Arizona

UNIFORM APPLICATION
FY 2017 BEHAVIORAL HEALTH REPORT

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 09/01/2016 - Expires 12/01/2016
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Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

I: State Information

State Information

I. State Agency for the Block Grant

Agency Name	Arizona Health Care Cost Containment System (AHCCCS)
Organizational Unit	
Mailing Address	701 E Jefferson MD 6500
City	Phoenix
Zip Code	85034

II. Contact Person for the Block Grant

First Name	Thomas
Last Name	Betlach
Agency Name	Arizona Health Care Cost Containment System
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III. Expenditure Period

State Expenditure Period

From	7/1/2015
To	6/30/2016

Block Grant Expenditure Period

From	10/1/2013
To	9/30/2015

IV. Date Submitted

Submission Date	12/1/2016 8:12:45 PM
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V. Contact Person Responsible for Report Submission

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VI. Contact Person Responsible for Substance Abuse Data

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Footnotes:

STATE OF ARIZONA
OFFICE OF THE GOVERNOR

DOUGLAS A. DUCEY
GOVERNOR

EXECUTIVE OFFICE

February 26, 2016

Grants Management Specialist
Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

Dear Grants Management Specialist:

Arizona has a long history of implementing significant and innovative initiatives related to integration and care coordination in the provision of services. As of July 1, 2016, the Arizona Department of Health Services, Division of Behavioral Health Services (DBHS) and the Arizona Health Care Cost Containment System (AHCCCS) will merge to fully integrate the implementation and oversight of behavioral and physical care services. The coming together of DBHS and AHCCCS builds a stronger and better informed Medicaid leadership and builds greater awareness of behavioral health services in the Medicaid program.

This merger requires the transition of the oversight of Substance Abuse and Mental Health Services Administration (SAMHSA) grants. As such, I am designating Tom Betlach, Director of AHCCCS, as the signature authority for the Substance Abuse Block Grant (SABG), Projects for Assistance in Transition from Homelessness Grant (PATH), and Mental Health Block Grant (MHBG) as well as for any discretionary grant. This authority includes the signing of any standard federal forms such as Assurances, Certifications and Disclosure of Lobbying Activities and shall have such authority during my term as Governor of Arizona. In addition, I am designating Director Betlach as the Single State Authority (SSA) for Arizona.

If you have any questions, please contact Kelly Charbonneau, Division of Health Care Management at (602) 364-1356.

Sincerely,

Douglas A. Ducey
Governor
State of Arizona

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II: Annual Report

Table 1 Priority Area and Annual Performance Indicators - Progress Report

Priority #: 1

Priority Area: Youth

Priority Type: SAT

Population(s): Other

Goal of the priority area:

Increase the number of youth in the behavioral health system identified as having a diagnosed substance use disorder.
Note- Goal is in progress and will be continued from previous submission.

Strategies to attain the goal:

The Regional Behavioral Health Authorities (RBHAs) will continue efforts to promote access to substance abuse treatment services for adolescents during meetings with providers and collaborators, and through school and community-based trainings. Trainings provided by the RBHAs have included components on how to screen for substance abuse in the adolescent population, and effective substance abuse treatment such as ACRA and other evidence-based practices targeting the adolescent population. Additionally, providers continue to utilize SA screening tools, including ASAM and CRAFFT.

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) will monitor enrollment numbers for youth diagnosed with a substance use diagnosis within the system of care.

The RBHAs will continue to collaborate and meet regularly with child/adolescent providers to share information on substance abuse screening, trends and best practices.

The ADHS/DBHS and the RBHAs will provide and promote access to substance abuse training initiatives available to child/adolescent providers- including those employed through other agencies such as the Department of Child Safety (DOCS) and Juvenile Justice. The ADHS/DBHS will also provide education to providers and teachers.

The ADHS/DBHS and RBHAs will educate treatment providers, prevention providers, and coalitions on how to engage community stakeholders in identifying and referring youth to early intervention and substance abuse treatment services.

The ADHS/DBHS will ensure the availability of a standardized, parent-friendly, screening tool to identify substance use/abuse in children and adolescents.

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) will monitor enrollment numbers for youth diagnosed with a substance use diagnosis within the system of care.

The Regional Behavioral Health Authorities (RBHAs) will continue to collaborate and meet regularly with child/adolescent providers to share information on substance abuse screening, trends and best practices.

The ADHS/DBHS and the RBHAs will provide and promote access to substance abuse training initiatives available to child/adolescent providers- including those employed through other agencies such as the Department of Child Safety (DOCS) and Juvenile Justice. The ADHS/DBHS will also provide education to providers and teachers.

The ADHS/DBHS and RBHAs will educate treatment providers, prevention providers, and coalitions on how to engage community stakeholders in identifying and referring youth to early intervention and substance abuse treatment services.

The ADHS/DBHS will ensure the availability of a standardized, parent-friendly, screening tool to identify substance use/abuse in children and adolescents.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Performance Indicators to measure success on a yearly basis.

Baseline Measurement: Baseline measurement, FY15 7% of those under the age of 18, in the behavioral health system who were diagnosed as having a substance use disorder or dependence.

First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2016), 7.5%

Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2017), 8%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

CIS enrollment numbers/data.

New Data Source*(if needed)*:

Description of Data:

CIS data can be stratified by age group, diagnosis, and services received. CIS captures all elements needed to measure outcomes for this population.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

No data related issues anticipated.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: b Achieved é Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

The RBHAs have worked to connect youth to appropriate SUD services by providing trainings to providers regarding screening tools to identify substance use in children and adolescents. Additionally the RBHAs have increased the capacity of SUD services for adolecents by increasing the number of evidence-based practices (i.e. A-CRA, MST, Matrix Model, Seven Challenges, etc.). In Pima County there have been two adolescent MAT programs added that comply with SAMHSA guidelines through use of buprenorphine and IOP services in the past year as well as an increased capacity for youth with SUD in SUD Behavioral Health Residential (BHRF) treatment. In Maricopa County the RBHA and their adolescent substance abuse treatment providers have collaborated with ADJC and MCJPD to provide treatment services for youth on probation or parole who are not eligible for Medicaid-funded services.

Priority #: 2

Priority Area: Older Adults

Priority Type: SAT

Population(s): Other (Entire population over the age of 55.)

Goal of the priority area:

Increase screenings, outreach, engagement and enrollment of adults over the age of 55 with a diagnosed substance use disorder.

Strategies to attain the goal:

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) will track and trend individuals screened for substance use and abuse in the Northern Regional Behavioral Health Authority (NARBHA) by age.

The ADHS/DBHS will evaluate the number of individuals over 55 who received a Brief Intervention/Brief Treatment related to their substance use/abuse.

The ADHS/DBHS will track and trend the number of individuals who were referred to a treatment provider for substance use/abuse.

The Arizona Department of Health services will educate the rest of the state on the Screening, Brief Intervention and Referral to Treatment (SBIRT) program.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Performance Indicators to measure success on a yearly basis. .

Baseline Measurement: In Fiscal Year 2016, 8% of those with a substance use disorder or dependence were over the age of 55.

First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2016), 8.5%

Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2017), 9%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

CIS enrollment data and SAIS data.

New Data Source*(if needed)*:

Description of Data:

Data in both systems can be stratified by age, diagnosis, and service received.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

SAMHSA has elected to eliminate the SAIS system and has rolled out the DCI. It is unclear how this will impact data collection and reporting.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: þ Achieved ¢ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Some RBHA efforts include:
- Providing outreach to members who are presenting in hospitals but are not enrolled with a SUD provider. Engagement Specialists go out into the community, including hospitals and home addresses to discuss services and facilitate intakes
- Increased availability of peer support and intensive-community based services to members in an effort to keep them engaged in SUD services.
- In Southern Arizona the RBHA is working with a provider to increase their membership in their integrated care service for older adults (55 and over) in a program called “Cactus Bloom”. The program focuses on screening and increasing accessibility to integrated services for older adults.

Priority #: 3

Priority Area: Service members and veterans

Priority Type: MHS

Population(s): Other

Goal of the priority area:

Increase enrollment of service members and veterans in the behavioral health system.

Strategies to attain the goal:

Enrollment of service members and veterans for substance abuse services out the total number enrolled in the behavioral health system increased from 0.6% in FY2012 to 1.1% in FY2013. Please note, the percent of service members and veterans out of the number of individuals enrolled in the Arizona behavioral health system for substance abuse services is 3.5%.

Our Regional Behavioral Health Authorities (RBHAs) have been collaborating in various capacities, including holding memberships in ACMF's Resource Network and ACMF Leadership Council, and collaborating on ACMF's Resource Navigator training and the VA's Veteran's Summit. Additionally, Rally Point Tucson, a program of CPSA, staffed by experienced veterans continues to help veterans and their families in Pima County navigate and access various resources. Providers throughout the state have been engaged in multiple trainings that are specific to the needs of service members, such as Mental Health First Aid for Military, Veteran and Their Families, Trauma Informed Care, PTSD, Traumatic Brain injury, and employment assistance.

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) will continue to be engaged in the Arizona Coalition for Military Families, and will conduct outreach efforts to connect service members, veterans and family members to services throughout the State. The ADHS/DBHS will disseminate information to all levels of service and will encourage collaboration for the provision of culturally competent care.

The ADHS/DBHS will assist the Regional Behavioral Health Authorities (RBHAs) in establishing a relationship their local Veterans Affairs (VAs) in order to coordinate care and participate in trainings.

The ADHS/DBHS and RBHAs will educate behavioral health providers (treatment and prevention) to offer culturally competent services for service members, veterans, and their families.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Annual Performance Indicators to measure success on a yearly basis.
Baseline Measurement:	Baseline measurement, FY 2016 1278/205000 (.6%)
First-year target/outcome measurement:	First-year target/outcome measurement (Progress to end of SFY 2016), Increase FY16 data by 6%
Second-year target/outcome measurement:	Second-year target/outcome measurement (Final to end of SFY 2017), Increase FY17 data by an additional 2% from the outcome for 2016.

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Client Information System (CIS) data.

New Data Source*(if needed)*:

Description of Data:

Data can be stratified by military and veteran status, diagnoses, and services received.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

No data related issues anticipated.

New Data issues/caveats that affect outcome measures:

CIS data ran this year shows in FY2015 2,364 veterans and service members were enrolled with the behavioral health system, 1085 with a SUD.

Report of Progress Toward Goal Attainment

First Year Target: € Achieved þ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

CIS data shows that in FY2016 2417 veterans and service members were enrolled with the behavioral health system, 1094 with a SUD. This is a 2% increase in enrollment of veterans and service members and a .82% increase in the enrollment of veterans and service members with a SUD. The state will work with the RBHAs to identify barriers to enrolling veterans and service members into services as well as discuss opportunities for implementing and supporting additional outreach and engagement programs.

CIS data shows that in FY2016 2417 veterans and service members were enrolled with the behavioral health system, 1094 with a SUD. This is a 2% increase in enrollment of veterans and service members and a .82% increase in the enrollment of veterans and service members with a SUD.

The following are activities aimed and outreaching and engaging veterans into services:

Agencies contracted to provide outreach via community engagement specialists are also targeting efforts to enroll veterans who present in the emergency departments, detox facilities and those who are homeless. Cenpatico also participates in the planning and marketing of Veteran Specific events around the state. Some of these events are the “Stand Downs”, the veteran employment/resource fairs, and symposiums. Cenpatico set up training for the local warm lines on effective practices for working with veterans and families. This training certified all their warm line employees as Veteran Navigators trained by the Arizona Coalition for Military Families.

A new program called Project R.E.S.P.E.C.T. was launched in 2016 that focuses on re-entry from jail, and provides services based on Moral Reconation Therapy (MRT), also serving veterans.

Rally Point Phoenix, a program of Empact, attended peer support certification training to improve their engagement activities of service members and veterans
Mercy Maricopa Outcome data for Rally Point Phoenix mentioned above:
This program has seen an increase in call volume and member engagement, receiving 1120 calls to their hotline and 446 new veterans engaged in services. Approximately 72% of veterans in this program complete services within 3 months and 97% complete within 6 months. This provider reports an approximate increase of 35%, overall, of veterans and service members engaging into services

Mercy Maricopa Integrated Care are engaged with the VA system to improve response and engagement of service members and veterans into needed services to include high-needs members, members involved with court and legal system, incarcerated and vulnerable adults involved with Adult Protective Services

How first year target was achieved *(optional)*:

Priority #: 4

Priority Area: Healthcare Integration

Priority Type: SAT, MHS

Population(s): SMI

Goal of the priority area:

Increase Behavioral Health staff knowledge of health related topics and connection between physical and mental health, and improve the coordination of care between behavioral health providers and the recipients' Primary Care Physician.

Note- goal is continued.

Strategies to attain the goal:

ADHS will monitor and assist Maricopa County with the pilot healthcare integration program to provide behavioral and physical health care in one location for Seriously Mentally Ill (SMI) members in FY14. MMIC, the RBHA for Maricopa County has assigned Care Management staff at each Adult Provider Network Organization (APNO) direct clinic in order to provide a direct link to education and technical assistance; this has allowed an increase in awareness of the medical health related needs, service utilization monitoring, identify gaps, and provide educational resources related to coordination of care with medical providers. The Care Management staff also ensures the treatment goals in the members’ Care Plans address both their physical and behavioral health needs. Efforts to increase Primary Care Providers (PCP) knowledge of behavioral health needs is also being addressed through the Integrated Care Training Academy which occurs quarterly, and includes topics such as the SBIRT process.

Effective October 2015, the state of Arizona will have integrated physical and behavioral health care for individuals diagnosed with a serious mental illness (SMI). The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) will track the overall health for these individuals.

The ADHS/DBHS will work closely with healthcare providers to ensure that clients are receiving both physical and behavioral health services and that there is continued collaboration between all professionals.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Annual Performance Indicators to measure success on a yearly basis.
Baseline Measurement:	Statewide SMI coordination of care in FY16 - 90%
First-year target/outcome measurement:	First-year target/outcome measurement (Progress to end of SFY 2016), 95%
Second-year target/outcome measurement:	Second-year target/outcome measurement (Final to end of SFY 2017), 100%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Case review

New Data Source*(if needed)*:

Description of Data:

The ADHS/DBHS performs a random sample case file review for coordination of care for those with a seriously mentally ill diagnosis. Review will contain specific elements that will evaluate coordination of care activities.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

No data related issues anticipated.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ¢ Achieved b Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

The random sample case file review previously conducted by ADHS/DBHS has been discontinued and was not performed in SFY 2016 therefore Arizona cannot report progress towards this goal using previously indicated data source. The RBHAs conduct periodic reviews to ensure care coordination is occurring within their provider networks and implement performance improvement plans as needed to assist providers in improving care coordination efforts. For contract year 2017, AHCCCS has included multiple methods to measure coordination efforts for its integrated plans, but will not have that data to report until 2017. Some of the coordination efforts the RBHAs are monitored on include but are not limited to:

• Contractually required annual reports that focus on activities specifically demonstrating integration and coordination between physical and mental health providers on behalf of members diagnosed with a serious mental illness. These reports focus on planned activities for the upcoming year, as well as an evaluation of the previous year's activities.

• Contractual requirements for Integrated Health Plans to monitor specific coordination activities (via regular chart audits) between behavioral health professionals and primary care physicians.

Below are activities involving care coordination as reported by the RBHAs.

Activities in Maricopa County:

In SFY2016, Maricopa County focused on the development of integrated care practices, workforce development and information sharing to support integrated care models of care. To better understand our provider's readiness to implement integrated care models, Mercy Maricopa utilized the SAMHSA Integrated Provider Assessment Tool (IPAT). Then based on evaluation results, Mercy Maricopa has provided an variety of resources such as toolkits, trainings, curriculum and Practice Transformation Consultant (PTC) to providers preparing for and implementing integrated care programs.

To date, three integrated health homes, launched a virtual health home model primary care sites and have also added the inclusion of primary care on several Assertive Community Treatment teams.

Moving forward, Mercy Maricopa will continue to stay focused on four main areas: integrated care model development and provider expansion, workforce development, value based contracting and technology and evaluation. As stated prior, we continue to expand our integrated care network and provide resources to ensure behavior health staff is knowledge on health related topics and the importance of an integrated care approach. We have implemented integrated care treatment plan and expanded our scopes of work to ensure provides are have integrated case consultations inclusive of medical providers. To ensure we have sufficient and skilled professionals, Mercy Maricopa has developed a certified training program so that providers can deliver training to develop skills in the delivery of integrated healthcare and work processes that will result in positive outcomes. To drive positive outcomes, Mercy Maricopa has implemented value based contracts which have shared incentives with medical providers for medical outcomes such as reduced emergency room utilization, inpatient medical utilization and increased contact with a member's physical health providers. These contracts also include the inclusion of health outcomes such as smoking cessation and diabetic care. Mercy Maricopa has deliverable that addresses gaps in care and requires SMI clinic providers to work with members to close identified gaps. To support the delivery of integrated care, Mercy Maricopa recognizes the importance of real time data and ability to share data to coordinate care in an integrated fashion. Mercy Maricopa is working to implement a population health management tool that will allow for real time collaboration and the delivery of comprehensive integrated healthcare services.

Activities in Southern Arizona:

Cenpatico-IC conducts a wide range of coordination of care activities for all members, inclusive of the SABG funded members with an SMI diagnosis. All integrated and SMI members can receive care management or care coordination from Cenpatico-IC. At the provider level, all members are assigned to a Recovery Coach to assist in coordinating their care.

For SMI-Integrated members that have substance abuse diagnosis, the Care Management department provides the following services:
• Coordination of care for medical and behavioral health
• Transitional planning for members that are transitioning into substance abuse inpatient services
• Discharge planning for members transitioning into the community to maintain outpatient substance abuse treatment services towards maintaining their recovery
• Monitoring referrals for specialty services provided by ICCA's and Specialty Providers
• Adult Recovery Team participation with the member and the clinical team
• Continued outreach and comprehensive assessment to support members behavioral health and medical health needs
• Care Planning for high risk SMI members
• For complex member issues, concerns may be referred to the Interdisciplinary Team Meeting that consist of Medical Doctors, Pharmacy, Housing, Cenpatico clinical staff and external stakeholders to provide recommendations, appropriate interventions towards supporting the member's needs
In addition to care management, members are able to access Adult Recovery Team (ART) Facilitators to assist in any issues that may arise. Cenpatico-IC's Health and Wellness Program Development Specialist provided support and technical assistance to clinical and leadership teams within each Intake and Coordination of Care Agency (ICC Agency) to assist in the development of chronic disease and wellness programs, focusing on a whole-person approach in support of SAMHSA's eight dimensions of wellness. Support and assistance included providing information and education related to specific evidenced-based disease management programs and best practices and coordinating with Envolve PeopleCare, Centene Corporation's Disease Management subsidiary. Examples of current wellness and disease management programs currently in progress include:
• Stanford Chronic Disease Self-Management Program
• Specialized Diabetes Management Programs, including utilization of Clinical Pharmacist for diabetes med reconciliation
• In SHAPE program: Several of our ICC Agencies are former or current In SHAPE grant recipients. This is a competitive program through Dartmouth that trains ICC Agencies' staff to address obesity within their population, and provides them with tablets and other equipment to do so. https://www.thenationalcouncil.org/training-courses/dartmouths-shape-implementation-study/
• Exercise groups/classes: Several ICC Agencies have a certified personal trainer on staff to facilitate group exercise classes. Other ICC Agencies have exercise equipment (treadmills, stationary bikes, etc.) on site and allow members to drop in and use the equipment as desired. Other exercise programming include walking groups or group exercise using workout videos.
• Cooking/nutrition classes and demonstrations.
• Weekly walk in wellness clinics for screenings.
Members of the Health Home Development Team coordinate with Envolve PeopleCare to provide quarterly disease management trainings for providers to develop their ability to coordinate care and assist members in managing their chronic conditions. We have also developed a health education library and website for additional provider education. In addition, Envolve PeopleCare is recruiting for a Certified Diabetes Educator and a Respiratory Therapist who will be able to provide additional training as requested, assist C-IC Med Management with care plans, and also be of assistance to ICC Agencies for member-specific questions and case reviews. All of the ICC Agencies have developed ongoing training on various health and wellness topics to improve their staff's knowledge and skills related to physical health. Cenpatico has also met with the Arizona Smoker's Helpline (ASH Line) and the Pima County Health Department for the first of what will hopefully be regular meetings to develop a smoking cessation program for our members. Cenpatico is working with Choose Health, Cultural and Community Affairs, and Marketing teams to coordinate health promotion activities and messages for providers, members, and the community. We are ensuring consistent message C-IC wide. Cenpatico is also working with QI and training to develop pilot program for Motivational Interviewing specific to chronic disease management. As well as ongoing work with Med Management Chronic Disease Management Program
The Cenpatico Health Home Development team developed and delivered a 'train the trainer' program on Integrated Case Management in 4 different cities, covering all 19 ICC Agencies operating Health Homes, covering coordination of care. Provider agencies use this training as an integral part of their new employee orientation (NEO) onboarding process. The training is currently being updated and will be launched again during the next quarter.

Activities in Northern Arizona:
Approach to Integrated Care Coordination and Care Management
Health Choice Integrated Care utilizes data-driven and evidence-based strategies to provide integrated Care Coordination and Care Management services to all members. Our Care Management Department utilizes a team-based approach that serves as the single point of whole health treatment. Our approach is centered on the member and family through a behavioral health-based Integrated Health Management regardless of the member's need, risk or cost profile.
Given the challenges of Northern Arizona's expansive geography and the need to transform the delivery of healthcare, HCIC will assign HCIC care managers (called Integrated Care Managers) to regional Integrated Health Home (IHH) sites to provide medical and behavioral health expertise, oversight, increased integrated system coordination and resources for "Top Tier" members with SMI who are high need/high cost. These Integrated Care Managers will assist the Adult Recovery Teams in developing an integrated approach to understanding and organizing the member's physical and behavioral health needs and services based on member/guardian/family preferences. This expertise will be supported by additional HCIC care managers (called Leads) with population-specific expertise, and our available technology suite and quality management systems to offer a comprehensive approach to serving members' needs.
The intensive ("Top Tier") approach to Care Management for members who have been identified as high need/high cost uses our experienced staff, technology and community relationship resources to identify and track high risk/high cost members in order to ensure seamless care coordination across the service delivery system, and to identify and track how the program will improve overall health outcomes.
CARE MANAGEMENT
HCIC's care management program design promotes and supports "seamless" care coordination across the entire delivery system by

offering members a single point contact for whole health treatment, while also offering a central point of clinical responsibility for outcomes from a managed care perspective. Data and support will be shared between the providers and HCIC in order to eliminate blind spots and gaps in medically necessary care. This is achieved through a step by step approach that begins with an initial assessment to determine the member's specific Care Coordination or Care Management needs and the development of a Care Management Plan for members in the Top Tier.

The Integrated Health Home (IHH)

HCIC's approach to providing integrated Top Tier Care Management services for high need/high cost individuals will be based on the SAMHSA/HRSA Four Quadrant Model. This model stratifies members according to the degree of medical and behavioral health risk and need. Members with high medical and behavioral health needs are offered both physical health care and behavioral health care at the individual's behavioral health provider site, the Integrated Health Home. The HCIC Integrated Care Manager will also be assigned to the Integrated Health Home. Because services are located in the same facility, access to care, care coordination and care management activities are enhanced.

Integrated Health Home Case Manager

The Case Manager will be employed by the IHH, and serves as the single point of contact for members. The Case Manager will support the member's needs by developing a personal relationship with the member, collecting member information and helping the member navigate the system to obtain necessary services and supports. The Case Manager will work with the member/guardian/family and the ART/CFT to develop the Individual Recovery Plan/Individual Service Plan (IRP/ISP) as per policy. The Case Manager will assist the member in maintaining, monitoring and modifying covered services and other necessary resources. The Case Manager does outreach and engagement with the member when there is a missed appointment or crisis contact. The Case Manager is responsible for communication and coordination of care between the member's ART/CFT and the member's primary care provider. The Case Manager works closely with the Integrated Care Manager when a member is identified as high need/high cost.

Integrated Care Managers provide an administrative function that is not the day-to-day duties of case management or service delivery. Consistent with direction from ADHS/DBHS, the Integrated Care Managers will compile case analyses in collaboration with the member's clinical team, and ensure coordination of member care needs through development and oversight of a Care Management Plan for individuals with SMI who are included in the top tier care management program. The Integrated Care Manager will use a trauma-informed, and recovery-oriented approach, with a major focus on not introducing or re-introducing trauma in the members' life and also ensure that the clinical care maintains a focus on recovery, self-management and caregiver/family and peer supports.

The Integrated Care Managers are responsible for overseeing and assisting teams in:

- Effectively transitioning members from one level of care to another
- Streamlining, monitoring and adjusting members' Care Management Plans for individuals who are included in the SMI top tier program, based on progress and outcomes
- Reducing hospital admissions and unnecessary emergency department and crisis service use
- Providing ART/CFTs with the proper tools so members can self-manage care in order to safely live, work and integrate into the community
- Identifying and transferring important clinical information and test results, such as discharge summaries, critical lab results, medications, emergency room visits, etc.
- Updating the team on changes in member status, such as eligibility, court-ordered treatment, guardianship, DNR, transition to adulthood, SMI, incarceration, pregnancy, out of state treatment, all cause hospitalizations, etc.
- Ensuring members are scheduled for prevention, EPSDT, disease management and health promotion activities, consistent with need
- Analyzing predicted and actual outcomes and cost-effectiveness of a member's interventions/ services based on best practices

HCIC Interdisciplinary Care Team (ICT)

Members who are identified as high need/high cost will have an Interdisciplinary Care Team that is based on the member's needs. The ICT may consist of the member and family, the IHH Case Manager, peer/family supports, or physical and behavioral health providers. The Interdisciplinary Care Team is supported by HCIC's Care Manager and Population Care Lead. The ICT will provide more intensive oversight and coordination for the period of time when the member's need or risk is greatest.

The INTEGRATED Care Management Plan

The HCIC Integrated Care Manager will develop and implement an Integrated Care Management Plan (ICMP) for each TXIX member who has SMI in the Top Tier. The Care Management Plan will be consistent with the Individual Recovery Plan IRP)/Individual Service Plan (ISP), but does not take the place of it. The Care Management Plan incorporates the member's physical and behavioral health needs at a much higher level than the IRP/ISP, focusing on areas that have traditionally been overlooked or are high need. The Care Management Plan describes the clinical interventions and services recommended to the ART/CFT, based on an administrative review of the member's health risk assessment, identified needs, claims, IRP/ISP, diagnoses, predictive modeling and best practices done on a quarterly basis. The content of the member's Care Management Plan will be documented and maintained using EXL Landa's CareRadius TM suite of care management software products which will be available to the 24 hour Crisis System and Nurse Advice Line, and will be shared with the IHH team.

The Integrated Care Management Plan includes:

- Clinical interventions recommended to the treatment team
- Strategies for successful transitions between levels of care/facilities/providers, discharge planning and coordination of care gaps
- Delineation of responsibilities for involved providers across systems for monitoring referrals and follow-up specialty care
- A schedule for routine health care services, medication monitoring, prevention, EPSDT, disease management and health promotion activities

CARE COORDINATION AND COLLABORATION

HCIC coordinates care for all populations as per the Scope of Work Section 5.1 so that members achieve their recovery goals described in their IRP/ISP. HCIC will ensure that coordination of care occurs at both the system level and at the provider level depending on the member's need, goals and functional status. Care coordination is provided by HCIC care managers and clinical staff based on inter-agency collaboration with stakeholders, such as other AHCCCS Contractors and primary care physicians, DDD, tribal nations, justice and law enforcement, peer and family run organizations, DCS and other child-serving organizations. Care coordination and collaboration ensure:

- Early identification of health risk factors and special care needs
- Monitoring of the individual's health status and implementation/revision of the IRP/ISP, including periodic re-assessment and revisions to the IRP/ISP consistent with member needs
- Accurate and timely transmission of health care information, progress, services, lab reports, medications and member needs
- Communication between providers, family members and stakeholders so that services are delivered timely and meet the member's needs, especially in resolving complex, difficult care situations
- Participation in transitions to other RBHAs/ Health Plans, and in discharge planning from hospitals, jails or other institutions to ensure timely services post-discharge, member engagement and avoidance of gaps in care
- Referral management for providers, services and community resources
- Outreach and engagement of members who would benefit from services

For example, care coordination will be provided in a manner that recognizes the importance of Tribal Sovereignty and Nation Building, and will meet the needs of tribal members through the development of individualized tribal agreements. HCIC will also work to coordinate member access to Medicaid and state funded services as permitted during the pre-trial and post-release from jail or prison and during parole as per HCIC Memoranda of Understanding, agreements and protocols for jails and prisons. This will include coordination of care with forensic peer support programs and peer and family run organizations.

HCIC will provide coordination of care to children with developmental disabilities through strong collaboration with DDD and specifically via the HCIC Community Collaborative Care Team (CCCT). The purpose of the CCCT is to facilitate communication, collaboration, coordination of services and fiscal management in order to reach consensus and active decision making for the most complex DDD members.

How first year target was achieved *(optional)*:

Priority #: 5

Priority Area: Suicide Rate

Priority Type: MHS

Population(s): Other (Entire population)

Goal of the priority area:

Original goal achieved.

New Goal. Reduce the Arizona Suicide Rate to 14% per 100,000 by calendar year ending 2016.

Strategies to attain the goal:

The Arizona Department of Health Services/Division of Behavioral Health will research and implement strategies to reduce the suicide rate. Strategies will include but are not limited to: social media messaging, social market/public awareness, youth leadership programs, gatekeeper trainings, improved data surveillance, and ongoing collaboration with stakeholders or systemic improvement.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Performance Indicators to measure success on a yearly basis.

Baseline Measurement: The suicide rate in Arizona for CY14 was 16.2 per 100,000 population.

First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2016), 15.2 per 100,000

Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2017), 14.2 per 100,000

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Arizona Department of Health Services, Division of Public Health and Statistics (ADHS/PHS)

New Data Source*(if needed)*:

Description of Data:

Each fall, the Arizona Department of Health Services, Division of Public Health and Statistics (ADHS/PHS) calculates the State's suicide rate by determining the number of death certificates of Arizona residents where "Suicide" was indicated by a medical examiner as the cause of death during the second most recent complete calendar year (i.e. CY 2016 data will be made available in fall 2017). This number is then aggregated across the general population to establish a suicide rate per 100,000 persons.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

No data related issues identified.

New Data issues/caveats that affect outcome measures:

The Arizona Department of Health Services, Division of Public Health and Statistics (ADHS/PHS) has not yet released information on Statewide suicide rates for 2015. The most recent information available through ADHS/PHS and the CDC is CY2014. It is unknown when ADHS/PHS will release their CY2015 report. According to information reported to the statewide suicide prevention coordinator at AHCCCS, the number of deaths by suicide in 2015 was 1,340.

Report of Progress Toward Goal Attainment

First Year Target: € Achieved þ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

The Arizona Department of Health Services, Division of Public Health and Statistics (ADHS/PHS) has not yet released information on Statewide suicide rates for 2015. The most recent information available through ADHS/PHS and the CDC is CY2014. It is unknown when ADHS/PHS will release their CY2015 report. According to information reported to the statewide suicide prevention coordinator at AHCCCS, the number of deaths by suicide in 2015 was 1,340.

How first year target was achieved *(optional)*:

The State's 2017 End to Suicide in Arizona State Plan" is attached and outlines the state's plan to reduce deaths by suicide. The six targeted populations for suicide prevention in Arizona:
Veterans
Those age 65 and older
Native Americans
First Responders
Medical Examiners (for educational purposes)
Vendors of Firearms (for educational purposes)

Priority #: 6

Priority Area: IV Drug Users

Priority Type: SAT

Population(s): IVDUs, Other (Entire Substance Abuse Population)

Goal of the priority area:

Increase the availability and service utilization of Medication-Assisted Treatment (MAT) options for individuals with a substance use disorder. The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) will focus on reaching out to the IV drug use population.

Note- goal is in progress. Arizona has worked to improve MAT access and availability through provider network monitoring to assess needs, expanding lists of approved MAT medications, and increasing convenience of locations and hours. Providers and their prescribers receive training on the availability and use of MAT services, as well as education on MAT medications. Additionally, there is now Methadone and Suboxone Directories available for Maricopa County to assist in making appropriate referrals.

Strategies to attain the goal:

The ADHS/DBHS will further rollout the expanded MAT services available to those with a substance use diagnosis through additional advertising within the community.

The ADHS/DBHS and Regional Behavioral Health Authorities (RBHAs) will provide education for healthcare practitioners on best practices and availability of MAT services.

The ADHS/DBHS will compile a listing of various MATs available throughout the State to assist clients in locating appropriate services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual performance measurement for outcomes.

Baseline Measurement: 2014 measurement of individuals who are IVDU who received MAT services.

First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2016), 51%

Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2017), 53%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Client Information System (CIS) data.

New Data Source*(if needed)*:

Description of Data:

CIS report on the number of injecting clients with a SUD receiving MAT services out of number of injecting clients

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

No data related issues anticipated.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: € Achieved b Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

Arizona has worked to improve access to MAT and all three RBHAs continue to monitor adequate access to MAT services. Arizona requires all SUD providers to receive training on available MAT for Opioid Use Disorders. Each RBHA is monitoring and addressing barriers to accessing MAT and working with the State on strategies to increase access to MAT. RBHAs have focused efforts on increasing access to MAT in rural areas through utilization of telemedicine medication reviews. Arizona continues to monitor utilization and network capacity to identify areas for expansion and improvement.

How first year target was achieved *(optional)*:

Priority #: 7

Priority Area: Pregnant women and women with dependent children.

Priority Type: SAP, SAT

Population(s): PWWDC

Goal of the priority area:

Ensure that women have easy access to SAPT services.

Note- Goal is in progress. Strategies utilized by RBHAs and providers for collaborations include the following: creating a protocol for pregnant females using drugs intravenously in order to ensure MAT medications are appropriately prescribed for this population; collaboration with Arizona's Family First Program which provides substance use treatment services to parents who have involvement with DCS due to abuse of substances; and collaboration through the Women's Services Network who are currently developing tools for outreach to women in the community. In addition to statewide use of updated SABG posters, a Women's Services Directory was developed this last year that lists all treatment providers with treatment services and programs that are gender specific to women, and the Women's Treatment Group is developing a pamphlet and short video summarizing women's services that will be displayed for incarcerated women in jails, hospitals, and domestic violence shelters. Monitoring of the number of women

in substance abuse treatment (particularly those on the waitlist), encounter values is being conducted statewide.

Strategies to attain the goal:

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) and the Regional Behavioral Health Authorities (RBHAs) will collaborate on ways to expand public awareness campaigns directed towards the priority populations.

The RBHAs and the ADHS/DBHS staff will regularly monitor treatment waitlists to ensure access to care.

The ADHS/DBHS will review encounter codes to ensure that pregnant women and women with children receive the full array of covered services.

The ADHS/DBHS and RBHAs will monitor the utilization of services for this priority population.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Annual Performance Indicators to measure success on a yearly basis.
Baseline Measurement:	Number of pregnant and parenting women with dependent children within the system receiving SA treatment in 2015.
First-year target/outcome measurement:	Increase the FY 15 enrollment by 3%
Second-year target/outcome measurement:	Increase the FY 16 enrollment by 2%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Client Information System (CIS) data

New Data Source*(if needed)*:

Description of Data:

CIS enrollment data on number of pregnant and parenting women with dependent children receiving SA treatment. This data base is capable of stratifying data by gender, diagnosis, service received, number of children, pregnancy, etc..

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

No data related issues anticipated.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: þ Achieved ¢ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Below are activities focused on pregnant and parenting women the RBHAs have reported. Additionally the State works with the RBHAs and other stakeholders to support services for pregnant and parenting women. The State collects from the RBHAs information on what providers have services for PPW, including providers with gender specific services available.

Cenpatico Strategies and Updates:
• Cenpatico has updated the SABG posters for 2016 and has targeted marketing toward women and women with dependent children. All updated posters have been provided to SABG providers, and audits have been ongoing to ensure posters are posted at each clinic site.
• Cenpatico has collaborated with two Pima County providers to expand gender-specific treatment services to women, pregnant women and/or women with dependent children. One provider has recently established a collaborative relationship with Tucson Medical Center (hospital) to provide immediate SUD services for women and their infants, including MAT services. This initiative with both providers has resulted in a reduction of children removed by the Department of Child Safety, as providers are able to offer a full continuum of care, including BHRF, IOP, outpatient and transitional housing, for mother and her children.

AHCCCS and Mercy Maricopa will collaborate on ways to expand public awareness campaigns directed towards the priority populations.
• AHCCCS and Mercy Maricopa staff will regularly monitor treatment waitlists to ensure access to care. ALL SABG Residential Providers were trained on the electronic submission of the AHCCCS Waitlist Report and have implemented this process.
• AHCCCS and Mercy Maricopa will monitor the utilization of services for this priority population.
• Mercy Maricopa Integrated Care provided MAT Training for all GMH/SA providers in order to improve knowledge of this valuable service and strengthen partnerships resulting in better care for these members and increase referral and use of this service.
• Mercy Maricopa Integrated Care network providers are providing preventative care and coordinating care with the PCP and OBGYN as interim services in order to improve whole health and address risk factors associated with this population.
• Mercy Maricopa Integrated Care provided training to GMH/SA providers on the Opioid Epidemic in Arizona presented by ADHS Assistant Director, providing statistics and data and invite involvement in meeting the goals set by the State of Arizona to address this area.
• Mercy Maricopa Integrated Care continues to foster partnerships with MAT providers and the justice system to identify this 'at risk' population to engage them into MAT services prior to release and/or as being released.

Priority #: 8

Priority Area: Underage Drinking

Priority Type: SAP

Population(s): Other (Criminal/Juvenile Justice, Youth under the age of 21.)

Goal of the priority area:

Note- original goal was achieved.

New goal- Increase the percentage of youth who perceive 5 or more drinks of alcohol per day harmful to 2%, as measured by the Arizona Youth Survey

Strategies to attain the goal:

Conduct youth driven media campaigns to promote positive youth values and community pride. Campaigns will include: youth developed social messaging (radio; PSA poster contests; billboards; murals and alcohol free pledges.
• Collect samples of youth written letters to the editor with anti-alcohol messages.
• Host a statewide youth UAD prevention media display and recognition event.
• Verify that all prevention programs incorporate education on perception of harm into their prevention programs.

Implement afterschool and leadership programs for youth.
• Implement alcohol prevention focused peer leadership programs such as: SAD, YES, Sources of Strength, University leadership organizations.
• Host annual statewide and regional conferences/retreats/youth camps.
• Develop a statewide venue for recognition of youth UAD prevention projects and other successes.

Implement an adult targeted media campaign to educate parents about risks.
• Community media campaign/Draw the Line (DTL)/Hasta Aqui Implementation.
• Collect data on Inclusion of DTL.
• Identify programs needed to increase incorporation of DTL in their parenting program.
• Meet with Regional Behavioral Health Authorities (RBHAs) Prevention Administrators to determine a means for inclusion of DTL in their programs.
• Distribution of DTL materials to RBHAs during alcohol awareness month.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Annual Performance Indicators to measure success on a yearly basis.
Baseline Measurement:	2014 data reflects 78.9% of youths perceive having five or more alcoholic beverages in a row once or twice a week is of great risk.
First-year target/outcome measurement:	2% increase from baseline per post tests administered at the end of the year. 80.9 -2015 Arizona Youth Survey
Second-year target/outcome measurement:	2% increase from baseline per post tests administered at the end of the year. 82.9%- 2016 Arizona Youth Survey

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Pre and post test

New Data Source*(if needed)*:

Description of Data:

Data will be obtained from the Pre and Post Tests (Adolescent Core Measure) that is part of the Arizona Youth Survey

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Due to a change in AYS reporting, the indicator used in this report will need to change from the perception of 1 to 2 alcoholic drinks as harmful to the perception of 5 or more drinks in a row as harmful. As a result,

New Data issues/caveats that affect outcome measures:

The Arizona Youth Survey (AYS) is published every two years, typically in the fall. The 2016 AYS report has not yet been released and the data needed to update this indicator is not available. Below is the response from the Arizona Criminal Justice Commission, the state entity that administers the survey:

"Hi Lesley,

Thank you so much for reaching out to us. At this time, we are slated to release the AYS reports in the month of December. We are unable to process 2016 data requests until the full release has occurred, and all schools have received their reports. As a result, we will not be able to process this request by November 30th.

I'm happy to keep you posted on the release of these data, and will add your request to the queue for processing once the release has occurred. Please feel free to contact me with any questions or concerns.

Best,

Carlena A. Orosco, M.A.
Senior Research Analyst
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Report of Progress Toward Goal Attainment

First Year Target: € Achieved b Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

The Arizona Youth Survey (AYS) is published every two years, typically in the fall. The 2016 AYS report has not yet been released and the data needed to update this indicator is not available. Below is the response from the Arizona Criminal Justice Commission, the state entity that administers the survey:

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How first year target was achieved *(optional)*:

The Southern Arizona RBHA maintained contracts with the following coalitions to address underage drinking and perception of harm: Southern Arizona AIDS Foundation (SAAF) established the Youth Empowerment and LGBTQ Leadership (Y.E.L.L.) coalition and facilitates Botvins Life Skills in 4 Tucson school and is developing a youth leadership component targeting LGBTQ youth and young adults 15 – 24 years of age. Social media is used to promote youth developed messages. Also, The RISPNET Coalition, funded through La Frontera, targets refugee and immigrant youth and families. Vetted mentors facilitate Botvins Life Skills in schools with high concentration of refugee students and the Botvins parent component is facilitated with parents to support parents talking to their children. Native American Advancement Foundation Healthy People Coalition in the GuVo Village on the Tohono O'odham Nation has established an afterschool program facilitating the Too Good for Drugs life skills program and providing evening family activities to promote alcohol perception of harm.
Maricopa AkChin CAASA established the "Be Awesome" Maricopa coalition. The SADD club develops media messaging, participates in community events and activities to increase the perception of harm of alcohol and for parents to talk to their children. The IMPACT Sierra Vista coalition, funded through Southeastern Arizona Behavioral Health Services (SEABHS), has an established SADD club that engages in community activities and develops messaging for youth and parents. Douglas Community Coalition has an established SADD youth leadership group that designs media messages and is involved in promoting alcohol perception of harm within the community and for parents to talk to their children. Ajo Community Coalition and Yuma YMCA are also establishing SADD youth leadership groups that will promote alcohol perception of harm and design related media messages and parents talking to their children.

In Maricopa County the RBHA's strategic plan includes multi-mode media campaigns with messages targeting youth, aimed at changing norms and attitudes about substance use. Several coalitions developed enhanced materials and/or expanded their reach to include multiple substances. These campaigns target decreasing adult attitudes that enable underage drinking, marijuana use, and prescription drug misuse and abuse. There are also campaigns targeting increasing youth perceived harms of underage drinking, marijuana use, and prescription drug misuse and abuse. Coalitions engaged youth in developing messages and materials. A total of 4,502,485 individuals were reached through public information and social marketing strategies throughout FY16.
• Social Media (Facebook, websites, Twitter, online banners, Youtube, etc.)
• Video and radio Public Service Announcements aired via movie theater, local public access TV, and radio advertisements (i.e. Pandora, local radio and/or TV)
• Billboards
• Print materials (door hangers, bookmarks, postcards, magnets, flyers, stickers placed on liquor coolers or store windows in establishments selling alcohol, posters, shopping cart ads, table tents, brochures)
• Health fairs
• Magazines
• Newspapers (including press releases)
• Alcohol-free pledges

Additionally in Maricopa County youth created press releases and articles, specifically regarding successes/outcomes of educating about Party Patrol and Sticker Shock campaigns. Coalitions held Town Halls, marketing campaign launch events, youth and/or adult recognition events to raise awareness of UAD, and media representatives were invited and/or participated in some events. Media was also part of all coalitions and recognized throughout the year for their part in promotion and raising awareness.
The Tempe Coalition (City of Tempe), WOW Coalition (DrugFreeAZKids.org), Chandler Coalition on Youth Substance Use (ICAN), Scottsdale Neighborhoods in Action (Scottsdale Prevention Institute), South Mountain WORKS Coalition (Southwest Behavioral & Health Services), COPE Coalition (TERROS), CARE Coalition (Touchstone Behavioral Health), the HEAAL Coalition (Tanner Community Development Corporation), UICAZ (Phoenix Indian Center) and the NOPAL Coalition (Valle del Sol) all included youth leadership programs addressing alcohol prevention in their comprehensive strategic plans and coalitions. Many of the youth leadership programs are associated with schools, but also local churches and other local community organizations. Coalitions also have formalized youth councils or subcommittees of their coalitions which meet regularly at the community level. All of these peer leadership and coalition groups focus on empowering youth to become agents of community level change, and youth receive leadership training and specific training to engage in activities such as shoulder tapping, sticker shock, etc.

In Northern Arizona the RBHA and providers have conducted youth driven media campaigns to promote positive youth values and community pride. Additionally they have developed a project in Mohave County, including the Hualapai Tribe, to implement a “Not In My Home / Not In My House” project to spread awareness of the extent of harm for early use of alcohol

Priority #: 9

Priority Area: TB Screenings

Priority Type: SAT

Population(s): TB

Goal of the priority area:

Increase the number of clients entering substance abuse treatment who are screened for tuberculosis to 18% by CYE 2017.

Note- Goal is in progress. The Arizona Department of Health Services/Division of Behavioral Health Services did not achieve its goal to increasing each year by 5%.

Strategies to attain the goal:

Focus on developing mechanisms to document and verify TB screening of those entering substance abuse treatment were implemented this last year. Strategies providers are and will continue to implement include: integrating education on TB (along with other communicable diseases) into client orientations, providing educational materials on TB to clients, providing clients with referral handouts for TB and HIV testing at specified locations, as well as including elements to capture TB screening documentation in contractors’ audit tools.

In addition, the Arizona Department of Health Services/ Division of Behavioral Health Services (ADHS/DBHS) to provide guidance to the Regional Behavioral Health Authorities (RBHAs) regarding accurate documentation on screening and referrals for TB services.

Annual Performance Indicators to measure goal success

Indicator #:	-1
Indicator:	Annual Performance Indicators to measure success on a yearly basis.
Baseline Measurement:	FY14 data on the number of patients receiving substance abuse treatment with documentation of TB services documented in their chart. Current baseline will be 14.6
First-year target/outcome measurement:	First-year target/outcome measurement (Progress to end of SFY 2016), Increase FY15 data by 2%
Second-year target/outcome measurement:	Second-year target/outcome measurement (Final to end of SFY 2017), Increase FY 16 data by 2%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Independent Case Review

New Data Source*(if needed)*:

Description of Data:

A random sample of charts will be pulled and scored based on pre-determined elements that include documentation evidencing screenings and referrals for further TB services.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

No data related issues anticipated.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: b Achieved e Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

Based on the 2015 Independent Case Review (ICR), the percent of clients entering substance abuse treatment who are screened for tuberculosis increased from 24.0% in FY14 to 30.8% in FY15.

How first year target was achieved *(optional)*:

Footnotes:

An End to Suicide in Arizona
2017 State Plan

EXECUTIVE SUMMARY

According to officials at the World Health Organization (WHO), more than 800,000 people die by suicide annually; many more make an attempt. Suicide was the second leading cause of death among 15-29 year olds globally in 2012. It is a global phenomenon in all regions of the world and accounted for 1.4% of all deaths worldwide, making it the 15th leading cause of death in 2012.

In Arizona, the latest data shows some 1320 Arizonans died by suicide in 2015.

From 2009-2013, Arizona had more than 5,500 suicides, 2,000 homicides, and another almost 900 undetermined deaths. Many of those undetermined deaths were ruled unintentional poisonings; 750 Arizonans died by taking too much of one medication in 2012.
Suicide is not just a behavioral health concern. Suicide may be linked to depression and other mental illnesses, but the majority of those who have a behavioral health illness do not commit suicide. Suicide touches every family and community in Arizona, regardless of diagnoses, zip codes, ethnicities, or faith.
Suicide is the second leading cause of "years of potential life lost" in our state for American Indians, at 8.7%. Also of grave concern are suicides among our increasing populations of retirees and veterans. The 2015 state plan is a guideline for activities to prevent suicide in Arizona. This plan has been created with guidance and using the framework from the Substance Abuse and Mental Health Administration (SAMHSA) and the National Action Alliance's plan for Zero Suicide. Special thanks to the authors of the Texas State Plan for Suicide Prevention 2014. Its comprehensive plan served as the framework to create a similar strategy for Arizona.

HISTORY

The 2017 *End to Suicide in Arizona State Plan* follows the changes incorporated in the recommendations from the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action, a joint report from the U.S. Surgeon General and the National Action Alliance for Suicide Prevention: http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

Also of note, on July 1, 2016, all behavioral health services in the state of Arizona were transferred from the Arizona Department of Health Services (ADHS) to the Arizona Health Care Cost Containment System (the state Medicaid agency.) Suicide prevention is now managed by AHCCCS staff.

2017 STATE PLAN

The *2017 End to Suicide in Arizona State Plan* provides recommendations including strategic directions, objectives and strategies specific to our state. The four strategic directions are the

same as those given in the National Strategy with the goals, objectives, and strategies closely following the national plan. The statewide strategies identified in the plan are those that can be directly supported by the Arizona Suicide Prevention Coalition and AHCCCS.
The 2015 Arizona state plan was based on the same model; the 2017 goals and objectives have been modified slightly to meet more current issues, as decided by suicide data. AHCCCS leadership conducted extensive community outreach for the 2015 plan; this plan is an extension of that work, along with many additional conversations with stakeholders.
Also, AHCCCS is outreaching Garrett Lee Smith Memorial Act for suicide prevention. This federal funding to campuses can fund education and outreach activities related to mental health and substance abuse prevention, while funding to states and tribes can develop and implement youth suicide prevention and early intervention strategies. This federal suicide funding can be used toward government, university, and tribal projects. Previous recipients include:

- Arizona Department of Health Services
- Arizona State University
- Gila River Health Care Corporation
- Havasupai Tribal Government Office
- Native Americans for Community Action, Inc.
- Navajo Nation Dept. of Behavioral Health Services
- Tohono O'odham Nation
- University of Arizona
- White Mountain Apache/Johns Hopkins University

The following Arizona grantees have active funding:

The White Mountain Apache/Johns Hopkins collaborative:
http://www.sprc.org/grantees/listing?title=&field_grant_type_value_many_to_one=All&field_program_status_value_many_to_one=All&province=Arizona

Native Americans for Community Action, Inc.,: http://www.sprc.org/grantees/native-americans-community-action-inc-5

AHCCCS leadership will also be assessing other community resources for partnership, especially in rural communities. When appropriate, faith organizations and libraries may be excellent partners to disseminate suicide prevention education materials and hold trainings.
This plan was submitted to the Arizona Coalition for Suicide Prevention and other community partners for final review. As such, this plan is presented in collaboration with the Coalition, on behalf of the citizens of Arizona.
Together, our mission is to improve the health and wellbeing of all Arizonans by eliminating suicide.

KEY COMPONENTS
Suicide prevention should be community-based; the effort to reduce stigma associated with suicide, and/or asking for help to address mental illness needs to be communal. Key mental health and suicide prevention terms used in this document follow definitions in the National Strategy for Suicide Prevention:
http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

STRATEGIC DIRECTIONS:

1. Healthy individuals and communities
2. Ready access to prevention resources for clinicians and communities
3. Treatment and support services available to clinicians, communities, survivors
4. Continued evaluation and monitoring of prevention programming

A 2017 calendar is included in the index with a preliminary list of activities related to the following goals, objectives, and immediate points of action. As the year progresses, updates will be available on the AHCCCS blog.

GOALS:

1. Reduce the number of suicides in Arizona to zero through coordinated prevention activities
2. Develop broad-base support for the Zero Suicide model
3. Reduce stigma related to suicide
4. Promote responsible media reporting of suicide
5. Promote efforts to reduce access to lethal means of suicide among those with identified suicide risk
6. Provide training to schools, community, clinical, and behavioral health service providers on the prevention of suicide and related behaviors
7. Promote suicide prevention as a core component of health care services
8. Promote suicide prevention best practices among Arizona's largest health care providers for patients and staff
9. Provide care and support to individuals affected by suicide deaths or suicide attempts and implement community best practice-based post-vention strategies to help prevent further suicides
10. Increase the timeliness and usefulness of national, state, tribal, and local surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action
11. Improve timeliness of data collection and analysis regarding suicide deaths
12. Evaluate the impact and effectiveness of suicide prevention interventions and systems, and synthesize and disseminate findings
13. Coordinate statewide calendar of suicide prevention activities, fostering a collaborative community of support

GOAL 1. Reduce the number of suicides in Arizona to zero through coordinated prevention activities

OBJECTIVE 1.1: Integrate zero suicide prevention into the core values, culture, leadership, conversation and work of a broad range of organizations and programs with a role to support suicide prevention activities.
STRATEGY 1.1.1: Implement programs and policies to build social connectedness and promote positive mental and emotional health.
STRATEGY 1.1.2: Implement organizational changes to promote mental and emotional health in the workforce.
STRATEGY 1.1.3: Increase the number of local, state, tribal, professional, and faith-based groups that integrate suicide prevention activities into their programs.
OBJECTIVE 1.2: Establish effective, sustainable, and collaborative suicide prevention programming at the state, county, tribal, and local levels.
STRATEGY 1.2.1: AHCCCS, in collaboration with the Arizona Coalition for Suicide Prevention, will coordinate and convene public and private stakeholders, assess needs and resources, and update and implement a comprehensive strategic state suicide prevention plan annually.
STRATEGY 1.2.2: Through the support of the AHCCCS, in collaboration with the Arizona Coalition for Suicide Prevention, county health departments and representatives from each RBHA will participate in local coalitions of stakeholders to promote and implement comprehensive suicide prevention efforts at the community level.
STRATEGY 1.2.3: AHCCCS will support the annual conference organized by the Arizona Coalition for Suicide Prevention.
OBJECTIVE 1.3: Sustain and strengthen collaborations across agencies and organizations to advance suicide prevention.
STRATEGY 1.3.1: Strengthen partnerships with agencies that serve individuals at higher risk of suicide, such as military, veterans, substance abuse, foster care, juvenile justice, youth, elderly, American Indian, middle-aged white males, mental health consumers, suicide attempt survivors, those bereaved by suicide, GLBTQ2S (gay/lesbian/bisexual/transgender/questioning/two-spirited people), and other higher risk groups.
STRATEGY 1.3.2: Educate local, state, professional, volunteer and faith-based organizations about the importance of integrating suicide prevention activities into their programs, and distribute specific suggestions and examples of integration.
STRATEGY 1.3.3: Collaborate with AHCCCS' injury and violence prevention committee
OBJECTIVE 1.4: Integrate Zero Suicide into all relevant health care policy efforts.
STRATEGY 1.4.1: Encourage businesses and employers to ensure that mental health services are included as a benefit in health plans and encourage employees to use these services as needed.

AHCCCS 2017 actions: AHCCCS will organize regional meetings of suicide prevention stakeholders to discuss the Zero Suicide model and successful prevention activities. This will include coordination of Zero Suicide prevention plans by the regional behavioral health authorities, veteran groups, 22 American Indian tribes in Arizona, state universities, hospital systems, faith organizations, and major employers. AHCCCS will work with each of these entities to create and manage such plans.

GOAL 2. Develop broad-base support for the Zero Suicide model.

OBJECTIVE 2.1: Develop, implement, and evaluate communication efforts designed to reach defined segments of the population.
STRATEGY 2.1.1: Develop and implement an effective communications strategy for defined higher risk audiences and school personnel promoting suicide prevention, mental health, and emotional well-being, incorporating traditional and new media.
OBJECTIVE 2.2: Reach policymakers with dedicated communication efforts.
STRATEGY 2.2.1: Increase policymakers' understanding of suicide, its impact on constituents and stakeholders, and effective suicide prevention efforts.
OBJECTIVE 2.3: Increase communication efforts in mass and social media that promote positive messages and support safe crisis intervention strategies.
STRATEGY 2.3.1: Incorporate emerging technologies in suicide prevention programs and communication strategies, using best practices guidelines, and link to Teen LifeLine.
STRATEGY 2.3.2: Incorporate positive messages and safe crisis intervention information in suicide prevention communication programs.
OBJECTIVE 2.4: Increase knowledge of risk factors and warning signs for suicide and how to connect individuals in crisis with assistance and care.
STRATEGY 2.4.1: Increase public awareness of the role of the national and local crisis lines in providing services and support to individuals in crisis.
STRATEGY 2.4.2: Increase the use of new and emerging technologies such as tele-health, chat, text services, websites, mobile applications, AHCCCS social media, and online support groups for suicide prevention communications.

AHCCCS 2017 actions: AHCCCS will report on state Zero Suicide prevention efforts using AHCCCS website and will report activities from partners statewide.

GOAL 3. Reduce stigma related to suicide

OBJECTIVE 3.1: Promote effective programs and practices that increase protection from suicide risk. STRATEGY 3.1.1: Provide opportunities for social participation and inclusion for those who may be isolated or at risk.
STRATEGY 3.1.2: Implement programs and policies to prevent abuse, bullying, violence, and social marginalization or exclusion.
STRATEGY 3.1.3: Encourage individuals and families to build strong, positive relationships with family and friends.
STRATEGY 3.1.4: Encourage individuals and families to become involved in their community's volunteer efforts (e.g. mentor or tutor youth, join a faith or spiritual community, reach out to older adults in the community.)
OBJECTIVE 3.2: Reduce prejudice, discrimination or stigma associated with suicidal behaviors, and mental health and substance use disorders.

STRATEGY 3.2.1: Promote mental health, increase understanding of mental and substance abuse disorders and eliminate barriers to accessing help through broad communications, public education, and public policy efforts.
STRATEGY 3.2.2: Increase funding and access to mental health services in an effort to reduce suicide attempts, hospitalizations, or incarcerations due to mental health related behaviors.
O20**B**1**J**5**E**A**C**n**T**En**IV**d **E**to **3**Su.**3**ic.:idPe rinoAmrioztneatshtaeteuPnlad**n**erstanding that recovery from mental health illness and substance use disorders is possible for all.
STRATEGY 3.3.1: Communicate messages of resilience, hope, and recovery to communities, patients, clients, and their families with mental health and substance use disorders.
http://suicidepreventionmessaging.actionallianceforsuicideprevention.org/

AHCCCS 2017 actions: AHCCCS will coordinate suicide stigma reduction activities during the month of September—suicide prevention month. AHCCCS will also reach out to media to discuss suicide in our community and share effective prevention mechanisms. AHCCCS staff will be counseled in using the word "suicide" in lieu of softer language.
AHCCCS will also work with the Spanish-speaking population for the creation of Spanish support groups for survivors and loss survivors.

GOAL 4. Promote responsible media reporting of suicide

OBJECTIVE 4.1: Encourage and recognize news and online organizations that develop and implement policies and practices addressing the safe and responsible reporting of suicide and other related behaviors.
STRATEGY 4 .1.1: Disseminate *Recommendations for Reporting on Suicide* to news and online organizations. *http://reportingonsuicide.org*
STRATEGY 4.1.2: Encourage communication and feedback to news and online organizations in response to stories related to suicide, noting when they are appropriate and/or inappropriate, utilizing a variety of communications such as letters to the editor, op-eds, articles, online article comments, personal contacts, and phone calls.
STRATEGY 4 .1.3: Develop a sample response template for recommendations to media and a procedure for dissemination of the recommendations.
STRATEGY 4.1.4: Recognize selected members of the news media industry who follow safe messaging guidelines at suicide prevention symposiums and regional meetings/summits.
OBJECTIVE 4.2: Encourage and recognize members of the entertainment industry who follow recommendations regarding the appropriate representation of suicide and other related behaviors. STRATEGY 4.2.1: Develop a sample response template for recommendations to the entertainment industry and a procedure for dissemination of the recommendations.
OBJECTIVE 4.3: Promote and disseminate national guidelines on the safety of online content for new and emerging communication technologies and applications.
STRATEGY 4.3.1: Encourage statewide groups, local coalitions, and gatekeepers to monitor and respond to the safety of online content and encourage the use of national guidelines on safe messaging and suicide prevention.
OBJECTIVE 4.4: Disseminate national guidelines for journalism and mass communication schools regarding how to address consistent and safe messaging on suicide and related behaviors in their curricula.
STRATEGY 4.4.1: Develop a distribution list of journalism and mass communications schools in Arizona and disseminate the national guidelines.

AHCCCS 2017 actions: AHCCCS will develop stronger relationships with local and national media to discuss suicide prevention efforts in an appropriate way. AHCCCS will also foster these relationships to ensure suicide reporting is conducted effectively.

GOAL 5. Promote efforts to reduce access to lethal means of suicide among those with identified suicide risk

OBJECTIVE 5.1: Encourage providers who interact with individuals and groups at risk for suicide to routinely assess for access to lethal means.
STRATEGY 5.1.1: Sponsor trainings and disseminate information on means restriction to mental health and healthcare providers, professional associations, patients, and their families.
STRATEGY : 5.1.2: Incorporate lethal means counseling into suicide risk assessment protocols and address means restriction in safety plans.
STRATEGY 5.1.3: Sponsor medication take-back days and ongoing methods for the disposal of unwanted medications (e.g. secure collection kiosks at police departments or pharmacies).
STRATEGY 5.1.4: Encourage individuals and families to dispose of unused medications, particularly those that are toxic or abuse-prone, and take additional measures (e.g. medication lock box) if a member of the household is at high risk for suicide.
STRATEGY 5.1.5: Educate clergy, parent groups, schools, juvenile justice personnel, rehabilitation centers, defense and divorce attorneys, healthcare providers, and others about the importance of promoting efforts to reduce access to lethal means among individuals at risk for suicide.
STRATEGY 5.1.6: Encourage all individuals and families to store household firearms locked and unloaded with ammunition locked separately.
STRATEGY 5.1.7: For households with a member at high risk for suicide, take additional measures such as recommendations in the Means Matter website hsph.harvard.edu/means-matter/

OBJECTIVE 5.2: Partner with firearm dealers, gun owners, concealed handgun trainers and law enforcement to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.
STRATEGY 5.2.1: Develop a list of potential firearm suicide safe advocacy groups in Arizona, such as gun retailers, shooting clubs and ranges, manufacturers, firearm retail insurers, concealed handgun instructors, law enforcement, farm and ranch associations, and veterans groups.
STRATEGY 5.2 .2: Initiate partnerships with firearm advocacy groups (e.g. retailers, shooting clubs, manufacturers, firearm retail insurers, concealed handgun instructors, law enforcement, farm and ranch associations and veterans groups) to increase suicide prevention awareness.
STRATEGY 5.2.3: Develop and implement pilot community projects to promote gun safety and suicide safe homes, incorporating the National Action Alliance's Zero Suicide recommendations. *http://zerosuicide.actionallianceforsuicideprevention.org*

OBJECTIVE 5.3: Encourage the implementation of safety technologies to reduce access to lethal means.
STRATEGY 5.3.1: Promote safety technologies to reduce access to lethal means (e.g. reducing carbon monoxide, restricting medication pack sizes, pill dispensing lockboxes, barriers to bridges.)

AHCCCS 2017 actions: AHCCCS will work with community partners to advertise medication take-back days and the dangers of prescription medications left unattended. Additionally, AHCCCS will work with firearm vendors and advocacy groups to provide suicide prevention materials and education. AHCCCS, along with community partners, will develop appropriate materials for distribution at firing ranges, gun clubs and places where guns are sold.

GOAL 6. Provide training to schools, community, clinical, and behavioral health service providers on the prevention of suicide and related behaviors

OBJECTIVE 6.1: Provide training to community groups in the prevention of suicide and related behaviors.
STRATEGY 6.1.1: AHCCCS will promote the use of best practice programs and the Zero Suicide model.
STRATEGY 6.1.2: AHCCCS will support the Arizona Coalition for Suicide Prevention and Teen Lifeline on their work with schools in Arizona concerning suicide prevention, including helping to provide technical assistance to interested school districts in the creation of suicide prevention plans. store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669

OBJECTIVE 6.2: Provide training to all health care providers, including mental health, substance abuse and behavioral health, on the recognition, assessment, and management of risk factors, warning signs, and the delivery of effective clinical care for people with suicide risk.
STRATEGY 6.2.1: Increase the capacity of health care providers to deliver suicide prevention services in a linguistically and culturally appropriate way.
STRATEGY 6.2.2: Increase the capacity of healthcare providers to deliver routine suicide prevention screening and services using best practice guidelines.

OBJECTIVE 6.3: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education. STRATEGY 6.3.1: Integrate core suicide prevention competencies into relevant curricula and continuing education programs (e.g. nursing, medicine, allied health, pharmacy, social work, education, counseling, therapists.)
OBJECTIVE 6.4: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.
STRATEGY 6.4.1: Review current core requirements for credentialing and accreditation bodies and make recommendations regarding suicide prevention and intervention guidelines to their curricula. **OBJECTIVE 6.5:** Develop and implement protocols, programs, and policies for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.

STRATEGY 6.5.1: Add suicide risk-specific protocols to programs and policies for mental health clinicians, supervisors, first responders, and their support staff.
STRATEGY 6.5.2: Enhance effective communication and coordination among mental health clinicians, supervisors, first responders, their support staff, and others on responding to clients at imminent risk.

AHCCCS 2017 actions: AHCCCS will provide support to behavioral health providers concerning recognizing suicide behaviors in members and how to prevent suicide. AHCCCS will encourage behavioral health providers and integrated health providers to ask specific questions about depression and suicidal thoughts. AHCCCS will also ask behavioral health providers to ask their members who are veterans, to better coordinate services with veteran service organizations (including the VA.)

GOAL 7. Promote suicide prevention as a core component of health care services

OBJECTIVE 7.1: Promote the adoption of Zero Suicide as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.
STRATEGY 7.1.1: AHCCCS will develop a pilot program and Zero Suicide Toolkit on how to implement suicide safe care centers in communities.
STRATEGY 7.1.2: Promote zerosuicide.com website in publications and communications about treatment and support services.
STRATEGY 7.1.3: Educate providers of health care and community support systems about adopting zero suicide as an aspirational goal, and promote the organizational readiness survey of the National Action Alliance for Suicide Prevention.
OBJECTIVE 7.2: Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.
OBJECTIVE 7.3: Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.
STRATEGY 7.3.1: Advocate for funding for prevention and postvention for clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.
OBJECTIVE 7.4: Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.
STRATEGY 7.4.1: Promote the use of safety planning and other best practices for emergency department care as highlighted in the Suicide Prevention Resource Center's Best Practices Registry *sprc.org/bpr*
OBJECTIVE 7.5: Encourage healthcare delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts. **OBJECTIVE 7.6:** Establish linkages among providers of primary care, mental health and substance abuse services and community-based programs, including peer support programs.
STRATEGY 7.6.1: AHCCCS and the Arizona Coalition for Suicide Prevention will promote suicide prevention regional summits to enhance linkages among providers of primary care, mental health and substance abuse services and community-based programs, including peer support programs.
OBJECTIVE 7.7: Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.

OBJECTIVE 878: Develop collaborations between emergency departments and other health care providers to provide safe alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up and ongoing care after discharge.
STRATEGY 7.8.1: Promote rapid enhanced programs for immediate care after discharge, such as caring letters, postcards, texts, and letters.

AHCCCS 2017 actions: AHCCCS will work with healthcare entities statewide to provide training for staff concerning suicide prevention among patients and staff. AHCCCS will also help to develop suicide prevention materials for healthcare settings and materials for loss survivors upon a suicide death. AHCCCS will encourage healthcare providers to have policies on the discharge of suicidal patients.

GOAL 8. Promote suicide prevention best practices among Arizona's largest health care providers for patients and staff

OBJECTIVE 8.1: Promote national guidelines for the assessment of suicide risk among persons receiving care in all settings.
STRATEGY 8.1.1: Educate providers about best practice-based toolkits and ways to implement the national guidelines for the assessment of suicide risk among persons receiving care in all settings, which can be found on the Suicide Prevention Resource Center's Best Practices Registry, *sprc.org/bpr*
OBJECTIVE 8.2: Disseminate and implement best practice-based guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk, such as guidelines posted on the best practices registry at *sprc.org/bpr*
STRATEGY 8.2.1: Educate providers about the best practice-based national guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk, which can be found on the Suicide Prevention Resource Center's Best Practices Registry, *sprc.org/bprr*
OBJECTIVE 8.3: Promote the safe disclosure of suicidal thoughts and behaviors by all patients.
STRATEGY 8.3.1: The Arizona Coalition for Suicide Prevention will advocate to eliminate penalties for suicide attempts from insurance providers.

STRATEGY 8.3.2: AHCCCS and community partners will educate providers about safe and effective guidelines for conducting safe suicide risk assessments such as the Chronological Assessment of Suicide Events (CASE approach -*suicideassessment.com*), Columbia Suicide Severity Rating Scale (CSSRS - *cssrs.columbia.edu/*), Assessing and Managing Suicide Risk (AMSR - *sprc.org/training-institute/amsr*), Collaborative Assessment and Management of Suicidality (CAMS - psychology.cua.edu/faculty/jobes.cfm , and other programs identified on the Suicide Prevention Resource Center's best practice registry, *http://www.sprc.org/bpr*, beginning with local mental health authorities, by 2017.
OBJECTIVE 8.4: Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for persons with suicide risk.
STRATEGY 8.4.1: Engage families and those at risk of suicide about the importance of including families and concerned others in the safety planning process.
OBJECTIVE 8.5: Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among patients receiving care for mental health and/or substance use disorders.

STRATEGY 8.5.1: Promote best practice risk stratification systems and pathways of clinical care.
OBJECTIVE 8.6: Promote standardized protocols for use within emergency departments based on common clinical presentation to allow for more differentiated responses based on risk profiles and assessed clinical needs.
OBJECTIVE 8.7: Promote guidelines on the documentation of assessment and treatment of suicide risk and establish a training and technical assistance capacity to assist providers with implementation.
STRATEGY 8.7.1: Promote best practice-based recommendations such as those identified in suicide prevention and resources for primary care by the Suicide Prevention Resource Center (sprc.org) and SAMHSA (samhsa.gov) related to assessment and treatment of those identified with suicidal thoughts and behaviors. Example: Recognizing and Responding to Suicide Risk in Primary Care, sprc.org/bpr/section-III/recognizing-and-responding-suicide-risk-primary- care-rrsr—pc.

AHCCCS 2017 actions: AHCCCS will reach out to Arizona's largest employers to determine what policies are currently in place for helping suicidal employees and help create an appropriate plan for referring employees for further care. We will also continue to support the use of SafeTalk and ASSIST, so all community members are aware of the warning signs of suicide and how to get help.

GOAL 9. Provide care and support to individuals affected by suicide deaths or suicide attempts and implement community best practice-based post-vention strategies to help prevent further suicides

OBJECTIVE 9.1: Promote guidelines for effective comprehensive support programs for individuals with lived experience, including those bereaved by suicide and survivors of suicide attempts, and promote the full implementation of these guidelines at the state, county, tribal, and community levels.
actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/The-Way-Forward-Final-2014-07-01.pdf
STRATEGY 9.1.1: AHCCCS will add links and/or information on best-practice support programs or g2u01id5 eAlninEendS tfoSrupicoidSetivneAnritzionnaSstarteatPelagnies to the state website.

OBJECTIVE 9.2: Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.
STRATEGY 9.2.1: Disseminate guidelines on trauma informed care to clinicians, agencies, and first responders. *samhsa.gov/traumajustice/traumadefinition/guidelines.aspx*

STRATEGY 9.2.2: AHCCCS will collaborate with state initiatives on trauma informed care and systems of care to include suicide prevention and postvention.
OBJECTIVE 9.3: Engage suicide attempt survivors and those bereaved by suicide in suicide prevention planning, including support services, treatment, community suicide prevention education, and promote guidelines and protocols for support groups for suicide attempt survivors and those bereaved by suicide.
STRATEGY 9.3.1: AHCCCS will promote the development of follow-up services for attempt survivors, and those bereaved by suicide, in emergency departments and other community providers after a suicide attempt or death by suicide. Follow-up may include phone calls, post cards, email, or texts at intervals with caring messages and contact information for help.

STRATEGY 9.3.2: AHCCCS will promote inclusion of people with lived experience, including suicide attempt survivors and those bereaved by suicide, in local, regional, and state initiatives.

OBJECTIVE 9.4: Promote community postvention best practice-based policies and programs to help prevent suicide clusters and contagion.

STRATEGY 9.4.1: Inform communities and school districts about support for postvention including how to address suicide clusters and contagion through the local mental health authority suicide prevention coordinator, local suicide prevention coalitions, and the state suicide prevention coordinator.

OBJECTIVE 9.5: Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.

STRATEGY 9.5.1: Support and encourage communities to develop a LOSS Team (Local Outreach to Suicide Survivors), trainings, support groups, and offer best practice-based bibliotherapy and other resources. *lossteam.com/About-LOSSteam-2010.shtml*

STRATEGY 9.5.2: Provide support for open and direct talk about suicide postvention through best practice-based presentations, debriefing, and counseling.

STRATEGY 9.5.3: Provide support to schools and school districts for training and facilitated discussions with teachers, administrators, support staff, and parents after a suicide loss.

STRATEGY 9.5.4: Provide support to students after a suicide loss in one-to-one or small group discussions only.

STRATEGY 9.5.5: Provide awareness about the need for best practice supports to medical examiner officers, victim services groups, first responders, funeral homes and faith-based organizations for those bereaved by suicide deaths or affected by suicide attempts.

STRATEGY 9.5.6: Disseminate guidelines about best practices for online and social media after suicide attempt or loss.

STRATEGY 9.5.7: Develop or disseminate best practice based support materials targeted to youth after a suicide loss.

STRATEGY 9.5.8: Encourage safe messaging training for all individuals and organizations involved in prevention, intervention and postvention activities. *SuicidePreventionMessaging.org*

OBJECTIVE 9.6: Provide health care providers, first responders, and others with best practice-based care and support when a patient under their care, or a colleague, dies by suicide.

STRATEGY 9.6.1: Provide support (including training, facilitated discussions, and counseling support) to professional caregivers in communities and schools after a patient or a colleague dies by suicide.

STRATEGY 9.6.2: Consider utilizing hospital or health care organizations' regular communications to inform other providers about increased suicide risk and potential clusters.

AHCCCS 2017 actions: AHCCCS will reach out to healthcare providers to see what information is being provided to loss and attempt survivors. AHCCCS will partner with Arizona Coalition for Suicide Prevention to develop appropriate resources and materials. AHCCCS will encourage healthcare providers to reach out to both groups within 24 hours after the event. AHCCCS will encourage loss and attempt survivor participation in suicide prevention policy creation and at the quarterly suicide prevention meetings statewide.

GOAL 10. Increase the timeliness and usefulness of national, state, tribal, and local surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action

OBJECTIVE 10.1: Improve the timeliness of reporting vital records data at state, county, local, school, and higher education levels.
STRATEGY 10.1.1: Improve capacity for state epidemiologists and the state suicide prevention coordinator to review and report suicide data
OBJECTIVE 10.2: Improve the usefulness and quality of suicide related data, including death, attempt, ideation, and exposure to suicide.
STRATEGY 11.2.1: Promote a mechanism in Arizona to collect and disseminate suicide attempt data. **OBJECTIVE 10.3:** Improve and expand state, county, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.
STRATEGY 10.3.1: As allowed by law, encourage government entities to enter into memorandums of understanding to share suicide data that does not name a deceased person.
OBJECTIVE 10.4: Increase the number of national and state representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.
STRATEGY 10.4.1: AHCCCS will review and make recommendations for the addition of questions to the Arizona Behavioral Risk Factor Surveillance System Survey related to suicide prevention and gay/lesbian/bisexual/transgender/two-spirited adults.
STRATEGY 10.4.2: AHCCCS will collaborate with Arizona State University on the state's data included in the National Violent Death Reporting System.

AHCCCS 2017 actions: AHCCCS will encourage the White River Apache Reservation to provide technical assistance to other Arizona American Indian tribes concerning suicide surveillance.

GOAL 11. Improve timeliness of data collection regarding suicide deaths

OBJECTIVE 11.1: Develop an Arizona suicide prevention research agenda with comprehensive input from multiple stakeholders.
STRATEGY .11 .1.1: Form partnerships with higher education to promote and support suicide prevention research, including support of the National Violent Death Reporting System (NVDRS) -- new to Arizona: http://www.cdc.gov/violenceprevention/nvdrs/stateprofiles.html
STRATEGY 11.1.2: Consult with the research prioritization task force of the National Action Alliance for Suicide Prevention on how Arizona can develop a mechanism to prioritize state research.

OBJECTIVE 11.2: Disseminate national and Arizona-based suicide prevention research agenda. STRATEGY 11.2.1: Encourage Arizona researchers to apply for national grants and research opportunities on suicide prevention, intervention, and postvention.
STRATEGY 11.2.2: Encourage suicide prevention researchers to inform the AHCCCS about their articles and research projects so that their results can be shared statewide.
Objective 11.3: Promote the timely dissemination of suicide prevention research findings.
STRATEGY 11.3.1: Provide timely dissemination of suicide research findings through links on the AHCCCS website, Facebook, newsletters, Twitter, and other social media.
OBJECTIVE 11.4: Support a repository of research resources to help increase the amount and quality of research on suicide prevention and care in the aftermath of suicidal behaviors.
STRATEGY 11.4.1: Provide links to repositories of national suicide prevention, intervention and postvention toolkits and websites.
OBJECTIVE 11.5: Encourage Arizona foundations to support suicide prevention research.

AHCCCS 2017 actions: AHCCCS will foster relationships with state and private universities in Arizona to promote the research of suicide prevention. We will support the work of ASU with the NVDRS. We will outreach medical examiners and funeral home directors to have conversations about accuracy of death data. We will encourage and promote grant writing technical assistance for those needing help in applying for suicide research funding.

GOAL 12. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

OBJECTIVE 12.1: Evaluate the effectiveness of suicide prevention interventions in Arizona.
STRATEGY 12.1.1: AHCCCS will publicize evaluation results of best practice-based suicide prevention projects, including the Zero Suicide pilot project.
OBJECTIVE 12.2: Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions in Arizona.
OBJECTIVE 12.3: Examine how suicide prevention efforts are implemented in different states/counties and communities to identify the types of delivery structures that may be most efficient and effective.

AHCCCS 2017 actions: AHCCCS will work with other SAMHSA region 9 state suicide prevention coordinators to share information about state plans, successful programming and noted trends.

GOAL 13. Coordinate a statewide calendar of suicide prevention activities, fostering a collaborative community of support.

OBJECTIVE 13.1: Organize a statewide calendar, promoted by AHCCCS.
STRATEGY 13.1.1: Collaborate with as many community stakeholders as possible to keep an up-to- date calendar of community events related to suicide prevention and awareness.

WHAT COMMUNITIES CAN DO TO ADVANCE THE STATEWIDE GOALS

STRATEGIC DIRECTION 1—HEALTHY AND EMPOWERED INDIVIDUALS, FAMILIES AND COMMUNITIES

- Participate in local coalitions of stakeholders to promote and implement comprehensive suicide prevention efforts at the community level. For more information, email: kelli.donley@azahcccs.gov
- Develop and implement communication strategies that convey messages of help, hope, and resiliency. suicidepreventionmessaging.org/
- Provide opportunities for social participation and inclusion for those who may be isolated or at risk.
- Include those with lived experience such as attempt survivors and those bereaved by suicide for planning and implementation of programs.
- Consider sharing recommendations for reporting on suicide and safe messaging to media and encourage communication and feedback to news and online communities in response to local stories related to suicide. suicidepreventionmessaging.org/

STRATEGIC DIRECTION 2—CLINICAL AND COMMUNITY PREVENTIVE SERVICES

- Implement suicide prevention programs that address the needs of groups at risk for suicide and that are culturally, linguistically, and age appropriate.
- Initiate partnership with firearm advocacy groups (e.g. retailers, shooting and hunting clubs, manufacturers, firearm retail insurers) to increase suicide awareness. hsph.harvard.edu/means-matter/examples-of-means-restriction-programs/
- Educate first responders, clergy, parent groups, schools, juvenile justice personnel, rehabilitation centers, defense and divorce attorneys, and others about the importance of promoting efforts to reduce access to lethal means among individuals at risk for suicide. hsph.harvard.edu/means-matter/ and sprc.org/search/apachesolr_search/means%20matters?filters=
- Advocate with your local hospital, emergency departments and other health care providers to provide follow up connections through rapid enhanced programs for immediate care after discharge, such as caring letters, postcards, texts and letters. bjp.rcpsych.org/content/197/1/5.full

STRATEGIC DIRECTION 3—TREATMENT AND SUPPORT SERVICES

- Coordinate the services of community-based and peer-support programs with the support available from local providers of mental health and substance abuse services to better serve individuals at risk for suicide.
- Consider providing support services for those with lived experience such as suicide attempt survivors and those bereaved by suicide.

STRATEGIC DIRECTION 4 —SURVEILLANCE RESEARCH, AND EVALUATION

- Work with a local university to evaluate your suicide prevention program

RESOURCES:

2012 National Strategy for Suicide Prevention -

http://www.surgeongeneral.gov/library/reports/national-_strategy-suicide-prevention/ .
After a Suicide: A Toolkit for Schools
https://www.afsp.org/coping-with-suicide-loss/education-training/after-a-suicide-a-toolkit-for-schools
Assessing and Managing Suicide Risk (AMSR)
http://www.sprc.org/training-institute/amsr
Best Practices Registry, Suicide Prevention Resource Center
http://www.sprc.org/bpr
Counseling on Access to Lethal Means Project (CALM)
http://www.hsph.harvard.edu/means-matter/examples-of-means-restriction-programs/ Center for Elimination of Disproportionality and Disparities
http://www.hhsc.state.tx.us/hhsc_projects/cedd/
Chronological Assessment of Suicide Events (CASE approach - www.suicideassessment.com),
Clinical Workplace Preparedness and Comprehensive Blueprint for Workplace Suicide Prevention http://actionallianceforsuicideprevention.org/task-force/workplace/cspp/training
Collaborative Assessment and Management of Suicidality (CAMS)
http://psychology.cua.edu/faculty/jobes.cfm
Columbia Suicide Severity Rating Scale
(CSSRS) http://www.cssrs.columbia.edu/)
Framework for Successful Messaging
www.SuicidePreventionMessaging.org
LOSS Team Postvention Workshops and Trainings
http://www.lossteam.com/About-LOSSteam-2010.shtml Means Matters, Harvard School of Public
Health
http://www.hsph.harvard.edu/means-matter/examples-of-means-restriction-programs/
National Registry of Evidence-Based Prevention Programs
http://nrepp.samhsa.gov
National Suicide Prevention Lifeline, 1-800-273-8255
http://www.suicidepreventionlifeline.org
Preventing Suicide: A Toolkit for Schools
http://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669
Recommendations for Reporting on Suicide
http://reportingonsuicide.org
Self-Directed Violence Surveillance Uniform Definition and Recommended Data Elements
http://www.cdc.gov/violenceprevention/pdf/self-directed-violence-a.pdf.
Suggested Guidelines for Implementation of a Trauma-informed
Approach
http://www.samhsa.gov/traumajustice/traumadefinition/guidelines.aspx
The Way Forward - Pathways to hope, recovery, and wellness with insights from lived experience
http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/The-_Way-_Forward-Final-2014-07-01.pdf
Zero Suicide in Health and Behavioral Health Care

http://zerosuicide.actionallianceforsuicideprevention.org

PARTNERS:

- Area Agency on Aging
- Arizona Coalition to End Sexual and Domestic Violence
- Arizona Coalition for Military Families
- Arizona Criminal Justice Commission
- Arizona Coalition for Suicide Prevention
- ASU – Center for Applied Behavioral Health Policy
- AHCCCS Bureau of Public Health Statistics
- AHCCCS Office of Injury Prevention
- First Things First
- Gila River Indian Community Police Department
- Glendale Police Department
- Goodyear Police Department
- Pasadera Behavioral Health Network
- Phoenix Police Department
- Pima County Administrator's Office
- Pima County Medical Society
- St. Joseph's Hospital and Medical Center
- Teen Lifeline
- Tucson Police Department
- Maricopa County Justice System Planning and Information
- Mercy Maricopa Integrated Care
- Northern Arizona Regional Behavioral Health Authority
- Cenpatico Integrated Care
- University of Arizona Medical Center

2017 CALENDAR OF EVENTS:

AHCCCS Regional Suicide Prevention Community Conversations

Tucson, Phoenix, Flagstaff
February May August November
Locations to be determined

Arizona Suicide Prevention Coalition: Second Tuesday of the month
JFCS
2033 N. 7th St. Phoenix, AZ
Dial in: 1-619-326-2772 #5131264

Verde Valley Suicide Prevention Coalition Second Wednesday of the Month
3:30-4:30 pm
Location varies

September:
Suicide Prevention Month

III: Expenditure Reports

Table 2 - State Agency Expenditure Report

This table provides a report of SABG and State expenditures by the State Substance Abuse Authority during the State fiscal year immediately preceding the federal fiscal year for which the state is applying for funds for authorized activities to prevent and treat substance abuse. For detailed instructions, refer to those in the Block Grant Application System (BGAS).

Expenditure Period Start Date: 7/1/2015 Expenditure Period End Date: 6/30/2016

Activity (See instructions for using Row 1.)	A. SA Block Grant	B. MH Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment	$30,379,312		$185,068,486	$1,512,261	$4,814,122	$70,950	$0
a. Pregnant Women and Women with Dependent Children*	$4,274,549		$0	$0	$0	$0	$0
b. All Other	$26,104,763		$185,068,486	$1,512,261	$4,814,122	$70,950	$0
2. Substance Abuse Primary Prevention	$8,168,864		$0	$2,037,531	$0	$0	$0
3. Tuberculosis Services	$0		$0	$0	$30,503	$0	$0
4. HIV Early Intervention Services**	$0		$0	$0	$0	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention							
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	$611,775		$6,847,576	$398,970	$3,555	$0	$0
11. Total	$39,159,951	$0	$191,916,062	$3,948,762	$4,848,180	$70,950	$0

* Prevention other than primary prevention

** Only HIV designated states should enter information in this row

Please indicate the expenditures are actual or estimated.

(•) Actual ( ) Estimated

Footnotes:

Arizona transitioned its Statewide Accounting System beginning July 1, 2015 and is in the process of developing the reports required to meet the State's reporting requirements for State Fiscal Year 2016. This includes federal block grant reporting due 12/1/2016. We anticipate to have the information to meet a January 6, 2017 deadline. Revision Request 04/18/17

III: Expenditure Reports

Table 3 - SAPT Block Grant Expenditure By Service

Expenditure Period Start Date: 7/1/2015 Expenditure Period End Date: 6/30/2016

Service	Expenditures
Healthcare Home/Physical Health	$
Specialized Outpatient Medical Services;	
Acute Primary Care;	
General Health Screens, Tests and Immunizations;	
Comprehensive Care Management;	
Care coordination and Health Promotion;	
Comprehensive Transitional Care;	
Individual and Family Support;	
Referral to Community Services Dissemination;	
Prevention (Including Promotion)	$
Screening, Brief Intervention and Referral to Treatment ;	
Brief Motivational Interviews;	
Screening and Brief Intervention for Tobacco Cessation;	
Parent Training;	
Facilitated Referrals;	
Relapse Prevention/Wellness Recovery Support;	
Warm Line;	
Substance Abuse (Primary Prevention)	$
Classroom and/or small group sessions (Education);	
Media campaigns (Information Dissemination);	
Systematic Planning/Coalition and Community Team Building(Community Based Process);	

Parenting and family management (Education);	
Education programs for youth groups (Education);	
Community Service Activities (Alternatives);	
Student Assistance Programs (Problem Identification and Referral);	
Employee Assistance programs (Problem Identification and Referral);	
Community Team Building (Community Based Process);	
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);	
Engagement Services	$
Assessment;	
Specialized Evaluations (Psychological and Neurological);	
Service Planning (including crisis planning);	
Consumer/Family Education;	
Outreach;	
Outpatient Services	$
Evidenced-based Therapies;	
Group Therapy;	
Family Therapy ;	
Multi-family Therapy;	
Consultation to Caregivers;	
Medication Services	$
Medication Management;	
Pharmacotherapy (including MAT);	
Laboratory services;	
Community Support (Rehabilitative)	$
Parent/Caregiver Support;	

Skill Building (social, daily living, cognitive);	
Case Management;	
Behavior Management;	
Supported Employment;	
Permanent Supported Housing;	
Recovery Housing;	
Therapeutic Mentoring;	
Traditional Healing Services;	
Recovery Supports	$
Peer Support;	
Recovery Support Coaching;	
Recovery Support Center Services;	
Supports for Self-directed Care;	
Other Supports (Habilitative)	$
Personal Care;	
Homemaker;	
Respite;	
Supported Education;	
Transportation;	
Assisted Living Services;	
Recreational Services;	
Trained Behavioral Health Interpreters;	
Interactive Communication Technology Devices;	
Intensive Support Services	$
Substance Abuse Intensive Outpatient (IOP);	

Partial Hospital;	
Assertive Community Treatment;	
Intensive Home-based Services;	
Multi-systemic Therapy;	
Intensive Case Management ;	
Out-of-Home Residential Services	$
Children's Mental Health Residential Services;	
Crisis Residential/Stabilization;	
Clinically Managed 24 Hour Care (SA);	
Clinically Managed Medium Intensity Care (SA) ;	
Adult Mental Health Residential ;	
Youth Substance Abuse Residential Services;	
Therapeutic Foster Care;	
Acute Intensive Services	$
Mobile Crisis;	
Peer-based Crisis Services;	
Urgent Care;	
23-hour Observation Bed;	
Medically Monitored Intensive Inpatient (SA);	
24/7 Crisis Hotline Services;	
Other (please list)	$
Total	$0

Footnotes:

III: Expenditure Reports

Table 4 - State Agency SABG Expenditure Compliance Report

Expenditure Period Start Date: 10/1/2013 Expenditure Period End Date: 9/30/2015

Category	FY 2014 SAPT Block Grant Award
1. Substance Abuse Prevention* and Treatment	$30,180,343
2. Primary Prevention	$8,254,859
3. Tuberculosis Services	$0
4. HIV Early Invervention Services**	$0
5. Administration (excluding program/provider level)	$887,921
6. Total	$39,323,123

*Prevention other than Primary Prevention

**HIV Designated States

Footnotes:

Arizona was not a designated State for FFY 2014. The unspent balance of the FFY 2014 award ($125.45) corresponds with the final FFR dated January 6, 2016.

III: Expenditure Reports

Table 5a - Primary Prevention Expenditures Checklist

Expenditure Period Start Date: 10/1/2013 Expenditure Period End Date: 9/30/2015

Strategy	IOM Target	SAPT Block Grant	Other Federal	State	Local	Other
Information Dissemination	Selective	$	$	$	$	$
Information Dissemination	Indicated	$	$	$	$	$
Information Dissemination	Universal	$	$	$	$	$
Information Dissemination	Unspecified	$	$	$	$	$
Information Dissemination	Total	$	$	$	$	$
Education	Selective	$	$	$	$	$
Education	Indicated	$	$	$	$	$
Education	Universal	$	$	$	$	$
Education	Unspecified	$	$	$	$	$
Education	Total	$	$	$	$	$
Alternatives	Selective	$	$	$	$	$
Alternatives	Indicated	$	$	$	$	$
Alternatives	Universal	$	$	$	$	$
Alternatives	Unspecified	$	$	$	$	$
Alternatives	Total	$	$	$	$	$
Problem Identification and Referral	Selective	$	$	$	$	$
Problem Identification and Referral	Indicated	$	$	$	$	$
Problem Identification and Referral	Universal	$	$	$	$	$
Problem Identification and Referral	Unspecified	$	$	$	$	$
Problem Identification and Referral	Total	$	$	$	$	$
Community-Based Process	Selective	$	$	$	$	$

Community-Based Process	Indicated	$	$	$	$	$
Community-Based Process	Universal	$	$	$	$	$
Community-Based Process	Unspecified	$	$	$	$	$
Community-Based Process	Total	$	$	$	$	$
Environmental	Selective	$	$	$	$	$
Environmental	Indicated	$	$	$	$	$
Environmental	Universal	$	$	$	$	$
Environmental	Unspecified	$	$	$	$	$
Environmental	Total	$	$	$	$	$
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Universal	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Total	$	$	$	$	$
Other	Selective	$	$	$	$	$
Other	Indicated	$	$	$	$	$
Other	Universal	$	$	$	$	$
Other	Unspecified	$	$	$	$	$
Other	Total	$	$	$	$	$
	Grand Total	$	$	$	$	$

Footnotes:

Per the Terms and Conditions of the FY2014 Notice of Grant Award, Arizona submitted a Corrective Action Plan June 30, 2014 describing steps to come into compliance with reporting requirements. Please see attached documentation (SAMHSA Reporting CAP Update 2017 Report.docx) regarding updates on steps taken to date.

Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) submitted a Corrective Action Plan (CAP) June 30, 2014 as required by Substance Abuse and Mental Health Services Administration (SAMHSA) to meet the special terms of the award in the June 6, 2014 Notice of Grant Award, SABG Grant Number 2B08TIO10004-14. The CAP described steps which would be taken by ADHS/DBHS in order to comply with block grant reporting requirements.

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

ADHS/DBHS/AHCCCS has developed reporting spreadsheets for each for each of the prevention tables in order to capture information for each contracted provider. The information conforms precisely to the reporting tables for the SABG Report. Each contractor will be required to submit the spreadsheets for each Federal Fiscal Year which will allow AHCCCS to confirm that the amount reported conforms to the required set aside. All prevention activities are reported based on IOM category for each Federal Fiscal Year. As indicated in the CAP, AHCCCS will come into compliance for FFY2016 reporting. AHCCCS has disseminated the newly developed spreadsheets and has provided training and technical assistance to all contractors. AHCCCS is on track for reporting the FFY2016 SABG Block Grant in the December 1, 2018 reporting cycle.

III: Expenditure Reports

Table 5b - Primary Prevention Expenditures by IOM Category

Expenditure Period Start Date: 10/1/2013 Expenditure Period End Date: 9/30/2015

Activity	SAPT Block Grant	Other Federal Funds	State Funds	Local Funds	Other
Universal Direct					
Universal Indirect					
Selective					
Indicated					
Column Total	$0.00	$0.00	$0.00	$0.00	$0.00

Footnotes:

Per the Terms and Conditions of the FY2014 Notice of Grant Award, Arizona submitted a Corrective Action Plan June 30, 2014 describing steps to come into compliance with reporting requirements. Please see attached documentation (SAMHSA Reporting CAP Update 2017 Report.docx) regarding updates on steps taken to date.

Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) submitted a Corrective Action Plan (CAP) June 30, 2014 as required by Substance Abuse and Mental Health Services Administration (SAMHSA) to meet the special terms of the award in the June 6, 2014 Notice of Grant Award, SABG Grant Number 2B08TIO10004-14. The CAP described steps which would be taken by ADHS/DBHS in order to comply with block grant reporting requirements.

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ADHS/DBHS/AHCCCS has developed reporting spreadsheets for each for each of the prevention tables in order to capture information for each contracted provider. The information conforms precisely to the reporting tables for the SABG Report. Each contractor will be required to submit the spreadsheets for each Federal Fiscal Year which will allow AHCCCS to confirm that the amount reported conforms to the required set aside. All prevention activities are reported based on IOM category for each Federal Fiscal Year. As indicated in the CAP, AHCCCS will come into compliance for FFY2016 reporting. AHCCCS has disseminated the newly developed spreadsheets and has provided training and technical assistance to all contractors. AHCCCS is on track for reporting the FFY2016 SABG Block Grant in the December 1, 2018 reporting cycle.

III: Expenditure Reports

Table 5c - SABG Primary Prevention Priorities and Special Population Categories

Expenditure Period Start Date: 10/1/2013 Expenditure Period End Date: 9/30/2015

Targeted Substances	
Alcohol	é
Tobacco	é
Marijuana	é
Prescription Drugs	é
Cocaine	é
Heroin	é
Inhalants	é
Methamphetamine	é
Synthetic Drugs (i.e. Bath salts, Spice, K2)	é
Targeted Populations	
Students in College	é
Military Families	é
LGBTQ	é
American Indians/Alaska Natives	é
African American	é
Hispanic	é
Homeless	é
Native Hawaiian/Other Pacific Islanders	é
Asian	é
Rural	é
Underserved Racial and Ethnic Minorities	é

Footnotes:

Per the Terms and Conditions of the FY2014 Notice of Grant Award, Arizona submitted a Corrective Action Plan June 30, 2014 describing steps to come into compliance with reporting requirements. Please see attached documentation (SAMHSA Reporting CAP Update 2017 Report.docx) regarding updates on steps taken to date.

Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) submitted a Corrective Action Plan (CAP) June 30, 2014 as required by Substance Abuse and Mental Health Services Administration (SAMHSA) to meet the special terms of the award in the June 6, 2014 Notice of Grant Award, SABG Grant Number 2B08TIO10004-14. The CAP described steps which would be taken by ADHS/DBHS in order to comply with block grant reporting requirements.

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ADHS/DBHS/AHCCCS has developed reporting spreadsheets for each for each of the prevention tables in order to capture information for each contracted provider. The information conforms precisely to the reporting tables for the SABG Report. Each contractor will be required to submit the spreadsheets for each Federal Fiscal Year which will allow AHCCCS to confirm that the amount reported conforms to the required set aside. All prevention activities are reported based on IOM category for each Federal Fiscal Year. As indicated in the CAP, AHCCCS will come into compliance for FFY2016 reporting. AHCCCS has disseminated the newly developed spreadsheets and has provided training and technical assistance to all contractors. AHCCCS is on track for reporting the FFY2016 SABG Block Grant in the December 1, 2018 reporting cycle.

III: Expenditure Reports

Table 6 - Resource Development Expenditure Checklist

Expenditure Period Start Date: 10/1/2013 Expenditure Period End Date: 9/30/2015

Resource Development Expenditures Checklist						
Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment						$0.00
2. Quality Assurance						$0.00
3. Training (Post-Employment)						$0.00
4. Program Development						$0.00
5. Research and Evaluation						$0.00
6. Information Systems						$0.00
7. Education (Pre-Employment)						$0.00
8. Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Footnotes:

Per the Terms and Conditions of the FY2014 Notice of Grant Award, Arizona submitted a Corrective Action Plan June 30, 2014 describing steps to come into compliance with reporting requirements. Please see attached documentation (SAMHSA Reporting CAP Update 2017 Report.docx) regarding updates on steps taken to date.

Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) submitted a Corrective Action Plan (CAP) June 30, 2014 as required by Substance Abuse and Mental Health Services Administration (SAMHSA) to meet the special terms of the award in the June 6, 2014 Notice of Grant Award, SABG Grant Number 2B08TIO10004-14. The CAP described steps which would be taken by ADHS/DBHS in order to comply with block grant reporting requirements.

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

ADHS/DBHS/AHCCCS has developed reporting spreadsheets for each for each of the prevention tables in order to capture information for each contracted provider. The information conforms precisely to the reporting tables for the SABG Report. Each contractor will be required to submit the spreadsheets for each Federal Fiscal Year which will allow AHCCCS to confirm that the amount reported conforms to the required set aside. All prevention activities are reported based on IOM category for each Federal Fiscal Year. As indicated in the CAP, AHCCCS will come into compliance for FFY2016 reporting. AHCCCS has disseminated the newly developed spreadsheets and has provided training and technical assistance to all contractors. AHCCCS is on track for reporting the FFY2016 SABG Block Grant in the December 1, 2018 reporting cycle.

III: Expenditure Reports

Table 7 - Statewide Entity Inventory

Expenditure Period Start Date: 10/1/2013 Expenditure Period End Date: 9/30/2015

	Entity Number	I-BHS ID		Area Served (Statewide or SubState Planning Area)	Provider / Program Name	Mailing Address	City	State	Zip	SAPT Block Grant - A. Block Grant Funds (B + D + E)	SAPT Block Grant - B. Prevention (other than primary prevention) and Treatment Services	SAPT Block Grant - C. Pregnant Women and Women with Dependent Children	SAPT Block Grant - D. Primary Prevention	SAPT Block Grant - E. Early Intervention Services for HIV
*	*622987*	*AZ101844*		*Maricopa County*	*EMPACT SPC*	*4425 W OLIVE AVE STE 194*	*GLENDALE*	*AZ*	*85302*	*($41)*	*($41)*	*$12,128*	*$0*	*$0*
*	*AZ101147*	*AZ101147*		*Maricopa County*	*Mercy Maricopa Integrated Care (MMIC)*	*4351 East Cotton Center Boulevard Building D*	*Phoenix*	*AZ*	*85040*	*$1,437,149*	*$1,781,552*	*$158,532*	*($344,403)*	*$0*
	094421	AZ100811		Southeast Arizona	Alternative Counseling Services Inc	999 East Fry Boulevard	Sierra Vista	AZ	85635	$1,238	$1,238	$0	$0	$0
	AZ101018	AZ101018		Maricopa County	AREA AGENCY ON AGING	1366 EAST THOMAS ROAD SUITE 108	Phoenix	AZ	85014	$217,772	$0	$0	$217,772	$0
	580533	AZ102727		Southeast Arizona	Arizona Counseling And Treatment	114 & 116 S. Arizona Avenue	Willcox	AZ	85644	$6,076	$6,076	$335	$0	$0
	581244	AZ102728		Southeast Arizona	Arizona Counseling And Treatment	2039 E. Wilcox Dr., Ste. A	Sierra Vista	AZ	85635	$68,853	$68,853	$0	$0	$0
	581226	AZ102730		Southeast Arizona	Arizona Counseling And Treatment	301 E. 4th St., Ste. A	Safford	AZ	85546	$35,685	$35,685	$5,368	$0	$0
	581235	AZ102731		Southeast Arizona	Arizona Counseling And Treatment	562 N. Coronado Blvd.	Cliffton	AZ	85533	$398	$398	$0	$0	$0
	581257	AZ102733		Southeast Arizona	Arizona Counseling And Treatment	500 S. Highway 80, Ste. A	Benson	AZ	85602	$4,786	$4,786	$0	$0	$0
	477855	AZ102736		Yuma and La Paz Counties	Arizona Counseling And Treatment	1021 Kofa Avenue	Parker	AZ	85344	$1,042	$1,042	$0	$0	$0
	476817	AZ102738		Yuma and La Paz Counties	Arizona Counseling And Treatment	679 N. First Avenue, Ste E	San Luis	AZ	85349	$4,183	$4,183	$0	$0	$0
	448320	AZ102739		Yuma and La Paz Counties	Arizona Counseling And Treatment	10318 William Street	Wellton	AZ	85356	$4,147	$4,147	$0	$0	$0
	536715	AZ102734		Pinal and Gila Counties	Arizona Counseling And Treatment	13100 S. Sunland Gin Road, Ste. 1	Arizona City	AZ	85123	$1,458	$1,458	$0	$0	$0
	AZ101843	AZ101843		Yuma and La Paz Counties	Arizona Csl and Treatment Servs LLC	2545 South Arizona Avenue	Yuma	AZ	85364	$98,119	$98,119	$4,655	$0	$0
	754451	AZ102732		Southeast Arizona	Arizona Csl and Treatment Servs LLC	24 Howell St.	Bisbee	AZ	85603	$14,104	$14,104	$0	$0	$0
	AZ102735	AZ102735		Yuma and La Paz Counties	Arizona Csl and Treatment Servs LLC - Quartzsite	730 West Cowell Street	Quartsite	AZ	85346	$6,683	$6,683	$6,683	$0	$0
	AZ100251	AZ100251		Statewide	Arizona Department of Health Services	701 East Jefferson Street Suite 400a	Phoenix	AZ	85034	$27,604	$0	$0	$27,604	$0
	AZ101019	AZ101019		Statewide	Arizona Suicide Prevention	P.O. Box 10745	Phoenix	AZ	85064	$3,000	$0	$0	$3,000	$0
	006006	AZ101020		Statewide	Arizona Youth Partnership - Rural (CER)	4239 W. Ina Rd, Ste 101	Tucson	AZ	85741	$208,858	$0	$0	$208,858	$0
	AZ101021	AZ101021		Statewide	Arizonans for Prevention	7658 South Bosworth Field Way	Tucson	AZ	85746	$50,894	$0	$0	$50,894	$0
	AZ101022	AZ101022		Statewide	ASU	P.O. Box 874906	Tempe	AZ	85287	$2,917	$0	$0	$2,917	$0

	668806	AZ100956		Pima County	AZI House LLC	5986 South Jakemp Trail	Tucson	AZ	85747	$1,806	$1,806	$0	$0	$0
	AZ101530	AZ101530		Maricopa County	BAART BEHAVIORAL HEALTH	908B W CHANDLER BLVD STE 4	Chandler	AZ	85225	$131,785	$131,785	$0	$0	$0
	AZ100957	AZ100957		Maricopa County	BAYLESS	3620 N. 3rd Street	Phoenix	AZ	85012	$29,850	$29,850	$0	$0	$0
	941593	AZ100958		Yuma and La Paz Counties	CALLOWAY LABORATORIES	9305 W THOMAS RD STE 270	Phoenix	AZ	85037	$67,064	$67,064	$840	$0	$0
	50281801	AZ101144		Pima County	Casa De Los Ninos	140 N. Tucson Blvd. Tucson, AZ	Tucson	AZ	85716	$23,526	$23,526	$0	$0	$0
	AZ101024	AZ101024		Pinal and Gila Counties	Casa Grande Alliance	901 E Cottonwood Lane	Casa Grande	AZ	85211	$71,696	$0	$0	$71,696	$0
	168444	AZ100057		Yuma and La Paz Counties	CATHOLIC COMMUNITY SVC SOUTHERN AZ	690 E 32ND ST	Yuma	AZ	85365	$271	$271	$22	$0	$0
	551922	AZ101072		Yuma and La Paz Counties	CENPATICO 2	1501 W. Fountainhead Parkway	Tempe	AZ	85282	$216,243	$178,329	$10,610	$37,914	$0
	560049	AZ101073		Southeast Arizona	CENPATICO 3	1501 W. Fountainhead Parkway	Tempe	AZ	85282	$189,390	$127,912	$12,550	$61,478	$0
	944563	AZ101074		Pinal and Gila Counties	CENPATICO 4	1501 W. Fountainhead Parkway	Tempe	AZ	85282	$202,925	$182,457	$13,758	$20,468	$0
	AZ102105	AZ102105		Maricopa County	CENTER FOR BEHAVIORAL HEALTH	2123 E SOUTHERN AVE STE 2	Tempe	AZ	85282	$105,647	$105,647	$50,242	$0	$0
	210401	AZ901153		Maricopa County	CENTER FOR BEHAVIORAL HEALTH PHOENIX	1501 E WASHINGTON ST	Phoenix	AZ	85034	$32,749	$32,749	$10,402	$0	$0
	925422	AZ102144		Maricopa County	Centered Spirit	9405 S Avenida Del Yaqui	Guadalupe	AZ	85283	$231,000	$0	$0	$231,000	$0
	112219	AZ301719		Maricopa County	CHICANOS POR LA CAUSA	4602 W INDIAN SCHOOL RD STE C-3	Phoenix	AZ	85031	$166,005	$166,005	$0	$0	$0
	112219	AZ105433		Maricopa County	CHICANOS POR LA CAUSA	901 East Buckeye Road	Phoenix	AZ	85034	$184,247	$176,632	$0	$7,615	$0
	AZ101026	AZ101026		Pima County	Child & Family Resources (CER)	2800 E. Broadway	Tucson	AZ	85718	$224,779	$0	$0	$224,779	$0
	445274	AZ100959		Northern Arizona 5 Counties	Child & Family Support Services	8652 E. Eastridge Road, Ste. 103	Prescott Valley	AZ	86314	$1,650	$1,650	$0	$0	$0
	AZ101027	AZ101027		Southeast Arizona	Circles of Peace	404 Crawford	Nogales	AZ	85621	$172,798	$0	$0	$172,798	$0
	047557	AZ101029		Maricopa County	CITY OF TEMPE	715 W. FIFTH STREET	Tempe	AZ	85281	$194,826	$0	$0	$194,826	$0
	52127901	AZ105599		Pima County	CODAC	127 S. 5th Ave.	Tucson	AZ	85701	$201,049	$201,049	$0	$0	$0
	AZ101415	AZ101415		Pima County	CODAC	700 N. 7th. Ave.	Tucson	AZ	85705	$131,643	$131,643	$33,433	$0	$0
	35421701	AZ105748		Pima County	CODAC	3100 N. First Ave.	Tucson	AZ	85719	$349,422	$349,422	$0	$0	$0
	40887401	AZ100577		Pima County	CODAC	502 N. Silverbell	Tucson	AZ	85745	$139,305	$139,305	$114,722	$0	$0
	AZ101416	AZ101416		Pima County	CODAC	1080 S. 10th. Ave.	Tucson	AZ	85701	$130,063	$0	$0	$130,063	$0
	AZ101826	AZ101826		Maricopa County	COMMUNITY BRIDGES	8825 N 23RD AVE STE 100	Phoenix	AZ	85021	$3,901,745	$3,814,546	$227,447	$87,199	$0
	AZ100587	AZ100587		Statewide	COMMUNITY BRIDGES	1855 W. Baseline Rd., Suite 101	Mesa	AZ	85202	$493,503	$272,278	$170,375	$221,225	$0
	388723	AZ101827		Statewide	Community Bridges, Inc.	5734 E. Hope Lane	Globe	AZ	85501	$43,570	$43,570	$2,385	$0	$0
	419683	AZ100973		Statewide	Community Bridges, Inc.	554 S. Bellview	Mesa	AZ	85204	$713,419	$713,419	$28,788	$0	$0

	363859	AZ100796	Maricopa County	Community Bridges, Inc.	2770 East Van Buren Street	Phoenix	AZ	85008	$983	$983	$0	$0	$0
	630855	AZ101831	Maricopa County	Community Bridges, Inc.	824 N. 99th Ave Ste. 108	Avondale	AZ	85323	$92	$92	$0	$0	$0
	677658	AZ100516	Maricopa County	Community Bridges, Inc.	358 E. Javelina Ave Ste 101	Mesa	AZ	85210	$599	$599	$0	$0	$0
	420941	AZ100518	Northern Arizona 5 Counties	Community Bridges, Inc.	995 North Hermosa Drive	Holbrook	AZ	86025	$50,447	$50,447	$0	$0	$0
	422788	AZ101833	Northern Arizona 5 Counties	Community Bridges, Inc.	105 N Cottonwood Ave	Winslow	AZ	86047	$40,021	$40,021	$0	$0	$0
	599812	AZ101832	Northern Arizona 5 Counties	Community Bridges, Inc.	110 E. 2nd St	Winslow	AZ	86047	$114,092	$114,092	$0	$0	$0
	677294	AZ101825	Pinal and Gila Counties	Community Bridges, Inc.	675 E. Cottonwood, Suite 101	Casa Grande	AZ	85122	$46,550	$46,550	$2,548	$0	$0
	AZ101829	AZ101829	Pinal and Gila Counties	Community Bridges, Inc.	803 W Main St	Payson	AZ	85541	$46,581	$46,581	$2,548	$0	$0
	576264	AZ100512	Southeast Arizona	Community Bridges, Inc.	646 W Union St	Benson	AZ	85602	$528,250	$528,250	$34,030	$0	$0
	488670	AZ101862	Yuma and La Paz Counties	Community Bridges, Inc.	3250 B East 40th Street	Yuma	AZ	85365	$237,364	$237,364	$21,612	$0	$0
	003450	AZ101317	Northern Arizona 5 Counties	Community Counseling Centers	105 N. Fifth Ave.	Holbrook	AZ	86025	$32,461	$32,461	$8,962	$0	$0
	007460	AZ105631	Northern Arizona 5 Counties	Community Counseling Centers	2500 East Show Low Lake Road	Show Low	AZ	85901	$44,412	$44,412	$11,283	$0	$0
	426191	AZ300158	Northern Arizona 5 Counties	Community Counseling Centers	1015 East 2nd Street	Winslow	AZ	86047	$57,800	$57,800	$6,884	$0	$0
	740227	AZ100960	Northern Arizona 5 Counties	Community Counseling Centers	423 S. Main St.	Snowflake	AZ	85937	$12,553	$12,553	$3,466	$0	$0
	620627	AZ102447	Southeast Arizona	Community Intervention Associates	1701 N Douglas Ave	Douglas	AZ	85607	$23,347	$23,347	$0	$0	$0
	620609	AZ102448	Southeast Arizona	Community Intervention Associates	1326 Hwy. 92 Suite J	Bisbee	AZ	85603	$23,353	$23,353	$0	$0	$0
	603657	AZ102449	Southeast Arizona	Community Intervention Associates	32 Blvd. Del Rey David	Nogales	AZ	85621	$88,530	$88,530	$9,676	$0	$0
	893893	AZ100005	Yuma and La Paz Counties	Community Intervention Associates	2851 S Ave B Bldg 3 & 4	Yuma	AZ	85364	$144,902	$144,902	$9,395	$0	$0
	495600	AZ101864	Yuma and La Paz Counties	Community Intervention Associates	1516 Ocotillo Avenue	Parker	AZ	85344	$11,474	$11,474	$0	$0	$0
	496988	AZ101865	Yuma and La Paz Counties	Community Intervention Associates	1938 E Juan Sanchez Blvd Bldg 6	San Luis	AZ	85349	$9,585	$9,585	$0	$0	$0
	342717	AZ102992	Maricopa County	COMMUNITY MEDICAL SERVICES	3825 N 24TH ST	PHOENIX	AZ	85016	$235,111	$235,111	$24,258	$0	$0
	AZ101145	AZ101145	Pima County	Community Partnership of Southern Arizona (CPSA)	4575 East Broadway Boulevard	Tucson	AZ	85711	$779,045	$638,366	$119,219	$140,679	$0
	456396	AZ101787	Southeast Arizona	Community Provider of Enrichment Service	14921 W Camdon Dr.	Casa Grande	AZ	85194	$9,950	$9,950	$0	$0	$0
	216806	AZ100961	Pinal and Gila Counties	CONNECTIONS SOUTHERN AZ - CRISIS	404 W AERO DRIVE	Payson	AZ	85541	$622	$622	$0	$0	$0
	40894901	AZ105524	Pima County	COPE	535 E Drachman	Tucson	AZ	85705	$296,167	$296,167	$75,028	$0	$0
	14561601	AZ100809	Pima County	COPE	101 S. Stone	Tucson	AZ	85701	$387,422	$387,422	$0	$0	$0
	AZ100809	AZ100809	Pima County	COPE	82 S. Stone	Tucson	AZ	85701	$12,578	$12,578	$0	$0	$0

	AZ105532	AZ105532		Pima County	COPE	85 W. Franklin	Tucson	AZ	85701	$350,909	$350,909	$0	$0	$0
	102238	AZ100559		Southeast Arizona	Corazon	1891 N. Mastick Way	Nogales	AZ	85621	$54,239	$54,239	$4,838	$0	$0
	102849	AZ100598		Southeast Arizona	Corazon	936 F. Avenue	Douglas	AZ	85607	$54,239	$54,239	$4,838	$0	$0
	100059	AZ102108		Statewide	Corazon	900 E. Florence Blvd.	Casa Grande	AZ	85122	$60,713	$60,713	$5,519	$0	$0
	704719	AZ100477		Statewide	Crossroads Mission	944 S ARIZONA AVE	Yuma	AZ	85364	$352,409	$352,409	$21,492	$0	$0
	AZ101031	AZ101031		Statewide	CV Lore and Associates	355 S. Balboa Dr	Gilbert	AZ	85296	$28,760	$0	$0	$28,760	$0
	599904	AZ100601		Maricopa County	Devereux Arizona	11000 N. Scottsdale Rd., Suite 260	Scottsdale	AZ	85254	$20,512	$20,512	$0	$0	$0
	319790	AZ750154		Maricopa County	EBONY HOUSE	6222 S 13TH ST	Phoenix	AZ	85042	$463,734	$463,734	$165,154	$0	$0
	100587	AZ101032		Maricopa County	Empact Suicide Prevention	1232 E Broadway, Suite 320	Tempe	AZ	85282	$65,000	$0	$0	$65,000	$0
	AZ100540	AZ100540		Statewide	Empact/Suicide Prevention Center	618 South Madison Drive	Tempe	AZ	85281	$2,500	$0	$0	$2,500	$0
	168072	AZ102753		Northern Arizona 5 Counties	Encompass Healthcare	463 S. Lake Powell Blvd.	Page	AZ	86040	$161,681	$98,673	$7,517	$63,008	$0
	737330	AZ102754		Northern Arizona 5 Counties	Encompass Healthcare	32 N. 10th Ave Ste 5	Page	AZ	86040	$66,959	$66,959	$0	$0	$0
	822503	AZ301016		Pima County	Epidaurus dba Amity Foundation	P. O. Box 3034	Tucson	AZ	85702	$8,365	$8,365	$0	$0	$0
	AZ101033	AZ101033		Pinal and Gila Counties	Gila County	5515 S Apache Ave, suite 100	Globe	AZ	85501	$21,248	$0	$0	$21,248	$0
	415712	AZ101722		Pinal and Gila Counties	Gila River Health Care BHS	PO BOX 38	Sacaton	AZ	85147	$211,611	$134,689	$4,677	$76,922	$0
	334582	AZ100964		Pinal and Gila Counties	Gila River Health Care Family Planning	PO BOX 2175	Sacaton	AZ	85147	$24,397	$24,397	$0	$0	$0
	683287	AZ101868		Pinal and Gila Counties	Gila River Health Care OASIS	291 W. Casa Blanca Rd.	Sacaton	AZ	85147	$13,958	$13,958	$0	$0	$0
	589093	AZ101809		Maricopa County	Gila River Health Care RTC	3850 N. 16th Street	Laveen	AZ	85339	$30,691	$30,691	$0	$0	$0
	AZ101034	AZ101034		Maricopa County	Gila River Traileriders Club	5594 W. Wildhorse Pass Blvd.	Chandler	AZ	85226	$12,000	$0	$0	$12,000	$0
	146516	AZ101861		Statewide	Helping Associates	1000 E Racine Pl	Casa Grande	AZ	85122	$127,225	$127,225	$5,519	$0	$0
	146516	AZ101861		Pinal and Gila Counties	Helping Associates, Inc.	1901 N. Trekell Rd., Suite A	Casa Grande	AZ	85222	$1,315	$1,315	$0	$0	$0
	AZ756638	AZ100853		Pima County	HOPE	1200 N Country Club	Tucson	AZ	85716	$36,666	$36,666	$14,666	$0	$0
	136384	AZ101827		Pinal and Gila Counties	Horizon Human Services	102 N Florence St.	Casa Grande	AZ	85122	$95,031	$95,031	$5,575	$0	$0
	AZ101035	AZ101035		Maricopa County	I.C.A.N.	650 E. Morelos St.	Chandler	AZ	85225	$195,477	$0	$0	$195,477	$0
	872095	AZ101044		Maricopa County	INTENSIVE TREATMENT SYSTEMS	651 W COOLIDGE ST	PHOENIX	AZ	85013	$378,597	$378,597	$10,402	$0	$0
	955023	AZ101490		Maricopa County	INTENSIVE TREATMENT SYSTEMS	19401 N CAVE CREEK RD STE 18	Phoenix	AZ		$225,185	$225,185	$7,792	$0	$0
	305538	AZ100965		Pima County	Intermountain Centers Summit	1310 N Speedway Pl	Tucson	AZ	85715	$56,301	$56,301	$0	$0	$0
	178348	AZ100966		Maricopa County	JEWISH FAMILY AND CHILDREN'S SERVICE	4747 North 7th Street	PHOENIX	AZ	85014	$120,173	$120,173	$0	$0	$0

	AZ101037	AZ101037		Maricopa County	Kathleen Stanton, Consultant	5342 N 3rd Ave	Phoenix	AZ	85013	$24,917	$0	$0	$24,917	$0
	NY100995	NY100995		Statewide	Kognito	135 W 26th St	NY	AZ	10001	$105,000	$0	$0	$105,000	$0
	454232	AZ750550/AZ105490		Pima County	La Frontera - Family Passages	410 So 6th	Tucson	AZ	85701	$165,348	$0	$0	$165,348	$0
	057837	AZ750550/AZ105490		Pima County	La Frontera - Level II	1900 W Speedway	Tucson	AZ	85745	$139,305	$139,305	$111,436	$0	$0
	069139	AZ750550/AZ105490		Pima County	La Frontera - Meth Center of Excellence	502 W 29th St	Tucson	AZ	85713	$262,219	$262,219	$0	$0	$0
	593849	AZ100152		Pima County	La Frontera - Methadone Clinic	260 S Scott Ave	Tucson	AZ	85701	$345,146	$345,146	$0	$0	$0
	806185	AZ100967		Maricopa County	LIFEWELL	2715 N 3RD ST	PHOENIX	AZ	85004	$1,229,464	$1,229,464	$485,149	$0	$0
	003442	AZ300133		Northern Arizona 5 Counties	Little Colorado Behavioral Health Center	470 West Cleveland Street	Saint Johns	AZ	85936	$29,104	$29,104	$490	$0	$0
	007519	AZ100665		Northern Arizona 5 Counties	Little Colorado Behavioral Health Center	50 N. Hopi	Springerville	AZ	85938	$17,700	$17,700	$6,561	$0	$0
	AZ101038	AZ101038		Pima County	Luz Social Services (CER)	2797 N. Introspect Dr.	Tucson	AZ	85745	$107,598	$0	$0	$107,598	$0
	23445601	AZ101039		Pima County	Marana Health Center	13395 N Marana Main St	Marana	AZ	85653	$119,358	$119,358	$54,427	$0	$0
	AZ101038	AZ101038		Pima County	Maricopa Ak-Chin	PO Box 144	Maricopa	AZ	85139	$55,289	$0	$0	$55,289	$0
	AZ101040	AZ101040		Northern Arizona 5 Counties	MATForce	8056 E. Vallet Road, Ste B.	Prescott	AZ	86314	$78,761	$0	$0	$78,761	$0
	116667	AZ101040		Northern Arizona 5 Counties	Mohave Mental Health Clinic	1145 Marina Boulevard	Bullhead City	AZ	86442	$35,732	$35,732	$7,132	$0	$0
	117136	AZ300174		Northern Arizona 5 Counties	Mohave Mental Health Clinic	3505 Western Ave.	Kingman	AZ	86409	$87,021	$87,021	$17,367	$0	$0
	147125	AZ100491		Northern Arizona 5 Counties	Mohave Mental Health Clinic	2187 Swanson Avenue	Lake Havasu City	AZ	86403	$37,663	$37,663	$5,637	$0	$0
	435192	AZ101063		Northern Arizona 5 Counties	Mohave Mental Health Clinic	2001 Stockton Hill Road Ste 104	Kingman	AZ	86401	$15,074	$15,074	$245	$0	$0
	515719	AZ100619		Northern Arizona 5 Counties	Mohave Mental Health Clinic	2580 Hwy 95 Ste. 208, 209, 210	Bullhead City	AZ	86442	$19,244	$19,244	$1,127	$0	$0
	589848	AZ102112		Northern Arizona 5 Counties	Mohave Mental Health Clinic	1741 Sycamore Avenue	Kingman	AZ	86409	$71,865	$71,865	$14,348	$0	$0
	690405	AZ100945		Northern Arizona 5 Counties	Mohave Mental Health Clinic	2002 Stockton Hill Road Ste 104	Kingman	AZ	86401	$12,075	$12,075	$74	$0	$0
	593908	AZ102128		Statewide	Mountain Health & Wellness	625 N. Plaza Drive	Apache Junction	AZ	85120	$98,226	$98,226	$5,462	$0	$0
	590001	AZ750535		Maricopa County	NATIONAL COUNCIL ON ALCOHOLISM	4201 N 16TH ST STE 140	Phoenix	AZ	85016	$644,074	$644,074	$424,505	$0	$0
	151346	AZ750162		Statewide	NATIVE AMERICAN CONNECTIONS	4520 N CENTRAL AVE STE 100	Phoenix	AZ	85012	$581,866	$581,866	$202,046	$0	$0
	871393	AZ102867		Statewide	NAZCARE INC	901 E COTTONWOOD LANE	Casa Grande	AZ	85122	$4,382	$4,382	$0	$0	$0
	098534	AZ750600		Maricopa County	New Casa de Amigas	1648 West Colter Street	Phoenix	AZ	85015	$65,134	$65,134	$31,166	$0	$0
	893554	AZ101283		Statewide	NEW HOPE BEHAVIORAL HEALTH CENTER	215 S POWER RD STE 114	Mesa	AZ	85206	$133,994	$133,994	$0	$0	$0
	539184	AZ101041		Northern Arizona 5 Counties	North Country Healthcare	2920 N. 4th Street	Flagstaff	AZ	86004	$61,585	$61,585	$0	$0	$0

	006579	AZ101080		Northern Arizona 5 Counties	Northern Arizona Regional Behavioral Health Authority	1300 South Yale St	Flagstaff	AZ	86001	$424,522	$296,396	$18,052	$128,126	$0
	71201	AZ750634		Maricopa County	Northwest Organization for	4425 West Olive Avenue Suite 200	GLENDALE	AZ	85302	$574,713	$574,713	$0	$0	$0
	AZ101148	AZ101148		Statewide	Office of HIV	150 North 18th Avenue	PHOENIX	AZ	85007	$28,537	$28,537	$0	$0	$0
	77257601	AZ100838		Pima County	Pantano	5055 E. Broadway	Tucson	AZ	85711	$60,641	$60,641	$0	$0	$0
	772542	AZ100281		Pinal and Gila Counties	PARK PLACE OUTREACH	13626 DEL RIO DR, ARIZONA CITY, AZ 85123	Arizona City	AZ	85123	$9,271	$9,271	$0	$0	$0
	830786	AZ102821		Statewide	PARK PLACE OUTREACH	11349 E 24TH LN	Yuma	AZ	85367	$13,302	$13,302	$0	$0	$0
	AZ101042	AZ101042		Yuma and La Paz Counties	Parker Alliance for Community Empowerment	1309 9th Street	Parker	AZ	85344	$109,918	$0	$0	$109,918	$0
	AZ101043	AZ101043		Maricopa County	PARTNERSHIP FOR DRUG FREE AMERICA	3030 NORTH CENTRAL, SUITE 509	Phoenix	AZ	85012	$267,682	$0	$0	$267,682	$0
	448846	AZ100728		Pima County	Pasadera BHN	1779 W. St. Mary's	Tucson	AZ	85745	$24,932	$24,932	$0	$0	$0
	AZ100727	AZ100727		Pima County	Pasadera BHN	2502 N. Dodge	Tucson	AZ	85716	$103,488	$103,488	$98,271	$0	$0
	807753	AZ105565		Pima County	Pasadera BHN	2499 Ajo Rd	Tucson	AZ	85713	$1,037,542	$1,037,542	$180,964	$0	$0
	592578	AZ102120		Pima County	Pasadera BHN	2950 N. Dodge	Tucson	AZ	85716	$902,319	$902,319	$258,586	$0	$0
	218075	AZ101774		Pima County	Pascua Yaqui	7490 S. Camino Oeste	Tucson	AZ		$118,750	$118,750	$0	$0	$0
	740367	AZ101748		Maricopa County	PHOENIX INDIAN CENTER	4520 N. CENTRAL AVE., STE. 250	Phoenix	AZ	85012	$133,988	$0	$0	$133,988	$0
	557514	AZ102093		Maricopa County	PIMA PREVENTION PARTNERSHIP	1475 North Oracle Road	Tucson	AZ	85705	$170,629	$0	$0	$170,629	$0
	557514	AZ102093		Statewide	Pima Prevention Partnership	924 North Alvernon Way	Tucson	AZ	85711	$28,891	$22,947	$0	$5,944	$0
	557514	AZ101046		Pima County	Pima Prevention Partnership (CER)	2525 E. Broadway Ste 100	Tucson	AZ	85716	$214,713	$0	$0	$214,713	$0
	AZ101049	AZ101049		Pinal and Gila Counties	Pinal Gila Council for Senior Citizens	8969 W McCartney	Casa Grande	AZ	85294	$96,063	$0	$0	$96,063	$0
	164567	OTC6003		Pinal and Gila Counties	Pinal Hispanic Council	556 S Arizona Blvd.	Coolidge	AZ	85128	$18,914	$18,914	$8,278	$0	$0
	591324	AZ102267		Southeast Arizona	Pinal Hispanic Council	275 N Grand Court Plaza	Nogales	AZ	85621	$19,784	$19,784	$2,419	$0	$0
	598482	AZ102268		Statewide	Pinal Hispanic Council	1940 E 11th St.	Douglas	AZ	85607	$20,124	$20,124	$2,419	$0	$0
	48480601	AZ102276		Pima County	Providence	1181 N El Dorado Place	Tucson	AZ	85715	$185,287	$33,103	$0	$152,184	$0
	752701	AZ101418		Maricopa County	Red Mountian Behavioral Health, LLC	2915 E. Baseline Rd., Ste 115	Gilbert	AZ	85234	$1,562	$1,562	$0	$0	$0
	AZ101419	AZ101419		Statewide	Reister Sonoran	802 N. 3rd Ave	PHOENIX	AZ	85003	$1,755,516	$0	$0	$1,755,516	$0
	AZ101052	AZ101052		Statewide	Sally Riggs	5820 N Calle Grandeza	Tucson	AZ	85718	$17,723	$0	$0	$17,723	$0
	AZ101155	AZ101155		Southeast Arizona	San Carlos Apache Wellness Center	San Carlos, Arizona	San Carlos	AZ	85550	$35,876	$0	$0	$35,876	$0
	AZ901708	AZ901708		Pinal and Gila Counties	San Carlos Apache Tribe	San Carlos, Arizona	San Carlos	AZ	85550	$40,330	$0	$0	$40,330	$0

	AZ101053	AZ101053		Maricopa County	SCOTTSDALE PREVENTION INSTITUTE	6908 E. THOMAS RD., STE. 302	Scottsdale	AZ	85251	$261,648	$0	$0	$261,648	$0
	452152	AZ100991		Statewide	SONORA QUEST LABORATORIES	1255 W WASHINGTON ST	Tempe	AZ	85281	$1,468	$1,468	$0	$0	$0
	361463	AZ101678		Pinal and Gila Counties	Sothwest Behavioral Health Services	111 W CEDAR LANE	Payson	AZ	85541	$497	$497	$0	$0	$0
	783673	AZ102746		Pinal and Gila Counties	Southeastern AZ Behav Health Services - (SEABHS)	996 Broad St. Suite 10	Globe	AZ	85501	$15,831	$15,831	$8,278	$0	$0
	117888	AZ101876		Southeast Arizona	Southeastern AZ Behav Health Services - (SEABHS)	430 N. Coronado Blvd	Clifton	AZ	85533	$38,709	$229	$47	$38,480	$0
	336159	AZ101885		Southeast Arizona	Southeastern AZ Behav Health Services - (SEABHS)	4755 Campus Dr.	Sierra Vista	AZ	85635	$118,967	$24,517	$3,810	$94,450	$0
	895659	AZ101886		Southeast Arizona	Southeastern AZ Behav Health Services - (SEABHS)	1615 S. 1st Ave	Safford	AZ	85546	$55,234	$8,845	$1,361	$46,389	$0
	082893	AZ104907		Southeast Arizona	Southeastern AZ Behav Health Services - (SEABHS)	404 Rex Allen Dr.	Willcox	AZ	85646	$1,861	$1,861	$286	$0	$0
	658575	AZ100848		Statewide	Southeastern AZ Behav Health Services - (SEABHS)	611 W. Union St	Benson	AZ	85602	$25,220	$25,220	$4,172	$0	$0
	AZ100992	AZ100992		Statewide	Southern Arizona AIDS Foundation	375 S Euclid Ave	Tucson	AZ	85719	$144,436	$0	$0	$144,436	$0
	435457	AZ100994		Northern Arizona 5 Counties	Southwest Behavioral Health Clinic	2580 HWY 95 Ste 119-125	Bullhead City	AZ	86442	$45,361	$45,361	$2,427	$0	$0
	454331	AZ100993		Northern Arizona 5 Counties	Southwest Behavioral Health Clinic	1515 E. Cedar Ave. Ste B2	Flagstaff	AZ	86004	$62,374	$62,374	$3,337	$0	$0
	522645	AZ100668		Northern Arizona 5 Counties	Southwest Behavioral Health Clinic	2215 Hualapai Mountain Rd. Ste. H&I	Kingman	AZ	86401	$24,458	$24,458	$1,308	$0	$0
	633167	AZ102777		Northern Arizona 5 Counties	Southwest Behavioral Health Clinic	7600 E. Florentine Ave Ste. 101	Prescott Valley	AZ	86314	$80,234	$80,234	$4,292	$0	$0
	633183	AZ100678		Northern Arizona 5 Counties	Southwest Behavioral Health Clinic	809 Hancock Rd Ste 1	Bullhead City	AZ	86442	$121,964	$121,964	$6,525	$0	$0
	647081	AZ100679		Northern Arizona 5 Counties	Southwest Behavioral Health Clinic	1845 McColloch Blvd Ste B1	Lake Havasu City	AZ	86403	$1,760	$1,760	$94	$0	$0
	654156	AZ102820		Northern Arizona 5 Counties	Southwest Behavioral Health Clinic	7763 East Florentine Road	Prescott Valley	AZ	86314	$19,098	$19,098	$1,022	$0	$0
	888373	AZ101003		Maricopa County	SOUTHWEST BEHAVIORAL HEALTH SERVICES	3450 N. 3rd Street	Phoenix	AZ	85012	$460,220	$381,340	$60,644	$78,880	$0
	404093	AZ101156		Maricopa County	SOUTHWEST BEHAVIORAL HEALTH SERVICES	1545 W. BROADWAY AVE., STE 1 & 2	Apache Junction	AZ	85220	$144,192	$0	$0	$144,192	$0
	361463	AZ101678		Pinal and Gila Counties	Southwest Behavioral Health Services	111 W CEDAR LANE	Payson	AZ	85541	$11,042	$11,042	$5,519	$0	$0
	AZ101004	AZ101004		Maricopa County	SOUTHWEST NETWORK	2700 N Central Ave, Ste 1050	Phoenix	AZ	85004	$21,185	$21,185	$0	$0	$0
	AZ100384	AZ100384		Northern Arizona 5 Counties	Spectrum Healthcare Group	8 E. Cottonwood St. Bldg C	Cottonwood	AZ	86326	$510,539	$510,539	$34,106	$0	$0
	755689	AZ101170		Northern Arizona 5 Counties	Spectrum Healthcare Group	452 Finnie Flats Road	Camp Verde	AZ	86322	$15,661	$15,661	$1,027	$0	$0
	AZ101157	AZ101157		Statewide	State Lab HIV	150 North 18th Avenue	PHOENIX	AZ	85007	$9,999	$9,999	$0	$0	$0
	AZ101056	AZ101056		Maricopa County	TANNER COMMUNITY DEVELOPMENT	700 E. JEFFERSON ST. - SUITE 200	Phoenix	AZ	85034	$182,058	$0	$0	$182,058	$0

	283809	AZ100002		Maricopa County	TERROS	3003 N. Central Ave, Suite 200	Phoenix	AZ	85012	$2,696,511	$2,313,154	$479,677	$383,357	$0
	AZ101422	AZ101422		Maricopa County	TERROS	333 E. Indian School Rd.	Phoenix	AZ	85012	$642,389	$642,389	$0	$0	$0
	078528	AZ100434		Northern Arizona 5 Counties	The Guidance Center	2187 N. Vickey Street	Flagstaff	AZ	86004	$399,905	$338,022	$774	$61,883	$0
	116807	AZ101006		Northern Arizona 5 Counties	The Guidance Center	220 W. Grant Street	Williams	AZ	86046	$4,646	$4,646	$248	$0	$0
	158133	AZ101007		Northern Arizona 5 Counties	The Guidance Center	2695 E. Industrial Dr	Flagstaff	AZ	86004	$375,602	$375,602	$18,387	$0	$0
	969884	AZ101008		Northern Arizona 5 Counties	The Guidance Center	2697 E. Industrial Dr	Flagstaff	AZ	86004	$335,190	$335,190	$17,868	$0	$0
	592867	AZ750311		Pima County	The Haven	1107 E Adelaide Dr.	Tucson	AZ	85719	$538,474	$538,474	$99,532	$0	$0
	AZ101098	AZ101098		Southeast Arizona	Tides of Change Center of Wellness	333 W. Wilcox Dr., Suite 303	Sierra Vista	AZ	85635	$64	$64	$0	$0	$0
	357279	AZ101009		Maricopa County	TOUCHSTONE BEHAVIORAL	15648 N. 35th Ave	Phoenix	AZ	85053	$545,998	$282,694	$0	$263,304	$0
	AZ101059	AZ101059		Yuma and La Paz Counties	Town of Quartzsite	P.O. Box 2812	Quartzsite	AZ	85346	$12,611	$0	$0	$12,611	$0
	384591	AZ101627		Yuma and La Paz Counties	Transitional Living Center Recovery	1360 S. 4th Avenue	Yuma	AZ	85364	$43,937	$43,937	$3,807	$0	$0
	617407	AZ102368		Southeast Arizona	Transitional Living Center Recovery	2073 N. Grande Avenue #19	Nogales	AZ	85621	$13,914	$13,914	$3,964	$0	$0
	425931	AZ101727		Pinal and Gila Counties	Transitional Living Center Recovery	117 E. 2nd Street, Suite 2	Casa Grande	AZ	85122	$69,974	$69,974	$15,873	$0	$0
	AZ101060	AZ101060		Statewide	U of A ERAD (CER)	1717 E. Speedway Blvd Suite #1101	Tucson	AZ	85719	$149,496	$0	$0	$149,496	$0
	388606	AZ100504		Maricopa County	VALLE DEL SOL	3807 N. 7th St.	Phoenix	AZ	85014	$1,003,280	$793,374	$60,894	$209,906	$0
	366233	AZ101842		Northern Arizona 5 Counties	West Yavapai Guidance Center	3345 N. Windsong Drive	Prescott Valley	AZ	86314	$35,029	$35,029	$1,698	$0	$0
	540303	AZ100688		Northern Arizona 5 Counties	West Yavapai Guidance Center	625 Hillside Ave	Prescott	AZ	86301	$2,638	$2,638	$179	$0	$0
	AZ100689	AZ100689		Northern Arizona 5 Counties	West Yavapai Guidance Center	642 Dameron Dr	Prescott	AZ	86301	$707,625	$636,628	$41,633	$70,997	$0
	989634	AZ101017		Northern Arizona 5 Counties	WOMEN'S TRANSITION PROJ	240 OHARA AVE	Bisbee	AZ	85603	$50,619	$50,619	$5,430	$0	$0
	349127	AZ101835		Maricopa County	YOUTH ETC.	4414 N. 19th Avenue	Phoenix	AZ	85015	$52,130	$52,130	$0	$0	$0
	AZ101061	AZ101061		Yuma and La Paz Counties	Yuma Family YMCA	1917 W 32nd Street	Yuma	AZ	85364	$213,870	$0	$0	$213,870	$0
	872128	AZ100066		Yuma and La Paz Counties	Yuma Treatment Center	1290 W 8th Pl	Yuma	AZ	85364	$184,034	$184,034	$0	$0	$0
Total										$38,435,200	$30,180,341	$4,274,553	$8,254,859	$0

* Indicates the imported record has an error.

Footnotes:
Due to the transition from the Arizona Department of Health Services (ADHS) to the Arizona Health Care Cost Containment System (AHCCCS), the State was unable to access the Accounting Event Data Warehouse (AEDW) historical information to complete provider-level expenditure reporting for Table 7 by 12/1/16. The amounts entered in Table 7 currently are State expenditures to the RBHAs and TRBHAs. The State is currently working with the RBHAs and TRBHAs to receive detailed provider-level expenditures to update Table 7 by January 31, 2017.

III: Expenditure Reports

Table 8a - Maintenance of Effort for State Expenditures for SAPT

Total Single State Agency (SSA) Expenditures for Substance Abuse Prevention and Treatment		
Period (A)	Expenditures (B)	B1(2014) + B2(2015) 2 (C)
SFY 2014 (1)	$41,217,201	
SFY 2015 (2)	$48,437,339	$44,827,270
SFY 2016 (3)	$49,404,493	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

SFY 2014 Yes X No ____

SFY 2015 Yes X No ____

SFY 2016 Yes X No ____

Did the State or Jurisdiction have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

Yes ____ No X

If yes, specify the amount and the State fiscal year: ____

If yes, SFY: ____

Did the State or Jurisdiction include these funds in previous year MOE calculations?

Yes ____ No ____

When did the State submit an official request to the SAMHSA Administrator to exclude these funds from the MOE calculations? ____

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: ____

Please provide a description of the amounts and methods used to calculate the total Single State Agency (SSA) expenditures for substance abuse prevention and treatment 42 U.S.C. §300x-30
The calculations reflect the aggregate state expenditures spent on authorized activities at the State Mental Health Agency (SMHA), which directly administers the SABG. The methodology is based on the requirements of 42 U.S.C. §300x-30(a). The methodology utilizes generally accepted accounting principles and is applied consistently each year. The calculation includes expenditures from the State General Fund (GF) and the Substance Abuse Services Fund (SASF). The calculation excludes federal, city, and county funds. See Attached document "SABG Description of Calculations for December 1, 2016.docx"

Footnotes:
Arizona transitioned its Statewide Accounting System beginning July 1, 2015 and is in the process of developing the reports required to meet the State's reporting requirements for State Fiscal Year 2016. This includes federal block grant reporting due 12/1/2016. We anticipate to have the information to meet a January 6, 2017 deadline.

SABG Description of Calculations for SFY2016

Table 8a: Maintenance of Effort for State Expenditures for SABG as required by 42 U.S.C. §300x-30(a);

The calculations reflect the aggregate state expenditures spent on authorized activities at the State Mental Health Agency (SMHA), which directly administers the SABG. The methodology is based on the requirements of 42 U.S.C. §300x-30(a). The methodology utilizes generally accepted accounting principles and is applied consistently each year. The calculation includes expenditures from the State General Fund (GF) and the Substance Abuse Services Fund (SASF). The calculation excludes federal, city, and county funds.

Table 8b: TB; Base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. §300x-24(d);

Calculations for Column (A) in Table I were based on the FY94 SAPT Block Grant Application. Expenditures reported for TB services in the Bureau of Epidemiology and Disease Control Services (formerly Disease Prevention Services) were $916,654 in FY91 and $860,717 in FY92.

Calculations for Column (B) were revised in the FY09 application after reviewing how the initial base was calculated. According to information available from the Client Information System (CIS), no persons with TB were identified in substance abuse treatment during 1991 and only one person identified with TB received substance abuse treatment in 1992, making the percent of TB expenditures spent on clients who were substance abusers in treatment 0.69%. Therefore, the total state funds spent on clients who were substance abusers in treatment was $5,939 and the new base for Tuberculosis Services is $2,970.

Table I: Statewide Non-Federal Expenditures for TB Services to Individuals in Substance Use Disorder Treatment (Base Table)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were in Substance Use Disorder Treatment (B)	Total State Funds Spent on Clients who were in Substance Use Disorder Treatment (AxB) (C)	Average of Columns C1 & C2 (C1 + C2)
SFY 1991 (1)	$916,654	0%	$0	$2,970
SFY1992 (2)	$860,717	.69%	$5,939	

The Arizona Department of Health Services (ADHS), Office of Infectious Disease Services provided the total number of TB Cases in SFY16, which are 134. The Division of Behavioral Health Services then compared identifying information provided by the Office of Infectious Disease Services to the Client Information System (CIS) in order to determine if any clients received substance use disorder treatment during SFY16. Of those 134 cases, 7 reported a substance use disorder. The result was 7 cases or 5.22% of the total TB cases in Arizona.

Therefore, the total of all State funds spent on TB services ($584,350) multiplied by the percent of TB expenditures spent on TB clients with a substance use disorder (5.22%) equals the total State funds spent on clients who were in substance use disorder treatment ($30,503).

Table 8c: HIV; for designated states, the base and MOE for HIV early intervention services as required by 42 U.S.C. §300x-24(d); (See 45 C.F.R. §96.122(f)(5)(ii)(A)(B)(C)).

ADHS does not spend state appropriated funds on HIV Early Intervention Services.

Table 8d: Women's base for services to pregnant women and women with dependent children as required by 42 U.S.C §300x-22(b)(1); and for 1994 and subsequent fiscal years;

Calculations for the Women's Base are grounded in a survey done in FY92 attempting to capture all specialty women's treatment programs operating during that year. The total value of services to pregnant women, and women with dependent children who received primarily residential treatment services in FY92 at state supported treatment programs equaled $1,225,977, which consisted of $1,164,678 of Federal funds and $61,299 of State Appropriations. This became the FY92 Women's Base (**Table II**).

For FY93, States must spend not less than 5% of grant to increase, relative to FY92, the availability of treatment services designed for pregnant women and women with dependent children. In FY93, 5% of the block grant award equated to $768,307. For FY94, States must spend not less than 5%, relative to FY93, for these services. In FY94, 5% of the block grant award equated to $801,732 **(Table III). T**he state will expend for such services for women not less than an amount equal to the amount expended for FY94 with equates to $2,796,016.

Table II: Expenditures for Services to Pregnant Women & Women with Dependent Children (Base)

Period	(1992) Amount from ADMS Block Grant Spent for Pregnant Women and Women with Dependent Children	(1992) State Expenditures for Pregnant Women and Women with Dependent Children	(1992) Women's Base
1992	$1,164,678	$61,299	$1,225,977

Table III: Expenditures for Services to Pregnant Women & Women with Dependent Children (MOE)

Period	Total Women's Base From Previous Year (A)	Total SAPT Block Grant Award (B)	5 % of SAPT Block Grant Award (C)	State Expenditures (D)	Total Women's Base (A+B+C+D)
1993	$1,225,977	$15,366,146	$768,307	$0	$1,994,284
1994	$1,994,284	$16,034,641	$801,732	$0	$2,796,016
1995					$2,796,016
1996					$2,796,016

ADHS has an Index code in the Legacy Accounting System and a Major Program in the new AFIS Accounting System that tracks all disbursements for Women's Services from the SABG Block Grant. The amount reported for the SFY2016 reporting year reflects the total amount of federal expenditures for

Women's Services from the FFY2014 SAPT Block Grant ($4,274,549, to ensure consistency in reporting with prior year applications.

Table 8d: Expenditures for Services to Pregnant Women & Women with Dependent Children

Period (State Fiscal Year)	Total Women's Base (A)	Total Expenditures (B)	Reflects Grant Award
1994	$2,796,016		
2008		$3,500,777	FFY2006
2009		$3,500,777	FFY2007
2010		$3,500,777	FFY2008
2011		$3,500,777	FFY2009
2012		$3,515,680	FFY2010
2013		$3,860,921	FFY2011
2014		$3,500,777	FFY2012
2015		$3,496,101	FFY2013
2016		$4,274,549	FFY2014

Footnote: Expenses reported in Column B reflect the Federal Fiscal Year Grant Award to maintain consistency in reporting.

III: Expenditure Reports

Table 8b - Base and Maintenance of Effort for State Expenditures for TB

State Expenditures for Tuberculosis Services to Individuals in Substance Use Disorder Treatment BASE				
Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Individuals in Substance Use Disorder Treatment (B)	Total State Funds Spent on Individuals in Substance Use Disorders Treatment (A x B) (C)	Average of Column C1 and C2 $\frac{C1+C2}{2}$ (MOE BASE) (D)
SFY 1991 (1)	$916,654	0.00%	$0	
SFY 1992 (2)	$860,717	0.69%	$5,939	$2,969

State Expenditures for Tuberculosis Services to Individuals in Substance Use Disorder Treatment MAINTENANCE			
Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Individuals in Substance Use Disorder Treatment (B)	Total State Funds Spent on Individuals in Substance Use Disorders Treatment (A x B) (C)
SFY 2016 (3)	$584,350	5.22%	$30,503

Please provide a description of the amounts and methods used to calculate the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. §300x-24(d)
Please see attachment: SABG Description of Calculations for December 1, 2016.

Footnotes:

SABG Description of Calculations for SFY2016

Table 8a: Maintenance of Effort for State Expenditures for SABG as required by 42 U.S.C. §300x-30(a);

The calculations reflect the aggregate state expenditures spent on authorized activities at the State Mental Health Agency (SMHA), which directly administers the SABG. The methodology is based on the requirements of 42 U.S.C. §300x-30(a). The methodology utilizes generally accepted accounting principles and is applied consistently each year. The calculation includes expenditures from the State General Fund (GF) and the Substance Abuse Services Fund (SASF). The calculation excludes federal, city, and county funds.

Table 8b: TB; Base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. §300x-24(d);

Calculations for Column (A) in Table I were based on the FY94 SAPT Block Grant Application. Expenditures reported for TB services in the Bureau of Epidemiology and Disease Control Services (formerly Disease Prevention Services) were $916,654 in FY91 and $860,717 in FY92.

Calculations for Column (B) were revised in the FY09 application after reviewing how the initial base was calculated. According to information available from the Client Information System (CIS), no persons with TB were identified in substance abuse treatment during 1991 and only one person identified with TB received substance abuse treatment in 1992, making the percent of TB expenditures spent on clients who were substance abusers in treatment 0.69%. Therefore, the total state funds spent on clients who were substance abusers in treatment was $5,939 and the new base for Tuberculosis Services is $2,970.

Table I: Statewide Non-Federal Expenditures for TB Services to Individuals in Substance Use Disorder Treatment (Base Table)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were in Substance Use Disorder Treatment (B)	Total State Funds Spent on Clients who were in Substance Use Disorder Treatment (AxB) (C)	Average of Columns C1 & C2 (C1 + C2)
SFY 1991 (1)	$916,654	0%	$0	$2,970
SFY1992 (2)	$860,717	.69%	$5,939	

The Arizona Department of Health Services (ADHS), Office of Infectious Disease Services provided the total number of TB Cases in SFY16, which are 134. The Division of Behavioral Health Services then compared identifying information provided by the Office of Infectious Disease Services to the Client Information System (CIS) in order to determine if any clients received substance use disorder treatment during SFY16. Of those 134 cases, 7 reported a substance use disorder. The result was 7 cases or 5.22% of the total TB cases in Arizona.

Therefore, the total of all State funds spent on TB services ($584,350) multiplied by the percent of TB expenditures spent on TB clients with a substance use disorder (5.22%) equals the total State funds spent on clients who were in substance use disorder treatment ($30,503).

Table 8c: HIV; for designated states, the base and MOE for HIV early intervention services as required by 42 U.S.C. §300x-24(d); (See 45 C.F.R. §96.122(f)(5)(ii)(A)(B)(C)).

ADHS does not spend state appropriated funds on HIV Early Intervention Services.

Table 8d: Women's base for services to pregnant women and women with dependent children as required by 42 U.S.C §300x-22(b)(1); and for 1994 and subsequent fiscal years;

Calculations for the Women's Base are grounded in a survey done in FY92 attempting to capture all specialty women's treatment programs operating during that year. The total value of services to pregnant women, and women with dependent children who received primarily residential treatment services in FY92 at state supported treatment programs equaled $1,225,977, which consisted of $1,164,678 of Federal funds and $61,299 of State Appropriations. This became the FY92 Women's Base (**Table II**).

For FY93, States must spend not less than 5% of grant to increase, relative to FY92, the availability of treatment services designed for pregnant women and women with dependent children. In FY93, 5% of the block grant award equated to $768,307. For FY94, States must spend not less than 5%, relative to FY93, for these services. In FY94, 5% of the block grant award equated to $801,732 **(Table III). T**he state will expend for such services for women not less than an amount equal to the amount expended for FY94 with equates to $2,796,016.

Table II: Expenditures for Services to Pregnant Women & Women with Dependent Children (Base)

Period	(1992) Amount from ADMS Block Grant Spent for Pregnant Women and Women with Dependent Children	(1992) State Expenditures for Pregnant Women and Women with Dependent Children	(1992) Women's Base
1992	$1,164,678	$61,299	$1,225,977

Table III: Expenditures for Services to Pregnant Women & Women with Dependent Children (MOE)

Period	Total Women's Base From Previous Year (A)	Total SAPT Block Grant Award (B)	5 % of SAPT Block Grant Award (C)	State Expenditures (D)	Total Women's Base (A+B+C+D)
1993	$1,225,977	$15,366,146	$768,307	$0	$1,994,284
1994	$1,994,284	$16,034,641	$801,732	$0	$2,796,016
1995					$2,796,016
1996					$2,796,016

ADHS has an Index code in the Legacy Accounting System and a Major Program in the new AFIS Accounting System that tracks all disbursements for Women's Services from the SABG Block Grant. The amount reported for the SFY2016 reporting year reflects the total amount of federal expenditures for

Women's Services from the FFY2014 SAPT Block Grant ($4,274,549, to ensure consistency in reporting with prior year applications.

Table 8d: Expenditures for Services to Pregnant Women & Women with Dependent Children

Period (State Fiscal Year)	Total Women's Base (A)	Total Expenditures (B)	Reflects Grant Award
1994	$2,796,016		
2008		$3,500,777	FFY2006
2009		$3,500,777	FFY2007
2010		$3,500,777	FFY2008
2011		$3,500,777	FFY2009
2012		$3,515,680	FFY2010
2013		$3,860,921	FFY2011
2014		$3,500,777	FFY2012
2015		$3,496,101	FFY2013
2016		$4,274,549	FFY2014

Footnote: Expenses reported in Column B reflect the Federal Fiscal Year Grant Award to maintain consistency in reporting.

III: Expenditure Reports

Table 8c - Base and Maintenance of Effort for Expenditures for HIV Early Intervention Services

State Expenditures for HIV Early Intervention Services to Individuals in Substance Use Disorder Treatment BASE		
Period	Total of All State Funds Spent on Early Intervention Services for HIV (A)	Average of Columns A1 and A2 A1+A2 / 2 (MOE Base) (B)
(1) SFY 1991	$0	
(2) SFY 1992	$0	$0

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Individuals in Substance Use Disorder Treatment MAINTENANCE	
Period	Total of All State Funds Spent on Early Intervention Services for HIV (A)
(3) SFY 2016	$0

Please provide a description of the amounts and methods used to calculate (for designated states only) the base and MOE for HIV early intervention services as required by 42 U.S.C. §300x-24(d) (See 45 C.F.R. §96 122(f)(5)(ii)(A)(B)(C))
The SMHA does not spend state appropriated funds on HIV
Early Intervention Services.

Footnotes:

SABG Description of Calculations for SFY2016

Table 8a: Maintenance of Effort for State Expenditures for SABG as required by 42 U.S.C. §300x-30(a);

The calculations reflect the aggregate state expenditures spent on authorized activities at the State Mental Health Agency (SMHA), which directly administers the SABG. The methodology is based on the requirements of 42 U.S.C. §300x-30(a). The methodology utilizes generally accepted accounting principles and is applied consistently each year. The calculation includes expenditures from the State General Fund (GF) and the Substance Abuse Services Fund (SASF). The calculation excludes federal, city, and county funds.

Table 8b: TB; Base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. §300x-24(d);

Calculations for Column (A) in Table I were based on the FY94 SAPT Block Grant Application. Expenditures reported for TB services in the Bureau of Epidemiology and Disease Control Services (formerly Disease Prevention Services) were $916,654 in FY91 and $860,717 in FY92.

Calculations for Column (B) were revised in the FY09 application after reviewing how the initial base was calculated. According to information available from the Client Information System (CIS), no persons with TB were identified in substance abuse treatment during 1991 and only one person identified with TB received substance abuse treatment in 1992, making the percent of TB expenditures spent on clients who were substance abusers in treatment 0.69%. Therefore, the total state funds spent on clients who were substance abusers in treatment was $5,939 and the new base for Tuberculosis Services is $2,970.

Table I: Statewide Non-Federal Expenditures for TB Services to Individuals in Substance Use Disorder Treatment (Base Table)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were in Substance Use Disorder Treatment (B)	Total State Funds Spent on Clients who were in Substance Use Disorder Treatment (AxB) (C)	Average of Columns C1 & C2 (C1 + C2)
SFY 1991 (1)	$916,654	0%	$0	$2,970
SFY1992 (2)	$860,717	.69%	$5,939	

The Arizona Department of Health Services (ADHS), Office of Infectious Disease Services provided the total number of TB Cases in SFY16, which are 134. The Division of Behavioral Health Services then compared identifying information provided by the Office of Infectious Disease Services to the Client Information System (CIS) in order to determine if any clients received substance use disorder treatment during SFY16. Of those 134 cases, 7 reported a substance use disorder. The result was 7 cases or 5.22% of the total TB cases in Arizona.

Therefore, the total of all State funds spent on TB services ($584,350) multiplied by the percent of TB expenditures spent on TB clients with a substance use disorder (5.22%) equals the total State funds spent on clients who were in substance use disorder treatment ($30,503).

Table 8c: HIV; for designated states, the base and MOE for HIV early intervention services as required by 42 U.S.C. §300x-24(d); (See 45 C.F.R. §96.122(f)(5)(ii)(A)(B)(C)).

ADHS does not spend state appropriated funds on HIV Early Intervention Services.

Table 8d: Women's base for services to pregnant women and women with dependent children as required by 42 U.S.C §300x-22(b)(1); and for 1994 and subsequent fiscal years;

Calculations for the Women's Base are grounded in a survey done in FY92 attempting to capture all specialty women's treatment programs operating during that year. The total value of services to pregnant women, and women with dependent children who received primarily residential treatment services in FY92 at state supported treatment programs equaled $1,225,977, which consisted of $1,164,678 of Federal funds and $61,299 of State Appropriations. This became the FY92 Women's Base (**Table II**).

For FY93, States must spend not less than 5% of grant to increase, relative to FY92, the availability of treatment services designed for pregnant women and women with dependent children. In FY93, 5% of the block grant award equated to $768,307. For FY94, States must spend not less than 5%, relative to FY93, for these services. In FY94, 5% of the block grant award equated to $801,732 **(Table III). T**he state will expend for such services for women not less than an amount equal to the amount expended for FY94 with equates to $2,796,016.

Table II: Expenditures for Services to Pregnant Women & Women with Dependent Children (Base)

Period	(1992) Amount from ADMS Block Grant Spent for Pregnant Women and Women with Dependent Children	(1992) State Expenditures for Pregnant Women and Women with Dependent Children	(1992) Women's Base
1992	$1,164,678	$61,299	$1,225,977

Table III: Expenditures for Services to Pregnant Women & Women with Dependent Children (MOE)

Period	Total Women's Base From Previous Year (A)	Total SAPT Block Grant Award (B)	5 % of SAPT Block Grant Award (C)	State Expenditures (D)	Total Women's Base (A+B+C+D)
1993	$1,225,977	$15,366,146	$768,307	$0	$1,994,284
1994	$1,994,284	$16,034,641	$801,732	$0	$2,796,016
1995					$2,796,016
1996					$2,796,016

ADHS has an Index code in the Legacy Accounting System and a Major Program in the new AFIS Accounting System that tracks all disbursements for Women's Services from the SABG Block Grant. The amount reported for the SFY2016 reporting year reflects the total amount of federal expenditures for

Women's Services from the FFY2014 SAPT Block Grant ($4,274,549, to ensure consistency in reporting with prior year applications.

Table 8d: Expenditures for Services to Pregnant Women & Women with Dependent Children

Period (State Fiscal Year)	Total Women's Base (A)	Total Expenditures (B)	Reflects Grant Award
1994	$2,796,016		
2008		$3,500,777	FFY2006
2009		$3,500,777	FFY2007
2010		$3,500,777	FFY2008
2011		$3,500,777	FFY2009
2012		$3,515,680	FFY2010
2013		$3,860,921	FFY2011
2014		$3,500,777	FFY2012
2015		$3,496,101	FFY2013
2016		$4,274,549	FFY2014

Footnote: Expenses reported in Column B reflect the Federal Fiscal Year Grant Award to maintain consistency in reporting.

III: Expenditure Reports

Table 8d - Expenditures for Services to Pregnant Women and Women with Dependent Children

Base		
Period	Total Women's Base (A)	Total Expenditures (B)
SFY 1994	$2,796,016	

Maintenance		
Period	Total Women's Base (A)	Total Expenditures (B)
SFY 2014		$3,500,777
SFY 2015		$3,496,101
SFY 2016		$4,274,549

Enter the amount the State plans to expend in 2017 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A (1994)): $ 3500777.00

Please provide a description of the amounts and methods used to calculate the base and, for 1994 and subsequent fiscal years, report the Federal and State expenditures for such services for services to pregnant women and women with dependent children as required by 42 U.S.C. §300x-22(b)(1).
Please see attachment: SABG Description of calculations for
December 1, 2016.

Footnotes:
Expenses reported in Column B reflect the Federal Fiscal Year Grant Award to maintain consistency in reporting.

SABG Description of Calculations for SFY2016

Table 8a: Maintenance of Effort for State Expenditures for SABG as required by 42 U.S.C. §300x-30(a);

The calculations reflect the aggregate state expenditures spent on authorized activities at the State Mental Health Agency (SMHA), which directly administers the SABG. The methodology is based on the requirements of 42 U.S.C. §300x-30(a). The methodology utilizes generally accepted accounting principles and is applied consistently each year. The calculation includes expenditures from the State General Fund (GF) and the Substance Abuse Services Fund (SASF). The calculation excludes federal, city, and county funds.

Table 8b: TB; Base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. §300x-24(d);

Calculations for Column (A) in Table I were based on the FY94 SAPT Block Grant Application. Expenditures reported for TB services in the Bureau of Epidemiology and Disease Control Services (formerly Disease Prevention Services) were $916,654 in FY91 and $860,717 in FY92.

Calculations for Column (B) were revised in the FY09 application after reviewing how the initial base was calculated. According to information available from the Client Information System (CIS), no persons with TB were identified in substance abuse treatment during 1991 and only one person identified with TB received substance abuse treatment in 1992, making the percent of TB expenditures spent on clients who were substance abusers in treatment 0.69%. Therefore, the total state funds spent on clients who were substance abusers in treatment was $5,939 and the new base for Tuberculosis Services is $2,970.

Table I: Statewide Non-Federal Expenditures for TB Services to Individuals in Substance Use Disorder Treatment (Base Table)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were in Substance Use Disorder Treatment (B)	Total State Funds Spent on Clients who were in Substance Use Disorder Treatment (AxB) (C)	Average of Columns C1 & C2 (C1 + C2)
SFY 1991 (1)	$916,654	0%	$0	$2,970
SFY1992 (2)	$860,717	.69%	$5,939	

The Arizona Department of Health Services (ADHS), Office of Infectious Disease Services provided the total number of TB Cases in SFY16, which are 134. The Division of Behavioral Health Services then compared identifying information provided by the Office of Infectious Disease Services to the Client Information System (CIS) in order to determine if any clients received substance use disorder treatment during SFY16. Of those 134 cases, 7 reported a substance use disorder. The result was 7 cases or 5.22% of the total TB cases in Arizona.

Therefore, the total of all State funds spent on TB services ($584,350) multiplied by the percent of TB expenditures spent on TB clients with a substance use disorder (5.22%) equals the total State funds spent on clients who were in substance use disorder treatment ($30,503).

Table 8c: HIV; for designated states, the base and MOE for HIV early intervention services as required by 42 U.S.C. §300x-24(d); (See 45 C.F.R. §96.122(f)(5)(ii)(A)(B)(C)).

ADHS does not spend state appropriated funds on HIV Early Intervention Services.

Table 8d: Women's base for services to pregnant women and women with dependent children as required by 42 U.S.C §300x-22(b)(1); and for 1994 and subsequent fiscal years;

Calculations for the Women's Base are grounded in a survey done in FY92 attempting to capture all specialty women's treatment programs operating during that year. The total value of services to pregnant women, and women with dependent children who received primarily residential treatment services in FY92 at state supported treatment programs equaled $1,225,977, which consisted of $1,164,678 of Federal funds and $61,299 of State Appropriations. This became the FY92 Women's Base (**Table II**).

For FY93, States must spend not less than 5% of grant to increase, relative to FY92, the availability of treatment services designed for pregnant women and women with dependent children. In FY93, 5% of the block grant award equated to $768,307. For FY94, States must spend not less than 5%, relative to FY93, for these services. In FY94, 5% of the block grant award equated to $801,732 **(Table III). T**he state will expend for such services for women not less than an amount equal to the amount expended for FY94 with equates to $2,796,016.

Table II: Expenditures for Services to Pregnant Women & Women with Dependent Children (Base)

Period	(1992) Amount from ADMS Block Grant Spent for Pregnant Women and Women with Dependent Children	(1992) State Expenditures for Pregnant Women and Women with Dependent Children	(1992) Women's Base
1992	$1,164,678	$61,299	$1,225,977

Table III: Expenditures for Services to Pregnant Women & Women with Dependent Children (MOE)

Period	Total Women's Base From Previous Year (A)	Total SAPT Block Grant Award (B)	5 % of SAPT Block Grant Award (C)	State Expenditures (D)	Total Women's Base (A+B+C+D)
1993	$1,225,977	$15,366,146	$768,307	$0	$1,994,284
1994	$1,994,284	$16,034,641	$801,732	$0	$2,796,016
1995					$2,796,016
1996					$2,796,016

ADHS has an Index code in the Legacy Accounting System and a Major Program in the new AFIS Accounting System that tracks all disbursements for Women's Services from the SABG Block Grant. The amount reported for the SFY2016 reporting year reflects the total amount of federal expenditures for

Women's Services from the FFY2014 SAPT Block Grant ($4,274,549, to ensure consistency in reporting with prior year applications.

Table 8d: Expenditures for Services to Pregnant Women & Women with Dependent Children

Period (State Fiscal Year)	Total Women's Base (A)	Total Expenditures (B)	Reflects Grant Award
1994	$2,796,016		
2008		$3,500,777	FFY2006
2009		$3,500,777	FFY2007
2010		$3,500,777	FFY2008
2011		$3,500,777	FFY2009
2012		$3,515,680	FFY2010
2013		$3,860,921	FFY2011
2014		$3,500,777	FFY2012
2015		$3,496,101	FFY2013
2016		$4,274,549	FFY2014

Footnote: Expenses reported in Column B reflect the Federal Fiscal Year Grant Award to maintain consistency in reporting.

IV: Populations and Services Reports

Table 9 - Prevention Strategy Report

Expenditure Period Start Date: 10/1/2013 Expenditure Period End Date: 9/30/2015

Column A (Risks)	Column B (Strategies)	Column C (Providers)
No Risk Assigned	1. Information Dissemination	
	1. Clearinghouse/information resources centers	1
	3. Media campaigns	9
	4. Brochures	26
	5. Radio and TV public service announcements	10
	6. Speaking engagements	15
	7. Health fairs and other health promotion, e.g., conferences, meetings, seminars	18
	8. Information lines/Hot lines	2
	9. Social Media	21
	2. Education	
	1. Parenting and family management	9
	2. Ongoing classroom and/or small group sessions	12
	3. Peer leader/helper programs	11
	4. Education programs for youth groups	13
	5. Mentors	3
	6. Preschool ATOD prevention programs	5
	7. Promotion for Seniors	5
	3. Alternatives	
	1. Drug free dances and parties	5
	2. Youth/adult leadership activities	6
	3. Community drop-in centers	1
	4. Community service activities	9
	6. Recreation activities	4
	4. Problem Identification and Referral	
	4. Total number of programs	23
	5. Community-Based Process	
	1. Community and volunteer	

	training, e.g., neighborhood action training, impactor-training, staff/officials training	15
	2. Systematic planning	2
	3. Multi-agency coordination and collaboration/coalition	12
	4. Community team-building	
	5. Accessing services and funding	
	6. Environmental	
	2. Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drugs	2
	7. Other	
	2. Sticker shock	6
	3. Prescription drug drop boxes	2
	6. Shoulder Tapping	1
	8. Party patrol	1
	11. Dump the drug events	5

Footnotes:

IV: Populations and Services Reports

Table 10 - Treatment Utilization Matrix

Expenditure Period Start Date: 7/1/2015 Expenditure Period End Date: 6/30/2016

Level of Care	Number of Admissions ≥ Number of Persons Served		Costs per Person		
	Number of Admissions (A)	Number of Persons Served (B)	Mean Cost of Services (C)	Median Cost of Services (D)	Standard Deviation of Cost (E)
DETOXIFICATION (24-HOUR CARE)					
1. Hospital Inpatient	441	324	$3,180	$1,042	$5,910
2. Free-Standing Residential	1733	1159	$2,550	$2,273	$2,008
REHABILITATION/RESIDENTIAL					
3. Hospital Inpatient	4808	3857	$9,760	$4,678	$16,605
4. Short-term (up to 30 days)	4786	3809	$9,655	$5,486	$14,386
5. Long-term (over 30 days)	1093	1001	$1,792	$981	$3,183
AMBULATORY (OUTPATIENT)					
6. Outpatient	60511	53164	$2,678	$1,334	$5,014
7. Intensive Outpatient	900	855	$2,292	$757	$3,584
8. Detoxification	0	0	$0	$0	$0
OPIOID REPLACEMENT THERAPY					
9. Opioid Replacement Therapy	5486	5071	$405	$220	$436
10. ORT Outpatient	0	0	$0	$0	$0

Footnotes:

Table 11 - Unduplicated Count of Persons

Expenditure Period Start Date: 7/1/2015 Expenditure Period End Date: 6/30/2016

Age	A. Total	B. WHITE		C. BLACK OR AFRICAN AMERICAN		D. NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER		E. ASIAN		F. AMERICAN INDIAN / ALASKA NATIVE		G. MORE THAN ONE RACE REPORTED		H. Unknown		I. NOT HISPANIC OR LATINO		J. HISPANIC OR LATINO	
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
1. 17 and Under	4755	2499	1482	193	81	10	6	7	4	196	144	62	44	19	8	1720	1154	1247	607
2. 18 - 24	6926	3162	2448	265	177	16	12	23	10	252	222	63	62	151	63	2433	2099	1348	832
3. 25 - 44	26786	11274	10939	733	731	45	53	71	58	962	962	173	194	390	201	9587	9642	3671	3295
4. 45 - 64	16638	7338	6830	569	489	47	28	26	17	476	347	84	80	209	98	6761	6555	1779	1236
5. 65 and Over	1004	435	413	33	18	8	2	2	1	24	16	5	5	28	14	398	412	109	43
6. Total	56109	24708	22112	1793	1496	126	101	129	90	1910	1691	387	385	797	384	20899	19862	8154	6013
7. Pregnant Women	1298		1038		108		7		6		112		26		1		936		361

Number of persons served who were admitted in a period prior to the 12 month reporting period	20225
Number of persons served outside of the levels of care described on Table 10	0

Footnotes:

IV: Populations and Services Reports

Table 12 - HIV Designated States Early Intervention Services

Expenditure Period Start Date: 7/1/2015 Expenditure Period End Date: 6/30/2016

Early Intervention Services for Human Immunodeficiency Virus (HIV)		
1. Number of SAPT HIV EIS programs funded in the State	Statewide: _____	Rural: _____
2. Total number of individuals tested through SAPT HIV EIS funded programs		
3. Total number of HIV tests conducted with SAPT HIV EIS funds		
4. Total number of tests that were positive for HIV		
5. Total number of individuals who prior to the 12-month reporting period were unaware of their HIV infection		
6. Total number of HIV-infected individuals who were diagnosed and referred into treatment and care during the 12-month reporting period		
Identify barriers, including State laws and regulations, that exist in carrying out HIV testing services:		

Footnotes:
Arizona is not a designated state and the SMHA does not spend state appropriated funds on HIV Early Intervention Services.

IV: Populations and Services Reports

Table 13 - Charitable Choice

Expenditure Period Start Date: 7/1/2015 Expenditure Period End Date: 6/30/2016

Notice to Program Beneficiaries - Check all that apply:

- ☐ Used model notice provided in final regulation.
- ☐ Used notice developed by State (please attach a copy to the Report).
- ☐ State has disseminated notice to religious organizations that are providers.
- ☒ State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

- ☐ State has developed specific referral system for this requirement.
- ☒ State has incorporated this requirement into existing referral system(s).
- ☒ SAMHSA's Treatment Facility Locator is used to help identify providers.
- ☒ Other networks and information systems are used to help identify providers.
- ☐ State maintains record of referrals made by religious organizations that are providers.
- ☒ 0 Enter total number of referrals necessitated by religious objection to other substance abuse providers ("alternative providers"), as defined above, made in previous fiscal year. Provide total only; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

The Arizona Health Care Cost Containment System (AHCCCS) contracts with managed care organizations, known as Regional Behavioral Health Authorities (RBHAs), to administer Medicaid and grant-funded behavioral health services throughout the State. The RBHAs receive SAPT funds and are, therefore, held accountable to the compliance requirements of the grant – including the Charitable Choice provisions as outlined by 42 U.S.C. 300x–65 and 42 U.S.C. 290kk, et seq., and additionally defined in Arizona Revised Statute (A.R.S.) 41-3751 et seq. Accordingly, AHCCCS' Medical Policy Manual (AMPM) Policy 320-T requires that persons receiving substance abuse treatment services under the SAPT Block Grant have the right to receive services from a provider to whose religious character they do not object. Treatment subcontractors providing substance use disorder services under the Substance Abuse Prevention and Treatment Block Grant must notify persons of this right using a standard document (Exhibit 320-9). Providers must document that the person has received notice in the person's comprehensive clinical record. If a person objects to the religious character of a behavioral health provider, the provider must refer the person to an alternative provider within 7 days, or earlier when clinically indicated, after the date of the objection. The alternative provider must be accessible to the client and have the capacity to provide substance use treatment services. Upon making such a referral, providers must notify the RBHA of the referral and ensure that the person makes contact with the alternative provider. As part of regular business practices AHCCCS provides on-going training and technical assistance to the RBHAs regarding policies, including charitable choice compliance.

Footnotes:

V: Performance Indicators and Accomplishments

Table 14 - Treatment Performance Measure Employment/Education Status (From Admission to Discharge)

Short-term Residential(SR)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	24	19
Total number of clients with non-missing values on employment/student status [denominator]	334	334
Percent of clients employed or student (full-time and part-time)	7.2 %	5.7 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	608
Number of CY 2015 discharges submitted:	432
Number of CY 2015 discharges linked to an admission:	349
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	334
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	334

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Long-term Residential(LR)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	0	0
Total number of clients with non-missing values on employment/student status [denominator]	3	3
Percent of clients employed or student (full-time and part-time)	0.0 %	0.0 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	28
Number of CY 2015 discharges submitted:	16
Number of CY 2015 discharges linked to an admission:	3

Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	3
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	3

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Outpatient (OP)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	1,514	1,567
Total number of clients with non-missing values on employment/student status [denominator]	5,142	5,142
Percent of clients employed or student (full-time and part-time)	29.4 %	30.5 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	20,725
Number of CY 2015 discharges submitted:	15,113
Number of CY 2015 discharges linked to an admission:	5,645
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	5,162
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	5,142

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Intensive Outpatient (IO)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	0	0
Total number of clients with non-missing values on employment/student status [denominator]	0	0
Percent of clients employed or student (full-time and part-time)	0.0 %	0.0 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	3
Number of CY 2015 discharges submitted:	4
Number of CY 2015 discharges linked to an admission:	0

Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	0

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Footnotes:

V: Performance Indicators and Accomplishments

Table 15 - Treatment Performance Measure Stability of Housing (From Admission to Discharge)

Short-term Residential(SR)

Stability of Housing – Clients reporting being in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients in a stable living situation [numerator]	152	155
Total number of clients with non-missing values on living arrangements [denominator]	329	329
Percent of clients in stable living situation	46.2 %	47.1 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	608
Number of CY 2015 discharges submitted:	432
Number of CY 2015 discharges linked to an admission:	349
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	334
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	329

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Long-term Residential(LR)

Stability of Housing – Clients reporting being in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients in a stable living situation [numerator]	2	2
Total number of clients with non-missing values on living arrangements [denominator]	2	2
Percent of clients in stable living situation	100.0 %	100.0 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	28
Number of CY 2015 discharges submitted:	16
Number of CY 2015 discharges linked to an admission:	3

Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	3
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	2

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Outpatient (OP)

Stability of Housing – Clients reporting being in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients in a stable living situation [numerator]	4,412	4,431
Total number of clients with non-missing values on living arrangements [denominator]	4,982	4,982
Percent of clients in stable living situation	88.6 %	88.9 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	20,725
Number of CY 2015 discharges submitted:	15,113
Number of CY 2015 discharges linked to an admission:	5,645
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	5,162
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	4,982

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Intensive Outpatient (IO)

Stability of Housing – Clients reporting being in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients in a stable living situation [numerator]	0	0
Total number of clients with non-missing values on living arrangements [denominator]	0	0
Percent of clients in stable living situation	0.0 %	0.0 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	3
Number of CY 2015 discharges submitted:	4
Number of CY 2015 discharges linked to an admission:	0

Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	0

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Footnotes:

V: Performance Indicators and Accomplishments

Table 16 - Treatment Performance Measure Criminal Justice Involvement (From Admission to Discharge)

Short-term Residential(SR)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	312	317
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	340	340
Percent of clients without arrests	91.8 %	93.2 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	608
Number of CY 2015 discharges submitted:	432
Number of CY 2015 discharges linked to an admission:	349
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	340
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	340

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Long-term Residential(LR)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	3	3
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	3	3
Percent of clients without arrests	100.0 %	100.0 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	28
Number of CY 2015 discharges submitted:	16
Number of CY 2015 discharges linked to an admission:	3

Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	3
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	3

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Outpatient (OP)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	4,341	4,344
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	5,377	5,377
Percent of clients without arrests	80.7 %	80.8 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	20,725
Number of CY 2015 discharges submitted:	15,113
Number of CY 2015 discharges linked to an admission:	5,645
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	5,380
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	5,377

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Intensive Outpatient (IO)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	0	0
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	0	0
Percent of clients without arrests	0.0 %	0.0 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	3
Number of CY 2015 discharges submitted:	4
Number of CY 2015 discharges linked to an admission:	0

Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	0

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Footnotes:

V: Performance Indicators and Accomplishments

Table 17 - Treatment Performance Measure Change in Abstinence - Alcohol Use (From Admission to Discharge)

Short-term Residential(SR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	226	292
All clients with non-missing values on at least one substance/frequency of use [denominator]	340	340
Percent of clients abstinent from alcohol	66.5 %	85.9 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		69
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	114	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		60.5 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		223
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	226	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		98.7 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	608
Number of CY 2015 discharges submitted:	432
Number of CY 2015 discharges linked to an admission:	349
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	340
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	340

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Long-term Residential(LR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	3	3
All clients with non-missing values on at least one substance/frequency of use [denominator]	3	3
Percent of clients abstinent from alcohol	100.0 %	100.0 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		0
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	0	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		0.0 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		3
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		100.0 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	28
Number of CY 2015 discharges submitted:	16
Number of CY 2015 discharges linked to an admission:	3
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	3
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	3

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Outpatient (OP)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	3,723	3,858
All clients with non-missing values on at least one substance/frequency of use [denominator]	5,377	5,377
Percent of clients abstinent from alcohol	69.2 %	71.8 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		186
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,654	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		11.2 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		3,672
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,723	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		98.6 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	20,725
Number of CY 2015 discharges submitted:	15,113
Number of CY 2015 discharges linked to an admission:	5,645
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	5,380
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	5,377

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Intensive Outpatient (IO)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	0	0

All clients with non-missing values on at least one substance/frequency of use [denominator]	0	0
Percent of clients abstinent from alcohol	0.0 %	0.0 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		0
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	0	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		0.0 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		0
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	0	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		0.0 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	3
Number of CY 2015 discharges submitted:	4
Number of CY 2015 discharges linked to an admission:	0
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	0

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Footnotes:

V: Performance Indicators and Accomplishments

Table 18 - Treatment Performance Measure Change in Abstinence - Other Drug Use (From Admission to Discharge)

Short-term Residential(SR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	96	215
All clients with non-missing values on at least one substance/frequency of use [denominator]	340	340
Percent of clients abstinent from drugs	28.2 %	63.2 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION
Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		126
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	244	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		51.6 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION
Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		89
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	96	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		92.7 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	608
Number of CY 2015 discharges submitted:	432
Number of CY 2015 discharges linked to an admission:	349
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	340
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	340

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Long-term Residential(LR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	1	1
All clients with non-missing values on at least one substance/frequency of use [denominator]	3	3
Percent of clients abstinent from drugs	33.3 %	33.3 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION
Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		0
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		0.0 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION
Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		1
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		100.0 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	28
Number of CY 2015 discharges submitted:	16
Number of CY 2015 discharges linked to an admission:	3
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	3
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	3

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Outpatient (OP)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	2,740	2,930
All clients with non-missing values on at least one substance/frequency of use [denominator]	5,377	5,377
Percent of clients abstinent from drugs	51.0 %	54.5 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION
Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		274
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,637	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		10.4 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION
Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		2,656
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,740	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		96.9 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	20,725
Number of CY 2015 discharges submitted:	15,113
Number of CY 2015 discharges linked to an admission:	5,645
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	5,380
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	5,377

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Intensive Outpatient (IO)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	0	0

All clients with non-missing values on at least one substance/frequency of use [denominator]	0	0
Percent of clients abstinent from drugs	0.0 %	0.0 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		0
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	0	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		0.0 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		0
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	0	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		0.0 %

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	3
Number of CY 2015 discharges submitted:	4
Number of CY 2015 discharges linked to an admission:	0
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	0

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Footnotes:

V: Performance Indicators and Accomplishments

Table 19 - Treatment Performance Measure Change in Social Support Of Recovery (From Admission to Discharge)

Short-term Residential(SR)

Social Support of Recovery – Clients attending Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients attending self-help programs [numerator]	29	236
Total number of clients with non-missing values on self-help attendance [denominator]	340	340
Percent of clients attending self-help programs	8.5 %	69.4 %
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	60.9 %	
Notes (for this level of care):		
Number of CY 2015 admissions submitted:		608
Number of CY 2015 discharges submitted:		432
Number of CY 2015 discharges linked to an admission:		349
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		340
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):		340

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Long-term Residential(LR)

Social Support of Recovery – Clients attending Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients attending self-help programs [numerator]	0	1
Total number of clients with non-missing values on self-help attendance [denominator]	3	3
Percent of clients attending self-help programs	0.0 %	33.3 %
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	33.3 %	
Notes (for this level of care):		
Number of CY 2015 admissions submitted:		28
Number of CY 2015 discharges submitted:		16

Number of CY 2015 discharges linked to an admission:	3
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	3
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	3

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Outpatient (OP)

Social Support of Recovery – Clients attending Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients attending self-help programs [numerator]	912	982
Total number of clients with non-missing values on self-help attendance [denominator]	5,377	5,377
Percent of clients attending self-help programs	17.0 %	18.3 %
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	1.3 %	

Notes (for this level of care):	
Number of CY 2015 admissions submitted:	20,725
Number of CY 2015 discharges submitted:	15,113
Number of CY 2015 discharges linked to an admission:	5,645
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	5,380
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	5,377

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Intensive Outpatient (IO)

Social Support of Recovery – Clients attending Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients attending self-help programs [numerator]	0	0
Total number of clients with non-missing values on self-help attendance [denominator]	0	0
Percent of clients attending self-help programs	0.0 %	0.0 %
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	0.0 %	

Notes (for this level of care):

Number of CY 2015 admissions submitted:	3
Number of CY 2015 discharges submitted:	4
Number of CY 2015 discharges linked to an admission:	0
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2015 linked discharges eligible for this calculation (non-missing values):	0

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Footnotes:

V: Performance Indicators and Accomplishments

Table 20 - Retention - Length of Stay (in Days) of Clients Completing Treatment

Level of Care	Average (Mean)	25th Percentile	50th Percentile (Median)	75th Percentile
DETOXIFICATION (24-HOUR CARE)				
1. Hospital Inpatient	14	14	14	14
2. Free-Standing Residential	30	4	4	35
REHABILITATION/RESIDENTIAL				
3. Hospital Inpatient	76	17	79	110
4. Short-term (up to 30 days)	55	29	29	70
5. Long-term (over 30 days)	118	65	85	203
AMBULATORY (OUTPATIENT)				
6. Outpatient	117	56	106	165
7. Intensive Outpatient	0	0	0	0
8. Detoxification	0	0	0	0
OPIOID REPLACEMENT THERAPY				
9. Opioid Replacement Therapy	19	19	19	19
10. ORT Outpatient	119	54	112	167

Level of Care	2015 TEDS discharge record count	
	Discharges submitted	Discharges linked to an admission
DETOXIFICATION (24-HOUR CARE)		
1. Hospital Inpatient	1	1
2. Free-Standing Residential	168	142
REHABILITATION/RESIDENTIAL		
3. Hospital Inpatient	31	19

4. Short-term (up to 30 days)	432	349
5. Long-term (over 30 days)	16	3
AMBULATORY (OUTPATIENT)		
6. Outpatient	4	5430
7. Intensive Outpatient	15113	0
8. Detoxification	0	0
OPIOID REPLACEMENT THERAPY		
9. Opioid Replacement Therapy	0	1
10. ORT Outpatient	0	215

Source: SAMHSA/CBHSQ TEDS CY 2015 admissions file and CY 2015 linked discharge file
[Records received through 2/2/2017]

Footnotes:

Table 21 - Prevention Performance Measures - Reduced Morbidity-Abstinence from Drug Use/Alcohol Use; Measure: 30 Day Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	Source Survey Item: NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from [DATEFILL] through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?[Response option: Write in a number between 0 and 30.] Outcome Reported: Percent who reported having used alcohol during the past 30 days.		
	Age 12 - 17 - CY 2014	12.1	
	Age 18+ - CY 2014	55.8	
2. 30-day Cigarette Use	Source Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you smoke part or all of a cigarette?[Response option: Write in a number between 0 and 30.] Outcome Reported: Percent who reported having smoked a cigarette during the past 30 days.		
	Age 12 - 17 - CY 2014	5.1	
	Age 18+ - CY 2014	19.6	
3. 30-day Use of Other Tobacco Products	Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you use [other tobacco products][1]?[Response option: Write in a number between 0 and 30.] Outcome Reported: Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (snuff, chewing tobacco, pipe tobacco).		
	Age 12 - 17 - CY 2014	2.6	
	Age 18+ - CY 2014	6.6	
4. 30-day Use of Marijuana	Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?[Response option: Write in a number between 0 and 30.] Outcome Reported: Percent who reported having used marijuana or hashish during the past 30 days.		
	Age 12 - 17 - CY 2014	8.8	
	Age 18+ - CY 2014	8.6	
5. 30-day Use of Illegal Drugs Other Than Marijuana	Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use [any other illegal drug]?[2] Outcome Reported: Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors'orders).		
	Age 12 - 17 - CY 2014	4.0	
	Age 18+ - CY 2014	4.4	

[1]NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.
[2]NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

Footnotes:

V: Performance Indicators and Accomplishments

Table 22 - Prevention Performance Measures - Reduced Morbidity-Abstinence from Drug Use/Alcohol Use; Measure: Perception Of Risk/Harm of Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. Perception of Risk From Alcohol	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.		
	Age 12 - 17 - CY 2014	78.1	
	Age 18+ - CY 2014	81.0	
2. Perception of Risk From Cigarettes	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?[Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.		
	Age 12 - 17 - CY 2014	90.5	
	Age 18+ - CY 2014	93.4	
3. Perception of Risk From Marijuana	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.		
	Age 12 - 17 - CY 2014	62.3	
	Age 18+ - CY 2014	60.3	

Footnotes:

V: Performance Indicators and Accomplishments

Table 23 - Prevention Performance Measures - Reduced Morbidity-Abstinence from Drug Use/Alcohol Use; Measure: Age of First Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	Source Survey Item: NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink.?[Response option: Write in age at first use.] Outcome Reported: Average age at first use of alcohol.risk.		
	Age 12 - 17 - CY 2014	13.3	
	Age 18+ - CY 2014	17.6	
2. Age at First Use of Cigarettes	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?[Response option: Write in age at first use.] Outcome Reported: Average age at first use of cigarettes.		
	Age 12 - 17 - CY 2014	12.9	
	Age 18+ - CY 2014	16.2	
3. Age at First Use of Tobacco Products Other Than Cigarettes	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product][1]?[Response option: Write in age at first use.] Outcome Reported: Average age at first use of tobacco products other than cigarettes.		
	Age 12 - 17 - CY 2014	13.5	
	Age 18+ - CY 2014	20.3	
4. Age at First Use of Marijuana or Hashish	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?[Response option: Write in age at first use.] Outcome Reported: Average age at first use of marijuana or hashish.		
	Age 12 - 17 - CY 2014	13.4	
	Age 18+ - CY 2014	18.2	
5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used [other illegal drugs][2]?[Response option: Write in age at first use.] Outcome Reported: Average age at first use of other illegal drugs.		
	Age 12 - 17 - CY 2014	12.7	
	Age 18+ - CY 2014	21.2	

[1]The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.
[2]The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

Footnotes:

V: Performance Indicators and Accomplishments

Table 24 - Prevention Performance Measures - Reduced Morbidity-Abstinence from Drug Use/Alcohol Use; Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] Outcome Reported: Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2014	90.4	
2. Perception of Peer Disapproval of Cigarettes	Source Survey Item: NSDUH Questionnaire: "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] Outcome Reported: Percent reporting that their friends would somewhat or strongly disapprove.		
	Age 12 - 17 - CY 2014	88.7	
3. Disapproval of Using Marijuana Experimentally	Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] Outcome Reported: Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2014	77.1	
4. Disapproval of Using Marijuana Regularly	Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age using marijuana once a month or more?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] Outcome Reported: Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2014	77.0	
5. Disapproval of Alcohol	Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] Outcome Reported: Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2014	89.1	

Footnotes:

V: Performance Indicators and Accomplishments

Table 25 - Prevention Performance Measures - Employment/Education; Measure: Perception of Workplace Policy

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Perception of Workplace Policy	Source Survey Item: NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?[Response options: More likely, less likely, would make no difference] Outcome Reported: Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.		
	Age 18+ - CY 2014	36.9	
	Age 12 - 17 - CY 2014		

Footnotes:

V: Performance Indicators and Accomplishments

Table 26 - Prevention Performance Measures - Employment/Education; Measure: Average Daily School Attendance Rate

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	Source: National Center for Education Statistics, Common Core of Data: *The National Public Education Finance Survey* available for download at http://nces.ed.gov/ccd/stfis.asp. Measure calculation: Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.		
	School Year 2014	89.4	

Footnotes:

V: Performance Indicators and Accomplishments

Table 27 - Prevention Performance Measures - Crime and Criminal Justice; Measure: Alcohol-Related Traffic Fatalities

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Alcohol-Related Traffic Fatalities	Source: National Highway Traffic Safety Administration Fatality Analysis Reporting System Measure calculation: The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.		
	CY 2014	31.9	

Footnotes:

V: Performance Indicators and Accomplishments

Table 28 - Prevention Performance Measures - Crime and Criminal Justice; Measure: Alcohol and Drug Related Arrests

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Alcohol- and Drug-Related Arrests	Source: Federal Bureau of Investigation Uniform Crime Reports Measure calculation: The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.		
	CY 2014	27.1	

Footnotes:

V: Performance Indicators and Accomplishments

Table 29 - Prevention Performance Measures - Social Connectedness; Measure: Family Communications Around Drug and Alcohol Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. Family Communications Around Drug and Alcohol Use (Youth)	Source Survey Item: NSDUH Questionnaire: "Now think about the past 12 months, that is, from [DATEFILL] through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you.?[Response options: Yes, No] Outcome Reported: Percent reporting having talked with a parent.		
	Age 12 - 17 - CY 2014	54.5	
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12-17)	Source Survey Item: NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?[1][Response options: 0 times, 1 to 2 times, a few times, many times] Outcome Reported: Percent of parents reporting that they have talked to their child.		
	Age 18+ - CY 2014	88.5	

[1]NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

Footnotes:

V: Performance Indicators and Accomplishments

Table 30 - Prevention Performance Measures - Retention; Measure: Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Exposure to Prevention Messages	Source Survey Item: NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use][1]? Outcome Reported: Percent reporting having been exposed to prevention message.		
	Age 12 - 17 - CY 2014	85.4	

[1]This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context having been exposed to prevention message.

Footnotes:

V: Performance Indicators and Accomplishments

Table 31-35 - Reporting Period - Start and End Dates for Information Reported on Tables 31, 32, 33, 34, and 35

Reporting Period Start and End Dates for Information Reported on Tables 33, 34, 35, 36 and 37
Please indicate the reporting period (start date and end date totaling 12 months by the State) for each of the following forms:

Tables	A. Reporting Period Start Date	B. Reporting Period End Date
1. Table 31 - Prevention Performance Measures - Individual-Based Programs and Strategies; Measure: Number of Persons Served By Age, Gender, Race, And Ethnicity	7/1/2015	6/30/2016
2. Table 32 - Prevention Performance Measures - Population-Based Programs And Strategies; Measure: Number of Persons Served By Age, Gender, Race, And Ethnicity	7/1/2015	6/30/2016
3. Table 33 - Prevention Performance Measures - Number of Persons Served by Type of Intervention	7/1/2015	6/30/2016
4. Table 34 - Prevention Performance Measures - Number of Evidence-Based Programs by Types of Intervention	7/1/2015	6/30/2016
5. Table 35 - Prevention Performance Measures - Total Number of Evidence-Based Programs and Total SAPTBG Dollars Spent on Evidence-Based Programs/Strategies	7/1/2015	6/30/2016

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

Arizona currently utilizes a manual process for data collection. Each contractor is required to submit annual reports which conform to information submitted into WebBGAS . This information is then aggregated for state level reporting.

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race.
Indicate whether thes State added those participants to the number for each applicable racial category or whether the State added all those partipants to the More Than One Race subcategory.

The tool to collect demographic information used by all providers submitting data to the State used "Multiracial Direct", "Multiracial Indirect", and "Multiracial Total" to collect data that constitutes the "More than One Race" subcategory.

Footnotes:

V: Performance Indicators and Accomplishments

Table 31 - Prevention Performance Measures - Individual-Based Programs and Strategies; Measure: Number of Persons Served By Age, Gender, Race, And Ethnicity

Category	Total
Age	
0-4	
5-11	
12-14	
15-17	
18-20	
21-24	
25-44	
45-64	
65 and over	
Age Not Known	
Gender	
Male	
Female	
Gender Unknown	
Race	
White	
Black or African American	
Native Hawaiian/Other Pacific Islander	
Asian	
American Indian/Alaska Native	
More Than One Race (not OMB required)	

Race Not Known or Other (not OMB required)	
Ethnicity	
Hispanic or Latino	
Not Hispanic or Latino	
Ethnicity Unknown	

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race.
Indicate whether thes State added those participants to the number for each applicable racial category or whether the State added all those partipants to the More Than One Race subcategory.

Footnotes:

Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) submitted a Corrective Action Plan (CAP) June 30, 2014 as required by Substance Abuse and Mental Health Services Administration (SAMHSA) to meet the special terms of the award in the June 6, 2014 Notice of Grant Award, SABG Grant Number 2B08TIO10004-14. The CAP described steps which would be taken by ADHS/DBHS in order to comply with block grant reporting requirements.

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

ADHS/DBHS/AHCCCS has developed reporting spreadsheets for each for each of the prevention tables in order to capture information for each contracted provider. The information conforms precisely to the reporting tables for the SABG Report. Each contractor will be required to submit the spreadsheets for each Federal Fiscal Year which will allow AHCCCS to confirm that the amount reported conforms to the required set aside. All prevention activities are reported based on IOM category for each Federal Fiscal Year. As indicated in the CAP, AHCCCS will come into compliance for FFY2016 reporting. AHCCCS has disseminated the newly developed spreadsheets and has provided training and technical assistance to all contractors. AHCCCS is on track for reporting the FFY2016 SABG Block Grant in the December 1, 2018 reporting cycle.

V: Performance Indicators and Accomplishments

Table 32 - Prevention Performance Measures - Population-Based Programs And Strategies; Measure: Number of Persons Served By Age, Gender, Race, And Ethnicity

Category	Total
Age	
0-4	
5-11	
12-14	
15-17	
18-20	
21-24	
25-44	
45-64	
65 and over	
Age Not Known	
Gender	
Male	
Female	
Gender Unknown	
Race	
White	
Black or African American	
Native Hawaiian/Other Pacific Islander	
Asian	
American Indian/Alaska Native	
More Than One Race (not OMB required)	

Race Not Known or Other (not OMB required)	
Ethnicity	
Hispanic or Latino	
Not Hispanic or Latino	
Ethnicity Unknown	

Footnotes:

Per the Terms and Conditions of the FY2014 Notice of Grant Award, Arizona submitted a Corrective Action Plan June 30, 2014 describing steps to come into compliance with reporting requirements. Please see attached documentation (SAMHSA Reporting CAP Update 2017 Report.docx) regarding updates on steps taken to date.

Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) submitted a Corrective Action Plan (CAP) June 30, 2014 as required by Substance Abuse and Mental Health Services Administration (SAMHSA) to meet the special terms of the award in the June 6, 2014 Notice of Grant Award, SABG Grant Number 2B08TIO10004-14. The CAP described steps which would be taken by ADHS/DBHS in order to comply with block grant reporting requirements.

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V: Performance Indicators and Accomplishments

Table 33 - Prevention Performance Measures - Number of Persons Served by Type of Intervention

Number of Persons Served by Individual- or Population-Based Program or Strategy

Intervention Type	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct		N/A
2. Universal Indirect	N/A	
3. Selective		N/A
4. Indicated		N/A
5. Total	0	0

Footnotes:

Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) submitted a Corrective Action Plan (CAP) June 30, 2014 as required by Substance Abuse and Mental Health Services Administration (SAMHSA) to meet the special terms of the award in the June 6, 2014 Notice of Grant Award, SABG Grant Number 2B08TIO10004-14. The CAP described steps which would be taken by ADHS/DBHS in order to comply with block grant reporting requirements.

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V: Performance Indicators and Accomplishments

Table 34 - Prevention Performance Measures - Number of Evidence-Based Programs by Types of Intervention

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, Identifying and Selecting Evidence-based Interventions, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
  - Guideline 1:
    The intervention is based on a theory of change that is documented in a clear logic or conceptual model; and
  - Guideline 2:
    The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and
  - Guideline 3:
    The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to Identifying and Selecting Evidence-Based Interventions scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; and
  - Guideline 4:
    The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?

Table 34 - SUBSTANCE ABUSE PREVENTION Number of Evidence-Based Programs and Strategies by Type of Intervention

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selective	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded			0			0
2. Total number of Programs and Strategies Funded			0			0
3. Percent of Evidence-Based Programs and Strategies						

Footnotes:
Per the Terms and Conditions of the FY2014 Notice of Grant Award, Arizona submitted a Corrective Action Plan June 30, 2014 describing steps to come into compliance with reporting requirements. Please see attached documentation (SAMHSA Reporting CAP Update 2017 Report.docx) regarding updates on steps taken to date.

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V: Performance Indicators and Accomplishments

Table 35 - Prevention Performance Measures - Total Number of Evidence-Based Programs and Total SAPTBG Dollars Spent on Evidence-Based Programs/Strategies

	Total Number of Evidence-Based Programs/Strategies for IOM Category Below	Total SAPT Block Grant Dollars Spent on evidence-based Programs/Strategies
Universal Direct	Total #	$
Universal Indirect	Total #	$
Selective	Total #	$
Indicated	Total #	$
	Total EBPs: 0	Total Dollars Spent: $0

Footnotes:

Per the Terms and Conditions of the FY2014 Notice of Grant Award, Arizona submitted a Corrective Action Plan June 30, 2014 describing steps to come into compliance with reporting requirements. Please see attached documentation (SAMHSA Reporting CAP Update 2017 Report.docx) regarding updates on steps taken to date.

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V: Performance Indicators and Accomplishments

Prevention Attachments

Submission Uploads

FFY 2014 Prevention Attachment Category A:

File	Version	Date Added

FFY 2014 Prevention Attachment Category B:

File	Version	Date Added

FFY 2014 Prevention Attachment Category C:

File	Version	Date Added

FFY 2014 Prevention Attachment Category D:

File	Version	Date Added

Footnotes: