% of the time, up from 55% and 56% in SFY 2023 and SFY 2022, respectively. Other attempts made to reengage members included contacting other involved agencies; this occurred 60% of the time, a 49% increase from SFY 2023.

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

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
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)?*	56	49	88%	-	78%	81%
B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	49	30	61%	7	55%	56%
C. Were other attempts made to reengage the individual, such as*:						
• Home visit?	10	1	10%	-	11%	0%
• Call emergency contact(s)?	10	1	10%	-	0%	17%
• Contacting other involved agencies?	10	6	60%	-	11%	33%
• Street outreach?	10	0	0%	-	0%	0%

Measure IX — NOMs Key Findings

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

The review has shown a 54% increase in the number of members participating in social support recovery at intake versus at discharge. Further, there was also an increase at discharge (76%) compared to the previous year (64%). Abstinence from drugs and/or alcohol also showed an increase, from 61% in SFY 2023 to 84% in SFY 2024. Employment status at discharge showed a slight decrease, from 56% in SFY 2023 to 54% in SFY 2024. The number of members arrested within the past 30 days at discharge decreased, from 3% in SFY 2023 to 0% in SFY 2024.

Table 5-33: FY 2024 MC National Outcome Measures

2024	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
A. Employed?	98	44	45%	3	54	29	54%	47
B. Enrolled in school or vocational educational program?	90	4	4%	11	51	3	6%	50
C. On disability or retired?	82	10	12%	19	43	6	14%	58
D. Lived in a stable housing environment (e.g., not homeless)?	96	80	83%	5	52	51	98%	49
E. Arrested in the preceding 30 days?**	89	7	8%	12	46	0	0%	55
F. Abstinent from drugs and/or alcohol?	96	28	29%	5	49	41	84%	52
G. Participated in social support recovery in the preceding 30 days?	100	22	22%	20	50	38	76%	50

Table 5-34: FY 2023 MC National Outcome Measures

2023	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
Employed?	123	63	51%	5	98	55	56%	30

2023	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
A. Enrolled in school or vocational educational program?	115	4	3%	13	95	6	6%	33
B. On disability or retired?	108	14	13%	20	93	11	12%	35
C. Lived in a stable housing environment (e.g., not homeless)?	121	94	78%	7	95	78	82%	33
D. Arrested in the preceding 30 days?**	117	7	6%	11	95	3	3%	33
E. Abstinent from drugs and/or alcohol?	121	29	24%	7	82	50	61%	46
F. Participated in social support recovery in the preceding 30 days?	128	25	20%	17	89	57	64%	39

Section 6
Recommendations

Carryover Recommendations from SFY 2022 and SFY 2023 ICRs

- **Consider changes to sampling methodology for future reviews.** As an option in future reviews, AHCCCS should consider increasing validity and reliability by using a more randomized sampling methodology. One method for achieving this would be to have the independent reviewer randomly select the sample cases to be reviewed (from the entire population of files that meet inclusion criteria), and then ask the ACC-RBHAs to supply those specific records. This would add some time to the process (when compared to having the ACC-RBHAs select files to provide), but it would increase confidence in the results and contribute to overall project validity. Mercer used this sampling methodology in support of the Priority Mental Health Services review, which is conducted annually for AHCCCS. An additional benefit of using this sampling methodology is that the independent reviewer would have the opportunity to stratify the sample and increase the number of cases from small subpopulations that are reviewed (e.g., women, older adults, and transition-age youth). For example, this year's review only captured one pregnant woman (versus last year's three). This small representation within the sample makes it difficult to draw conclusions for this group. By using an appropriate sampling methodology, the independent reviewer could increase the representation of subpopulations in the sample while maintaining the randomness necessary for increased validity and reliability.
- **Clinical consideration for improved quality of care includes the following considerations:**
  - **Training and technical assistance on the importance and development of relapse plans at every LOC.** Relapse prevention plans were present in 70% of cases in SFY 2022 and FY 2023 but dropped to 54% in SFY 2024. Relapse prevention plans should be an important part of the member's recovery and be a living document that continues to be updated throughout all treatment levels of care.
  - **Training and technical assistance on the importance of SDoH in treatment planning and care.** The review tool was updated for SFY 2024 to include measurement of SDoH at assessment as well as in the ISP. The findings of the ICR further underscored the gap between identification of a SDoH and a goal for meeting that need in the ISP. For example, housing was identified in 83% of assessments but only addressed as a goal

in 20% of ISPs. Resources may be limited to address certain SDoH but should still be considered as part of the overall treatment needs.

During focus groups, both providers and members noted ongoing difficulties in resource availability for housing, employment, and transportation. Suggestions to address the lack of resources include seeking donations from the community, working with the Arizona Vocational Rehabilitation Program[27] for members that qualify, and continuing efforts to make connections in the community with food banks and other resources. In addition, it was recommended that staff be trained to address accessing resources in ISPs when identified as a need during the assessment process.

- **Offer training on ASAM criteria**. ASAM criteria are an internationally recognized set of dimensions for assessment of members with substance use as well as a continuum of substance use service settings. Additionally, the ASAM Criteria 4th Edition was released in 2023. Changes include a simplification of LOC, specificity within the dimensions, an increased emphasis on harm reduction, updating standards for co-occurring care, and emphasizing person-centered treatment planning. Although not currently required by any funding agency, such as SAMHSA, training on the new ASAM criteria will assist providers in improving system delivery and in offering the current best practices in substance use treatment, updating terminology, simplifying levels of care, and building specificity within the dimensions.

New Recommendations from SFY 2024 ICR

- **Conduct interim audits of providers in targeted areas such as ASAM utilization and relapse prevention planning.** There has been improvement in some areas from previous years, such as testing for tuberculosis, HIV, hepatitis C, and other infectious diseases, but other areas, such as the use of ASAM, could benefit from more frequent monitoring. Performance improvement projects or corrective action plans should be implemented for providers who consistently underperform, to encourage improvement and better service provision to members.
- **Provide training on cultural competency and person-centered planning.** The incorporation of cultural preferences in the ISP declined significantly this year, from 99% last year to 45% this year. Person-centered treatment has been found to be an important part of member engagement and success in treatment, ensuring the member is engaged in shared decision-making and invested in treatment goals. Cultural humility assists in

[27] Vocational Rehabilitation | Arizona Department of Economic Security

ensuring treatment is effective, incorporating an member's beliefs and preferences in the treatment delivery.[28]

- **Provide gender-specific groups for women.** The overall sample had 65 females, representing 33% of the overall sample population. Only 16% of records demonstrated programs that offered gender-specific groups for women. Women are more likely to have trauma, such as domestic violence, as well as co-occurring disorders. Women also have unique reproductive risks as a result of substance use. Having gender-specific groups could provide a safe space for women to address gender-specific issues and improve outcomes.[29]
- **Increase reengagement efforts for members who leave treatment early.** Reengagement efforts saw a decline in telephone follow up in SFY 2024 from SFY 2023, from 84% to 76%, respectively, and a decline of 65% to 60% for a follow-up letter being sent. The root cause of this decline is not known but could be an opportunity to further increase the use of peer support personnel to perform outreach. They may have more insight into the reason for disengagement as well as a potential opportunity for additional training for providers. Some cases indicated outreach by email and text due to the preferences of the member. Considering alternate outreach methods may be another opportunity to increase engagement. When outreaching members, it may also be an opportunity to survey them about why they have disengaged, even if they do not return to treatment, as a way to improve quality and outcomes long term. Peer support specialists can also provide valuable assistance in connecting members with other resources in the community upon discharge.
- **Ensure education on the use and availability of 12-Step groups.** Documentation of information on 12-Step groups given to members has declined, from 74% in SFY 2022 to 66% in SFY FY 2023 and 63% in SFY 2024. The efficacy of 12-Step groups in recovery, both as a part of formal treatment and independent of a treatment program, has been demonstrated. Encouraging attendance at 12-Step meetings can provide additional support and structure for long-term recovery.[30]
- **Continue to monitor and encourage MAT for alcohol disorder.** There was a decrease in the use of MAT compared to the previous year. Alcohol-specific MAT was used in only 17% of the cases. The benefits of MAT for alcohol addiction include:

[28] Recovery-Oriented, Person-Centered Behavioral Health

[29] Addressing the Specific Needs of Women for Treatment of Substance Use Disorders

[30] Donovan DM, Ingalsbe MH, Benbow J, Daley DC. 12-step interventions and mutual support programs for substance use disorders: an overview. Soc Work Public Health. 2013;28(3-4):313-32. doi: 10.1080/19371918.2013.774663. PMID: 23731422; PMCID: PMC3753023.

- *Reducing cravings and withdrawal symptoms*: MAT medications help alleviate severe withdrawal symptoms, making detoxification safer and more manageable.
- *Supporting long-term sobriety*: MAT provides ongoing support to prevent relapse, with medications, such as naltrexone, blocking the pleasurable effects of alcohol, helping members stay committed to recovery.
- *Enhancing psychological stability*: MAT stabilizes brain chemistry disrupted by chronic alcohol use, improving mood and cognitive function, allowing for better engagement in counseling and behavioral therapies.[31]

[31] https://www.brightviewhealth.com/latest-updates/benefits-of-mat-for-treating-alcohol-dependence/

Appendix A
Case File Review Tool

File Review Tool

Substance Abuse Prevention and Treatment

Case File Review Findings for Measure I–IX

I Intake/Treatment Planning

A. What was the primary substance used?

- Opioids
- Marijuana
- Alcohol
- Amphetamines
- Cocaine
- Other (please list)

B. What was the method of ingestion?

- Smoking
- Oral
- Inhalation
- Injection
- Transdermal
- Other (please list)

C. Was a behavioral health assessment completed?[32]

i. Was the assessment completed within 45 days of the initial appointment?

D. Did the behavioral health assessment:

i. Address substance-related disorder(s)?

ii. Describe the intensity/frequency of substance use?

[32] Assessment - Behavioral Health Definition

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Case File Review Findings for Measure I–IX

iii. Include the effect of substance use on daily functioning?

iv. Include the effect of substance use on interpersonal relationships?

v. Was a risk assessment completed?

vi. Document screening for tuberculosis (TB)?

vii. Document screening for hepatitis C, HIV, and other infectious diseases?

viii. Document screening for emotional and/or physical abuse/trauma issues?

ix. Documentation that review of the Prescription Drug Monitoring Program (PDMP) was completed?

E. Were social determinants of health issues documented as part of the assessment?

If yes, which domains?

i. Access to Medical Care?

ii. Housing?

iii. Food Insecurity?

iv. Domestic Violence?

v. Unemployment?

vi. Transportation?

vii. Other?

F. Regulatory requirements:

i. Was there documentation that Charitable Choice requirements were followed, if applicable?

ii. Was there documentation that individuals were notified of their HIPAA rights?

iii. Was there documentation that individuals were given information on informed consent?

G. Was an individual service plan (ISP) completed?

i. Was the ISP completed within 90 days of the initial appointment?

H. Was the ISP:

i. Developed with participation of the family/support network?

ii. Congruent with the diagnosis(es) and presenting concern(s)?

iii. Measurable objectives and timeframes to address the identified needs?

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Case File Review Findings for Measure I–IX

iv. Addressing the unique cultural preferences of the individual?

v. Were social determinants of health issues considered as part of, and incorporated into, the ISP?

If yes, which domains?

- Access to medical care?
- Housing?
- Food insecurity?
- Domestic violence?
- Unemployment?
- Transportation?
- What options were explored if transportation was determined to be a social determinant of health issue?
- Other?

II Placement Criteria/Assessment

A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?

1. If the ASAM Patient Placement Criteria were used, the level of service identified was:

Level 0.5: Early Intervention

OMT: Opioid Maintenance Therapy

Level 1: Outpatient Treatment

Level 2: Intensive Outpatient Treatment/Partial Hospitalization

Level 3: Residential/Inpatient Treatment

Level 4: Medically Managed Intensive Inpatient Treatment

B. Did the member receive the level of services identified by the placement criteria/assessment?

C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?

D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment? If yes, please list in box below:

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

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- Cognitive Behavioral Therapy (CBT)
- Contingency management
- Dialectal Behavioral Therapy (DBT)
- Helping Women Recover
- Matrix
- Moral Re-conation Therapy (MRT)
- Motivational Enhancement/ Interviewing Therapy (MET/MI)
- Relapse Prevention Therapy (RPT)
- Seeking Safety
- SMART Recovery
- Thinking for a Change
- Trauma Recovery and Empowerment Model (TREM)
- Trauma-Informed Care (TIC)
- Wellness Recovery Action Plan (WRAP)
- Other Practices or Programs (please list in box below):

Medication Assisted Treatment (MAT) and Peer Support

A. The following medication was used in treatment:

- Alcohol-related
- Acamprosate calcium (Campral)
- Disulfiram (Antabuse)
- Oral naltrexone (Vivitrol®, Revia) (naltrexone hydrochloride tablet)
- Opioid-related
- Buprenorphine (Brixadi®, Sublocade®)
- Buprenorphine and naloxone (Suboxone, Zubsolv®)
- Methadone
- Naltrexone (Vivitrol®, Revia)
- Nicotine (For Information Only)

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- Over-the-counter patch, gum, or lozenge
- Prescription inhaler or nasal spray
- Varenicline prescription (Chantix®)
- Bupropion prescription (Wellbutrin, Aplezin®, Forfivo®, Zyban®)

B. Was screening for substance use/abuse conducted during the course of treatment?

C. Was certified peer support offered as part of treatment?

i. If yes, were peer support specialists utilized?
ii. If peer support services were utilized, were the peer support specialists credentialed?

D. Was telehealth offered as an option to receive treatment?

IV Treatment/Support Services/Rehabilitation Services

A. The following services were used in treatment:
- Individual counseling/therapy
- Group counseling/therapy
- Family counseling/therapy
- Case management

B. Was there clear documentation of progress or lack of progress toward the identified ISP goals?

C. The number of completed counseling/therapy sessions during treatment was:
- 0–5 sessions
- 6–10 sessions
- 11 sessions or more

D. Was there documentation that the member was educated on the use of self-help or recovery groups?

E. Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:
- No documentation
- 0 times during treatment
- 1–4 times during treatment
- 5–12 times during treatment
- 13–20 times during treatment

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- 21 or more times during treatment

F. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation to facilitate positive outcomes?

G. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?

H. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?

I. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?

J. Does the documentation reflect that substance abuse services were provided?

K. Was member's access to a primary care physician (PCP) or other medical provider explored?

V Gender-Specific (Female and Female Identified only)

A. If there was a history of domestic violence, was there evidence that a safety plan was completed?

B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?

C. If the female was pregnant, did documentation show evidence of education on the effects of substance use on fetal development?

D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?

E. If the female had dependent children, was there documentation to show that childcare was addressed?

F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?

VI Opioid-Specific

A. Was there documentation of a diagnosed opioid use disorder (OUD)?

B. Was there documentation that the member was provided MAT education as a treatment option?

i. If yes to VI.B., were they referred to a MAT provider?

C. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?

D. If a physical health concern related to pain was identified, were alternative pain management options addressed?

E. 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?

F. 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?

G. Was the member provided with naloxone or information on how to obtain naloxone?

H. Were family members/natural supports provided information on how to obtain naloxone/provided naloxone, and actions to take in the event of an opioid overdose, if applicable?

Substance Abuse Prevention and Treatment	
Case File Review Findings for Measure I–IX	
	I. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?
VII	**Discharge and Continuing Care Planning (completed only if member completed treatment or declined further services)**
	A. Was there documentation present that a relapse prevention plan completed?
	B. Was there documentation that ASAM criteria was reassessed at the time of discharge?
	C. If yes, was the individual referred to the appropriate level of care?
	D. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g. crisis line)?
	E. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?
VIII	**Reengagement (completed only if member declined further services or chose not to appear for scheduled services**
	The following efforts were documented:
	A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?
	B. If telephone contact was unsuccessful, was a letter mailed requesting contact?
	C. Were other attempts made to reengage the individual, such as: • Home visit? • Call emergency contact(s)? • Contacting other involved agencies? • Street Outreach? • Other (please list other identified outreach efforts in the box below)

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

Appendix B
Case File Review Instructions

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

The items below correspond to the *2024 SUBG Case File Review Tool*. Each case file will contain **one treatment segment.** For the purposes of this review, only supporting documentation falling between the **"date of intake"** and the **"date of closure"** for the selected treatment segment will be reviewed. The date of intake and date of closure are prepopulated on the case file review tool. The length of treatment will range from 30 days to 365 days. There must be at least one episode of care. If there is not at least one episode of care, the case file should be deemed unusable, and a new case file should be requested from the oversample.

I. Intake/Treatment Planning:

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

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

C) **Assessment —** Review the case file to determine whether a **comprehensive** assessment was completed. Answer **YES** if a comprehensive assessment was completed. Answer **NO** if a comprehensive assessment is not present in the case file.

i. Review the case file to determine whether a comprehensive assessment was completed **within 45 days of the initial appointment**. The addendum sections of the core assessment are

completed based on the needs of the individual; however, a comprehensive assessment allowing for sound clinical formulation and diagnostic impression must be completed within 45 days of the initial appointment. Answer **YES** if a comprehensive assessment was completed within 45 days of the initial appointment. Answer **NO** if a comprehensive assessment is not present in the case file or if the assessment was not completed within 45 days of the initial appointment. Answer **N/A** if there is not a comprehensive assessment present, and the case closed prior to 45 days from the initial appointment.

D) For each component related to the assessment process below (1–9), consider the information contained in the comprehensive initial assessment.

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

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

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

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

v. Review the assessment to determine whether a risk assessment was completed. The risk assessment may be contained within the standardized core assessment or may consist of a comparable RBHA- or provider-specific form, but should be completed as part of the comprehensive assessment within 45 days of the initial appointment. Answer **YES** if the assessment

addressed this component. If the assessment did not address this component, answer **NO**.

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

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

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

ix. Review the assessment to determine whether the State's prescription drug monitoring program (PDMP) was reviewed to determine if the individual is receiving controlled substance prescriptions and addresses potential patient concerns in treatment. Answer **YES** if the assessment contains documentation of review of the PDMP and **NO** if the assessment did not contain evidence.

E) Social Determinants of Health (SDoH) — Review the assessment to determine whether SDoH were documented as part of the assessment. If yes, which domains?

i. Access to Medical Care? Answer **YES** if the assessment addressed this component. If the assessment did not address this component, answer **NO**.

ii. Housing? Answer **YES** if the assessment addressed this component. If the assessment did not address this component, answer **NO**.

iii. Food Insecurity? Answer **YES** if the assessment addressed this component. If the assessment did not address this component, answer **NO**.

iv. Domestic Violence? Answer **YES** if the assessment addressed this component. If the assessment did not address this component, answer **NO**.

v. Unemployment? Answer **YES** if the assessment addressed this component. If the assessment did not address this component, answer **NO**.

vi. Transportation? Answer **YES** if the assessment addressed this component. If the assessment did not address this component, answer **NO**.

vii. Other? Choose "**Other"** if the SDoH is not listed. List the other SDoH in the text box provided.

F) Regulatory requirements —

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

Review the case to determine whether it contains documentation to make sure that members know their HIPPA rights such as the ability to request their own records and have control over their PHI. Answer **YES** if there is documentation that HIPPA rights were included. If the assessment did not contain evidence, answer **NO**.

Review the case to determine whether it contains documentation the member was given information on informed consent, including the sharing of PHI between entities and the risks and benefits of doing so. Answer **YES** if the assessment included documentation that informed consent was discussed. If the assessment did not contain evidence, answer **NO**.

G) **Individual Service Plan (ISP) —** Review the case file to determine whether an ISP was completed. Answer **YES** if an ISP was completed. Answer **NO** if an ISP is not present in the case file.

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

H) For each component related to the ISP process below (i.–iv.), consider the information contained in the completed 90-day ISP. Updates to the service plan should not be considered when responding to the questions below:

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

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

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

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

v. Review the service plan to determine whether the earlier identified SDoH (Question I. E) were considered as part of, and incorporated into, the ISP.

   If the answer in **Question I. E)** was **YES as being assessed** for a specific SDoH, and **was identified as being issue** and that particular SDoH addressed in the ISP, answer **YES** to the corresponding SDoH in this question. If the SDoH was **identified as an issue but not addressed** in the ISP, answer **NO** in the corresponding SDoH in this question. If the SDoH was not identified in Question I. E as an issue it does not apply to the individual, and the below corresponding SDoH should be marked **N/A**:

   a. **Access to medical care** should consider whether the individual has access to a primary care physician and has had a physical within the past year.

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

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

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

   e. **Unemployment** refers to individuals who are old enough and are physically and mentally able to work but are not in

paid employment or self-employment.

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

If transportation is selected, provide what type of transportation options were explored in the text box provided.

g. **Other (please list)** should include any domain that might be considered a SDoH not listed above. If indicated as a **YES**, the blank should be filled in with a short description, such as childcare.

II. Placement Criteria/Assessment:

A) Review the case file to determine whether the American Society of Addiction Medicine (ASAM) dimensions were used at intake to determine the criteria to identify the appropriate level of care via the Patient Placement Criteria.

If the ASAM tool was completed, answer **YES**. If the ASAM tool was not completed, answer **NO**. Providers are allowed to create their own ASAM document.

i. If the ASAM tool was completed at intake, select the level of care identified by the tool:

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

C) Review the case file to determine whether an ASAM tool was completed during the course of treatment at any time subsequent to

intake/assessment. It is not necessary for the ASAM tool result to change if it is considered an updated tool. If an ASAM tool was completed after intake, answer **YES**. If an ASAM tool was not completed after intake, answer **NO**.

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

III. Best Practices:

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

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

- ☐ Adolescent Community Reinforcement Approach
- ☐ Beyond Trauma: A Healing Journey for Women
- ☐ Cognitive behavioral therapy
- ☐ Contingency management
- ☐ Dialectal behavioral therapy
- ☐ Helping Women Recover
- ☐ Matrix
- ☐ Moral re-conation therapy
- ☐ Motivational enhancement/Interviewing therapy
- ☐ Relapse prevention therapy
- ☐ Seeking Safety
- ☐ SMART recovery
- ☐ Thinking for a Change
- ☐ Trauma Recovery and Empowerment Model
- ☐ Trauma-informed care
- ☐ Wellness Recovery Action Plan
- ☐ Other: Identify other evidence-based practices utilized (Enter the evidence-based practice in the text box below.)

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

- **Alcohol- related:**
    - Acamprosate (Campral)
    - Disulfiram (Antabuse)
    - Oral naltrexone (Vivitrol®, Revia) (naltrexone hydrochloride tablet)
- **Opioid-related:**
    - Buprenorphine (Brixadi®, Sublocade®)
    - Buprenorphine and naloxone (Suboxone, Zubsolv®)
    - Methadone
    - Naltrexone (Vivitrol®, Revia)
- **Nicotine (informational only[33]):**
    - Over-the-counter patch, gum, or lozenge
    - Prescription inhaler or nasal spray
    - Varenicline prescription (Chantix®)
    - Bupropion prescription (Wellbutrin, Aplezin®, Forfivo®, Zyban®)

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

D) Review the case file to determine whether certified peer support (e.g., peer worker) was offered as part of the treatment continuum. If

[33] "Informational Only" means we are not scoring the item for provider performance but are collecting the information to inform AHCCCS

evidence is present in the case file, answer **YES**. If evidence is not present in the case file, answer **NO**. Answer **N/A** if the individual declined peer support services:

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

ii. If the answer is **YES** to D) i., review the case file to determine whether peer support specialists were credentialed. If evidence is present in the case file, answer **YES**. If evidence is not present in the case file, answer **NO**. If the answer to D)i. is **NO**, do not answer this item.

E) Review the case file to determine whether telehealth was offered as an option to receive treatment. If evidence is present in the case file, answer **YES**. If evidence is not available in the case file, answer **NO**.

IV. Treatment/Support Services/Rehabilitation Services:

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

Individual counseling/therapy

Group counseling/therapy

Family counseling/therapy

Case management

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

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

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

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

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

No documentation (no evidence of service being offered or attended in the record)

0 times during treatment (includes those individuals who were referred/offered to self-help groups but did not attend)

1–4 times during treatment

5–12 times during treatment

13–20 times during treatment

21 or more times during treatment

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

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

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

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

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

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

V. Gender-Specific (Female and Female-Identified Only):

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

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

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

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

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

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

F) Review the case file to determine whether gender-specific treatment services were offered and/or provided (e.g., women's-only group therapy sessions, female peer/recovery support/coaches) as part of the treatment continuum. If evidence is present in the case file, answer

YES. If evidence is not present in the case file, answer **NO**. Answer **N/A** if the individual declined gender-specific services.

VI. Opioid Specific (only for records that indicate opioid use):

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

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

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

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

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

E) If the **individual is pregnant**, review the case file to determine whether there is evidence that staff provided education pertaining to the safety of methadone and/or buprenorphine during the course of

the pregnancy. Answer **YES** if the case file contains evidence. Answer **NO** if evidence is not present. **Answer N/A if the individual is not pregnant.**

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

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

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

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

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

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

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

C) IF the answer to **VII. B) is YES**, review the case file to see whether the individual was referred to the appropriate level of care based on the ASAM determination. If evidence is present in the case file, answer **YES,** even if the referral is declined. If evidence is not present in the

case file, answer **NO.** If the answer to **VII. B)** is **NO**, mark the response **N/A.**

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

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

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

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

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

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

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

Home visit

Call emergency contact(s)

Contacting other involved agencies

Street outreach

Other (please enter the type of reengagement in the box below).

Answer **YES** next to each means of outreach attempted to reengage the individual. Answer **NO** next to each action that was not attempted. If other reengagement attempts were made that are not listed, list the other types in the box below. Answer **N/A** if attempts to reach the individual by other means of outreach were successful (e.g., the individual was successfully reached via telephone call). **N/A** may also be used if a particular means of outreach was not applicable to the individual (e.g., answer **N/A** for "contacting other involved agencies" if the individual did not have any other agencies involved).

IX. National Outcome Measures (NOMs) :

For each measure below, answer **YES** or **NO** based on the individual's status at the time of intake and at the time of discharge. Answer **MISSING** if there is no documentation of the NOMs at time of intake and/or discharge. Please note, answers should be based on information actually found in the record, not an assumption or an absence of information.

A) Employed at intake?
Employed at discharge?

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

C) On disability or retired at intake?

On disability or retired at discharge?

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

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

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

G) Participated in social support recovery 30 days prior to treatment?
Participated in social support recovery 30 days prior to discharge?

X. Comments:

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

Appendix C
Case File Electronic Review Tool

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

C. Was a behavioral health assessment completed at intake?

Was the assessment completed within 45 days of the initial appointment?

D. Did the behavioral health assessment:

Address substance-related disorder(s)?

Describe the intensity/frequency of substance use?

Include the effect of substance use on daily functioning?

Include the effect of substance use on interpersonal relationships?

Was a risk assessment completed?

Document screening for tuberculosis (TB)?

Document screening for Hepatitis C, HIV and other infectious diseases?

Document screening for emotional and/or physical abuse/trauma issues

Documentation that review of the Prescription Drug Monitoring Program (PDMP) was completed?

E. Were social determinants of health issues documented as part of the assessmnt?

If yes, choose all domains that apply.

Access to Medical Care

Food insecurity

Housing

Unemployment

Transportation

Domestic Violence

Other (please list in box below):

F. Regulatory requirements:

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

Was there documentation demonstrating that individuals were informed of their HIPPA rights?

Was there documentation demonstrating that individuals were given information on informed consent?

G. Was an Individual Service Plan (ISP) completed?

Was the ISP completed within 90 days of the initial appointment?

Appendix D
Arizona Focus Group Findings 2025

Overview

Mercer organized five focus groups, to provide additional qualitative information to the State of AHCCCS, including strengths and opportunities, areas of concern, and follow-up areas from the ICR such as access to community resources. The focus group session for SUD providers was conducted virtually and was open to SUBG providers across the three ACC-RHBAs. The sessions for members were facilitated in person at regional SUBG provider offices. Mercer staff prepared outreach materials to engage interested participants from SUBG providers and members receiving SUBG services. Each focus group had a minimum of at least three participants. Two Mercer consultants facilitated each group and transcribed the comments from group members. The goal of the focus groups was to provide qualitative information to AHCCCS to further enhance the findings of the ICR.

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

- What are the most significant changes in SUD treatment services that have improved treatment access, treatment completion, and outcomes in the last three (3) years?
- What are opportunities to change/improve the current SUD service system?
- What are new tools and/or services that you think are needed to improve treatment access, assessment, treatment completion, and outcomes?
- What are the most effective tools that are currently being used?
- What successes or barriers have there been with access to medication-assisted treatment (MAT)?
- What specific programming is available for women?
- How is Charitable Choice communicated?

- What are successes or barriers you have encountered when engaging family or natural supports?
- What are successes or barriers you have encountered in testing for communicable diseases, including tuberculosis, HIV, and other sexually transmitted infections?
- What practices or interventions are the most useful to individualize treatment plans to address the unique needs of each participant and their cultural preferences?
- Were there any tasks or situations that were not addressed due to a lack of resources? How is CommunityCares, the Arizona closed loop referral system,[34] utilized?
- What would you change about the SUD assessment, treatment, and discharge process?
- How can the SUD system work together better to provide SUD services to the uninsured and underinsured?

Member Focus Group Summary

Mercer conducted four focus groups for members on May 13, 14, and 15, 2025. Levels of care included a methadone maintenance program in the southern region (four male and four female participants), a co-ed residential level of care (five male and four female participants) in the northern region, a residential level of care for men (four participants), and a residential level of care for women(twelve participants) in the central region. There was general consensus among members that they felt safe and heard, and treatment was helpful in obtaining and maintaining sobriety. Members described what recovery meant to them, including sobriety as well as reintegrating into the community. There was universal concern that services will be reduced in the future due to changes at the federal level.

Topics discussed included treatment planning, efficacy of treatment, utilization of MAT, and access to resources such as housing and transportation. Resources for employment, housing, and transportation were limited, as was physical health insurance, to provide access to a primary care provider. Family engagement was an area of identified opportunity to assist in long-term support and recovery in the community.

[34] CommunityCares

Strengths

Treatment Planning

Members generally noted that they were involved in the treatment planning process and developing their goals. Members also described relapse prevention planning as part of the treatment plan process, one member describing it as a contract with themselves that they were able to review and see progress. There was consensus among members that goals were reviewed over time, and updates were made as needed.

Tuberculosis, Hepatitis B, and HIV Testing

Members described how they received testing, although in some cases, it took some time to get results. Some tests were done at clinics or while a member was incarcerated, but the program did review to see whether tests had been done or were needed. There were some concerns about the lack of sufficient quarters for quarantine in residential settings for members who tested positive for conditions such as COVID 19 or the flu.

Peer Supports

Members found that peer support specialists were helpful resources in learning about addiction. One program used peers to train on the use of Narcan. Having direction and interaction with staff that were also in recovery allowed members to discuss coping strategies and lessons learned. Many members also saw value in 12-Step meetings and moving from paid peer supports to having a sponsor and peers in the community.

Group Services

Many members thought that groups were an effective part of their treatment program. Preferred topics noted by members included developing life skills, addressing emotions, and root causes of addiction. Anger management was also thought to be an important group topic. Other effective groups included co-occurring conditions such as anxiety and depression. Members expressed a greater understanding of themselves and have been given tools to help make better choices. Staff were believed to be nonjudgmental and effective in promoting a safe environment.

MAT

Members had positive responses about the efficacy of MAT in treatment.. When members were connected to MAT, they found it helpful in maintaining recovery. Staff discussed MAT options with members, and members believed they were able to discuss their concerns with utilizing MAT. Members who were using pain pills noted that Suboxone was very helpful in

dealing with withdrawal and has been an important part of their continued recovery. One member found that Vivitrol was effective in addressing alcohol cravings and was helpful. Members expressed concerns with access to other medications for mental and physical health conditions such as depression or diabetes, in part due to lack of insurance to help cover the cost.

Opportunities

Transportation and Housing

Although some resources, such as bus passes, are provided, members believe a need for additional assistance with transportation and housing. One suggestion was for providers to obtain bicycles for members to use to reach bus stops that are too far away to reach on foot. Members also noted in some cases that they have financial issues impacting their ability to find sober housing such as funds for the first month of rent and security deposits. Case managers provide assistance, but in many cases, resources for housing and transportation are not always readily available. It was noted that Oxford House services are effective, if available.

Primary Care Provider Access

Although many members noted their access to a primary care physician was discussed, receiving services was more difficult. In some cases, this was due to a lack of insurance. Some members believed they could use more support from their case managers to coordinate obtaining identification, filling out forms, and addressing out-of-state residency issues, which may be a barrier for members to apply for health insurance.

Employment

Employment was a common theme as an opportunity for improvement, especially for members with a history of justice involvement. The need for assistance in finding employment was noted in all stakeholder groups. Although employment is not the responsibility of the program, it can be a critical part of recovery and a connection between the substance use treatment program and an employment service, such as Arizona's vocational rehabilitation program, could reduce barriers to employment support services.

Family Engagement

For members in residential treatment, there was a concern about limits on time for family engagement, such as having only five minutes for phone contact. Some members suggested using Zoom for meetings with out-of-state family members. Other suggestions included groups to educate family members on addiction and having open Al-Anon or Alateen

meetings available for family to attend. It was noted that psychoeducation for family members could be an important part for returning to the community so that family members can understand addiction and how to provide support to the member. Members expressed that they have ruined relationships with their families due to their behaviors during their active addiction and could use assistance to reengage with them. It was noted that there was a balance to family engagement at the beginning of treatment, with a 14-day period of no visitation for members, to reflect on themselves being helpful. One program noted that family visitation had been limited due to visitors bringing drugs into the facility.

In the residential program for women, additional needs were identified for parenting skills and identifying and addressing the needs of children. It was noted that there was a space for visitation with children, but it was not being used.

Cultural Sensitivity

Members reported that cultural preferences were not always discussed. Additionally, a lack of Spanish-speaking staff was noted in one program with a high Spanish speaking population. Some members stated that they were aware of their right to choose a different provider, including the right to the choice of a program that aligned with their religious beliefs.

Provider Focus Group Summary

Mercer conducted a two-hour provider focus group on May 14, 2025. There were 29 participants in the group, representing 17 different providers from all three geographic service areas. Providers represented multiple levels of care, including MAT, outpatient, intensive outpatient, and residential.

Funding was a primary area of concern noted, with administrative burden, such as prior authorization requirements, increasing due to recent fraud findings in some of Arizona's public system substance use providers. Measures, such as prior authorization, have been put in place to control fraud, waste, and abuse but have also led to higher administrative burden. Additional funding concerns centered around length of time in treatment being limited due to limited funding, leading to ending treatment too early and before members are ready to be sober and self-sufficient. Bridge funding is also lacking for individuals who no longer meet SUBG criteria due to factors, such as income levels, but are working and not eligible for Medicaid, leading to a lack of available support and potential relapse.

Additional areas of discussion included outreach efforts, evidence-based and culturally competent services, MAT, and community resources to assist in recovery. Group participants also reflected on family engagement in treatment and efforts to reengage members who have terminated treatment early. A person-centered approach to treatment was discussed,

as was the importance of a member's integration into the community, to successfully remain sober, and the need to provide education on the science of what is happening in the mind and body as part of the addiction process.

Strengths

Outreach

Providers noted that outreach is not necessarily a reimbursable activity, but efforts made by several providers included utilization of a mobile treatment van to help connect people to services, as well as providers having a co-location with police, jails, and neonatal intensive care units, and regular outreach into areas where homeless members congregate. Providers are also working with their Wellness Recovery Action Plan (WRAP) teams in the central and southern regions to locate homeless camps and assist members who have lost access to their Medicaid benefits.

Gender-Specific Services

Several services for women, including pregnant and parenting women, were discussed as having a positive impact on gender-specific substance use treatment and recovery. One provider discussed the value of sober housing for pregnant and parenting women, noting the value for the identified member, but also, the alleviation of burden on the foster care and Medicaid system by providing a needed resource for the whole family. Another resource noted was a partnership with the local hospital, where registered nurses provide wellness checks on mothers and infants while in supportive housing. Although not covered specifically by SUBG funds, nurse well checks were noted to be a good resource to assist with long-term care and recovery. One provider also described an alumni network for women in recovery who had been in supportive housing. A picnic was held for alumni, with over 300 women and children attending, most of whom had five years of employment and sobriety, serving as a support for newer members still in the program.

Tuberculosis, Hepatitis C, and HIV Testing

Screening for tuberculosis, HIV, hepatitis C, and other infectious diseases has been an area of marked improvement in the 2024 ICR. Several providers noted working with a grant funded program, the Viral Elimination Network, as an extremely effective partner that will come to the substance use program, perform testing, and provide medication in some cases. Grant funding, in general, has contributed to improved outcomes in infectious disease testing. Barriers include members still opting out, as they do not want additional testing or labs if they are not required. There can also be difficulty accessing medication for treatment if a

member is positive for an infectious disease, as protocols, such as those for hepatitis C, can be very costly. One provider noted they have a small grant that assists with coverage of medication costs. Several providers reported a significant increase in cases of syphilis and are working to address treatment for this concern in the community.

Culturally Competent Resources

Several methods of ensuring cultural competency were discussed. Providers in the Northern Arizona region noted that they serve the Native American population and incorporate cultural programs, such as talking circles, to assist in treatment. Residential programs also noted cultural outings on Sunday, assisting residents in attending a gathering of their choice, such as church. Providers will also accommodate alternate times members would like to worship if Sunday is not their preference. Other methods used to meet the cultural needs of members were having translators, both on-site and through a remote service, and having peer supports to offer services in Spanish. Training for staff on different cultures and their norms was also discussed, such as cultural responses to mental health and substance use issues, which may be considered taboo topics not to be discussed outside of the family. Providers also ask questions on intake for any cultural preferences.

Evidence-Based Practices

Evidence-based practices continue to be an area of focus for providers. Providers discussed increased focus on trauma-informed services, such as utilization of the TREM and expanded use of EMDR. MRT has also been expanded in some areas and, anecdotally, has been showing good results. One provider also noted starting a program designed for users of methamphetamine to include MAT in an intensive outpatient setting: a current promising practice in the field. An additional EBP noted was ACRA. Life coaches for adolescents were also identified as good practice. Contingency management was noted to have good outcomes, although it is currently funded through the SSI/SSDI Outreach, Access, and Recovery program, and not SUBG. The importance of peer supports was also discussed, for example, in addressing stigma regarding admitting to injecting substances. Providers indicated it sometimes takes a few meetings for members to admit to a peer about using drugs intravenously. Having a peer with a similar background was noted to be important to engage members and develop trust. Co-occurring treatment programs and being able to have a fully operational Health Information Exchange to capture whole person care were noted as efforts that are in place but not fully implemented.

Family Engagement

Providers discussed efforts they have made in the last year and a half to engage family and natural supports in treatment. This appears to have started gaining traction in some residential programs, which are paid with a day rate, allowing family interactions to be included in rates. The group noted that psychoeducation about substance use and family involvement in the process are more effective in residential treatment, with a referral to outpatient family services upon discharge. One residential provider noted that family members will call the unit when the member relapses to see what the family's next steps should be. Outpatient therapists offer family services, as well as co-parenting options, for members sharing children but who are not in a relationship. Time and transportation were noted to be two of the biggest barriers to family engagement.

Opportunities

Charitable Choice

Although the findings of the ICR have been consistently positive in the area of Charitable Choice, many of the providers in the focus group were unfamiliar with Charitable Choice requirements, and a recommendation from the group was for AHCCCS to provide a flyer on Charitable Choice requirements and resources. Another suggestion was to add information on Charitable Choice to the SUBG posters providers currently use. AHCCCS does have a sample notice of requirements as an attachment to AMPM 320T1 available on the AHCCCS website that providers could use as a resource.

Housing and Transportation

Housing and transportation remain two of the largest concerns with resources. Housing was noted as a problem across populations, including pregnant and parenting women. In some cases, housing placements that can be found are not close to the member's support system and resources. Transportation also is a concern, limiting members from attending treatment and limiting family and other social supports from participating in treatment if transportation is not available, as public transportation is not reliable. An additional lack of resources in Northern Arizona were shelters for victims of domestic violence, with only two being available in the area. One provider noted that additional training for staff would be useful to ensure that areas of need identified in the assessment are included in the ISP.

Many providers noted dissatisfaction with the statewide closed-loop referral system, CommunityCares[35]. In some cases, providers have declined to use the system at all, as the resources that are needed do not utilize the system such as some community food banks. Providers believe resources may not be participating because there is an administrative lift to manage the program and respond to incoming referrals, while smaller programs cannot afford the fee required to participate in the program. Providers described the process flow as an open loop rather than a closed loop, as there are limited resources housed in the CommunityCares system. So, providers require additional staffing to both do the referral and to manually refer and find resources. Some providers have had success in providing vending machines containing items, such as bus passes, Narcan, hygiene kits, and condoms, to ameliorate some social issues.

MAT

Many providers expressed difficulty with funding MAT, especially injectable medications. The majority of providers noted the use of Suboxone and methadone for opioid use disorder, while a few providers also offered MAT for alcohol use disorder. One concern noted for Suboxone was that treatment support is not required, and members seeking Suboxone from a program requiring treatment, as well as MAT, are harder to engage and will seek out a program where counseling or additional treatment support is not required. Some providers reported that members that are incarcerated begin MAT prior to discharge, which is allowing for a smoother transition and stabilization upon release into the community.

Other concerns regarding MAT included retention in services and utilization of harm reduction options. Providers reported many members disengage but are seen as readmissions due to ambivalence to change, with trends in relapse at certain times of the year such as around the holidays. Providers in the southern part of the state also saw trends in members relapsing or using drugs for the first time due to easy availability of substances coming over the border from Mexico. MAT has been a good resource in assisting members in the southern region when they are ready to seek treatment. Providers have taken steps to address some of the retention issues noted, such as providers not titrating methadone as quickly as needed, to maintain a therapeutic dose. This has led to a change in how providers talk to members, beginning treatment with a higher dose and closely monitoring members. The providers use other grant dollars for a virtual application to communicate with members about triggers and geofence, which are areas of high relapse risk. Improvement has also been seen since they have been able to increase take-home dosages due to federal policy changes. Needle exchange programs are in effect, although there have been some negative

[35] CommunityCares

interactions, with law enforcement arresting members with clean needles. Some providers have made efforts to outreach and educate law enforcement on the importance of harm reduction efforts. It was noted that intravenous drug use has had some decline due to a rise in fentanyl use.

Most providers reported screening for smoking and vaping at intake and, at a minimum, offering referrals to the Arizona Quit Line as well as options for MAT for smoking cessation. Concerns noted about smoking cessation focused on vaping, which has been especially normalized among youth, and concerns about the legalization of marijuana. Providers are finding that youth do not see vaping as being as much of a health risk as cigarettes or other tobacco products, and legalization of marijuana has also made marijuana use an acceptable social activity, leading to an increase in use of both products and the need for increased education efforts concerning the risks of use for both.

Reengagement

Providers noted there are opportunities for improvements in the discharge and continuing care process, especially in the transition from inpatient to outpatient services, in which referrals and information can get dropped. Housing also continues to be a barrier for discharge, with some providers discussing how they have successfully managed to develop relationships with community housing resources. An additional best practice providers discussed was ensuring that appointment dates and times, as well as the names of case managers when known, be included in the discharge plan, to ensure better connectivity between providers during discharge. There was also a suggestion for increased access to members' records within the health information system that would include all historical information from providers as well as the treatment received.

Conclusion

There was active participation in all focus groups, both from providers and members. Some common themes included overall feedback that treatment is effective, although most focus group participants had concerns regarding continuing funding and the ability to access additional resources to support long-term recovery. Providers noted efforts to increase family engagement, access to gender-specific treatment, and implementation of EBPs. Members continued to note family engagement as a potential area of opportunity but did note that peer support services have improved treatment experience. Both groups agreed there has been an improvement in treatment planning and in testing for tuberculosis, hepatitis C, HIV, and other infectious diseases. Recommendations include education on Charitable Choice, continued connectivity with natural and community-based resources, and ongoing efforts to improve family engagement and cultural competency, as needed.

Recommendations

Charitable Choice

Members did express awareness of the ability to choose a program based on religious preference, but providers seemed unfamiliar with the requirement. Suggestions were made to have materials developed explaining the regulation as well as how to access participating providers. Additional education in this area is recommended.

Access to Resources

Providers described efforts to connect members to resources, including the use of vending machines to provide Narcan, hygiene products, and other resources. Both providers and members noted ongoing difficulties in resource availability for housing, employment, and transportation. Suggestions to address the lack of resources include seeking donations from the community, working with the Arizona Vocational Rehabilitation Program[36] for members that qualify, and continuing efforts to make connections in the community with food banks and other resources. In addition, it was recommended that staff be trained to address accessing resources in ISPs when identified as a need during the assessment process.

Family Engagement

There was some discrepancy in the perception of family engagement between providers and members. Providers noted that efforts had been made to increase family education about substance use and how to support the member in recovery as well as making referrals to outpatient providers for family therapy. Members believed that more time with their family while in treatment could be effective and did not think there was enough education provided to their family members on addiction and recovery. It is possible that members voicing concerns were not receiving services from the providers that reported family education was in place. Promoting family psychoeducation on addiction and recovery at all treatment providers is recommended, as are referrals to family counseling when indicated.

Cultural Competency

Cultural competency was identified as an area of concern during the ICR, and members noted that cultural preferences were not always discussed. Providers did note that, in some agencies, there is specific training on culture for staff, including cultural norms regarding addiction and mental illness as well as efforts to address the cultural needs of specific

[36] Vocational Rehabilitation | Arizona Department of Economic Security

populations such as Native Americans. Expanding training to all providers is recommended, to include consideration of culture in the assessment and treatment planning process.

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