Arizona Opioid Emergency Response

June 2017 to June 2018

ARIZONA DEPARTMENT
OF HEALTH SERVICES

azhealth.gov/opioid

Arizona Opioid Emergency Response: June 2017 – June 2018

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Executive Summary

The Arizona Department of Health Services (ADHS) released the 2016 Arizona Opioid Report on June 1, 2017. This report revealed that in 2016, 790 Arizonans died from opioid overdoses – more than two people per day. Arizona has experienced an alarming increase in opioid deaths of 74 percent since 2012. In the past decade, 5,932 Arizonans died from opioid-induced causes with death rates starting to rise in the late teens and peaking at ages 45-54. This data highlighted a need for action.

On June 5, 2017, Governor Doug Ducey declared a public health emergency to address the increase in opioid deaths in Arizona. The requirements under the emergency declaration included:

- Providing consultation to the Governor on identifying and recommending necessary elements for an Enhanced Surveillance Advisory
- Initiating emergency rule making with the Arizona Attorney General's Office to develop rules for opioid prescribing and treatment within health care institutions
- Developing guidelines to educate healthcare providers on responsible prescribing practices
- Developing and providing training to local law enforcement agencies on proper protocols for carrying, handling, and administering naloxone in overdose situations; and
- Providing a report on findings and recommendations, including additional needs and response activities, and preliminary recommendations that require legislative action to the Governor by September 5, 2017.

The resulting Opioid Action Plan issued in September 2017 contained 12 major recommendations, including a set of preliminary legislative recommendations for stakeholders and policy makers to consider. ADHS and several partner organizations worked diligently to implement the Opioid Action Plan through June 2018. Governor Ducey signed the comprehensive Arizona Opioid Epidemic Act on January 26, 2018, with most provisions of the law going into effect April 26, 2018. With the completion of the emergency response deliverables, and the implementation of the Opioid Action Plan and Arizona Opioid Epidemic Act, Governor Ducey officially called an end to the public health emergency on May 29, 2018.

This report outlines the emergency response actions taken over the past year, and provides data from two sources: the new real-time opioid surveillance system of suspected cases, and the 2017 confirmed deaths and hospital discharge information. While the formal emergency declaration has ended, the fight to save lives and turn the tide on the opioid epidemic continues. The opioid crisis Arizona faces today did not start overnight, and will take time and tireless work to turn it around.

Public Health Emergency Declaration

On June 5, 2017, Governor Doug Ducey declared a public health emergency to address the increase in opioid deaths. The requirements under the emergency declaration included:

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- Providing a report on findings and recommendations, including additional needs and response activities, and preliminary recommendations that require legislative action to the Governor by September 5, 2017.

A summary of activities related to the emergency declaration follows.

Health Emergency Operations Center

The ADHS team immediately sprang into action and activated the Health Emergency Operations Center (HEOC) within hours of the Governor's emergency declaration. More than 75 agency staff across ADHS responded to the Governor's calls to action. ADHS staff reported over 10,000 hours of staff time dedicated to addressing the emergency response through May 2018.

Enhanced Surveillance Advisory

With consultation from ADHS, Governor Ducey issued an executive order on June 15, 2017 to require the reporting of opioid-related data, allowing state health officials to receive information within 24-hours of specific events. This was a first step toward understanding the current opioid burden in Arizona in real time and building recommendations to better target prevention and intervention. These reporting requirements greatly increased the Department's ability to assess and apply timely interventions in comparison with traditional data sources, which are 6 to 18 months delayed. The specific health conditions required in the enhanced surveillance advisory included suspected opioid overdoses, suspected opioid deaths, naloxone doses administered in response to either condition, naloxone doses dispensed, and neonatal abstinence syndrome.

To facilitate collection of data, the agency's secure web-based surveillance systems, Medical Electronic Disease Surveillance Intelligence System (MEDSIS) and Arizona Prehospital Information & EMS Registry System (AZ-PIERS), were utilized for designated reporters to electronically submit mandatory surveillance data. These systems were quickly modified to

accommodate data submitted from 464 unique MEDSIS reporters and 143 AZ-PIERS reporters. ADHS coordinated a series of three webinars that trained a total of 171 healthcare, EMS, and law enforcement reporters. In order to simplify the data collection process for law enforcement and EMS, the EMS data registry was updated to add the opioid overdose and naloxone utilization data elements into the basic electronic patient care record.

Post-Mortem Lab Testing

The Arizona State Public Health Laboratory (ASPHL) developed a test to analyze post-mortem blood from individuals suspected of experiencing a fatal opioid overdose. The test is capable of detecting opioids, emerging fentanyl analogues, benzodiazepines, stimulants, and cannabinoids. Test results are rapidly returned to the Medical Examiners and ADHS epidemiologists for surveillance to help identify specific drugs involved with overdose deaths in Arizona. Testing is offered at no cost to Arizona County Medical Examiners and tribal nations, and includes courier pick-up of samples throughout Arizona. Between April and June 15, 2018, ASPHL has analyzed 97 post-mortem blood samples from Maricopa, Pima, Coconino, and Pinal Counties and has identified 52 drugs, the most prevalent of which are opioids followed by stimulants. Approximately 50% of samples which tested positive for drugs were found to contain multiple drugs. In addition, laboratory data shows that 24% of positive samples contained naloxone.

Treatment Capacity Survey

In order to ascertain the current capacity and occupancy for substance abuse treatment in the state, ADHS requested the completion of an anonymous behavioral health, substance abuse treatment, and healthcare facilities survey. The survey was disseminated through the Regional Behavioral Health Authority system. Survey data was used to gain a better understanding of the distribution of services across the state, understand the utilization and availability of treatment, and better target future resources for treatment capacity in Arizona. Overall, the data collected demonstrated that there are not an adequate number of treatment services available in the state. It was also noted that when seeking care, many individuals may be turned away or placed on waiting lists. Starting in September 2018, ADHS will be collecting treatment capacity data from health care facilities and will issue quarterly reports noting gaps and recommendations.

Emergency Rule Making

As directed in the emergency declaration, the Department rapidly initiated emergency rule-making for opioid prescribing and treatment practices in licensed health care institutions. Rules were completed in coordination with Arizona's Attorney General's Office and approved by the Secretary of State for immediate implementation on June 28, 2017. These rules focus on health and safety; provide regulatory consistency for all health care institutions; establish, document, and implement policies and procedures for prescribing, ordering, or administering opioids as part of treatment; include specific processes related to opioids in a health care institution's quality management program, and require notification to the Department of a death of a

patient from an opioid overdose. To support the agency's stakeholders and partners, a series of four webinars on the emergency rules were held, training a total of 458 attendees.

After the emergency rule implementation, the Department initiated the regular rule making process, which included opportunities for stakeholder input on the final rules through several stakeholder workgroup meetings and surveys in September and October 2017. An oral proceeding was held on December 18, 2017. Written comments were accepted through December 18, 2017. The final rules went into effect March 6, 2018.

In addition, ADHS drafted and submitted emergency opioid-related reporting rules to the Attorney General's Office in order to maintain reporting requirements initiated by the Enhanced Surveillance Advisory. These rules require continued reporting of suspected opioid deaths, suspected opioid overdoses, naloxone doses administered in response to a suspected opioid overdose, naloxone doses dispensed, and neonatal abstinence syndrome cases. Ongoing reporting requirements will allow sustainable and continued collection of timely data throughout Arizona to better target prevention. Following stakeholder meetings and surveys through the regular rule making process, the opioid-related reporting rules went into effect on April 5, 2018.

Opioid Prescribing Guidelines

ADHS utilized the Arizona Prescription Drug Initiative Health Care Advisory Team, which has been in place since 2015, to review and update the Arizona Opioid Prescribing Guidelines published in 2014. The Rx Initiative Health Care Advisory Team, made up of professional health care associations, practicing clinicians, and subject matter experts, met nine times since June 2017 to review and update the guidelines. The Guidelines are a voluntary, consensus document that promotes patient safety and best practices if prescribing opioids for acute and chronic pain. Nineteen Arizona healthcare organizations have endorsed the new guidelines. The content of the guidelines was completed in December 2017, and the final version is posted at www.azhealth.gov/opioidprescribing/.

Current updates reflect:

- Incorporation of the most recent evidence, national guidelines (including the *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain, 2017* and *CDC Guideline for Prescribing Opioids for Chronic Pain, 2016*), best practices from other states, and Arizona data.
- A shift in pain care that avoids unnecessary exposure to opioids in order to reduce the risk of adverse outcomes. Previous guidelines focused on the "safe prescribing" of opioid therapy, while these guidelines aim to prevent initiating unnecessary opioid therapy while addressing patients' pain from a whole-person perspective.
- Emphasis on non-stigmatizing language. Health care providers can counter stigma by using accurate, nonjudgmental language. These guidelines employ person-first language ("Patients with substance use disorder" instead of "addicts"), nonjudgmental

terminology ("negative urine drug test" instead of "dirty") and supportive terms ("recovery" instead of "no cure").

- Increased focus on prevention, recognition, and treatment of opioid use disorder in patients receiving long-term opioid therapy for chronic pain, given the high risk of developing opioid use disorder in this population.
- Integration into clinical workflow (operationalization). A key element of success of guideline implementation is how seamlessly it can be incorporated into a clinician's normal activities. This revised version includes specific operationalization actions under each guideline.

Expanding Access to Naloxone

ADHS identified a need to train local law enforcement agencies on proper protocols for carrying, handling, and administering naloxone in overdose situations, in order to positively impact the opioid epidemic through rapid treatment of encountered suspected overdoses. Approximately 1,000 law enforcement officers have been educated through training events held throughout the state. Professionals from 153 agencies have been trained on opioid overdose recognition and treatment, and naloxone administration through May 31, 2018. ADHS is coordinating continuing requests for law enforcement training with the Arizona Peace Officer Standards and Training Board (AZ-POST).

Progress on naloxone distribution includes:

- ADHS has free naloxone kits available for law enforcement agencies and first responders who are unable to bill for naloxone. Agencies can request naloxone by completing the request form on the ADHS website.
- ADHS has provided 6,316 naloxone kits for 63 law enforcement agencies since June 2017.
- 86% of people experiencing non-fatal overdoses since June 15, 2017 when enhanced surveillance was initiated received naloxone pre-hospital.
- Law enforcement officers have administered naloxone 549 times to 405 people since June. In all but 9 cases, the individual survived the immediate out-of-hospital event.

In order to support increased use of naloxone to save lives in Arizona, ADHS Director Dr. Cara Christ signed standing orders that allow pharmacists to dispense naloxone to any individual in the state and allow ancillary law enforcement, correctional officers, and EMS to use naloxone for suspected opioid overdoses. A naloxone pamphlet was developed in both English and Spanish to assist in public education of opioid safety and naloxone use.

Goal Council 3: Opioid Breakthrough Project

With Director Cara Christ as the lead of the Governor's Goal Council 3 on Healthy People, Places and Resources, the ADHS team assisted Director Christ in launching several subgroups to recommend actions that will reduce opioid deaths. On June 26, 2017, partners from across the state convened to learn more about the opioid emergency and the work of the Goal Council on Healthy People, Places, and Resources.

Participants were asked to join one or more subgroups to help define problems, set goals, and determine what actions would be most impactful to prevent and reduce opioid deaths. Subgroups worked together in July and August of 2017 to identify recommendations and convened again on August 23, 2017 to share draft recommendations. Approximately 200 committed Arizonans volunteered their time to contribute ideas and prioritize recommendations that shaped much of the content of the recommendations in Opioid Action Plan delivered by ADHS to Governor Ducey. Over the course of the emergency declaration, ADHS has held over 50 stakeholder meetings and engaged over 1,350 Arizonans statewide.

Communication and Resources

ADHS has developed several mechanisms to allow for partner interaction and information distribution. One such mechanism is the development of a dedicated webpage, azhealth.gov/opioid. This webpage organizes resources and allows stakeholders to quickly access up-to-date opioid-related information. Within these webpages the Department has posted numerous unique resources covering various topics including FAQs, reporting-related case definitions, publicly released data, setting-specific guidance and resources, and a 50 State Review on Opioid Related Policy. A centralized email, azopioid@azdhs.gov, and digital interface within the opioid webpage allow for direct stakeholder communication for concerns and interest in partnering with the Department.

Arizona Opioid Action Plan

The public health emergency declaration directed the Arizona Department of Health Services to submit a report of the accomplished activities and identify recommendations for combating the opioid epidemic in Arizona. ADHS submitted the Opioid Action Plan to Governor Ducey on September 5, 2017. The Opioid Action Plan includes 12 major recommendations with over 50 actions slotted for completion by June 30, 2018.

Goals to address the opioid epidemic:

- Increase patient and public awareness and prevent opioid use disorder
- Improve prescribing and dispensing practices
- Reduce illicit acquisition and diversion of opioids
- Improve access to treatment
- Reduce opioid deaths

Recommendations, created through multiple meetings with partner agencies, impacted stakeholders, Goal Council 3 subgroups, and policy makers to address the above goals include:

1. Enacting legislation that impacts opioid deaths by addressing identified barriers;
2. Creating a free, statewide consultative call line resource for prescribers seeking advice about prescribing opioids and caring for patients with opioid use disorder;

3. Requiring Arizona medical education programs to incorporate evidence-based pain management and substance-use disorder treatment into their curriculum;
4. Engaging the federal government to address necessary federal-level changes;
5. Establishing a regulatory board workgroup to identify prescribing trends and enforcement issues;
6. Encouraging law enforcement agencies to expand the Angel Initiative and other existing diversion programs and assist the DEA with filling local vacancies on the Tactical Diversion Squad;
7. Increasing access to naloxone for high risk individuals released from correctional facilities;
8. Pulling together experts into task forces to address identified barriers by:
    - Identifying specific improvements to enhance the Arizona Controlled Substance Prescription Monitoring Program;
    - Identifying, utilizing, and building upon Arizona's existing peer recovery support services;
    - Providing recommendations regarding insurance parity and standardization of substance abuse treatment and chronic pain management across the state; and
    - Identifying and implementing school-based prevention curriculum, expanding after school opportunities and identifying resource needs.

Goal	Recommendations	Progress through June 2018
Reduce Opioid Deaths	Enact legislation that impacts opioid deaths by reducing illicit acquisition and diversion of opioids, promoting safe prescribing and dispensing, decreasing the risk of opioid use disorder, and improving access to treatment.	On January 26, 2018, Governor Ducey, with unanimous, bipartisan support of the Arizona Legislature, passed the Arizona Opioid Epidemic Act, or Senate Bill 1001, a comprehensive approach to addressing opioid related issues statewide. Most provisions of the bill went into effect April 26, 2018.
Improve Prescribing & Dispensing Practices	Establish a Regulatory Board work group to identify prescribing trends and discuss enforcement issues.	ADHS convened three meetings of the Regulatory Board Workgroup and developed an Action Plan for the next year. The group will continue to meet quarterly to enhance coordination and implement the action plan. See Appendix A.

Goal	Recommendations	Progress through June 2018
	Establish a taskforce to identify specific improvements that should be made to enhance the Arizona Controlled Substances Prescription Monitoring Program (CSPMP).	The Arizona Board of Pharmacy convened the taskforce and identified a set of initial improvements regarding registration of prescribers and improved outreach, technical assistance, and education. See Appendix B. New training modules are available on how to use the Arizona Controlled Substances Prescription Monitoring Program on their website. The specialty logic regarding the prescriber reports has improved, and the number of complaints has been cut in half. The Board of Pharmacy plans to add staffing resources to improve outreach and technical assistance to providers. The CSPMP will provide automatic electronic patient alerts delivered directly to a prescriber user's dashboard, and to the user's registered email) to notify the providers when prescribing practices put a patient at higher risk of overdose.
Reduce Illicit Acquisition & Diversion of Opioids	Meet with leaders of law enforcement and first responder agencies to expand Angel Initiative and other OUD diversion programs and assist the DEA with filling vacancies in the DEA Tactical Diversion Squad.	ADHS and Homeland Security leadership met with law enforcement leadership in September. Two law enforcement agencies are participating in the Angel Initiative with 150 individuals enrolled.
Improve Access to Treatment	Require all undergraduate and graduate medical education programs to incorporate evidence-based pain management and substance-use disorder treatment into their curriculum.	ADHS has worked with 100% of Arizona academic partners to develop a statewide curriculum on opioid prescribing, treatment of opioid use disorder and management of chronic pain. Find more information at www.azhealth.gov/curriculum. See Appendix C.
	Create a call-in line resource to provide consultation to prescribers seeking advice about prescribing opioids and caring for patients with opioid use disorder.	The Opioid Assistance and Referral Line, a free 24/7 call resource for prescribers, has been implemented in partnership with Arizona's Poison and Drug Information Centers. New OARLine: Opioid Assistance + Referral Line for Arizona Providers: 1-888-688-4222. See Appendix D.

Goal	Recommendations	Progress through June 2018
	Establish through executive order a work group to identify, utilize, and build upon Arizona's existing peer recovery support services.	Arizona's Medicaid agency and state substance abuse authority, AHCCCS, convened the peer support work group and is working to enhance the peer support resources in Arizona. Through federal funding, 34 additional peer support navigators have been hired in identified hot spots in Arizona, and efforts to include peer support navigation in the Centers of Excellence, jails, emergency departments and at first responder scenes in the hotspot areas have been increased. See Appendix E.
	Convene an Insurance Parity Task Force to research and provide recommendations regarding parity and standardization across the state.	The Task Force conducted a survey of current insurance coverage related to pain management and opioid use disorder treatment, and articulated a set of recommendations for the Governor. The group will be reconvened in 2019 to assess progress. See Appendix F.
	Engage the federal government outlining necessary federal changes to assist Arizona with our response to the opioid epidemic.	The Governor's office sent the letter requesting federal changes to assist Arizona's response to the opioid epidemic. See Appendix G.
	Increase access to naloxone and Vivitrol for individuals leaving state and county correctional institutions and increase access to MAT therapy for individuals with opioid use disorder while incarcerated.	ADHS is working with the Arizona Department of Corrections to implement a naloxone pilot program for formerly incarcerated individuals who are at high risk for overdose after release. ADHS has provided 1,000 doses of naloxone for Corrections to distribute to high-risk inmates being released. An overdose prevention and education video has been completed for this population--a shorter version with education on recognizing overdose and using naloxone, and a longer version with a compelling story. The videos can be found under the naloxone tab at www.azhealth.gov/opioid.
Prevent Opioid Use Disorder/ Increase	Utilize Public Service Announcements (PSAs) to educate patients, providers, and the public	The Governor's Office of Youth, Faith, and Family developed new PSAs that began airing in December and are scheduled to continue through 2018. See www.RethinkRxabuse.org.

Goal	Recommendations	Progress through June 2018
Patient Awareness	regarding opioid use and naloxone.	A new campaign authorized and funded through the Arizona Opioid Epidemic Act is scheduled to launch in the fall of 2018.
	Create a youth prevention taskforce to identify and implement evidence-based, emerging and best practice substance abuse prevention/early identification curriculum, expand after-school opportunities, and identify resource needs.	The Governor's Office of Youth, Faith, and Family convened the youth prevention task force to assess existing programs and make recommendations regarding prevention programs. A report of survey results and recommendations regarding evidence based programs was completed and submitted to the Governor. See Appendix H.

Arizona Opioid Epidemic Act

On January 26, 2018, Governor Doug Ducey signed the Arizona Opioid Epidemic Act, Senate Bill 1001, the first bill to become law in 2018, following a four-day Special Session and unanimous passage in the House and Senate. The legislation takes aggressive steps to address opioid addiction, hold bad actors accountable, expand access to treatment, and provide life-saving resources to first responders, law enforcement, and community partners. Most provisions of the act went into effect on April 26, 2018.

Specific policy initiatives in the Arizona Opioid Epidemic Act include:

- Identifying gaps in and improving access to treatment, including for uninsured or underinsured Arizonans, with a new $10 million investment;
- Expanding access to the overdose reversal drug, naloxone, for law enforcement or corrections officers currently not authorized to administer it;
- Holding bad actors accountable by ending pill mills, increasing oversight mechanisms, and enacting criminal penalties for manufacturers who defraud the public about their products;
- Enhancing continuing medical education for all professions that prescribe or dispense opioids;
- Enacting a Good Samaritan law to allow people to call 911 for a potential opioid overdose;
- Improving patient safety and cracking down on forged prescriptions by requiring e-prescribing;
- Requiring all pharmacists to check the Controlled Substances Prescription Monitoring Program prior to dispensing an opioid or benzodiazepine;

- Developing a social media youth prevention campaign;
- Requiring emergency departments and hospitals to make referrals to treatment for overdose patients;
- Reducing prior authorization timeframes for insurers and requiring insurers to make at least one form of Medication Assisted Treatment available without prior authorization;
- And, limiting the first-fill of an opioid prescription to five days for all opioid naïve patients and limiting dosage levels to align with federal prescribing guidelines. These proposals contain important exemptions to protect chronic pain suffers, cancer, trauma or burn patients, hospice or end-of-life patients, and those receiving medication assisted treatment for substance use disorder.

Other Opioid-Related Activities

Expanding Access to Treatment

Arizona is expanding access to opioid use disorder treatment and support resources through federal and state funding.

- Arizona received $24 million dollars through the SAMHSA State Targeted Response (STR) Grant to use towards Opioid Use Disorder (OUD) prevention and treatment. Through these funds, the Arizona Health Care Cost Containment System (AHCCCS) has expanded access to treatment in identified hotspots in Arizona, including five designated Centers of Excellence that are open 24 hours a day, 7 days a week to provide immediate access to opioid treatment. The centers are open in Mohave, Yavapai, Maricopa and Pima Counties. In addition, two Medication Units were opened in Pinal and Graham Counties to expand access to Medication Assisted Treatment in rural Arizona, with additional units planned to open in other rural communities by the end of 2018.
- The Arizona Opioid Epidemic Act provided $10 million in state general fund dollars for substance use disorder services for the uninsured and underinsured. AHCCCS conducted community forums to gather input to target use of the funding and identify priority needs. Funds are being used to support a continuum of treatment services, including outreach, navigation, peer and family support services and residential and outpatient treatment.

Drug Overdose Fatality Review Team

ADHS recently formed a drug overdose mortality review team, per §A.R.S. 36-198, to develop a data collection system regarding drug overdoses, conduct an annual analysis relating to drug overdose fatalities, develop standards and protocols, provide training and technical assistance to local overdose review teams, and develop investigation protocols for law enforcement and the medical community. The first meeting of the state Drug Overdose Fatality Review Team was held on November 28, 2017, and the team meets every other month. The team will conduct analysis of the incidence and causes of drug overdose fatalities and make recommendations to reduce preventable overdoses in the future.

SAMSHA First Responder Grant

The Substance Abuse and Mental Health Services Administration (SAMHSA) awarded ADHS $3.1 million in the fall of 2017 for a comprehensive First Responder opioid/naloxone program in partnership with the University of Arizona and the Arizona Police Officer Standards and Training Board. Grant funds provide approximately $785,000 per year for the next four years. Grant activities will accomplish three goals:

1. Train EMS and law enforcement staff on opioid overdose recognition and treatment
2. Provide naloxone kits to EMS and law enforcement staff who have completed that training
3. Train EMS staff how to conduct Strategic, Brief Intervention and Referral to Treatment (SBIRT) interviews and then deploy that training to the field as they interact with individuals who may have a substance use disorder. To ensure that the referral will be regionally specific, the Bureau of EMS is partnering with the Governor's Office of Youth Faith and Family, regional substance abuse treatment programs and the Arizona's Opioid Assistance and Referral Line to verify that referral handoff is effective.

CDC Prescription for State Drug Overdose Grant

In the summer of 2017, Arizona received an additional $1.2 million in supplemental grant funds from the CDC to expand activities funded through the Prescription for States Drug Overdose Grant. In January 2018, ADHS utilized these funds to begin contracting with three new county health departments (Pinal, Cochise, Coconino), bringing the total number of counties implementing local prescription drug prevention activities to nine. County Health Departments are implementing the Rx Initiative Community Toolkit, which is available online at www.rethinkrxabuse.org. ADHS also utilized these funds to aid in the development of a new communication campaign for chronic pain management, along with launching the CDC Rx Awareness campaign across the state. Supplemental funds have aided in the development of the statewide Drug Overdose Fatality Review team. ADHS has also begun the process of developing a statewide naloxone program to provide training and technical assistance to local agencies and organizations interested in becoming a naloxone distribution site.

Neonatal Abstinence Syndrome

Arizona was selected to participate in a National Governor's Association initiative providing technical assistance to states to address neonatal abstinence syndrome. State agencies and other partners are working together to develop an action plan to better address the prevention and treatment of Neonatal Abstinence Syndrome. Four priority areas have been identified: training of healthcare and other key providers on substance use and opioid use disorders, temporary transitional housing for substance using pregnant women, expansion of the use of Peer Support Specialists and the development of a media campaign to reduce stigma around substance use disorder and opioid use disorder and women in an effort to increase referrals to treatment resources. Implementation of activities will start in 2018.

Chronic Pain Management

ADHS is launching a new approach adopting chronic pain as a public health issue. In follow-up to a chronic pain summit held in May of 2017, ADHS developed a dedicated webpage, azhealth.gov/chronicpainmanagement, to increase public awareness and utilization of safe, effective approaches to managing chronic pain. With an emphasis on promoting non-pharmacological therapies that are proven to ease pain and increase function, ADHS aims to help Arizonans with chronic pain resume daily activities and maximize their quality of life. A major component of this initiative will be a new media campaign emphasizing options and self-management strategies for addressing chronic pain.

Arizona's Progress

While it is early to evaluate the outcomes associated with Arizona's response to the opioid crisis, there are some promising indicators of success.

- The percent of patients receiving referrals to behavioral health or substance abuse treatment services after an overdose has increased from 45% in June 2017 to 73% in May 2018.
- The number of naloxone prescriptions dispensed by pharmacists has more than tripled in recent months. July – September 2017, fewer than 900 naloxone kits were dispensed each month. In May 2018, 3,498 kits were dispensed to the public.
- The number of opioid prescriptions filled declined 40% between June 2017 and June 2018.
- The number of opioid pills dispensed decreased 43% between June 2017 and June 2018.
- The 4 & 4 report is a list of patients who have obtained controlled medications from 4 different doctors and 4 different pharmacies in a given month. The Arizona Board of Pharmacy sends any prescriber with a patient on the 4 & 4 list an unsolicited letter to alert the prescriber of the patient's possible doctor and pharmacy shopping. There has been a 62% decline in the number of patients on this report – from 99 in July 2017 to 38 in June 2018.

Opioid Data

ADHS is able to paint a picture of how the opioid crisis is impacting the state through two sets of data. One set is the data newly collected in the past year as part of the emergency response. This is the opioid surveillance system reporting suspected opioid overdoses, suspected opioid fatalities, suspected cases of neonatal abstinence syndrome, naloxone kits dispensed to the public by pharmacists, and naloxone administered by first responders to people experiencing a suspected overdose. This data is reported to ADHS within five business days of the event. This data is detailed in Appendix I and generally follows the timeframe of June 2017 – June 2018.

The second set of data is the official data reported through vital records (death certificates) and the hospital discharge database describing opioid deaths and hospitalizations by calendar year. While this data can be compared to the 2016 Opioid Report released in June 2017, it cannot be compared to the new opioid overdose data reported June 2017 – June 2018. This 2017 opioid death and hospitalization data is described in Appendix J.

Here are a few highlights of what we've learned from the new opioid surveillance system, June 2017 – June 2018:

- Most overdoses (59%) occur among men.
- People ages 25-34 years old had the highest percent of opioid overdoses.
- For women, deaths from overdoses were most common among 55-64 year olds.
- Chronic pain (e.g. lower back pain, joint pain, arthritis) is the most common pre-existing physical condition reported for those who had a verified opioid overdose, followed by depression and history of substance use disorder, including alcohol.
- About 40% of people who had a suspected overdose (between June 15, 2017 and June 14, 2018) had nine or more prescriptions for opioids filled between January 1, 2017 and June 12, 2018.
- Thirty-six percent (36%) of people who had a suspected opioid overdose were prescribed opioids by 10 or more providers since January 2017.
- Heroin, oxycodone, and benzodiazepines were the most commonly identified drugs involved in verified opioid overdoses.
- Heroin alone or in combination with other drugs, was reported to be involved in 29% of verified opioid overdoses.
- Reported overdoses frequently involve multiple drugs. Polydrug use was indicated in 42% of the overdose fatalities.
- The most common drug combination in fatal and non-fatal overdoses was heroin and methamphetamine, followed by the combination of oxycodone and benzodiazepines.

From the official report on 2017 opioid deaths and hospitals, here's what we know:

- The number of reported 2017 deaths directly attributed to opioids among Arizona residents or non-residents in Arizona is 949, a 20% increase from the 800 deaths reported in 2016.
- Heroin deaths were 36% of the total opioid deaths in Arizona in 2017.
- Opioid deaths among men have historically been higher than women, and are continuing to increase at a faster rate.
- Hospital data indicates that in 2017 there were 51,473 unique opioid-related encounters in Arizona hospitals, totaling an estimated $431 million in healthcare costs.

Next Steps

The Arizona Department of Health Services will continue its public health role of promoting, protecting, and improving the health and wellness of individuals and communities in Arizona. Some of our next steps in addressing the opioid crisis include:

- ADHS will be launching a chronic pain program and campaign promoting options for pain management and self-management strategies.
- The Governor's Office of Youth, Faith, and Family and ADHS is producing a new youth prevention campaign for the fall of 2018, which was authorized and funded by the Arizona Opioid Epidemic Act.
- ADHS is working with stakeholders to develop new regulations for pain management clinics. Arizona will license pain management clinics starting January 2019.
- ADHS will implement new treatment capacity reporting by September 2018.
- The new OARLine: Opioid Assistance + Referral Line for Arizona Providers: 1-888-688-4222 is available for health care clinicians to call for free consultation on patients with complex pain or opioid use disorder, as well as to provide consultations required for patients that need to exceed a dosage of 90MME. The hotline will be expanded in the future to provide information and referrals to the public.
- Arizona health professional schools will begin implementing components of the new pain and addiction curriculum. ADHS is working with licensing boards to deem students that complete the curriculum as eligible to provide buprenorphine treatment to patients.
- The Insurance Parity Taskforce will reconvene in 2019 to assess progress.
- ADHS will continue monitoring opioid surveillance data.
- State agencies will apply for new federal funding opportunities to address the opioid crisis as they become available.
- Identify and implement new strategies to address the crisis.

Conclusion

Today's opioid crisis began building more than a decade ago, and will take time to shift the trend and see fewer Arizonans tragically impacted. With significant policy changes and many other interventions just going into effect in 2018 and 2019, we expect to see more positive outcomes occurring in the next few years. The work across Arizona to prevent opioid addiction and overdoses continues with an unrelenting commitment to save lives.

For more information, visit www.azhealth.gov/opioids

Appendices

Appendix A

Regulatory Board Workgroup Action Plan

REGULATORY BOARDS WORKGROUP ACTION PLAN

Original Action Plan Recommendation: Establish a Regulatory Board work group to identify prescribing trends and discuss enforcement issues. The Regulatory Board work group consists of representatives from the each of the following entities:

- Arizona Regulatory Boards that regulate prescribers,
- Arizona State Board of Pharmacy,
- Drug Enforcement Agency,
- High Intensity Drug Trafficking Agency, and
- Attorney General's Office

Goal: Enhance coordination and connectivity between regulatory and law enforcement entities related to management of controlled substances.

Actions	Lead Agency	Timeline
1. Share and/or develop Frequently Asked Questions related to opioid laws and regulations	All	Complete by Dec. 2018
2. Coordinate work on new e-prescribing statutes (criteria for waiver, feasibility study, resources for prescribers)	Board of Pharmacy	Complete by Dec. 2018
3. Review prescribing trends to identify progress and/or areas in need of intervention: • % of times prescriber checked the CSPMP for all controlled substances they wrote for that month/quarter • % of prescribers checking the CSPMP by specialty • # and/or % of prescribers with high number of prescriptions written without checking the CSPMP • # and/or % of prescribers that prescribe very high numbers (outliers) of opioid prescriptions by specialty • # and/or % of prescribers and pharmacists that still need to register for CSPMP	Board of Pharmacy	Semi-Annually or as available
4. Share information about emerging trends in illicit activity	All	Ongoing
5. Share best practices regarding enforcement	All	Ongoing

Performance Metrics

1. By June 30, 2019, implement 100% (5 of 5) of the action items in the Regulatory Board Action Plan.
2. By end of FY19, 100% (4 of 4) of workgroup meetings will be held:
    - FY19 Q1 meeting
    - FY19 Q2 meeting
    - FY19 Q3 meeting
    - FY19 Q4 meeting

Appendix B

Arizona Controlled Substances Prescription Monitoring Program Recommendations

Controlled Substance

Prescription Monitoring Program

Task Force Committee

Summary of Initial Recommendations

11-30-2017

Mission of the Task Force:

Establish a task force of healthcare professionals, licensing boards, Board of Pharmacy, Arizona Department of Health Services, and law enforcement agencies to identify specific improvements that should be made to enhance the Arizona Controlled Substances Prescription Monitoring Program (CSPMP). Considerations should include but are not limited to:

i. Potential need for grant funding and/or technical assistance to assist health care providers to link their electronic health records to the CSPMP
ii. Additions to CSPMP to flag patients at higher risk of overdose
iii. Additions to CSPMP to flag patients who exhibit drug diverting behaviors
iv. Addition of veterinarians to reporting into and checking the CSPMP
v. Assessment of exemptions from mandate to check the CSPMP
vi. Improvement to prescriber report cards
vii. Use of CSPMP as a public health surveillance tool

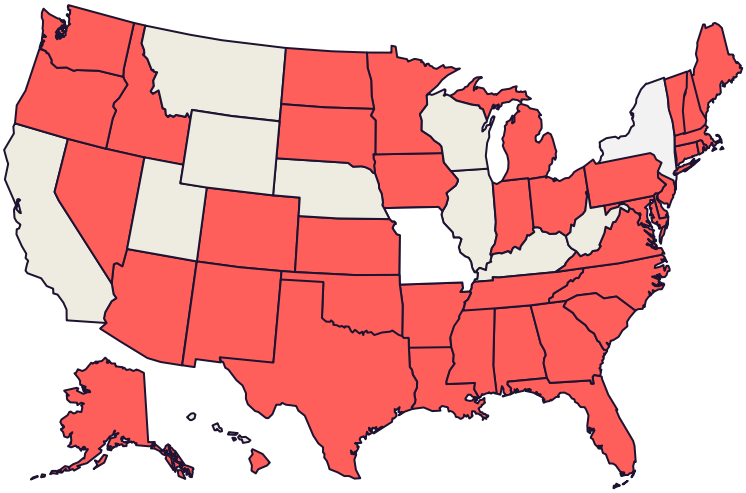
(highlighted in yellow was not discussed and will be addressed in a future meeting)

Task Force Members:

Task Force Members:	
Board of Pharmacy	Tom Van Hassel (Chair)
Medical Board	Pat Mcsorley
Osteopathic Board	Jenna Jones
AZ Medical Association	Pele Peacock
AHCCCS	Shana Malone
ADHS	Sheila Sjolander
Arizona Pain Society	Stephen Borowsky
Attorney General's office	Mary McGray
Attorney General's office	Travis Williams / Ron Davis
DEA	Julie Antilla
Arizona Pharmacist Association	Kelly Fine
Board of Pharmacy	Kam Gandhi
Board of Pharmacy	Douglas Skvarla
Hospital Associations	Jennifer Carusetta
Hospital Associations	Debbie Johnston
Arizona Pain Society leadership	Dr. Julian Grove
Arizona Society of Interventional Pain Physicians	Dr. Bill Thompson
Arizona Association of Health Plans	Deb Gullet
Arizona Osteopathic Association	Pete Wertheim

Current Database – APPRISS

- 42 prescription drug monitoring programs now use Appriss Health to operate their platforms nationwide.
- The most responsive, scalable, cost effective PDMP platform in the market
- Highly configurable to meet states' diverse needs
- Delivers information, insights, and tools to research, public health professionals, clinicians, and law enforcement



Recommendations:

1. Improve registration process (Bill needed)

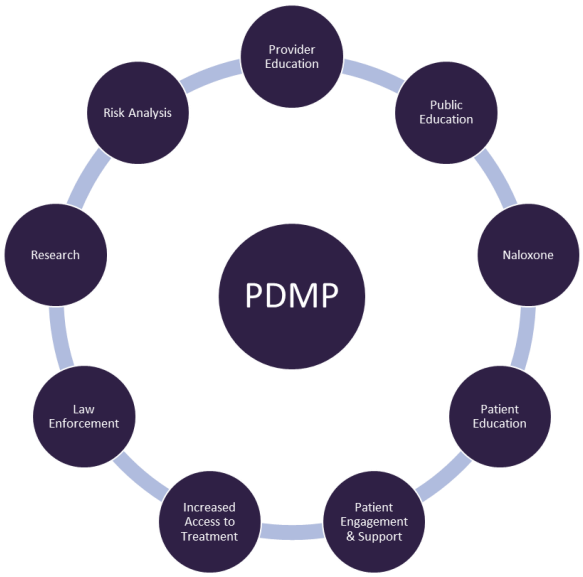
During the last legislative session, Arizona Board of Pharmacy (ASBP) modified the Controlled Substance Prescription Monitoring Program language to streamline the registration process. The ASBP further learned that interlinking with the other Health Boards could further improve registration. As the process to interlink with the Health Board was underway, it was quickly identified that though the process became somewhat easier, we could improve this process by having collected data that was uniform with what is required to register for the CSPMP. Below is a spreadsheet identifying the variability in data being collected by the Health Boards. A standard collection of data by all health board would help smoothen the registration process with the CSPMP.

		Data Collected by Health Boards							
	Board of Pharmacy	Medical Board	Dental Board	Naturopathic Board	Podiatry Board	Nursing Board	Osteopathic Board	Optometry Board	Physican Assistant
DEA #	X			X	X	X			
DEA Suffix # (Medical Residents Only)	X								
NPI #	X								
Exact Professional License #	X	X	X	X	X	X	X	X	X
License Type (MD/DO/DDS/DMD)	X	X	X	X	X	X	X		X
Email Address Belonging ONLY to Prescriber	X	X		SOME	X			X	X
First Name	X	X	X	X	X	X	X	X	X
Last Name	X	X	X	X	X	X	X	X	X
Date of Birth	X	X	X	X	X	X	X	X	X
Last 4 digits of SSN	X	X	X	X	X	X	X	X	X
Healthcare Specialty	X	X	X	X	X	X	X	X	X
Primary Contact Phone Number	X	X	X	X	X	X	X	X	X
Primary Work Location	X	X		X	X	X	X	X	X
Employer Name	X	X		X	X	X		X	X
Employer Address	X	X		X	X	X		X	X
Employer City	X	X		X	X	X		X	X
Employer State	X	X		X	X	X		X	X
Employer Zip Code	X	X		X	X	X		X	X
Employer Phone Number	X	X		X	X	X		X	X

2. **Implement CSPMP Add-on** (Funds needed approximately $500,000)
   - **CSPMP Add-on** provides **discrete SUD/PDMP data for incorporation into native EHR displays and decision support and includes:**
     i. **Use scores, risk scores, plain text alerts, and more**
   - **CSPMP Add-on** that is a **substance use disorder prevention and management platform that leverages the PDMP's status into a full suite of SUD functionality.**

- **CSPMP Add-on** that is a **care coordination platform that allows for person to person messaging, care notes, referrals – supporting the care of our highest at-risk individuals.**

Putting the PDMP at the Center of the Solution



Additional data sources

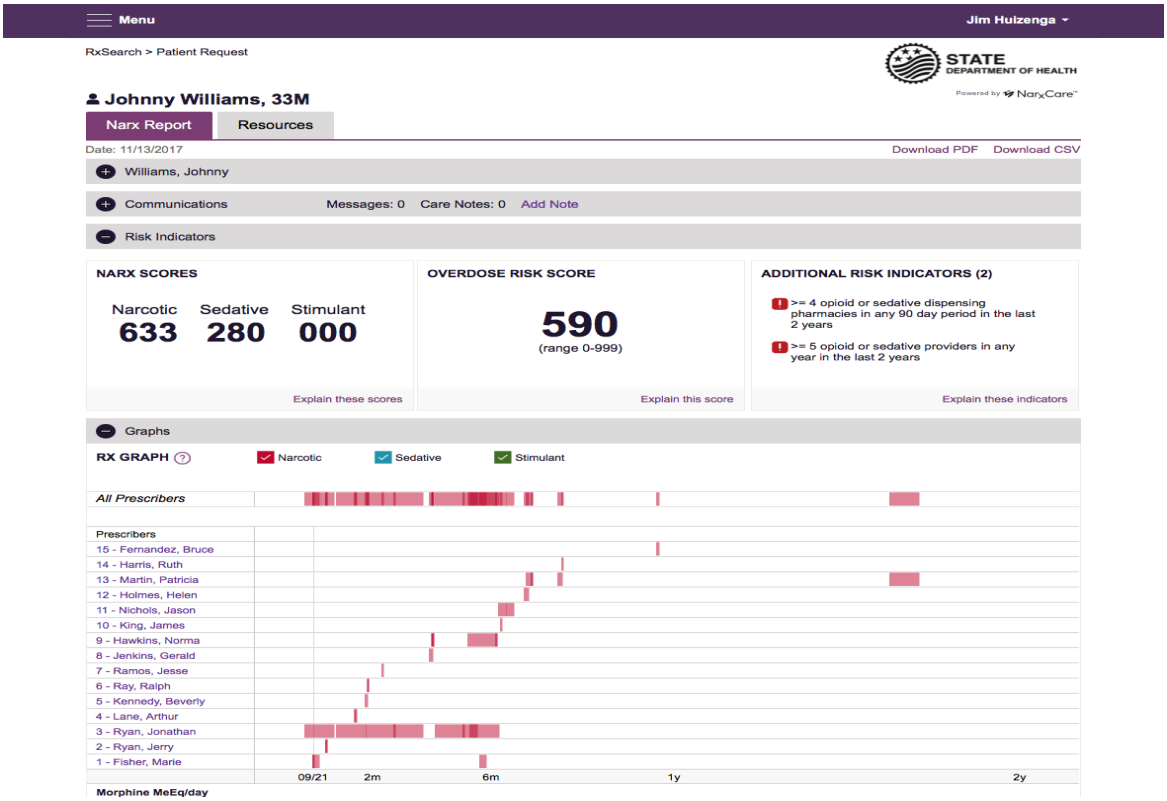
Visualizations

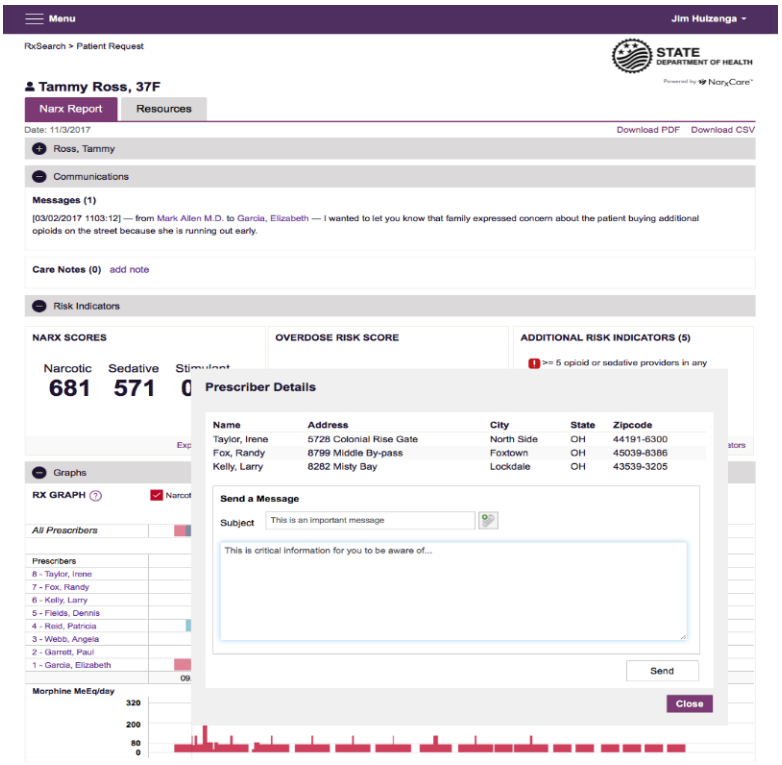
Analytics and predictive modeling

Provider and patient education and support

Care coordination

Sample of a Narxcare report:





Goal is to increase care coordination for those most at risk.

Simply click on any provider's name (or several of them), compose and send your message

3. Enhance Communication:
   Arizona State Board of Pharmacy has been tasked to implement a PDMP database that is cutting edge and the best in the country. As the Arizona State Board of Pharmacy moves in that direction, there has to be one communication/message lead by one entity. The task force feels that this entity to be the Arizona State Board of Pharmacy. The task force, has agreed that communication will be distributed to all the practitioners and dispensers via their respective Board and Association. This will result in a more improved process of sharing one message/communication. Further discussion and plan of action will be discussed at future task force meetings.

4. Enhance marketing/training:
   The Arizona State Board of Pharmacy has moved quickly to upgrade the database to be the best in the industry. As we evolved to fight the opioid epidemic, we now need to bring the users up to speed and to leverage the tools available at their fingertips to make a difference. The Arizona State Board of Pharmacy is ready to share with the database users of this state how valuable and useful this tool is and how it will play a KEY role in saving lives.

5. Enhance staff support to optimize use of the CSPMP
   Additional staff support is needed to:
   - Provide robust data analysis to evaluate trends and patterns and present findings to the public or policy makers;
   - Perform a variety of complex administrative tasks; and
   - Provide training and technical assistance on the CSPMP throughout Arizona.

Appendix C

Arizona Health Professionals Curriculum

Redefining pain + addiction

CREATION OF A STATEWIDE CURRICULUM

Public Health State of Emergency

On June 5, 2017, the Governor of Arizona declared a Public Health State of Emergency due to the Opioid Epidemic. More than two Arizonans were dying each day from an opioid overdose.

4 Meetings with Program Deans and Curriculum Representatives

January 10 | February 26 | March 29 | April 30

Educational leaders from 18 Arizona undergraduate health educational programs (and registered nurse practitioner programs) gathered and agreed that a change in education must be made. Over the course of four meetings, best practices were shared and educational theories and national trends were reviewed. The group developed and systemically reviewed curriculum drafts for relevance and scope.

Developing a Modern Approach

The following foundations were established upon which to build a modern curriculum:

- The link between pain and addiction
- The flip to a macro-to-micro perspective on pain and addiction (a socio-psycho-biological model)
- The influence of the pharmaceutical industry on clinicians
- The introspection of clinicians and systems, both in personal biases and excellence of care

100% Arizona Program Participation in Curriculum Development

The University of Arizona – College of Medicine Phoenix
The University of Arizona – College of Medicine Tucson
Mayo Clinic School of Medicine – Arizona Campus
Creighton University School of Medicine – Phoenix Regional Campus
Midwestern University – Arizona College of Osteopathic Medicine
A.T. Still University – School of Osteopathic Medicine in Arizona
A.T. Still University – School of Dentistry & Oral Health in Arizona
Midwestern University – Arizona School of Podiatric Medicine
Northern Arizona University – Post-Master's Family Nurse Practitioner
Northern Arizona University – Doctor of Nursing Practice
Grand Canyon University – College of Nursing and Health Care Professions
Arizona State University – College of Nursing and Health Innovation
Southwest College of Naturopathic Medicine and Health Sciences
University of Phoenix – College of Health Professions
A.T. Still University – Physician Assistants Program in Arizona
Northern Arizona University – Physician Assistant Program
Midwestern University – Arizona Physician Assistant Program
University of Arizona – College of Nursing

ARIZONA DEPARTMENT OF HEALTH SERVICES

THE ARIZONA PAIN AND ADDICTION CURRICULUM

VISION: To redefine pain and addiction as multidimensional, interrelated public health issues.

CORE COMPONENTS:

REDEFINE PAIN + ADDICTION

1	Define pain and addiction as multidimensional, public health problems.
2	Describe the environmental, healthcare systems and care model factors that have shaped the current opioid epidemic and approach to pain care.
3	Describe the interrelated nature of pain and opioid use disorder, including their neurobiology and the need for coordinated management.

APPLY AN EVIDENCE-BASED, WHOLE-PERSON APPROACH TO PAIN + ADDICTION

4	Use a socio-psycho-biological model to evaluate persons with pain and opioid use disorder.
5	Use a socio-psycho-biological model to develop a whole-person care plan and prevention strategies for persons with pain and/or opioid use disorder.
6	Reverse the medicalization of chronic pain by empowering persons with self-management strategies, and include an awareness of chemical coping.
7	Use and model language that destigmatizes addiction, reflects a whole-person perspective, builds a therapeutic alliance and promotes behavior change.

INTEGRATE CARE WITH A SYSTEMS PERSPECTIVE

8	Employ an integrated, team-based approach to pain and/or addiction care.
9	Engage family and social support in the care of pain and/or addiction.
10	Critically evaluate systems and seek evidence-based solutions that deliver quality care and reduce pharmaceutical influence in the treatment of pain and opioid use disorder.

NEXT STEPS

- Create a Faculty Guide, with further details, explanation and readings.
- Hold an Arizona Curriculum Summit, inviting faculty from all prescribing programs to strategize implementation.
- Collect standardized metrics from all programs (annually) and learners (after first + last years of training) for the next five years.

Appendix D

Opioid Assistance + Referral Line

Opioid Assistance & Referral

A free 24/7 hotline that assists providers with complex patients with pain and opioid use disorders, answered by medical experts at the Poison and Drug Information Centers in Arizona.

Arizona OAR Line

1-888-688-4222

ARIZONA DEPARTMENT OF HEALTH SERVICES

Center for Toxicology & Pharmacology Education & Research

The OAR Line is joint project between the Arizona Department of Health Services, the Arizona Health Care Cost Containment System and Poison and Drug Information Centers in Arizona.

Appendix E

Peer Support/Continuity of Care Recommendations

Continuity of Care/Peer Support Recommendations

Original proposal in Opioid Action Plan: Establish a work group to identify current existing peer support programs, develop a communication plan to providers about existing programs, and build upon those existing resources to establish statewide peer support programs for all payers that can facilitate linkages to substance abuse treatment through warm handoffs and street-based reach-in programs.

The workgroup would be directed to:

- Develop a resource guide of existing peer support services in Arizona
- Develop a communications plan to increase awareness and promote utilization of peer based services to health care facilities and provider
- Identify resource needs to establish statewide peer support programs to:
    - increase availability to ensure a warm hand off to a substance abuse facility
    - implement reach in programs by peers in hotspot areas to provide ancillary needs (water, blankets, etc) and navigation to medical and substance abuse treatment, and
    - Include peer supports as part of the first responder non-fatal overdose scene response
- Identify and recommend pilot projects that serve:
    - Hospitals: Implement a program based on Rhode Islands AnchorED that connects people who have been admitted to emergency rooms for an opioid-related overdose with trained peer recovery coaches as included in the ADHS Draft Hospital Discharge Planning Guidelines: Preventing Overdose from a Hospital Setting. AHCCCS and ADHS should work together to provide resources and technical assistance to expand approaches that improve connections with treatment following an opioid-related emergency department visit or hospitalization.
    - First Responders: Explore the expansion of the Treat and Refer program to include post-discharge follow-up and readiness to help individuals with SUD receive recovery treatments.
    - Work with the substance abuse coalitions to on-board peer recovery coaches.

Update on Progress through June 2018

In September 2017, AHCCCS hosted a collaborative stakeholder meeting that included peer support organizations, treatment providers, law enforcement, hospital staff, correctional health staff, the Regional Behavioral Health Authorities and representatives from SAMHSA. This meeting was focused on identifying high impact points where peer supports could be enlisted to increase the likelihood of engaging individuals with Opioid-Use Disorder (OUD) and navigating them to treatment and other resources. A heavy focus was placed on identifying barriers to implementation of peer support utilization in these systems and ways that the group could identify to find viable solutions to improve access to peer supports. The group discussed options through the Opioid State Targeted Response grant for jail "reach in" activities prior to release, hospital and emergency department discharge, community-based outreach to high risk populations and utilization of the 24/7 Centers of Excellence in Arizona for timely access to treatment.

The following month, AHCCCS launched a concentrated effort through the Opioid State Targeted response grant to increase peer support utilization for individuals with Opioid Use Disorder. Through the

STR grant, 34 additional peer support navigators have been hired in identified hot spots in Arizona, and efforts to include peer support navigation in the Centers of Excellence, jails, and emergency departments and at first responder scenes in the hotspot areas have been increased.

In February 2018, AHCCCS hosted a second collaborative stakeholder meeting that included peer support organizations, treatment providers, Arizona Department of Health Services and other involved entities throughout Arizona. This multi-sector collaboration was focused on enhancing current peer support strategies to better engage and serve those in the community and to identify desired trainings that would better equip peer support specialists. From this collaborative meeting, a sub-work group of peer support specialists, peer support managers and other subject matter experts was formed. Since the development of the sub-work group, AHCCCS now facilitates monthly meetings to determine proper action items towards the identified strategic goals:

1. Developing standards of practice for advanced peer support trainings serving OUD populations
2. Developing ways to integrate the standards of practice into policy
3. Providing equitable access to ongoing learning for peer and recovery support specialists statewide

Current developments of the workgroup

- The workgroup has identified certain specialized training that would be highly beneficial to include in peer support trainings to best serve individuals with opioid use disorder. Examples of the standards of practice and specialized training include;
    - Harm Reduction Education Relevant to OUD),
    - Medication-assisted treatment (basic knowledge around the medications and interactions with other substances),
    - Education around pregnancy and opioid use, evidence-based de-escalation techniques for peers that engage with individuals during high risk moments (Emergency Department, overdose responses in the community, those leaving correctional settings)
    - Serving rural areas/communities and
    - Continued training around motivational interviewing.

- The group will develop a training curriculum to ensure that peer supports throughout the state who serve the OUD population receive standardized and consistent training.

- The group will also create consistent recovery messaging to the peer support community to ensure that individuals with OUD receive respectful, trusting and non-judgmental information on the multiple modality options for treatment and recovery, including access to MAT.

In August, 2018 AHCCCS and ADHS will coordinate a third stakeholder meeting focused on local hospitals and emergency departments to discuss streamlining peer support utilization in these settings. In addition, ADHS will be holding quarterly meetings with emergency departments to facilitate implementation of safe discharge for individuals who overdose.

Appendix F

Opioid Insurance Parity Task Force Report

Opioid Insurance Parity Task Force Report

June 2018

ARIZONA DEPARTMENT OF HEALTH SERVICES

azhealth.gov/opioid

Contents

INSURANCE PARITY TASK FORCE: FINAL REPORT

Executive Summary

Pursuant to recommendations included in its Opioid Action Plan, the Arizona Department of Health Services (ADHS) established an Insurance Parity Task Force to identify recommendations to ensure prevention of opioid use disorder (OUD), adequate access to care for substance abuse and chronic pain management, and decreased barriers to care available across health insurance plans within Arizona.

The Task Force consisted of representatives from a variety of important stakeholders including commercial insurers, Medicaid plans, professional organizations, the International Pain Foundation and government agencies. The Task Force designed and implemented a survey intended to capture information about covered Opioid Use Disorder (OUD) treatment services and a variety of non-opioid pain management alternatives. The Task Force surveyed insurers about coverages included in individual, group, and self-funded major medical plans, Medicaid plans and University health plans across the state. The survey did not collect information about more limited/supplemental types of health insurance plans, such as specified disease, accident and sickness, short-term or hospital indemnity.

The survey results indicate broad coverage for the majority of pain management and OUD services appears to be in place across Arizona. While Medicaid and the Industrial Commission have the widest array of covered services, most insurers are covering the majority of services included in the survey. Many employ a variety of medical management mechanisms such as prior authorization to administer the benefit, but few impose hard limits on services.

Based on the results of the survey and robust discussions in its meetings, the Task Force makes the following recommendations:

1. Encourage Naloxone coverage
2. Leverage ADHS toolkit on self-management of chronic pain and insurer best practices to develop education and training partnership
3. Distribute the Arizona Pain and Addiction Curriculum and 2018 Arizona Opioid Prescribing Guidelines to inform insurer coverage criteria
4. Reconvene in 2019 to evaluate the impact of the Opioid Epidemic Act and the Opioid Action Plan on coverage of certain types of OUD and non-opioid chronic pain treatment
5. Monitor data required by the Act to assess Substance Use Disorder (SUD) treatment capacity
6. Consider future strategies to improve coverage and access

The Opioid Epidemic Act ("the Act"), which passed in spring 2018, will impact the implementation of some of these recommendations. Thus, for recommendation numbers 4, 5 and 6, the Task Force recommends reconvening after insurers and other stakeholders have had time to implement the Act's provisions. Task Force members expressed continued commitment to supporting implementation of the recommendations and remaining engaged in a collaborative effort to reduce and prevent opioid abuse and misuse, and ensure Arizonans have access to comprehensive treatment and pain management services.

Introduction and Background

The Arizona Department of Health Services (ADHS) released the 2016 Arizona Opioid Report on June 1, 2017. This report revealed, among other alarming findings, that in 2016, 790 Arizonans died from opioid overdoses – more than two people per day. This data highlighted a need for action. On June 5, 2017, Governor Doug Ducey declared a public health emergency to address the increase in opioid deaths in Arizona. This emergency declaration directed ADHS to submit a report identifying recommendations for combatting the opioid epidemic in Arizona. This report, the Opioid Action Plan, identified 12 specific recommendations that ADHS, with input from numerous stakeholders statewide, considered critical to reducing opioid-related deaths in Arizona.

One recommendation was for ADHS to convene an Insurance Parity Task Force to identify recommendations to ensure prevention of opioid use disorder (OUD), adequate access to care for substance abuse and chronic pain management, and decreased barriers to care available across *all* health insurance plans available within Arizona.

The goals of the Task Force were to examine the following issues:

1. *Increase Access to Care and Treatment*
   Stakeholders suggested exploring variability in covered services and coverage criteria as well as a lack of reimbursement for important services.
2. *Improve Pain Management*
   Stakeholders identified opportunities for improved access to non-opioid pain management and coordinated pain management care.
3. *Reduce Barriers*
   Stakeholders recommended exploring opportunities to reduce barriers to care and ensuring medical management practices are employed appropriately and with recognition of the complex needs of individuals seeking OUD treatment.

Task Force Structure

The Insurance Parity Task Force convened for its first meeting on December 12, 2017 and met on 3 additional dates: February 5, 2018, May 11, 2018, and June 11, 2018. Meetings were led by ADHS Director, Dr. Cara Christ. Task Force membership included representatives from the Governor's Office, commercial and Medicaid health plans, professional organizations, the International Pain Foundation, the Arizona Department of Health Services, the Arizona Health Care Cost Containment System, the Arizona Department of Insurance, the Industrial Commission of Arizona and the United States Department of Veterans Affairs.

Approach

The Task Force was called upon to explore strategies to increase access to care and treatment for those suffering from pain or opioid use disorder by evaluating parity across payers in Arizona by understanding:

- The services clients currently can access under various insurance plans
- The processes and procedures insurance plans use to authorize services, including an understanding of the limitations and exclusions for access
- The extent to which Substance Abuse and Mental Health Services (SAMHSA) recommendations and other evidence-based practices for pain management and opioid use disorder treatment are covered by various insurance plans

In order to ascertain this information, the Task Force developed a survey to collect usable data for the purpose of assessing comparability in benefits across the different individual, group, and self-funded major medical health insurance plans administered in Arizona, which was reviewed by the Arizona Department of Insurance prior to finalization. The survey included both yes/no and open-ended questions. The survey was administered through Survey Monkey. On February 23, 2018, Dr. Christ sent the original survey invitation to Task Force members and other key insurance points of contact within Arizona and asked for it to be distributed throughout their networks. The survey did not collect information about more limited/supplemental types of health insurance plans, such as specified disease, accident and sickness, short-term or hospital indemnity. Respondents had one month to complete the survey. Of note, survey responses were due prior to implementation of the Arizona Opioid Epidemic Act ("the Act"). Some responses are expected to differ following full implementation of the Act.

Findings

The Arizona Health Care Cost Containment System (Arizona's Medicaid agency), the Arizona Industrial Commission (Worker's Compensation), commercial insurers, Medicare plans and a university health plan responded to the survey. Below is a summary of Medicaid and Worker's Compensation coverage in Arizona, along with the percentage of survey respondents indicating the services were included in their offered coverage. More complete details regarding coverage are available in Appendices B, C, and D. Between all three categories of insurance, broad coverage for the majority of pain management and OUD services appears to be in place across Arizona.

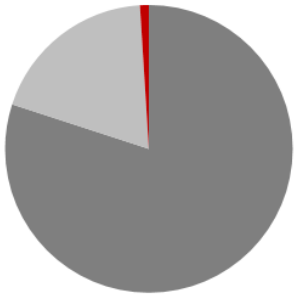
Table 1: Summary of coverage for OUD and pain management services in Arizona

Service Category	Medicaid	Worker's Compensation	Survey Respondents
Inpatient Services	Yes	Yes	98%
Partial Hospitalization	Yes	Yes	81%
Intensive Outpatient Services	Yes	Yes	98%
Residential Treatment	Yes	Yes	88%
Counseling/Behavioral Therapy	Yes	Yes	84%
Case Management	Yes	Yes	79%
Other Recovery Supports	Yes	Yes	50%
Medication Assisted Treatment	Yes	Yes	89%
Naltrexone (tablets)	Yes	Yes	92%
Naltrexone (injectable)	Yes	Yes	90%
Methadone	Yes	Yes	88%
Buprenorphine	Yes	Yes	92%
Urine/Blood Screening	Yes	Yes	89%
Screening, brief intervention, & referral to treatment (SBIRT)	No	Yes	N/A
Other Substance Use Screening Tools	Yes	No	N/A
Non-opioid Pain medications	Yes	Yes	91%
Acetaminophen	Yes	Yes	28%
NSAIDs	Yes	Yes	100%
Corticosteroids	Yes	Yes	100%
Anticonvulsants	Yes	Yes	100%
Disease modifying anti-rheumatic drugs (DMARDs)	Yes	No	100%
Tricyclic antidepressants, SSRIs, SNRIs	Yes	Yes	100%
Topical agents	Yes	Yes	100%
Psychological therapy (cognitive behavioral therapy)	Yes	Yes	84%
Physical therapy (PT) or Movement Therapies	Yes		98%
Exercise therapy	No	Yes	N/A
Interventional Procedures (spinal cord stimulation, joint injections, steroid injections)	Yes	Yes	96%
Interdisciplinary care	Yes	Yes	11%
Other non-opioid pain management options	Yes	Yes	96%
Acupuncture	No	Yes	N/A
Massage	No	Yes	N/A
Self-management programs	Yes	No	N/A
Biofeedback	Yes	Yes	N/A
Chiropractic services	Yes	Yes	N/A
Osteopathic manipulation	Yes	Yes	N/A
Durable Medical Equipment	Yes	Yes	N/A
Naloxone	Yes	Yes	84%

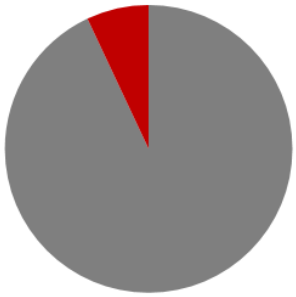
Following is a summary of data collected through the survey, which does not include Medicaid and Industrial Commission data. Comprehensive survey data is available in Appendix 2. A total of 71 respondents answered the initial set of survey questions, although approximately 55 respondents completed the survey in its entirety. The responses to open-ended questions varied. Not all respondents answered the open-ended questions, and the responses indicated that not every survey respondent had the same understanding of the survey purpose. For example, some of the narrative responses about limits and exclusions spoke to prior authorization or other medical management mechanisms that were addressed in other questions, or framed prior authorization for medical necessity as a limit. Others provided generic answers or referred back to their own internal documents. Therefore, while these responses are very useful in helping to understand the availability of coverage, the numbers reported should be viewed as illustrative rather than true quantitative metrics.

Survey data were stratified based on geographical coverage (urban – any plans that include coverage of Maricopa and/or Pima Counties; and rural – any plans that exclude coverage in Maricopa and/or Pima Counties), plan type (commercial/self-insured, Medicare, and university student), and group type for the commercial/self-insured plans (individual, large, or small).

Most respondents represented Commercial or Self Insurers.
A smaller number represented Medicare or University plans.



Most plans covered urban areas.
Fewer than 10% of plans covered only rural areas.
Every AZ County was covered by at least 5 responses.



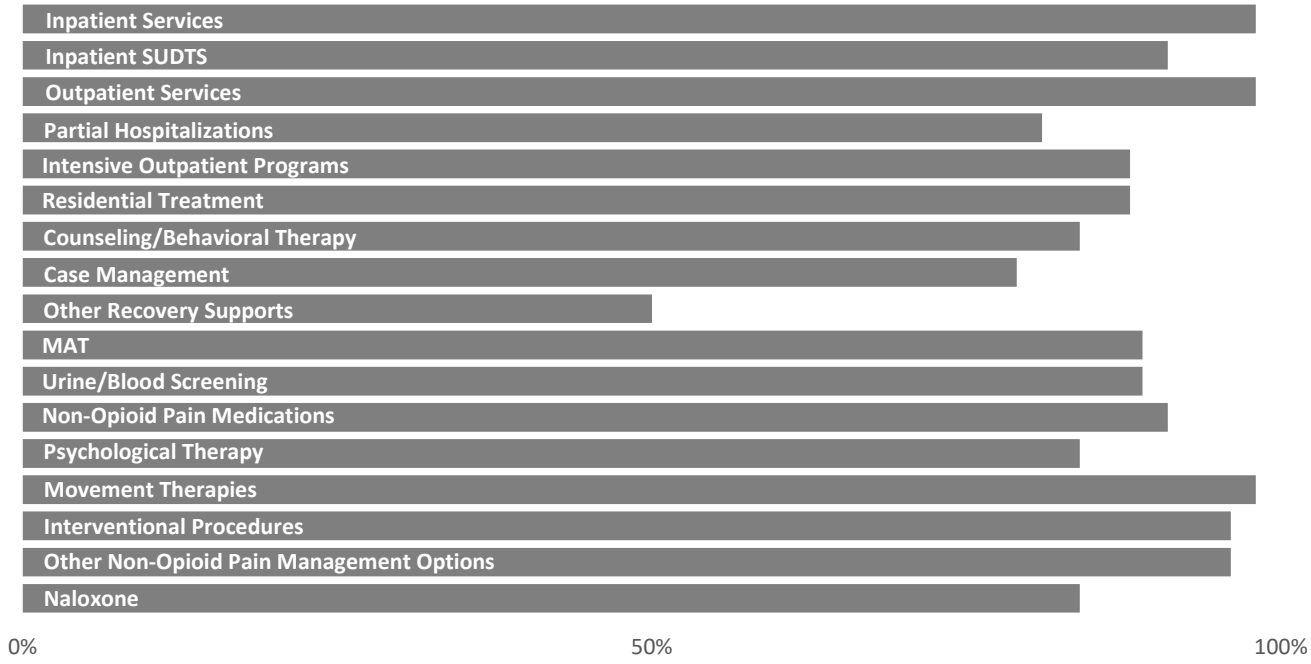
Respondents reported an average of 330,759 covered lives (median- 14,659 covered lives)

Covered Services

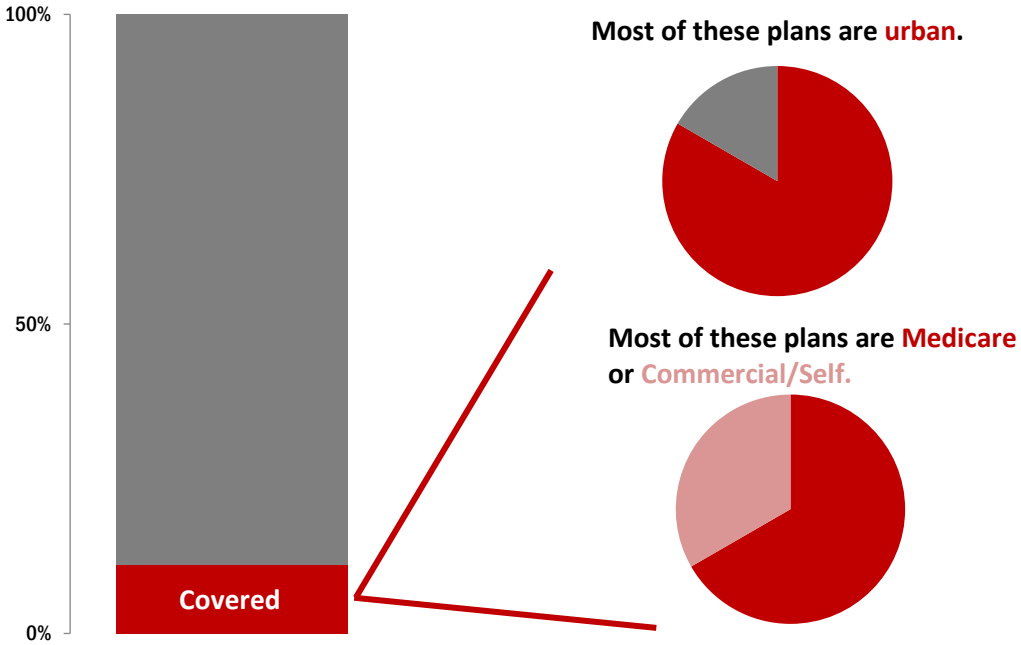
Respondents were asked about their coverage of various services related to treatment of chronic pain and opioid use disorder. As indicated below, coverage for these services was widely available for the majority of plans with the exception of other recovery supports like peer support, which were only covered by 50% of respondents, and interdisciplinary care, which only 11% of respondents indicated was separately covered. No notable differences in geographical coverage, plan type, or group type were identified in covered services for those services widely covered.

Specific questions were asked to clarify how respondents were defining or covering certain categories. For example, the 79% of respondents who covered case management indicated that this service is available to help members manage their own health conditions and provide support for members with complex healthcare needs. Nearly all respondents cover movement therapies, with therapies like occupational therapy, physical therapy, and speech therapy most frequently noted.

Most plans cover opioid-related services.



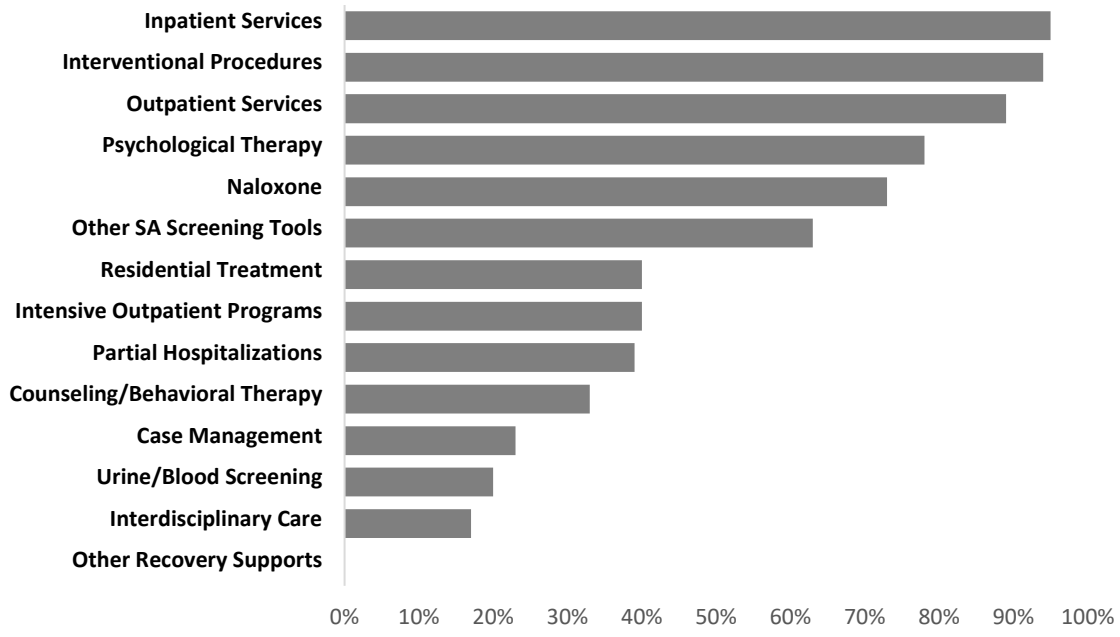
However, only 11% of plans cover interdisciplinary care.



Limitations and Exclusions

Despite covering the majority of services identified for treatment of pain management and opioid use disorder, limitations and exclusions applied to varying degrees for most of these services. No notable differences were identified in geographical coverage, plan type or group type related to whether limitations or exclusions from coverage existed for a covered service.

Most plans have some limitations or exclusions for covered services.



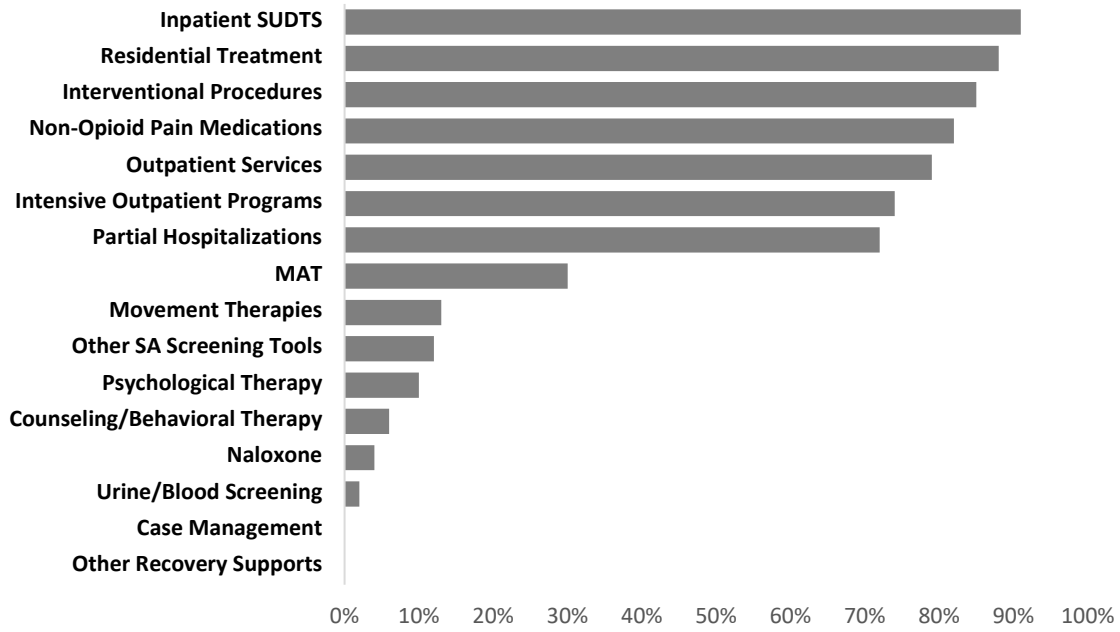
There were very few hard limits or exclusions reported for most services. It is important to note that many of the respondents indicated "medical necessity" as a limit applied to coverage. For the purposes of this report, those medical necessity responses have been excluded from the open-ended questions' narrative responses, as it is presumed insurers only cover medically necessary services. However, those responses are still captured in the quantitative summaries reported above. Some respondents provided meaningful narrative responses regarding limitations or exclusions in coverage. Examples include the following:

- A quarter of respondents who indicated limitations in covered expenses for residential treatment are stated that these services are limited to a maximum of 50% of the cost of a semi-private room and that the insured must have first been in a hospital or skilled nursing home and moved to residential treatment within 30 days of discharge
- A majority of those who maintain limitations on methadone coverage (66%) indicated that outpatient methadone coverage requires confirmation of use as medication-assisted treatment (MAT) versus pain management
- Respondents indicated that urine/blood screenings are often covered with certain frequency limitations. This includes day and annual limits on both presumptive and definitive encounters, most commonly up to 8 presumptive and 8 definitive tests per year, with a few reporting higher limits.

Prior Authorization Requirements

Most respondents require prior authorizations (PA) for one or more covered services, although the frequency of this requirement varies for each covered service. Higher-cost/higher-intensity services were more likely to have PA requirements. No notable differences were identified in geographical coverage, plan type, or group type related to whether PA was required for a covered service.

Most plans require prior authorizations for some covered services.



Some respondents provided additional information regarding prior authorization requirements. Examples include the following:

- Over half of the 85% of respondents requiring PA for interventional procedures indicated that this is most commonly required for dorsal column stimulation, joint injections, facet injections, epidural steroid, spinal denervation, and regional sympathetic blocks.
- Over half of the 79% of respondents requiring PA for outpatient services indicated that this is most commonly required for outpatient detoxification, applied behavioral analysis, psychological and neuropsychological testing, and transcranial magnetic stimulation.

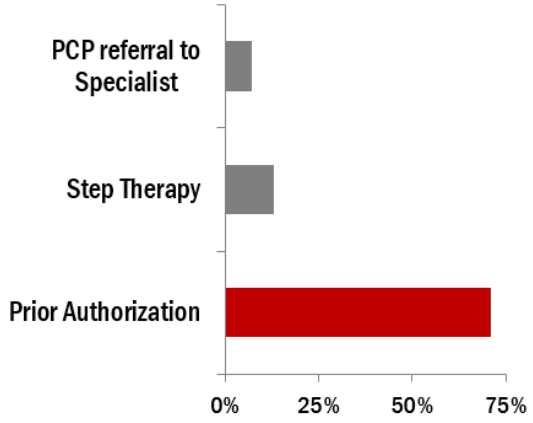
Most respondents indicated that their plans do not require step therapy prior to authorizing a covered service. When asked about limits on the duration of PA, most of those responding indicated limits equivalent to similar medical services without providing specific examples, although over half of respondents limit the duration of PA for interventional procedures to 6 months or subject to clinical review.

Medication Management Mechanisms

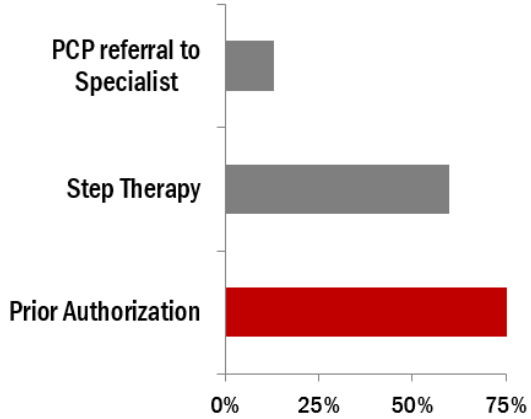
Respondents were also asked about specific medication management mechanisms related to opioid use disorder and pain management. Nearly 75% of respondents require prior authorizations as a medical management mechanism, which is a notably higher proportion than those requiring step therapy or primary care physician referral to a specialist. No notable differences were identified in geographical coverage, plan type, or group type related to medical management mechanisms for either OUD or pain management.

Related to OUD, prior authorizations apply primarily to detoxification, inpatient and residential treatments, partial hospitalization, and intensive outpatient programs. Related to pain management, prior authorizations are not typically required for generic drugs, but primarily apply for things like joint injections, facet injections, epidural steroids, spinal denervation, and regional sympathetic blocks.

Prior authorizations are the most common medical management mechanism related to OUD.



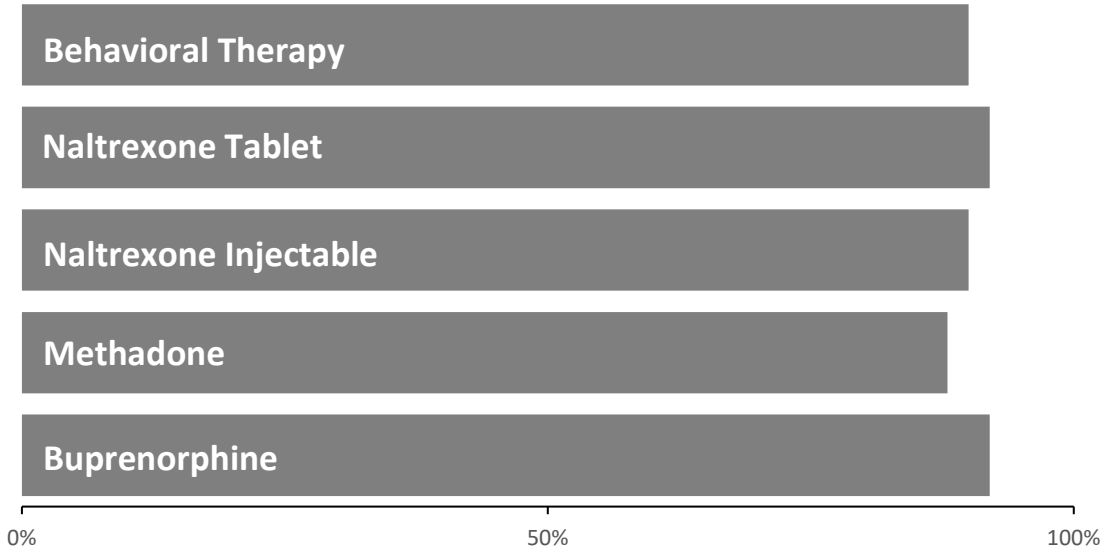
Prior authorizations are the most common medical management mechanism related to pain management.



Medication-Assisted Treatment

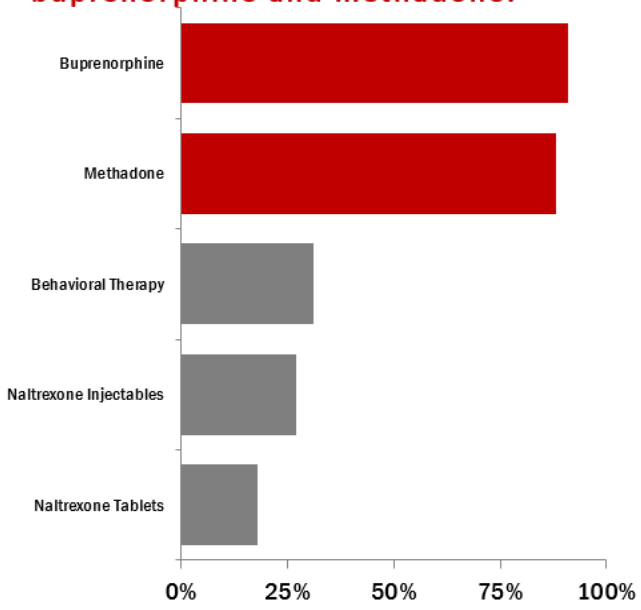
Medication-assisted treatment (MAT) is an important intervention related to OUD and one that is widely covered by respondents. No notable differences were identified in geographical coverage, plan type or group type related to MAT coverage.

Of the 89% of plans that cover MAT, most cover multiple forms.



Most MAT services (70%) are available without prior authorization, with the exception of buprenorphine and methadone, which frequently require PA. Of those who responded about whether any MAT service was available without PA, 93% indicate at least one MAT service available without PA. Fail first (step therapy) requirements are rarely in place for MAT. The vast majority (90%) of plans cover behavioral therapy as part of MAT, which Task Force members note is an integral component of treatment.

While 70% of services covered in the MAT category are available without prior authorization, PA requirements vary by MAT type, with most plans requiring PA for buprenorphine and methadone.

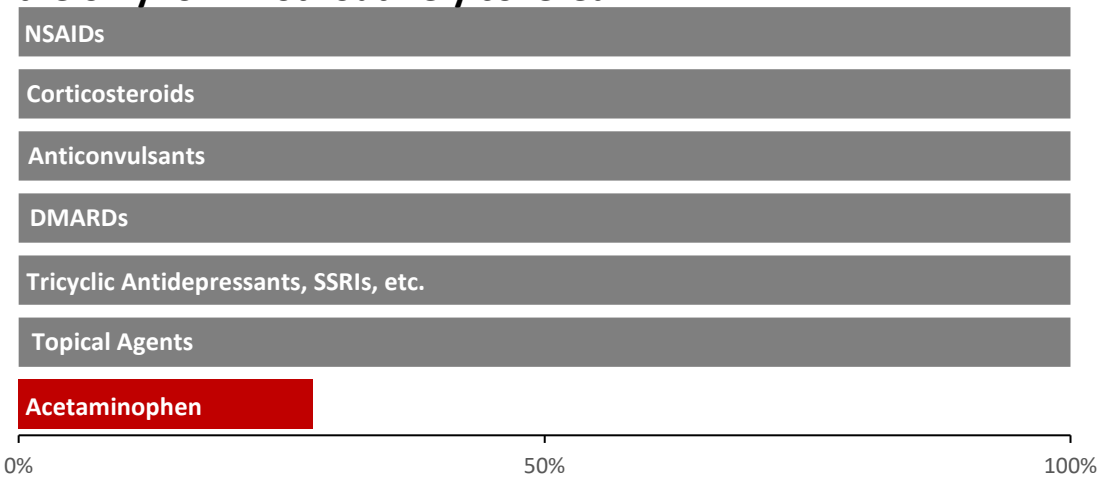


89% of respondents indicated that there are services in the MAT category available without prior authorization.

Non-Opioid Pain Medications

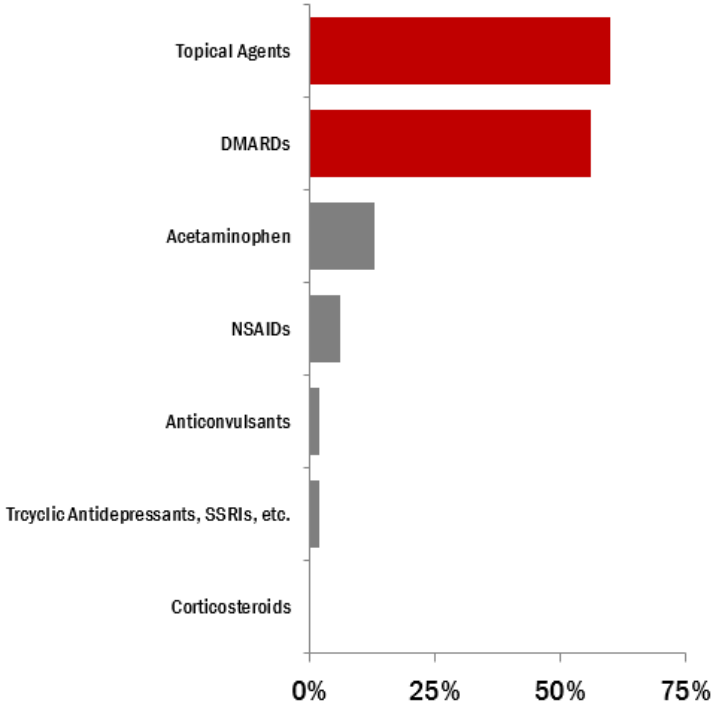
Respondents, regardless of geographical coverage, plan type, or group type, indicated near universal coverage of all types of non-opioid pain medications with the exception of acetaminophen.

Of the 91% of plans that cover non-opioid pain medications, acetaminophen is the only form not routinely covered.



While most respondents (82%) covering non-opioid pain management medications require PA, these requirements are most commonly in place for topical agents and disease-modifying anti-rheumatic drugs (DMARDs). Most generic medications do not require PA. According to many respondents, specialty drugs typically have 6-month limits, but are eligible to be renewed. Step therapy is frequently required for DMARDs.

While 82% of services covered in the non-opioid pain medication category require prior authorization, PA requirements vary by type of medication, with most plans requiring PA for topical agents and DMARDs.



Topical Agents:
- 19% of respondents request verification of step therapy prior to authorizing
- 100% of respondents apply limitations and exclusions

DMARDs:
- 100% of respondents request verification of step therapy prior to authorizing
- 89% of respondents apply limitations and exclusions

Naloxone

Naloxone is a medication that can successfully reverse the effects of an opioid overdose if administered in a timely manner. Most respondents (84%) indicate coverage of naloxone, with no notable differences by geographical coverage, plan type, or group type. Only 4% of respondents indicate PA requirements for naloxone. Standing orders exist in Arizona to allow pharmacists to dispense naloxone to any member of the public requesting it. Most respondents (82%) cover naloxone dispensed by a pharmacy through a standing order.

Recommendations

The Task Force was charged with identifying recommendations to ensure prevention of opioid use disorder, adequate access to care for opioid use disorder and chronic pain management, and decreased barriers to care are available across all Arizona health insurance plans. The Task Force evaluated the survey results to formulate recommendations that reflected the current status of opioid use disorder prevention, access to care, and barriers to care. The survey results indicate that insurers are generally providing comprehensive coverage of OUD treatment, but that additional data would help inform best practices. Based on these results, and the robust discussion within the Task Force meetings, the Task Force makes the following recommendations:

1. **Encourage Naloxone coverage**
   Health care insurers in Arizona should provide coverage of at least one form of naloxone without prior authorization. This coverage should include acceptance of any standing orders issued by state or local health officials. The Task Force recognizes naloxone is a critical tool in preventing opioid-related deaths and supports Arizona's goals to increase access to naloxone.

2. **Leverage ADHS toolkit on self-management of chronic pain and insurer best practices to develop education and training partnership.**
   This partnership could include a workgroup to develop content for insurer provider networks and members on non-opioid pain management techniques and distribution of the ADHS chronic pain toolkit, as well as a partnership on Continuing Medical Education that could be accessed by providers. In addition, insurers can collaboratively share best practices to inform future education and training efforts.

3. **Distribute the Arizona Pain and Addiction Curriculum and 2018 Arizona Opioid Prescribing Guidelines to inform insurer coverage criteria.**
   ADHS and partners have developed academic curriculum for prescribers as well as opioid prescribing guidelines. The Department of Insurance and AHCCCS will distribute this information so insurers can leverage this curriculum and guidelines to evaluate their coverage criteria and identify opportunities to align coverage with recommended prescribing practices.

4. **Reconvene in 2019 to evaluate the impact of the Opioid Epidemic Act and the Opioid Action Plan on coverage of certain types of OUD and non-opioid chronic pain treatment.**
   The Act established numerous provisions designed to prevent opioid use disorder and expand access to treatment. The legislation established requirements that may impact insurance coverage and plan design as insurers implement the provisions, including:
   - Limiting first-fill of opioid prescriptions to five days and 90 morphine milligram equivalents (MME) for opioid naïve patients, and limiting dosage levels to federal prescribing guidelines.
   - Establishing prior authorization timelines and requirements for the diagnosis, management or treatment of acute pain, chronic pain or opioid use disorder, including medications, devices and durable medical equipment. Requirements include:
     - Posting information about PA requirements on websites or provider portals and accepting PA requests electronically.
     - Responding to PA requests for urgent services within 5 days, and non-urgent services within 14 days.
     - Honoring PA approval for at least 6 months or through the last day of the enrollee's coverage, whichever is earlier.

- Requiring insurers to offer at least one modality of MAT to be available without prior authorization.
- Limiting the types of providers who can dispense opioids.

The Task Force recognizes that a further exploration of insurance coverage will be affected by the implementation of the changes required by the Act. In addition, numerous additional strategies designed to prevent OUD and increase access to certain types of treatment (e.g., naloxone) have been implemented as part of the ADHS Opioid Action Plan. Because it may take several months to fully implement and begin to see results of these changes, the Task Force recommends reconvening in early 2019 for discussion about additional data members may want to collect.

At a minimum, when it reconvenes, the Task Force recommends conducting a more comprehensive evaluation of the following areas:

a. **Medication Assisted Treatment**
   Task Force members expressed interest in collecting additional data regarding limits, exclusions and medical management mechanisms employed for coverage of MAT. In addition, members recommend gathering information about insurer formularies and cost-sharing structures to evaluate whether those structures impact how patients access MAT.

b. **Pharmacy-applied limits**
   Task Force members reported anecdotally that, in response to the opioid epidemic, pharmacies were setting internal limits on opioid quantities and MME limits. The Task Force expressed a desire to learn more about the application of these limits and how they intersect with both state law and insurer-applied limits.

c. **Non-opioid pain management alternatives**
   As insurers implement additional restrictions on opioid quantities, and expand access to treatment, Task Force members expressed interest regarding how insurers were pairing these new limits with increased access to evidence-based non-opioid pain management alternatives. Task Force members felt that access to these alternatives is critical and that insurers should comprehensively evaluate their coverage in light of changes they may be making to opioid access. Insurers should also evaluate whether prescribers are responding to the availability of information and training on non-opioid pain management alternatives by tracking prescribing practices for these alternatives.

d. **Screening, Brief Intervention and Referral to Treatment (SBIRT)**
   SAMHSA defines SBIRT as an evidence-based "approach to the delivery of early intervention and treatment to people with substance use disorders and those at risk of developing these disorders." The responses to the survey question regarding SBIRT coverage were vague and did not provide perspective on whether insurers were covering that distinct service. Task Force members recommended educating insurers on the value of SBIRT and gathering better information about its coverage.

e. **Naloxone access**
Both the Act and the Opioid Action plan include strategies to increase access to naloxone, including the issuance of a standing order by the Director of ADHS. While most survey respondents indicated coverage of naloxone, the Task Force recommends a reevaluation of this coverage to determine whether these strategies have helped to strengthen naloxone coverage or if additional education/action may be needed.

f. **Evidence-Based decision-making and Criteria**
The Task Force discussed gathering information about the types of criteria insurers use to determine their coverage criteria and authorization practices, as well as sharing evidence-based information that could inform insurer decision-making.

5. **Monitor data required by the Act to assess Substance Use Disorder (SUD) treatment capacity**
The Act also adds requirements for licensed health care facilities who provide SUD treatment to report data to ADHS including the number of available beds and the number of days the facility is at capacity and unable to accept referrals for treatment. This reporting will provide additional insight into the availability of SUD treatment (including OUD) beyond what is captured through the Task Force survey. It may also help inform what additional data the Task Force may want to gather regarding access to treatment such as provider network capacity.

6. **Consider future strategies to improve coverage and access**
After the Act is fully implemented and treatment capacity is evaluated, if certain barriers or gaps in access remain, Task Force members recommend consideration of strategies to increase access to comprehensive OUD treatment modalities as well as non-opioid pain management alternatives. Depending on the magnitude of the gaps, strategies could include recommendations to policymakers to require certain types of coverage, more provider network transparency or developing a best-practice summary for insurers and employers to reference when designing their benefits. Task Force members did not reach consensus on these strategies but agreed that their recommendations would depend upon the results of the implementation of the requirements of the Act and a re-evaluation of the coverage after that implementation.

Appendix A – Opioid Insurance Parity Task Force Work Group Roster

Name	Organization
Steve Barclay	**Barclay Legal, representing the Arizona Medical Association**
Charles Bassett	**Blue Cross Blue Shield**
Thomas Betlach	**Arizona Health Care Cost Containment System**
Mary Boatright	**Arizona Department of Insurance**
Cara Christ	**Arizona Department of Health Services**
Christina Corieri	**Office of the Governor**
Monica Coury	**Arizona Complete Health**
Laura Dearing	**Arizona Academy of Family Physicians**
Dan Derksen	**University of Arizona Center for Rural Health**
Monica Faria	**American Society of Addiction Medicine – Arizona Chapter**
Deb Gullett	**Arizona Association of Health Plans**
Barby Ingle	**International Pain Foundation**
Marie Isaacson	**Arizona Department of Administration**
Emily Jenkins	**Arizona Council of Human Service Providers**
Erin Klug	**Arizona Department of Insurance**
Beth Kohler	**Beth Kohler Consulting**
Jacqueline Kurth	**Industrial Commission of Arizona**
Aram Mardian	**Phoenix Veteran's Affairs (VA) Health Care System**
Sunshine Moore	**America's Health Insurance Plans (AHIP)**
Marcus Osborn	**Kutak Rock, representing AHIP**
Pele Peacock Fischer	**Arizona Medical Association**
Jessica Rigler	**Arizona Department of Health Services**
Paul Shannon	**Arizona Department of Administration**
Jami Snyder	**Arizona Health Care Cost Containment System**
Anne Stafford	**American Academy of Pediatrics – Arizona Chapter**
Ken Taylor	**International Pain Foundation**
William Thompson	**Arizona Society of Interventional Pain Physicians**

Appendix B – Survey Findings

Opioid Insurance Parity Survey Summary
Medicaid Plans Excluded

CONTENTS

The following tables summarize responses to a survey administered by the Arizona Department of Health Services on behalf of the Opioid Insurance Parity Task Force. Insurance plans across Arizona were surveyed. Responses are presented for all insurance plan types excluding Medicaid plans.

Data in the survey are stratified based on the following categories:

- Geographical Coverage
  - Urban – any plans that include Maricopa and/or Pima Counties within their coverage region
  - Rural – any plans that exclude Maricopa and/or Pima Counties from their coverage region
- Plan Type
  - Commercial/Self Insured
  - Medicare
  - University Student
- Group Type – only presented for Commercial/Self Insured Plans
  - Individual
  - Large
  - Small

RESPONDENT OVERVIEW

1. Payer Type: N=71

	Total	Urban	Rural
Commercial Insurer/Self Insured	57 (80%)	52 (98%)	1 (2%)
Medicare Advantage/Medicare Part D	13 (19%)	4 (57%)	3 (43%)
University Student Health	1 (1%)	0	1 (100%)

2. Commercial Insurer/Self Insured Products with Survey Responses: N=53

Fully Insured: HMO Individual (ACA) On/Off	**3 (6%)**
Fully insured: HMO Individual Grandfathered	1 (2%)
Fully insured: HMO Individual Transitional	1 (2%)
Fully Insured: HMO Small Group (ACA)	4 (4%)
Fully insured: HMO Small Group Grandfathered	1 (2%)
Fully insured: HMO Small Group Transitional	1 (2%)
Fully Insured: PPO Individual (ACA)	6 (11%)
Fully insured: PPO Individual Grandfathered	6 (11%)
Fully insured: PPO Individual Transitional	4 (8%)
Fully Insured: PPO Large Group	5 (9%)
Fully Insured: PPO Small Group (ACA)	4 (8%)
Fully insured: PPO Small Group Grandfathered	3 (6%)
Fully insured: Small Group Transitional	2 (4%)
Fully Insured: HMO Large Group	4 (8%)
Self-Funded/ASO: HMO Small Group	2 (4%)
Self-Funded/ASO: HMO Large Group	2 (4%)
Self-Funded/ASO: PPO Small Group	1 (2%)
Self-Funded/ASO: PPO Large Group	5 (9%)

3. Counties Served by Respondents: N=71

Apache	**5 (9%)**
Cochise	6 (11%)
Coconino	4 (7%)
Gila	4 (7%)
Graham	6 (11%)
Greenlee	5 (9%)
La Paz	5 (9%)
Maricopa	14 (25%)
Mohave	5 (9%)
Navajo	11 (19%)
Pima	6 (9%)
Pinal	7 (9%)
Santa Cruz	6 (11%)
Yavapai	6 (11%)
Yuma	5 (9%)
All Counties	37 (65%)

4. Average number of product cover lives: N=54

330,759 (min 0, max=8,441,242, median = 14,659)

5. Average total insured population: N=57

83,705 (min 0, max=902,496, median = 11,460)

INPATIENT SERVICES

6. Does this plan cover inpatient services: N=58

Yes	**57 (98%)**
No	1 (2%)

No= Urban; Commercial/Self; Large Group Plan

7. Are there limitations/exclusions to the covered inpatient services: N=56

Yes	**53 (95%)**
No	3 (5%)

No= Some Urban; Commercial/Self, Large (n=1) & Small (n=2) Group Plans

INPATIENT SUBSTANCE USE DISORDER TREATMENT SERVICES

8. Does the plan cover inpatient Substance Use Disorder Treatment Services (SUDTS): N=56

Yes	**51 (91%)**
No	5 (9%)

No= Some Urban; Commercial/Self; Large Group Plans

9. Please describe limitations/exclusions to the covered inpatient SUDTS:

- Only 1 respondent spoke to a hard limit on coverage: 90 days per year, 2 Treatments per year.
- 24 respondents specifically indicated inpatient detoxification and rehabilitation were covered.
- 1 specifically indicated behavioral therapy, substance abuse and psychiatric services were covered.
- 6 respondents provided a list of services which may have either been a list of services covered under the plan or a list of exclusions (it was unclear from response). These services include: acute inpatient detoxification and inpatient rehabilitation (2) and Behavioral health, RTC, IP/OP scheduled admit, detox and possible LTAC, SNF, EAR (4)

10. Does the covered service require prior authorization: N=56

Yes	**51 (91%)**
No	5 (9%)

	Yes (%)	No (%)
Urban	47 (92%)	4 (8%)
Rural	4 (80%)	1 (20%)

	Yes (%)	No (%)
Commercial/Self	44 (92%)	4 (8%)
Medicare	6 (86%)	1 (14%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	16 (80%)	4 (20%)
Large	12 (100%)	0
Small	16 (100%)	0

11. Please provide any limits on the duration of the PA.:

- 4 respondents indicated the PA would be limited at the initial precert request at intake to 7 days. The authorization can be extended at concurrent review.
- 26 respondents indicated limits equivalent to similar medical services but did not provide specific examples.

12. Prior to authorizing, must the patient/provider verify that other treatments have not or will not be effective? (i.e., step-therapy) N=51

Yes	**9 (18%)**
No	42 (82%)

	Yes (%)	No (%)
Urban	9 (19%)	38 (81%)
Rural	0	4 (100%)

	Yes (%)	No (%)
Commercial/Self	6 (14%)	38 (86%)
Medicare	3 (50%)	3 (50%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	3 (19%)	13 (81%)
Large	3 (25%)	9 (75%)
Small	0	16 (100%)

OUTPATIENT SERVICES

13. Does this plan cover outpatient services: N=57

Yes	**56 (98%)**
No	1 (2%)

No= Urban; Commercial/Self; Large Group Plan

14. Are there limitations/exclusions to the covered outpatient services: N=56

Yes	**50 (89%)**
No	6 (11%)

	Yes (%)	No (%)
Urban	45 (88%)	6 (12%)
Rural	5 (100%)	0

	Yes (%)	No (%)
Commercial/Self	43 (90%)	5 (10%)
Medicare	6 (86%)	1 (14%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	20 (100%)	0
Large	9 (75%)	3 (25%)
Small	14 (88%)	2 (12%)

15. Please describe limitations/exclusions to the covered outpatient services:

- There were no specific responses regarding limits or exclusions. 24 respondents indicated limits equivalent to similar medical services but did not provide specific examples.

16. Does the covered service require prior authorization: N=56

Yes	**44 (79%)**
No	12 (21%)

	Yes (%)	No (%)
Urban	40 (78%)	11 (22%)
Rural	4 (80%)	1 (20%)

	Yes (%)	No (%)
Commercial/Self	37 (77%)	11 (23%)
Medicare	6 (86%)	1 (14%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	17 (85%)	3 (15%)
Large	8 (67%)	4 (33%)
Small	12 (75%)	4 (25%)

17. Are there any services in this category available without prior authorization: N = 44

Yes	**43 (98%)**
No	1 (2%)

No= Rural; Medicare Plan

18. Please describe services in this category available without prior authorization:

- 24 respondents indicated most services are available without PA except: outpatient detoxification, Applied Behavioral Analysis, psych and neuro psych testing and Transcranial Magnetic Stimulation.
- 1 respondent indicated "routine" outpatient services are available without PA, and provided Electroconvulsive Therapy and Applied Behavioral Analysis as examples of non-routine services that would require PA.
- 6 respondents indicated all non-surgical outpatient services are available without PA.
- 1 respondent specifically noted referrals for counseling, pain management and MAT were available without PA.
- 1 respondent indicated unspecified high-cost services, services that do not conform with established standards of practice, over-utilized services, inconsistently-covered services or conditions associated with a high disease burden would require PA.
- 1 respondent gave examples of services that do not require PA including physical or occupational rehab, office visits, most outpatient surgeries, some chemotherapy.

19. Please provide any limits on the duration of the PA.:

- 4 respondents indicated a limit of 30 days at the initial precert request at intake.

20. Prior to authorizing, must the patient/provider verify that other treatments have not or will not be effective? (i.e., step-therapy) N=44

Yes	**9 (20%)**
No	35 (80%)

	Yes (%)	No (%)
Urban	8 (20%)	32 (80%)
Rural	1 (25%)	3 (75%)

	Yes (%)	No (%)
Commercial/Self	7 (19%)	30 (81%)
Medicare	2 (33%)	4 (67%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	3 (18%)	14 (82%)
Large	3 (37%)	5 (63%)
Small	1 (8%)	11 (92%)

PARTIAL HOSPITALIZATIONS

21. Does this plan cover partial hospitalizations N=57

Yes	**46 (81%)**
No	11 (19%

	Yes (%)	No (%)
Urban	41 (79%)	11 (21%)
Rural	5 (100%)	0

	Yes (%)	No (%)
Commercial/Self	38 (78%)	11 (22%)
Medicare	7 (100%)	0
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	15 (75%)	5 (25%)
Large	10 (77%)	3 (23%)
Small	13 (81%)	3 (19%)

22. Are there limitations/exclusions to the covered services: N=46

Yes	**18 (39%)**
No	28 (61%)

	Yes (%)	No (%)
Urban	15 (37%)	26 (63%)
Rural	3 (60%)	2 (40%)

	Yes (%)	No (%)
Commercial/Self	13 (34%)	25 (66%)
Medicare	5 (71%)	2 (29%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	7 (47%)	8 (53%)
Large	4 (40%)	6 (60%)
Small	2 (15%)	11 (85%)

23. Please describe limitations/exclusions to the covered services:

- 1 respondent indicated an annual limit of 60 visits per year.

24. Does the covered service require prior authorization: N=18

Yes	**13 (72%)**
No	5 (28%)

	Yes (%)	No (%)
Urban	11 (73%)	4 (26%)
Rural	2 (67%)	1 (33%)

	Yes (%)	No (%)
Commercial/Self	9 (69%)	4 (31%)
Medicare	4 (80%)	1 (20%)
University Student	0	0

	Yes (%)	No (%)
Individual	6 (86%)	1 (14%)
Large	1 (25%)	3 (75%)
Small	2 (100%)	0

25. Are there any services in this category available without prior authorization: N = 13

Yes	**4 (31%)**
No	9 (69%)

Yes= Some Urban; Commercial/Self; Individual Plans

26. Please describe services in this category available without prior authorization:

- 2 respondents indicated PA requirement is limited to out-of-network providers.
- 1 respondent indicated any service provided on an outpatient basis is available without PA.

27. Please provide any limits on the duration of the PA.:

- 2 respondents indicated that PA is required for out-of-network providers and is limited to 7 days at the initial precert request at intake, which can be extended at concurrent review.

28. Prior to authorizing, must the patient/provider verify that other treatments have not or will not be effective? (i.e., step-therapy) N=18

Yes	**3 (22%)**
No	15 (78%)

	Yes (%)	No (%)
Urban	4 (26%)	11 (73%)
Rural	0	3 (100%)

	Yes (%)	No (%)
Commercial/Self	2 (15%)	11 (85%)
Medicare	2 (40%)	3 (60%)
University Student	0	0

	Yes (%)	No (%)
Individual	1 (14%)	6 (86%)
Large	1 (25%)	3 (75%)
Small	0	2 (100%)

INTENSIVE OUTPATIENT PROGRAMS

29. Does this plan cover intensive outpatient programs N=57

Yes	**50 (88%)**
No	7 (12%)

	Yes (%)	No (%)
Urban	46 (88%)	6 (12%)
Rural	4 (80%)	1 (20%)

	Yes (%)	No (%)
Commercial/Self	43 (88%)	6 (12%)
Medicare	6 (86%)	1 (14%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	15 (75%)	5 (25%)
Large	12 (92%)	1 (8%)
Small	16 (100%)	0

30. Are there limitations/exclusions to the covered services: N=50

Yes	**20 (40%)**
No	30 (60%)

	Yes (%)	No (%)
Urban	18 (39%)	28 (61%)
Rural	2 (40%)	2 (50%)

	Yes (%)	No (%)
Commercial/Self	16 (37%)	27 (63%)
Medicare	4 (67%)	2 (33%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	7 (47%)	8 (53%)
Large	5 (42%)	7 (58%)
Small	4 (25%)	12 (75%)

31. Please describe limitations/exclusions to the covered services:

- 1 respondent reported a hard limit on outpatient services of 60 visits per year.

32. Does the covered service require prior authorization: N=50

Yes	**37 (74%)**
No	13 (26%)

	Yes (%)	No (%)
Urban	34 (74%)	12 (26%)
Rural	3 (75%)	1 (25%)

	Yes (%)	No (%)
Commercial/Self	31 (72%)	12 (28%)
Medicare	5 (83%)	1 (17%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	11 (73%)	4 (27%)
Large	8 (67%)	4 (33%)
Small	12 (75%)	4 (25%)

33. Are there any services in this category available without prior authorization: N = 37

Yes	**2 (5%)**
No	35 (95%)

Yes= Some Urban; Commercial/Self; Individual Plans

34. Please describe services in this category available without prior authorization:

- 2 respondents indicated services provided by an in-network provider do not require PA.

35. Please provide any limits on the duration of the PA.:

- 2 respondents indicated that PA is required for out-of-network providers and is limited to 7 days at the initial precert request at intake, which can be extended at concurrent review.
- 1 respondent indicated PA is required for "non routine" outpatient services such as Intensive Outpatient Treatment Program, Outpatient Electro-convulsive therapy, psychological testing, methadone maintenance, extended outpatient treatment visits beyond 45-50 minutes in duration, Applied Behavioral Analysis.
- 26 respondents indicated limits similar to medical services but did not provide specific examples.

36. Prior to authorizing, must the patient/provider verify that other treatments have not or will not be effective? (i.e., step-therapy) N=50

Yes	**5 (10%)**
No	45 (90%)

	Yes (%)	No (%)
Urban	5 (11%)	41 (89%)
Rural	0	4 (100%)

	Yes (%)	No (%)
Commercial/Self	2 (5%)	41 (95%)
Medicare	3 (50%)	3 (50%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	1 (7%)	14 (93%)
Large	1 (8%)	11 (92%)
Small	0	16 (100%)

RESIDENTIAL TREATMENT

37. Does this plan cover residential treatment N=57

Yes	**50 (88%)**
No	7 (12%)

	Yes (%)	No (%)
Urban	47 (86%)	5 (14%)
Rural	3 (60%)	2 (40%)

	Yes (%)	No (%)
Commercial/Self	46 (94%)	3 (6%)
Medicare	3 (43%)	4 (57%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	20 (100%)	0
Large	12 (92%)	1 (8%)
Small	14 (88%)	2 (12%)

38. Are there limitations/exclusions to the covered services: N=50

Yes	**20 (40%)**
No	30 (60%)

	Yes (%)	No (%)
Urban	19 (40%)	28 (60%)
Rural	1 (33%)	2 (67%)

	Yes (%)	No (%)
Commercial/Self	19 (41%)	27 (59%)
Medicare	1 (33%)	2 (67%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	12 (60%)	8 (40%)
Large	5 (42%)	7 (58%)
Small	2 (14%)	12 (86%)

39. Please describe limitations/exclusions to the covered services:

- 5 respondents indicated covered expenses are limited to a maximum of 50% of the amount of a semi-private room. The insured must have first been in a hospital or Skilled Nursing Home and residential treatment must begin within 30 days of discharge from that facility.
- 1 respondent indicated limits similar to medical services but did not provide specific examples.

40. Does the covered service require prior authorization: N=50

Yes	**44 (88%)**
No	6 (12%)

No= Some Urban; Commercial/Self; Individual Plans

41. Please provide any limits on the duration of the PA:

- 4 respondents indicated that PA is limited to 7 days at the initial precert request at intake, which can be extended at concurrent review.
- 1 respondent indicated PA is required for “non routine” outpatient services such as Intensive Outpatient Treatment Program, Outpatient Electro-convulsive therapy, psychological testing, methadone maintenance, extended outpatient treatment visits beyond 45-50 minutes in duration, Applied Behavioral Analysis.
- 26 respondents indicated limits equivalent to similar medical services but did not provide specific examples.

42. Prior to authorizing, must the patient/provider verify that other treatments have not or will not be effective? (i.e., step-therapy) N=44

Yes	**7 (16%)**
No	37 (84%)

	Yes (%)	No (%)
Urban	7 (17%)	34 (83%)
Rural	0	3 (100%)

	Yes (%)	No (%)
Commercial/Self	6 (15%)	34 (85%)
Medicare	1 (33%)	2 (67%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	3 (21%)	11 (79%)
Large	3 (25%)	9 (75%)
Small	0	14 (100%)

COUNSELING/BEHAVIORAL THERAPY

43. Does this plan cover counseling/behavioral therapy N=57

Yes	**51 (84%)**
No	6 (16%)

No= Some Urban; Commercial/Self; Individual (n=5) and Large (n=1) Plans

44. Are there limitations/exclusions to the covered services: N=51

Yes	**17 (33%)**
No	34 (67%)

	Yes (%)	No (%)
Urban	14 (30%)	32 (68%)
Rural	3 (60%)	2 (40%)

	Yes (%)	No (%)
Commercial/Self	14 (33%)	29 (67%)
Medicare	3 (43%)	4 (57%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	7 (47%)	8 (53%)
Large	3 (25%)	9 (75%)
Small	4 (25%)	12 (75%)

45. Please describe limitations/exclusions to the covered services:

- 3 respondents indicated counseling was covered but behavioral therapy was not covered.
- 1 respondent indicated no limits or PA if provider is in-network.

46. Does the covered service require prior authorization: N=51

Yes	**3 (6%)**
No	48 (94%)

	Yes (%)	No (%)
Urban	2 (4%)	44 (96%)
Rural	1 (20%)	4 (80%)

	Yes (%)	No (%)
Commercial/Self	2 (5%)	41 (95%)
Medicare	1 (14%)	6 (86%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	2 (13%)	13 (87%)
Large	0	12 (100%)
Small	0	16 (100%)

47. Are there any services in this category available without prior authorization: N=4

Yes	**3 (100%)**
No	0

48. Please describe services in this category available without prior authorization:

- 1 respondent indicated the behavioral health crisis line is available without limit or PA.
- 1 respondent indicated outpatient services other than surgery are available without PA.

49. Please provide any limits on the duration of the PA:

- No responsive answers.

50. Prior to authorizing, must the patient/provider verify that other treatments have not or will not be effective? (i.e., step-therapy) N=3

Yes	**0 (0%)**
No	3 (100%)

CASE MANAGEMENT

51. Does this plan cover case management N=56

Yes	**44 (79%)**
No	12 (21%)

	Yes (%)	No (%)
Urban	40 (78%)	11 (22%)
Rural	4 (80%)	1 (20%)

	Yes (%)	No (%)
Commercial/Self	37 (77%)	11 (23%)
Medicare	6 (86%)	1 (14%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	11 (58%)	8 (42%)
Large	10 (77%)	3 (23%)
Small	16 (100%)	0

52. Please describe the definition of case management used or the services covered:

- Respondents generally indicated case management is available to help members manage their own health conditions and provider support for members with complex health care needs.
- 4 respondents specifically cited coordinating services and locating community resources.
- 1 respondent indicated case management was post-discharge follow up for patients discharging from inpatient and other settings.

53. Are there limitations/exclusions to the covered services: N=44

Yes	**10 (23%)**
No	34 (77%)

	Yes (%)	No (%)
Urban	9 (22%)	31 (78%)
Rural	1 (25%)	3 (75%)

	Yes (%)	No (%)
Commercial/Self	9 (24%)	28 (76%)
Medicare	1 (17%)	5 (83%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	2 (18%)	9 (82%)
Large	3 (30%)	7 (70%)
Small	4 (25%)	12 (100%)

54. Please describe limitations/exclusions to the covered services:

- 4 respondents indicate case management is only available for difficult, major conditions. Examples provider include cancer, transplant, mental illness/substance abuse.
- 3 respondents indicated services were available through telephone support during business hours.

55. Does the covered service require prior authorization: N=44

Yes	**0 (0%)**
No	44 (100%)

Questions 56-58 had no responses

OTHER RECOVERY SUPPORTS

59. Does this plan cover other recovery supports N=56

Yes	**28 (50%)**
No	28 (50%)

	Yes (%)	No (%)
Urban	25 (49%)	26 (51%)
Rural	3 (60%)	2 (40%)

	Yes (%)	No (%)
Commercial/Self	24 (50%)	24 (50%)
Medicare	3 (43%)	4 (57%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	8 (42%)	11 (58%)
Large	5 (38%)	8 (62%)
Small	11 (69%)	5 (31%)

60. Please describe the types of support services covered:

- 27 respondents indicated peer support is covered.
- 1 respondent indicated housing support is covered.
- 1 respondent indicated the behavioral health crisis line and case management are available and coordinate with non-covered local resources.

61. Are there limitations/exclusions to the covered services: N=28

Yes	**0 (0%)**
No	28 (100%)

Question 62 had no responses

63. Does the covered service require prior authorization: N=28

Yes	**0 (0%)**
No	28 (28%)

Questions 64-67 had no responses

MEDICATION ASSISTED TREATMENT

68. Does this plan cover Medication Assisted Treatment: N=56

Yes	**50 (89%)**
No	6 (11%)

No= Some Urban; Commercial/Self; Individual (n=5) and Large (n=1) Group Plans

69. Does this covered service require prior authorization: N=50

Yes	**15 (30%)**
No	35 (70%)

	Yes (%)	No (%)
Urban	14 (31%)	31 (69%)
Rural	1 (20%)	4 (80%)

	Yes (%)	No (%)
Commercial/Self	11 (26%)	31 (74%)
Medicare	4 (57%)	3 (43%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	2 (14%)	12 (86%)
Large	4 (33%)	8 (67%)
Small	5 (31%)	11 (69%)

70. Are there any services in this category available without prior authorization: N=15

Yes	**14 (93%)**
No	1 (7%)

No= Urban; Medicare Plan

71. Please describe services in this category available without prior authorization:

- 2 respondents indicated Belbuca and Methadone require PA, other MAT medications do not.
- 1 respondent indicated only bundled MAT programs require PA, most others do not.
- 2 respondents indicated Zubsolv, buprenorphine and Vivitrol are available without PA.
- Other respondents indicated services do not require PA.

72. Please provide any limits on the duration of the PA where required.:

- 2 respondents reported a limit of 6 months at the initial precert request at intake with a potential renewal review for continued coverage for 12 months.
- 1 respondent indicated suboxone could be authorized for the entire plan year, Subutex based upon use up to entire plan year.
- 2 respondents indicated non-covered products approved for duration of 1 year intervals.

73. Prior to authorizing, must the patient/provider verify that other treatments have not or will not be effective? (i.e., step-therapy) N=15

Yes	**4 (27%)**
No	11 (73%)

	Yes (%)	No (%)
Commercial/Self	2 (18%)	9 (82%)
Medicare	2 (50%)	2 (50%)
University Student	0	0

	Yes (%)	No (%)
Individual	1 (50%)	1 (50%)
Large	1 (25%)	3 (75%)
Small	0	5 (100%)

MAT – BEHAVIORAL THERAPY

74. Do you cover behavioral therapy as part of Medication Assisted Treatment? N=50

Yes	**45 (90%)**
No	5 (10%)

	Yes (%)	No (%)
Commercial/Self	38 (90%)	4 (10%)
Medicare	6 (86%)	1 (14%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	14 (100%)	0
Large	10 (83%)	2 (17%)
Small	14 (88%)	2 (12%)

75. Are there limitations or exclusions that apply: N=45

Yes	**14 (31%)**
No	31 (69%)

	Yes (%)	No (%)
Urban	12 (30%)	28 (70%)
Rural	2 (40%)	3 (60%)

	Yes (%)	No (%)
Commercial/Self	10 (26%)	28 (74%)
Medicare	4 (67%)	2 (33%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	6 (43%)	8 (57%)
Large	2 (20%)	8 (80%)
Small	2 (14%)	12 (86%)

76. Please describe limitations/exclusions to the covered services:

- 1 respondent indicated outpatient services have a 60-day limit.

MAT – NALTREXONE (TABLET)

77. Is Naltrexone (tablets) covered by the Medication Assisted Treatment: N=49

Yes	**45 (92%)**
No	4 (7%)

No= Some Urban, Commercial/Self, Large Group Plans

78. Are there limitations or exclusions that apply to this medication: N=45

Yes	**8 (18%)**
No	37 (82%)

	Yes (%)	No (%)
Urban	8 (20%)	32 (80%)
Rural	0	5 (100%)

	Yes (%)	No (%)
Commercial/Self	8 (23%)	29 (78%)
Medicare	0	7 (100%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	3 (23%)	10 (77%)
Large	2 (25%)	6 (75%)
Small	3 (19%)	13 (81%)

79. Please describe limitations/exclusions to the covered services:

- No hard limits or exclusions described. Respondents indicated coverage based on formulary (2), coverage guidelines (2) and FDA guidelines (4).

80. Are Fail First/step therapy requirements (e.g., requiring counseling only before approving MAT) applied to this medication: N=45

Yes	**0 (0%)**
No	45 (100%)

Question 81 had no responses

MAT – NALTREXONE (INJECTABLE)

82. Is Naltrexone (injectable) covered by the Medication Assisted Treatment: N=49

Yes	**44 (90%)**
No	5 (10%)

No= Some Urban; Commercial/Self (n=4) and Medicare (n=1); Large Group Plans

83. Are there limitations or exclusions that apply to this medication: N=44

Yes	**12 (27%)**
No	32 (73%)

	Yes (%)	No (%)
Urban	12 (31%)	27 (69%)
Rural	0	5 (100%)

	Yes (%)	No (%)
Commercial/Self	10 (27%)	27 (73%)
Medicare	2 (33%)	4 (67%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	4 (31%)	9 (69%)
Large	3 (38%)	5 (62%)
Small	3 (19%)	13

84. Please describe limitations/exclusions to the covered services:

- No hard limits or exclusions described. Respondents indicated coverage based on formulary (but covered with exception) (1), coverage guidelines (2), medical necessity (5) and FDA guidelines (4).

85. Are Fail First/step therapy requirements (e.g., requiring counseling only before approving MAT) applied to this medication: N=44

Yes	**1 (2%)**
No	43 (98%)

Yes= Urban, Medicare Plan

86. Please describe:

- No responsive answers.

MAT - METHADONE

87. Is Methadone covered by the Medication Assisted Treatment: N=49

Yes	**43 (88%)**
No	6 (12%)

	Yes (%)	No (%)
Urban	39 (89%)	5 (11%)
Rural	4 (80%)	1 (20%)

	Yes (%)	No (%)
Commercial/Self	37 (90%)	4 (10%)
Medicare	5 (71%)	2 (29%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	13 (100%)	0
Large	8 (67%)	4 (33%)
Small	16 (100%)	0

88. Are there limitations or exclusions that apply to this medication: N=43

Yes	**38 (88%)**
No	5 (12%)

	Yes (%)	No (%)
Urban	34 (87%)	5 (13%)
Rural	4 (100%)	0

	Yes (%)	No (%)
Commercial/Self	34 (92%)	3 (8%)
Medicare	3 (60%)	2 (40%)
University Student	1 (100)%	0

	Yes (%)	No (%)
Individual	11 (85%)	2 (15%)
Large	7 (88%)	1 (12%)
Small	16 (100%)	0

89. Please describe limitations/exclusions to the covered services:

- 25 respondents indicated a PA requirement on outpatient methadone to confirm use in MAT vs. pain.
- 1 respondent indicated there is a quantity limit for Methadone HCL (10 mg tablet) maximum of 12 tablets per day.
- 1 respondent indicated an unspecified quantity limit is applied.

90. Are Fail First/step therapy requirements (e.g., requiring counseling only before approving MAT) applied to this medication: N=43

Yes	**0 (0%)**
No	43 (100%)

Question 91 had no responses

MAT - BUPRENORPHINE

92. Is Buprenorphine covered by the Medication Assisted Treatment: N=49

Yes	**45 (92%)**
No	4 (8%)

No= Some Urban; Commercial/Self; and Large Group Plans

93. Are there limitations or exclusions that apply to this medication: N=45

Yes	**41 (91%)**
No	4 (9%)

	Yes (%)	No (%)
Urban	38 (95%)	2 (5%)
Rural	3 (60%)	2 (40%)

	Yes (%)	No (%)
Commercial/Self	35 (95%)	2 (5%)
Medicare	5 (71%)	2 (29%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	12 (92%)	1 (8%)
Large	8 (100%)	0
Small	15 (94%)	1 (6%)

94. Please describe limitations/exclusions to the covered services:

- 1 respondent indicated buprenorphine requires PA to ensure it is being used for opioid treatment and is subject to a quantity limit of 120 tablets/30 days.
- 1 respondent indicated Suboxone could be approved for the benefit year and Subutex duration is dependent upon diagnosis.
- 1 respondent indicated an unspecified buprenorphine quantity limit.
- 1 respondent indicated Zubsolv and buprenorphine SL tablets are covered without PA with unspecified supply limits. Other buprenorphine/naloxone products may be excluded depending on benefit plan. Probuphine and sublocade are covered.

95. Are Fail First/step therapy requirements (e.g., requiring counseling only before approving MAT) applied to this medication: N=45

Yes	**2 (4%)**
No	43 (96%)

	Yes (%)	No (%)
Urban	2 (5%)	38 (7%)
Rural	0	5 (100%)

	Yes (%)	No (%)
Commercial/Self	1 (3%)	36 (97%)
Medicare	1 (14%)	6 (96%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	0	13 (100%)
Large	0	8 (100%)
Small	1 (6%)	15 (94%)

96. Please describe:

- 1 respondent indicated PA may require trial/failure/contraindication to preferred product for non-preferred buprenorphine/naloxone products.
- 1 respondent indicated step therapy/fail first for Subutex when being used for maintenance need, requires documentation of contraindication to naloxone.

URINE/BLOOD SCREENING

97. Are urine or blood screenings for substances covered by this plan? N=55

Yes	**49 (89%)**
No	6 (11%)

No= Some Urban; Commercial/Self; and Individual (n=5) and Large (n=1) Group Plans

98. Do these services require prior authorization: N=49

Yes	**1 (2%)**
No	48 (98%)

Yes= Rural; Medicare Plan

99. Are there any services in this category available without prior authorization: N=1

No	**1 (100%)**

Question 100 had no responses

101. If any services require prior authorization, please provide limits on the duration of the PA where required:

- No responsive answers.

102. Are certain frequency limits applied to the coverage: N=49

Yes	**40 (82%)**
No	9 (18%)

	Yes (%)	No (%)
Urban	36 (82%)	8 (18%)
Rural	4 (80%)	1 (20%)

	Yes (%)	No (%)
Commercial/Self	36 (88%)	5 (12%)
Medicare	3 (43%)	4 (57%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	10 (77%)	3 (23%)
Large	11 (92%)	1 (8%)
Small	15 (94%)	1 (6%)

103. Please describe frequency limitations to the covered services:

- 25 respondents indicated limits of 1 presumptive encounter per day up to 8 presumptive encounters per rolling 12 month period across all providers and 1 definitive encounter per day up to 8 definitive encounters per rolling 12 month period across all providers.
- 1 respondent reported limits of 1 presumptive, 1 definitive test per day.
- 1 respondent reported limits of 32 presumptive, 128 definitive tests per year.
- 1 respondent indicated limits of 33 presumptive and 128 definitive encounters per year.
- 1 respondent indicated limits of 18 presumptive and 18 definitive encounters across an unspecified time frame (presumed to be the plan year).

104. Does the service have requirements for the location where the screening is conducted: N=49

Yes	**11 (22%)**
No	38 (78%)

	Yes (%)	No (%)
Urban	9 (20%)	35 (80%)
Rural	2 (40%)	3 (60%)

	Yes (%)	No (%)
Commercial/Self	7 (17%)	34 (83%)
Medicare	4 (57%)	3 (43%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	2 (15%)	11 (85%)
Large	4 (33%)	8 (67%)
Small	1 (6%)	15 (94%)

105. Please describe location requirements:

- 9 respondents indicated the testing must be done at an in-network location/lab

106. Are other limitations or exclusions applied to this service: N=49

Yes	**10 (20%)**
No	39 (80%)

	Yes (%)	No (%)
Urban	8 (18%)	36 (82%)
Rural	2 (40%)	3 (60%)

	Yes (%)	No (%)
Commercial/Self	8 (20%)	33 (80%)
Medicare	2 (29%)	5 (71%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	4 (31%)	9 (69%)
Large	2 (17%)	10 (83%)
Small	2 (12%)	14 (88%)

107. Please describe limitations to the covered services:

- 8 respondents indicated limits on drug testing of 1 presumptive encounter per day up to 8 presumptive encounters per rolling 12 month period across all providers and 1 definitive encounter per day up to 8 definitive encounters per rolling 12 month period across all providers.

OTHER SUBSTANCE USE SCREENING TOOLS

111. Are other substance use screening tools covered by this plan: N=55

Yes	**8 (15%)**
No	47 (85%)

	Yes (%)	No (%)
Urban	7 (14%)	43 (86%)
Rural	1 (20%)	4 (80%)

	Yes (%)	No (%)
Commercial/Self	7 (15%)	40 (85%)
Medicare	1 (14%)	6 (86%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	1 (6%)	17 (94%)
Large	5 (38%)	8 (75%)
Small	1 (6%)	15 (94%)

112. Please describe the tools covered:

- Some respondents indicated screening tools are used by providers in the context of the exam and would be covered as part of the exam. No specific tools were referenced.

113. Are limitations or exclusions applied to this service N=8

Yes	**5 (63%)**
No	3 (37%)

	Yes (%)	No (%)
Urban	4 (57%)	3 (43%)
Rural	1 (100%)	0

	Yes (%)	No (%)
Commercial/Self	4 (57%)	3 (43%)
Medicare	1 (100%)	0
University Student	0	0

	Yes (%)	No (%)
Individual	0	1 (100%)
Large	3 (60%)	2 (40%)
Small	1 (100%)	0

114. Please describe the tools covered:

- No specific tools were referenced.

115. Do these covered services require prior authorization: N=8

Yes	**1 (12%)**
No	7 (88%)

Yes= Some Urban, Commercial/Self Insured; Large Group Plans

116. Are there screening tools available without prior authorization: N=1

Yes	**1 (100%)**

117. Please describe the tools covered without PA:

- No specific tools were referenced.

NON-OPIOID PAIN MEDICATIONS

118. Are non-opioid pain medications covered by this plan: N=55

Yes	**50 (91%)**
No	5 (9%)

	Yes (%)	No (%)
Urban	45 (90%)	5 (10%)
Rural	5 (100%)	0

	Yes (%)	No (%)
Commercial/Self	34 (81%)	8 (19%)
Medicare	6 (86%)	1 (14%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	17 (94%)	1 (6%)
Large	10 (77%)	3 (23%)
Small	15 (94%)	1 (6%)

119. Are there any services in this category available with prior authorization: N=50

Yes	**41 (82%)**
No	9 (18%)

	Yes (%)	No (%)
Urban	37 (82%)	8 (18%)
Rural	4 (80%)	1 (20%)

	Yes (%)	No (%)
Commercial/Self	34 (81%)	8 (19%)
Medicare	6 (86%)	1 (14%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	12 (71%)	5 (29%)
Large	7 (70%)	3 (30%)
Small	15 (100%)	0

120. Please describe services in this category available with prior authorization:

- 23 respondents indicated most generics available do not require PA and provided specific examples of topical NSAIDs, TCA antidepressants, gabapentin, Lyrica.
- 2 respondents indicated NSAIDs (e.g. ibuprofen, meloxicam, naproxen, celecoxib), gabapentin, Lyrica, duloxetine, tricyclic antidepressants (e.g. amitriptyline, doxepin) are available without PA.
- 3 respondents indicated the following drugs are available WITH PA: lidocaine patch, Lyrica for neuropathic pain (requires step through other preferred medications).
- 1 respondent indicated Botox is available WITH PA.
- 5 respondents indicated PA is not required.
- 1 respondent indicated the plan covers prescription NSAIDs, topical agents, neuropathic pain options, injections but over the counter agents are not Part D eligible.

NON-OPIOID PAIN MEDICATIONS - ACETAMINOPHEN

121. Is acetaminophen covered: N=50

Yes	**14 (28%)**
No	36 (72%)

	Yes (%)	No (%)
Urban	14 (31%)	31 (69%)
Rural	0	5 (100%)

	Yes (%)	No (%)
Commercial/Self	12 (29%)	30 (71%)
Medicare	2 (29%)	5 (71%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	7 (41%)	10 (59%)
Large	2 (20%)	8 (80%)
Small	3 (20%)	12 (80%)

122. Does this covered service require prior authorization: N=15

Yes	**2 (13%)**
No	13 (87%)

Yes= Some Urban, Commercial/Self Insured, Large Group Plans

123. Please provide any limits on the duration of the PA where required:

- 1 respondent indicated only for Acetaminophen-Opioid combination products (ex. hydrocodone-acetaminophen), PA may be limited to either a 5-day supply, 14-day supply or a 3-month supply depending on age, medication history and diagnosis

124. Prior to authorizing, must the patient/provider verify that other treatments have not or will not be effective? (i.e., step-therapy) N=1

Yes	**0**
No	1

125. Are limitations or exclusions applied to this medication: N=1

Yes	**1**
No	0

126. Please provide any limits:

- 1 respondent indicated only for Acetaminophen-Opioid combination products (ex. hydrocodone-acetaminophen), PA may be limited to either a 5-day supply, 14-day supply or a 3-month supply depending on age, medication history and diagnosis

NON-OPIOID PAIN MEDICATIONS- NSAIDS

127. Are NSAIDs covered: N=50

Yes	**50 (100%)**
No	0

128. Does this covered service require prior authorization: N=50

Yes	**3 (6%)**
No	47 (94%)

Yes= Some Urban; Commercial/Self-Insured (n=2), Medicare (n=1); Large Group Plans

129. Please provide any limits on the duration of the PA where required:

- 2 respondents indicated PA is required for Vimovo and Duexis only
- 1 respondent indicated PA is limited to 1 year for select NSAIDs (ketorolac for over age 65, flector).

130. Prior to authorizing, must the patient/provider verify that other treatments have not or will not be effective? (i.e., step-therapy) N=3

Yes	**2 (67%)**
No	1 (33%)

131. Are limitations or exclusions applied to this medication: N=1

Yes	**3 (100%)**
No	0 (0%)

132. Please provide any limits:

- 2 respondents indicated members must try 2 generic NSAIDs before brand authorized.

NON-OPIOID PAIN MEDICATIONS - CORTICOSTEROIDS

133. Are corticosteroids covered: N=50

Yes	**50 (100%)**
No	0 (0%)

134. Does this covered service require prior authorization: N=50

Yes	**0 (0%)**
No	50 (100%)

Questions 135-138 had no responses

NON-OPIOID PAIN MEDICATIONS - ANTICONVULSANTS

139. Are anticonvulsants (e.g., Gabapentin, pregabalin, Tegretol) covered: N=50

Yes	**50 (100%)**
No	0 (0%)

140. Does this covered service require prior authorization: N=50

Yes	**1 (2%)**
No	49 (98%)

Yes= Urban, Commercial/Self Insured, Small Group Plan

141. Please provide any limits on the duration of the PA where required:

- 1 respondent indicated select multisource brands may require PA but generic is covered without PA. Lyrica for neuropathic pain requires step therapy through preferred medications. PA duration is limited to 12 months.

142. Prior to authorizing, must the patient/provider verify that other treatments have not or will not be effective? (i.e., step-therapy) N=1

Yes	**1 (100%)**
No	0 (0%)

143. Are limitations or exclusions applied to this medication: N=0

Yes	**1 (100%)**
No	0 (0%)

144. Please provide any limits:

- 1 respondent indicated members must try generic before brand is authorized. Lyrica has supply limit and step therapy requirement that requires appropriate diagnosis of condition, failure/contraindication/intolerance to covered first-line agents, or currently stable on Lyrica.

NON-OPIOID PAIN MEDICATIONS - DMARDs

145. Are disease-modifying anti-rheumatic drugs (DMARDs) covered: N=50

Yes	**50 (100%)**
No	0 (0%)

146. Does this covered service require prior authorization: N=50

Yes	**28 (56%)**
No	22 (44%)

	Yes (%)	No (%)
Urban	25 (56%)	20 (44%)
Rural	3 (60%)	2 (40%)

	Yes (%)	No (%)
Commercial/Self	25 (60%)	17 (40%)
Medicare	2 (29%)	5 (71%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	8 (47%)	9 (53%)
Large	6 (60%)	4 (40%)
Small	11 (73%)	4 (27%)

147. Please provide any limits on the duration of the PA where required:

- 23 respondents indicated a typical 6 month limit on PA for specialty drugs but can be renewed.
- 1 respondent indicated PA is required for biologics and specialty medication; initial authorization is for 12 months and reauthorization is issued for 24 months.
- 1 respondent indicated PA is required for injectables.
- 1 indicated PA is required to ensure appropriate utilization to labeled indication.

148. Prior to authorizing, must the patient/provider verify that other treatments have not or will not be effective? (i.e., step-therapy) N=28

Yes	**28 (100%)**
No	0 (0%)

149. Are limitations or exclusions applied to this medication: N=28

Yes	**25 (89%)**
No	3 (11%)

No= Some Urban; Commercial/Self Insured (n=2), Medicare (n=1); and Large Group Plans

150. Please provide any limits:

- 1 respondent indicated is step therapy is required for some products, not all (but did not specify); Some (unspecified) DMARDs have supply limits. Otrexup may be excluded.
- 1 respondent indicated step therapy requires a trial/failure of preferred oral DMARDs.

NON-OPIOID PAIN MEDICATIONS - TRICYCLIC ANTIDEPRESSANTS, SSRIS, etc.

151. Are tricyclic antidepressants, selective serotonin reuptake inhibitors and serotonin/norepinephrine reuptake inhibitors covered: N=50

Yes	**50 (100%)**
No	0 (0%)

152. Does this covered service require prior authorization: N=50

Yes	**1 (2%)**
No	49 (98%)

Yes= Some Urban, Medicare, Plans

153. Please provide any limits on the duration of the PA where required:

- 1 respondent indicated PA required for over age 65 for risk/benefit analysis.

154. Prior to authorizing, must the patient/provider verify that other treatments have not or will not be effective? (i.e., step-therapy) N=1

Yes	**0 (0%)**
No	1 (100%)

155. Are limitations or exclusions applied to this medication: N=1

Yes	**0 (0%)**
No	1 (100%)

Question 156 had no responses

NON-OPIOID PAIN MEDICATIONS - TOPICAL AGENTS

157. Are topical agents (e.g., lidocaine, capsaicin, NSAIDs) covered: N=50

Yes	**50 (100%)**
No	0 (0%)

158. Does this covered service require prior authorization: N=50

Yes	**30 (60%)**
No	20 (40%)

	Yes (%)	No (%)
Urban	25 (56%)	20 (44%)
Rural	5 (100%)	0

	Yes (%)	No (%)
Commercial/Self	24 (57%)	18 (43%)
Medicare	5 (71%)	2 (29%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	8 (47%)	9 (53%)
Large	4 (40%)	6 (60%)
Small	12 (80%)	3 (20%)

Question 159 had no responses

160. Prior to authorizing, must the patient/provider verify that other treatments have not or will not be effective? (i.e., step-therapy) N=31

Yes	**6 (19%)**
No	25 (81%)

	Yes (%)	No (%)
Urban	4 (15%)	22 (85%)
Rural	2 (40%)	3 (60%)

	Yes (%)	No (%)
Commercial/Self	3 (12%)	22 (88%)
Medicare	3 (60%)	2 (40%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	2 (25%)	6 (75%)
Large	0	5 (100%)
Small	1 (8%)	11 (92%)

161. Are limitations or exclusions applied to this medication: N=31

Yes	**31 (100%)**
No	0 (0%)

162. Please provide any limits:

- 24 respondents indicated PA required for additional supply above quantity safety limits and for FDA or medically acceptable indication.
- 2 respondents indicated Lidocaine patches are covered for individuals with neuropathic cancer pain, post-herpetic neuralgia, and diabetic neuropathy which is consistent with the FDA-approved and CMS sanctioned compendia-supported uses.
- 1 respondent indicated for Lidocaine patch, initial authorization will be issued for 6 months, reauthorization for 12. Indicated some (unspecified) products may have supply limits. Voltaren gel 1% is covered without prior authorization. Diclofenac sodium 1% gel generic and Flector may be excluded from coverage. Products available over-the-counter may be excluded. Flector and brand Lidoderm may be excluded from coverage. Capsaicin is not covered since available OTC.
- 1 respondent indicated Lidocaine 5% patch requires PA with a quantity limit of 3 per day. Capsaicin not Part D eligible (since OTC).
- 1 respondent indicated prescription topical agents are covered; may require PA, step therapy and have limits but those were not specified.

PSYCHOLOGICAL THERAPY

163. Is psychological therapy (i.e., cognitive behavioral therapy) covered by this plan: N=55

Yes	**46 (84%)**
No	9 (16%)

	Yes (%)	No (%)
Urban	41 (82%)	9 (18%)
Rural	5 (100%)	0

	Yes (%)	No (%)
Commercial/Self	38 (81%)	9 (19%)
Medicare	7 (100%)	0
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	13 (72%)	5 (28%)
Large	11 (85%)	2 (15%)
Small	14 (88%)	2 (12%)

164. Are limitations or exclusions applied to this service: N=46

Yes	**10 (78%)**
No	36 (22%)

	Yes (%)	No (%)
Urban	8 (20%)	33 (80%)
Rural	2 (40%)	3 (60%)

	Yes (%)	No (%)
Commercial/Self	8 (21%)	30 (79%)
Medicare	2 (29%)	5 (71%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	3 (23%)	10 (76%)
Large	3 (27%)	8 (73%)
Small	2 (14%)	12 (86%)

165. Please provide any limits:

- 1 respondent indicated behavioral therapy is only covered for treatment of Autism Spectrum Disorder.

166. Does this covered service require prior authorization: N=12

Yes	**1 (10%)**
No	9 (90%)

167. Are there any services in this category available without prior authorization: N=1

Yes	**0 (0%)**
No	1 (100%)

Question 168 had no responses

169. If any services require prior authorization, please provide any limits on the duration of the PA where required:

- 1 respondent indicated services subject to clinical coverage guidelines.

170. Prior to authorizing, must the patient/provider verify that other treatments have not or will not be effective? (i.e., step-therapy) N=1

Yes	**0 (0%)**
No	1 (100%)

MOVEMENT THERAPIES

171. Are movement therapies (e.g., Physical Therapy, Exercise Therapy) covered: N=55

Yes	**54 (98%)**
No	1 (2%)

No= Urban, Commercial/Self Insured, Large Group Plan

172. Please describe the covered movement therapies:

- 33 respondents listed Occupational Therapy, Physical Therapy and Speech Therapy are covered.
- 12 respondents listed Physical Therapy is covered.
- 4 respondents listed Physical Therapy and Occupational Therapy are covered.
- 1 respondent indicated Medicare-covered movement therapies are covered.
- 1 respondent listed Neuromuscular Re-education Gait Training Massage Manual Therapy is covered.
- 1 respondent indicated services are limited to 60 visits per year.

173. Does the covered service require prior authorization: N=54

Yes	**7 (13%)**
No	47 (87%)

	Yes (%)	No (%)
Urban	6 (12%)	43 (88%)
Rural	1 (20%)	4 (80%)

	Yes (%)	No (%)
Commercial/Self	4 (9%)	42 (91%)
Medicare	3 (43%)	4 (57%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	3 (17%)	15 (83%)
Large	1 (8%)	11 (92%)
Small	0	16 (100%)

174. Are there any services in this category available without prior authorization: N = 7

Yes	**2 (29%)**
No	5 (71%)

Yes= Some Urban, Commercial/Self Insured, Individual Plans

175. Please describe services in this category available without prior authorization:

- 2 respondents indicated outpatient services are available without PA.

176. If any services require prior authorization, please provide any limits on the duration of the PA where required:

- 1 respondent indicated a limit of 60 visits per year.
- 1 respondent indicated a limit of 59 visits per year.

177. Prior to authorizing, must the patient/provider verify that other treatments have not or will not be effective? (i.e., step-therapy) N=7

Yes	**0 (0%)**
No	7 (100%)

INTERVENTIONAL PROCEDURES

178. Are interventional procedures (e.g., spinal cord stimulation, joint injections, steroid injections) covered: N=55

Yes	**53 (96%)**
No	2 (4%)

No= Some Urban, Commercial/Self Insured, Large Group Plans

179. Please describe the covered procedures:

- 2 respondents gave examples of steroid injections, facet joint injections, radiofrequency ablation, spinal cord stimulation, trigger point injections.
- 4 respondents indicated injections are covered.
- 2 respondents indicated injections, neurotomies, ablations and spinal cord stimulators are covered.
- 2 respondents indicated joint injections, steroid injections, neurotomies, spinal cord stimulators and nerve blocks are covered.
- 9 respondents broadly listed medically necessary procedures.
- 1 respondent indicated "radiology transplants" as covered.
- 2 respondents listed "many types" including spinal cord stimulation, radiofrequency ablations, nerve blocks, epidural blocks, joint injections, steroid injections, pain pumps.
- 1 respondent listed Medicare-covered services such as spinal cord stimulation, joint injections and steroid injections as well as acupuncture.

180. Are there limitations/exclusions to the covered services: N=53

Yes	**50 (94%)**
No	3 (6%)

No= Some Urban; Commercial/Self Insured (n=2) and Medicare (n=1); Large Group Plans

181. Please describe limitations/exclusions to the covered services:

- 4 respondents specifically excluded spinal cord stimulators.
- 2 respondents indicated an unspecified visit limit.
- 2 respondent indicated only invasive services with "strong evidence" of beneficial clinical response and lack of harmful side effects are covered.

182. Does the covered service require prior authorization: N=53

Yes	**45 (85%)**
No	8 (15%)

	Yes (%)	No (%)
Urban	41 (85%)	7 (15%)
Rural	4 (80%)	1 (20%)

	Yes (%)	No (%)
Commercial/Self	38 (84%)	7 (16%)
Medicare	6 (86%)	1 (14%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	16 (89%)	2 (11%)
Large	9 (82%)	2 (18%)
Small	13 (81%)	3 (19%)

183. Are there any services in this category available without prior authorization: N = 45

Yes	**39 (87%)**
No	6 (13%)

	Yes (%)	No (%)
Urban	36 (88%)	5 (12%)
Rural	3 (75%)	1 (25%)

	Yes (%)	No (%)
Commercial/Self	36 (95%)	2 (5%)
Medicare	2 (33%)	4 (67%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	15 (94%)	1 (6%)
Large	8 (89%)	1 (11%)
Small	13 (100%)	0

184. Please describe services in this category available without prior authorization:

- 26 respondents indicated PA required for Dorsal Column Stimulation, joint injections, facet injections, epidural steroid, spinal denervation, regional sympathetic block.
- 6 respondents indicated medically necessary, non-surgical outpatient procedures available without PA.
- 2 respondents indicated most joint and tendon injections do not require PA, but most others do.
- 1 respondent indicated trigger point injections are available without PA, all others do.
- 4 respondents indicated some unspecified services are available without PA.

185. Please provide any limits on the duration of the PA.:

- 26 respondents indicated a limit of 6 months or subject to clinical review.
- 2 indicated the typical authorization window is 3 months.
- 1 indicated the initial request is authorized for 90 days but can be reauthorized.

186. Prior to authorizing, must the patient/provider verify that other treatments have not or will not be effective? (i.e., step-therapy) N=45

Yes	**36 (80%)**
No	9 (20%)

	Yes (%)	No (%)
Urban	33 (80%)	8 (20%)
Rural	3 (75%)	1 (25%)

	Yes (%)	No (%)
Commercial/Self	31 (82%)	7 (18%)
Medicare	4 (67%)	2 (33%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	10 (63%)	6 (37%)
Large	8 (89%)	1 (11%)
Small	13 (100%)	0

INTERDISCIPLINARY CARE

187. Is interdisciplinary care covered under this plan: N=55

Yes	**6 (11%)**
No	49 (89%)

	Yes (%)	No (%)
Urban	5 (10%)	45 (90%)
Rural	1 (20%)	4 (80%)

	Yes (%)	No (%)
Commercial/Self	2 (5%)	45 (95%)
Medicare	4 (57%)	3 (43%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	1 (6%)	17 (94%)
Large	1 (8%)	12 (92%)
Small	0	16 (100%)

Question 188-189 had no responses

190. Are there limitations/exclusions applied to this service: N=6

Yes	**5 (17%)**
No	1 (83%)

191. Please describe limitations/exclusions to the covered services:

- No responsive answers.

192. Do these covered services require prior authorization: N = 6

Yes	**0 (0%)**
No	6 (100%)

Questions 193 to 196 had no responses

OTHER NON-OPIOID PAIN MANAGEMENT OPTIONS

197. Are other non-opioid pain management options (e.g., acupuncture, massage, self-management programs, biofeedback, chiropractic and osteopathic manipulation, durable medical equipment, other external electrical stimulation) covered by the plan: N=55

Yes	**53 (96%)**
No	2 (4%)

No= Some Urban, Commercial/Self Insured (n=1) and Medicare (n=1), and Large Group Plans

198. Please specify other non-opioid pain management services or strategies covered:

Below is the list of services respondents indicated were covered, along with the number of responses:

Services Listed	# of Responses
Biofeedback, chiropractic treatment, and medically necessary durable medical equipment.	1
Biofeedback, chiropractic, durable medical equipment, self-management programs, and external electrical stimulation	1
Chiropractic (spinal manipulation), physical therapy, durable medical equipment as well as non-opioid pain management services provided by a pain management specialist.	1
Chiropractic and osteopathic manipulation: covered. Most plans have a frequency limit per year. Durable Medical Equipment(DME): Eligible DME is covered.	1
Chiropractic care, acupuncture, durable medical equipment, non experimental medically necessary treatment	1
Chiropractic care, DME	5
Chiropractic care, OMT, DME	4
Chiropractic care, OMT, DME.	1
Chiropractic, acupuncture, durable medical equipment, non-experimental medically necessary services	1
DME, acupuncture, chiropractic	1
DME, Biofeedback, chiropractic service, external electrical stimulation	1
Eg; Chiropractic, osteopathic manipulation, durable medical equipment, biofeedback. (Other self-funded groups may also elect to cover acupuncture, but most do not.)	1
OMT	1
Rental (not to exceed the purchase price) of a wheelchair, hospital bed, or other durable portable medical equipment Provided to an Insured in each event required for therapeutic treatment of Injuries or Sickness on an Outpatient basis.	5
Routine Chiro covered on some plans	1
RX not covered. Medical Only Plan	2
Self-management, DME	1
Medically necessary spinal manipulations and adjustments of the spine, durable medical equipment and acupuncture if performed by a licensed acupuncturist and prescribed by a licensed physician.	1
Medicare-covered services (e.g., chiropractic and osteopathic manipulation and durable medical equipment) and acupuncture.	1

NALOXONE

199. Does the plan cover Naloxone: N=55

Yes	**46 (84%)**
No	9 (16%)

	Yes (%)	No (%)
Urban	41 (82%)	9 (18%)
Rural	5 (100%)	0

	Yes (%)	No (%)
Commercial/Self	38 (81%)	9 (19%)
Medicare	7 (100%)	0
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	13 (72%)	5 (28%)
Large	10 (77%)	3 (23%)
Small	15 (94%)	1 (6%)

200. Do these require prior authorization for Naloxone: N = 55

Yes	**2 (4%)**
No	53 (96%)

Yes= Some Urban, Commercial/Self Insured, and Large (n=1) and Small (n=1) Group Plans

201. Does the plan cover naloxone dispensed by a pharmacy through a standing order: N = 55

Yes	**45 (82%)**
No	10 (18%)

	Yes (%)	No (%)
Urban	40 (80%)	10 (20%)
Rural	5 (100%)	0

	Yes (%)	No (%)
Commercial/Self	37 (79%)	10 (21%)
Medicare	7 (100%)	0
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	19 (90%)	2 (10%)
Large	6 (38%)	10 (62%)
Small	9 (60%)	6 (40%)

202. Are there limitations/exclusions applied to this service: N = 55

Yes	**40 (73%)**
No	15 (27%)

	Yes (%)	No (%)
Urban	38 (76%)	12 (24%)
Rural	2 (40%)	3 (60%)

	Yes (%)	No (%)
Commercial/Self	36 (77%)	11 (23%)
Medicare	3 (43%)	4 (47%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	13 (72%)	5 (28%)
Large	9 (69%)	4 (31%)
Small	15 (94%)	1 (6%)

203. Please describe limitations/exclusions to the covered services:

- 1 respondent indicated Evzio may be excluded from coverage. Naloxone may have supply limits (example given was 2 Narcan autoinjectors covered per copay).

MEDICAL MANAGEMENT MECHANISM RELATED TO OUD

MEDICAL MANAGEMENT MECHANISM RELATED TO OUD – PCP REFERRAL TO SPECIALISTS

204. Does your plan have PCP referral to specialists as a type of medical management mechanism that is related to opioid use disorder: N=55

Yes	**4 (7%)**
No	51 (93%)

	Yes (%)	No (%)
Urban	3 (6%)	47 (91%)
Rural	1 (25%)	4 (75%)

	Yes (%)	No (%)
Commercial/Self	2 (4%)	45 (96%)
Medicare	2 (29%)	5 (71%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	1 (6%)	17 (94%)
Large	1 (8%)	12 (92%)
Small	0	16 (100%)

205. Please list the services to which this applies:

- No responsive answers.

MEDICAL MANAGEMENT MECHANISM RELATED TO OUD – STEP THERAPY

206. Does your plan have step therapy as a type of medical management mechanism that is related to opioid use disorder: N=55

Yes	**7 (13%)**
No	48 (87%)

	Yes (%)	No (%)
Urban	7 (14%)	43 (86%)
Rural	0	5 (100%)

	Yes (%)	No (%)
Commercial/Self	5 (11%)	42 (89%)
Medicare	2 (29%)	5 (71%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	2 (11%)	16 (89%)
Large	3 (23%)	10 (77%)
Small	0	16 (100%)

207. Please list the services to which this applies:

- 3 respondents indicated it applied to certain outpatient services, medication step therapy and inpatient services.
- 3 respondents gave examples of admission to an RTC or any other inpatient facility, and for certain medication treatment.
- 1 respondent indicated it applied to outpatient services other than practitioner office visits, medication step therapy and all inpatient services other than stabilization less than 24 hours.

MEDICAL MANAGEMENT MECHANISM RELATED TO OUD – PRIOR AUTH

208. Does your plan have prior authorization as a type of medical management mechanism that is related to opioid use disorder: N=55

Yes	**39 (71%)**
No	16 (29%)

	Yes (%)	No (%)
Urban	36 (72%)	14 (28%)
Rural	3 (60%)	2 (40%)

	Yes (%)	No (%)
Commercial/Self	34 (72%)	13 (28%)
Medicare	4 (57%)	3 (43%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	12 (67%)	6 (33%)
Large	9 (69%)	4 (31%)
Small	13 (81%)	3 (19%)

209. Please list the services to which this applies:

- 24 respondents indicated it applies to detoxification, inpatient and residential treatments, partial hospitalization and intensive outpatient programs.
- 6 respondents indicate it applies to inpatient services.
- 3 respondents indicated it applies to certain outpatient services, medication step therapy and all inpatient services.
- 2 respondents indicated it applies to admission to RTC or any other inpatient facility, as well as certain medication treatment.
- 1 respondent indicated it applies to admission to RTC or any other inpatient facility.
- 1 respondent indicated that inpatient services require PA and are subject to medical management.
- 1 respondent indicated it applies to outpatient services other than practitioner office visits, medication step therapy and all inpatient services other than stabilization less than 24 hours.

MEDICAL MANAGEMENT MECHANISM RELATED TO PAIN MGMT

MEDICAL MANAGEMENT MECHANISM RELATED TO PAIN MGMT – PCP REFERRAL TO SPECIALIST

210. Does your plan have PCP referral to specialists as a type of medical management mechanism that is related to pain management: N=55

Yes	**7 (13%)**
No	48 (87%)

	Yes (%)	No (%)
Urban	6 (12%)	44 (88%)
Rural	1 (20%)	4 (80%)

	Yes (%)	No (%)
Commercial/Self	4 (9%)	43 (91%)
Medicare	3 (43%)	4 (57%)
University Student	0	1 (100%)

	Yes (%)	No (%)
Individual	2 (11%)	16 (89%)
Large	2 (15%)	11 (85%)
Small	0	16 (100%)

211. Please list the services to which this applies:

- 4 respondents indicated interventional services and all specialty visits.
- 1 respondent indicated all services except OB/GYN, Emergency and Urgent Care.
- 1 respondent indicated epidural steroid injections, radiofrequency ablations and imaging services.

MEDICAL MANAGEMENT MECHANISM RELATED TO PAIN MGMT – STEP THERAPY

212. Does your plan have step therapy as a type of medical management mechanism that is related to pain management: N=55

Yes	**33 (60%)**
No	22 (40%)

	Yes (%)	No (%)
Urban	31 (62%)	19 (38%)
Rural	2 (40%)	3 (60%)

	Yes (%)	No (%)
Commercial/Self	29 (62%)	18 (38%)
Medicare	3 (43%)	4 (57%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	10 (56%)	8 (44%)
Large	9 (69%)	4 (31%)
Small	10 (62%)	6 (38%)

213. Please list the services to which this applies:

- 23 respondents indicated most generics available in several drug classes do not require PA (e.g., oral and topical NSAIDs, TCA antidepressants, gabapentin, Lyrica).
- 4 respondents indicate it applies to interventional services.
- 1 respondent indicated step therapy applies to the start of certain opioid medications, prior to radiofreqency ablation, prior to botox injection and prior to epidural steroid injections.
- 1 respondent indicated it applied to opioid addiction treatment medication, radiofrequency ablation, botox injection, epidural steroid injections.
- 1 respondent indicated it applies to radiofreqency ablation, botox injection and epidural steroid injections.
- 2 respondents indicated it applies to unspecified "designated medications."

MEDICAL MANAGEMENT MECHANISM RELATED TO PAIN MGMT – PRIOR AUTH

214. Does your plan have prior authorization as a type of medical management mechanism that is related to pain management: N=55

Yes	**42 (76%)**
No	13 (24%)

	Yes (%)	No (%)
Urban	38 (76%)	12 (24%)
Rural	4 (80%)	1 (20%)

	Yes (%)	No (%)
Commercial/Self	36 (77%)	11 (23%)
Medicare	5 (71%)	2 (29%)
University Student	1 (100%)	0

	Yes (%)	No (%)
Individual	12 (67%)	6 (33%)
Large	10 (77%)	3 (23%)
Small	14 (88%)	2 (12%)

215. Please list the services to which this applies:

- 24 respondents indicated it applies to joint injections, facet injections, epidural steroid, spinal denervation, regional sympathic blocks.
- 7 respondents indicated it applies to inpatient services.
- 4 respondents indicated it applies to some (unspecified) medications.
- 2 respondents indicated it applies to injections, pain management services, physical therapy, and implants.
- 2 respondents indicated it applies to interventional services and specialty visits, and 1 additional respondent indicated it applies to interventional visits only.
- 1 respondent indicated it applies to epidural steroid injections, facet joint injections, radiofrequency ablation, and spinal cord stimulation.
- 1 respondent indicated it applies to radio frequency ablation, epidural steroid injections, facet injections, spinal cord stimulation.
- 1 respondent indicated it applies to initial/new pain management consults, sympathectomies, neurotomies, injections, infusions, blocks, pumps or implants.
- 1 respondent indicate Probuphine and Sublocade require the member to be established on oral or transmucosal buprenorphine.

Appendix C – Arizona's Substance Use Disorder Medicaid Benefit

Arizona's Substance Use Disorder (SUD) Medicaid Benefit

June 8, 2018

The Arizona Health Care Cost Containment System (AHCCCS) is the statewide Medicaid program that provides healthcare coverage to 1,849,093 Arizonans as of 6/1/18.

AHCCCS covers the full continuum of care for all Medicaid members with substance use disorders (SUDs) when medically necessary as detailed in Table I. There are no limitations/exclusions for services described in Table I apart from meeting medical necessity criteria with the following exceptions:

1) Other recovery supports: respite services--capped at 600 hours per member per year
2) Outpatient Physical therapy
    a. Limited to 15 visits per benefit year to restore a particular skill or function the individual previously had but lost due to injury or disease and maintain that function once restored
    b. Limited to 15 visits per benefit year to attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired
3) Chiropractic services: EPSDT-aged members only

For prior authorization (PA) requirements per service category, please refer to health plan-specific information contained within each respective health plan's completed survey.

For the pharmacy benefit, all AHCCCS contractors are required to maintain their own drug list to meet the unique needs of the members they serve; at a minimum, the Contractor's drug list must include all of the drugs listed on the AHCCCS Drug Lists. Contractors are prohibited from adding PA and/or step therapy requirements to medications listed on the AHCCCS Drug Lists when the list does not specify these requirements. Contractors may cover an over-the-counter medication under the pharmacy benefit when it is prescribed in place of a covered prescription medication that is clinically appropriate, equally safe and effective, and more cost effective than the covered prescription medication.

For more information about the behavioral health services available through AHCCCS, please see the AHCCCS Covered Behavioral Health Services Guide.

Table I

Service Category	Medicaid Coverage	Service Description/Additional Information
Inpatient Services	X	Continuous treatment that includes psychiatric care, medical detoxification, and/or medical services in a general hospital, general hospital with a distinct part, or a freestanding psychiatric facility. Requires 24 hour nursing supervision and physicians on-site and on-call.
Partial Hospitalization	X	H0035 and S0201 are not currently covered. However, AHCCCS does cover day treatment programs.
Intensive Outpatient Services	X	Specialized outpatient substance abuse programs provide 6-9 hours of active treatment per week; services may include: individual, group and/or family behavioral health counseling and therapy, skills training and development, behavioral health prevention/promotion, medication training and support, ongoing support to maintain employment, family support, medication monitoring, case management, self-help/peer services, and/or medical monitoring including detoxification services.

Residential Treatment	X	Structured treatment setting with 24 hour supervision and counseling or other therapeutic activities for persons who do not require on-site medical services, under the supervision of an on-site or on-call behavioral health professional.
Counseling/behavioral therapy	X	Individual, group, and family counseling/therapy services
Case Management	X	• Assistance in maintaining, monitoring and modifying covered services; • Brief telephone or face-to-face interactions with a person, family or other involved party for the purpose of maintaining or enhancing a person's functioning; • Assistance in finding necessary resources other than covered services to meet basic needs; • Communication and coordination of care with the person's family, behavioral and general medical and dental health care providers, community resources, and other involved supports including educational, social, judicial, community and other State agencies; • Coordination of care activities related to continuity of care between levels of care (e.g., inpatient to outpatient care) and across multiple services (e.g., personal assistant, nursing services and family counseling); • Outreach and follow-up of crisis contacts and missed appointments; • Participation in staffings, case conferences or other meetings with or without the person or their family participating; and • Other activities as needed that are not explicitly excluded.
Other Recovery Supports	X	• Skills training and development • Health Promotion including Medication Training • Pre-Job Training and Job Development • Job Coaching and Employment Support • Cognitive Rehabilitation • Personal Care Services • Family Support • Peer Support • Supported Housing • Transportation • Crisis Intervention Services
Medication Assisted Treatment	X	AHCCCS covers all FDA approved medications to treat SUD, medication management, counseling/behavioral therapy, laboratory services, case management and other recovery supports as indicated in other rows on this table
Naltrexone (tablets)	X	Available statewide without prior authorization
Naltrexone (injectable)	X	Available statewide without prior authorization
Methadone	X	Available statewide without prior authorization
Buprenorphine/naloxone	X	Available statewide without prior authorization
Buprenorphine	X	Available statewide without prior authorization for pregnant women (PA removed effective 7/1/18)

Laboratory services (urine or blood screenings for substances)	X	Medical tests ordered for diagnosis, screening or monitoring of a behavioral health condition includes blood and urine tests when medically necessary
Screening, brief intervention, and referral to treatment (SBIRT)	Not Covered	AHCCCS covers 96160 and 96161 in addition to evaluation and management codes
Other substance use screening tools	X	AHCCCS covers H0002
Non-opioid pain medications	X	AHCCCS Acute-Long Term Care Drug List contains non-narcotic medications available without prior authorization as further outlined in rows below
Non-opioid pain medication: acetaminophen	X	The following acetaminophen preparations are available on the AHCCCS Drug List without PA: acetaminophen capsules, chewable tablets, elixir, liquid, suppository, and suspension
Non-opioid pain medication: NSAIDs	X	The following NSAIDs are available on the AHCCCS Drug List without PA: diclofenac, etodolac, fenoprofen, flurbiprofen, ibuprofen, indomethacin, ketoprofen, ketorolac, meloxicam, nabumetone, naproxen, oxaprozin, piroxicam, suldinac
Non-opioid pain medication: corticosteroids	X	The following corticosteroids are available on the AHCCCS Drug List without PA: dexamethasone, methylprednisolone, and prednisolone
Non-opioid pain medication: anticonvulsants	X	The following anticonvulsants are available on the AHCCCS Drug List without PA: carbamazepine, gabapentin, lamotrigine, levetiracetam, oxcarbazepine, primidone, topiramate, zonisamide
Non-opioid pain medication: disease modifying anti-rheumatic drugs	X	The following anti-rheumatic drugs are available on the AHCCCS Drug List without PA: methotrexate. Adalimumab and etanercept are also available with PA.
Non-opioid pain medication: tricyclic antidepressants, SSRIs, SNRIs	X	The following TCAs, SSRIs and SNRIS are available on the AHCCCS Drug List without PA for members age six and older: citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline, desvenlafaxine, duloxetine, venlafaxine, amitriptyline, amoxapine, clomipramine, desipramine, doxepin, imipramine, maprotiline, nortriptyline, protriptyline, trimipramine
Non-opioid pain medication: topical agents	X	The following local anesthetics are available without PA: lidocaine cream, gel, lotion, solution, ointment and lidocaine-prilocaine cream
Psychological therapy (cognitive behavioral therapy)	X	CBT is a covered BH benefit when medically necessary
Physical therapy (PT)	X	Outpatient PT benefit limit 15/15 per year
Exercise therapy	Not covered	
Interventional Procedures (spinal cord stimulation, joint injections, steroid injections)	X	Covered when medically necessary with PA requirements as outlined in contractor survey results
Interdisciplinary care	X	99367, 99368, 99366, and G0175 are covered codes

Acupuncture	Not covered	
Massage	Not covered	
Self-management programs	X	Covered as an administrative benefit through health plans (care management for chronic condition)
Biofeedback	X	Biofeedback is covered modality under BH benefit
Chiropractic services	Covered with exclusions	Covered benefit for EPSDT aged children aged 0 to 21 years of age
Osteopathic manipulation	X	Covered when medically necessary
Durable Medical Equipment	X	AHCCCS covers medically necessary medical equipment and medical supplies under the home health services benefit as delineated within AHCCCS policy.
Naloxone	X	On AHCCCS Drug List and BH Drug List without prior authorization

Appendix D – Arizona's Opioid Use Disorder and Non-Opioid Pain Management Worker's Compensation Benefit

Arizona's Opioid Use Disorder (OUD) and Non-Opioid Pain Management Worker's Compensation Benefit

June 2018

Arizona's Worker's Compensation offers comprehensive services for treatment of Opioid Use Disorder (OUD) as well as non-opioid pain management alternatives.

Of note, per statute, preauthorization is not required for reasonable and appropriate medical treatment related to the industrial injury. Although preauthorization is not required most medical providers seek preauthorization to ensure payment for medical treatment or services.

Arizona WC utilizes the Official Disability Guidelines (ODG) Appendix A Drug Formulary. Pharmacy Benefit Management (PBM) are used by most all of the payers.

Service Category	Coverage	Additional Information
Inpatient Services	Yes	Pursuant to A.R.S. 23-1062.02(F)
Partial Hospitalization	Yes	Pursuant to A.R.S. 23-1062.02(F)
Intensive Outpatient Services	Yes	
Residential Treatment	Yes	Covered, however, Fee Schedule does not set fees for inpatient/outpatient hospital or residential programs.
Counseling/behavioral therapy	Yes	Covered under Fee Schedule
Case Management	Yes	Case management Conferences are covered. Most payers utilize case management services to assist patients with detoxification and rehabilitation services
Other Recovery Supports	Yes	Cognitive Rehabilitation, Transportation, Crisis Interventions Services covered under Fee Schedule
Medication Assisted Treatment	Yes	Covered under Fee Schedule
Naltrexone (tablets)	Yes	Covered on Drug Formulary
Naltrexone (injectable)	Yes	Covered on Drug Formulary
Methadone	Yes	Not on the Drug Formulary, however, payers can authorize
Buprenorphine/naloxone	Yes	Covered on Drug Formulary
Buprenorphine	Yes	
Laboratory services (urine or blood screenings for substances)	Yes	Covered under Fee Schedule
Screening, brief intervention, and referral to treatment (SBIRT)	Yes	Covered under Fee Schedule
Other substance use screening tools	No	
Non-opioid pain medications	Yes	Covered on Drug Formulary
Non-opioid pain medication: acetaminophen	Yes	Covered on Drug Formulary
Non-opioid pain medication: NSAIDs	Yes	Covered on Drug Formulary, except Indomethacin and Piroxicam

Non-opioid pain medication: corticosteroids	Yes	Covered on Drug Formulary, except Dexamethasone
Non-opioid pain medication: anticonvulsants	Yes	Covered on Drug Formulary, except Carbamazepine, Lamotrigine; Levetiracetam; Topiramate; and, Zonisamide
Non-opioid pain medication: disease modifying anti-rheumatic drugs	No	Rheumatoid typically not a WC injury
Non-opioid pain medication: tricyclic antidepressants, SSRIs, SNRIs	Yes	Covered on Drug Formulary
Non-opioid pain medication: topical agents	Yes	Voltaren and Ben are covered on Drug Formulary
Psychological therapy (cognitive behavioral therapy)	Yes	Covered under Fee Schedule
Physical therapy (PT)	Yes	Covered under Fee Schedule
Exercise therapy	Yes	Covered under Fee Schedule
Interventional Procedures (spinal cord stimulation, joint injections, steroid injections)	Yes	Covered under Fee Schedule but Treatment Guidelines does not recommend for all joints (i.e. Cervical not recommended)
Interdisciplinary care	Yes	CPT Codes 99367, 99368 and 99366 are covered under Fee Schedule
Acupuncture	Yes	Covered under Fee Schedule
Massage	Yes	Covered under Fee Schedule
Self-management programs	No	
Biofeedback	Yes	
Chiropractic services	Yes	Covered under Fee Schedule
Osteopathic manipulation	Yes	Covered under Fee Schedule
Durable Medical Equipment	Yes	The Industrial Commission does not set fees or regulate DME. Payers negotiate with DME vendors.
Naloxone	Yes	Covered on Drug Formulary

Appendix G

Federal Barriers Letter

STATE OF ARIZONA
OFFICE OF THE GOVERNOR

DOUGLAS A. DUCEY
GOVERNOR

EXECUTIVE OFFICE

June 1, 2018

Jim Carroll
Acting Director
U.S. Office of National Drug Control Policy
The White House
1600 Pennsylvania Ave., NW
Washington, DC 20500

Alex Azar
Secretary
U.S. Department of Health & Human Services
1600 Pennsylvania Ave., NW
Washington, DC 20500

Dear Director Carrol and Secretary Azar,

The opioid epidemic, impacting the entire nation, requires swift state and federal action, including removing barriers to save lives. Last year, 790 deaths in Arizona were directly related to opioids, more than two Arizonans each day.

On June 5, 2017, Arizona declared a State of Emergency in response to the opioid epidemic plaguing our state in order to support the development of a sustainable plan to address and mitigate the opioid crisis we are facing.

The Arizona Department of Health Services was tasked to identify the elements for an Enhanced Surveillance Advisory, develop training programs for healthcare professionals and first responders, and provide a report on findings and recommendations, including additional needs and response activities, and recommendations that require legislative action within our state.

During this process we have identified a number of federal barriers to Arizona's ability to effectively serve our citizens who are impacted by an opioid use disorder.

One of the greatest barriers Arizona faces is the prohibition of Medicaid reimbursement for inpatient stays longer than 15 days. This Institute of Mental Disease (IMD) exclusion impacts approximately 24 facilities and 1,700 individuals throughout Arizona. The IMD exclusion prevents Arizonans from getting effective inpatient treatment they need to break their addiction.

With a nationwide shortage of inpatient beds, healthcare professionals, and treatment programs, this federal restriction should be removed for all states, most critically for substance use disorder, immediately.

Another critical barrier is the current Medicaid rules restricting the coverage of Medication-assisted Treatment (MAT) programs for individuals who are in state or county correctional institutions. In 2017, the Arizona Department of Corrections reported that 77 percent of the 42,184 inmates assessed at intake had histories of significant substance abuse. Of those identified only 732 were enrolled into an addiction treatment program. We must do all we can to help individuals who are incarcerated overcome their addictions, including providing evidence based MAT therapy, in order to reduce recidivism, provide people with a second chance and become productive Arizona citizens. Indeed, these rules are contributing to a cycle of crime, costly incarceration, and a return to crime and prison because of addiction. These rules should be suspended and reevaluated to get effective treatment to those in state or county correctional facilities.

A significant contributor to the over prescribing of opioid medication is the Centers for Medicare and Medicaid Services (CMS) Hospital Consumer Assessment of Healthcare and Providers and Systems (HCHAP) still utilizes a pain satisfaction score in its overall hospital ratings which does not align with the current efforts to reduce opioid use. This score has already been removed from the HCHAP reimbursement formula but this initial assessment score causes Arizona to rank below the national average with patients who report that their pain was "always well controlled." The HCHAP should eliminate this scale from the survey to further enhance efforts to reduce the number of opioids being prescribed. We know that keeping people from getting addicted is the one sure way to reduce overdose and death, and eliminating this scale from the survey will help empower healthcare providers to make evidence based decisions.

While Arizona leads the nation in gathering real time data on this crisis, a significant federal barrier to understanding the scope of the epidemic are federal regulations regarding reporting restrictions from certain facilities. Currently CFR 42, Chapter I, Subchapter A, Part 2 prohibits facilities from sharing substance abuse use disorder data which is a hindrance to comprehensive health care and surveillance program in our state. These privacy protections were certainly well intentioned, but are impeding turning the tide on the opioid epidemic. The reporting restrictions should be removed and a requirement of federal facilities to meet HIPPA requirements should be instituted.

Lastly, the presence of federally controlled health care facilities, with no state oversight or state reporting requirements presents multiple challenges for Arizona. First, we request that federal health care facilities maintain state licensure. Currently, federal health care facilities do not meet the same requirements as other health care facilities in our state. This divide creates confusion for our citizens, and allows a disparate level of care to be delivered to our veterans and members of our Indian Tribes. Arizona wants to ensure that members of our community receive quality care regardless of the facility, be it federal, state or privately owned.

We would also request a requirement for federal healthcare providers to input dispensing data into the states' prescription drug monitoring programs. Without federal participation in the states drug monitoring program, there is an increased risk for over prescribing and dispensing. This would also include participating in state based communicable and non-communicable disease reporting, allowing Arizona's health care professionals access to information about an at-risk population and the potential impact to their communities.

Although these requests are spread across the full spectrum of federal health care agencies, a unified and cooperative approach from local, state, and federal health care providers is the only way that we can have an immediate and sustainable impact to this ever-growing crisis effecting not only Arizona but our country as a whole.

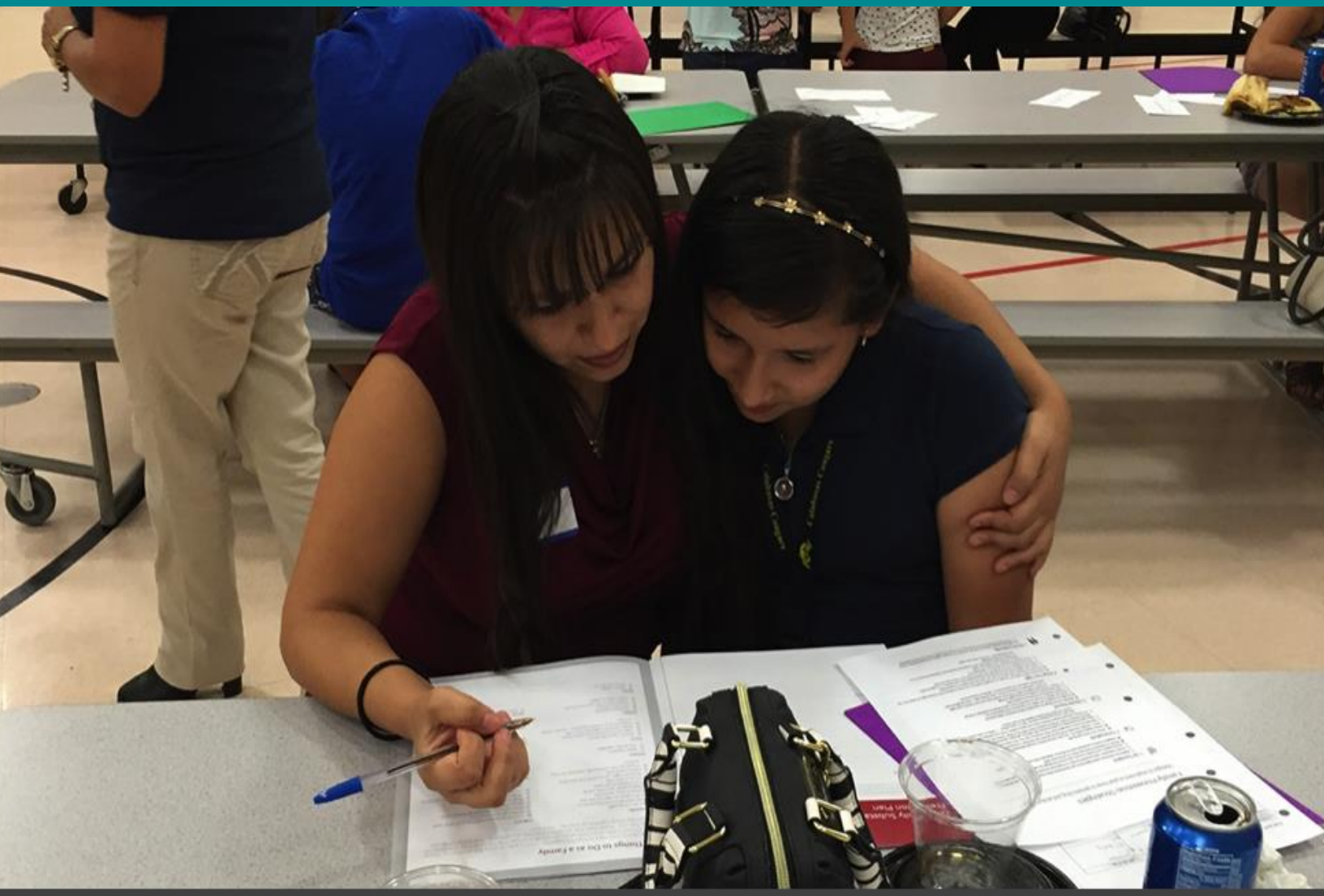
I hope that the work Arizona continues to do, and with the identifying of these federal barriers, we can form a partnership with the common goal and unwavering commitment to enhance the quality of healthcare and safety of our citizens.

Sincerely,

Douglas A. Ducey
Governor
State of Arizona

Appendix H

Youth Substance Abuse Prevention Report



School Substance Abuse Prevention Program Inventory:

Results and Recommendations

School Substance Abuse Prevention Program Inventory:

Results and Recommendations

Prepared by

Catie Clark, Director of the Statistical Analysis Center
Ashley Mully, Research Analyst

On behalf of

Governor's Goal Council on Healthy People, Places & Resources: Youth Prevention Sub-Team
Governor's Office of Youth, Faith and Family
Substance Abuse Epidemiology Work Group

The Arizona Criminal Justice Commission's Statistical Analysis Center would like to thank the Arizona National Guard's Counter Drug Task Force for their assistance in obtaining the survey data provided in this report, as well as the Governor's Office of Youth, Faith and Family and the Arizona Department of Education for their support of this project.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ARIZONA NATIONAL GUARD

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Executive Summary

In 2017, the Governor's Goal Council on Healthy People, Places & Resources created a sub-group of substance abuse and education experts from across Arizona, known as the Youth Prevention Sub-Team. At the direction of the Healthy Families Goal Council, and with the current opioid epidemic in mind, the group sought to gather information on the status of youth substance abuse prevention programming that is currently available in all primary and secondary schools in Arizona, and to evaluate and recommend the top substance abuse prevention and out-of-school programs for Arizona schools. The Youth Prevention Sub-Team partnered with the Substance Abuse Epidemiology Work Group (Epi), the Arizona Criminal Justice Commission (ACJC), and the Arizona National Guard's Counter Drug Task Force to construct a survey of Arizona's schools on the availability of programming for students, as well as the dissemination, collection, and reporting of data produced.

Findings from the Substance Abuse Prevention Programming Inventory (SAPPI) survey indicate that few schools in Arizona currently provide substance abuse prevention programming to students, and of those that are able to provide programming most programs have only started in the past one to two years. Compared with data from the 2016 Arizona Youth Survey (AYS) it appears that there is a substantial gap in Arizona schools in terms of the need for prevention programming and the accessibility of these programs.

As schools work to identify substance abuse prevention programming, it is critical that they first determine the level and types of needs that are present in their student population, and then select a prevention program that is suitable to both the specific needs of their students, as well as to the financial ability of the institution to initiate and maintain quality programming. Recommendations from this report include:

1. Continuation and expansion of the use of evidence-based substance abuse prevention programs such as those recommended in this report.

2. Continuation and expansion of funding for school-based substance abuse prevention programs and after-school programs.

3. Continuation of back-to-school substance abuse programs such as the Healthy Families Healthy Youth program in conjunction with ongoing evidence-based and evidence-informed prevention programs throughout the school year.

4. Further equipping schools with tools and timely data in the determination of needs and measurement of outcomes.

Introduction

In response to the drug epidemic that is sweeping the country and effecting all Arizona communities, Governor Doug Ducey took actions that improved access to substance abuse treatment, enacted a Good Samaritan law, increased public messaging on the dangers of opioid misuse and abuse, and strengthened laws that limit the number of opioids dispensed while protecting individuals suffering from chronic and debilitating pain.

As part of the continued efforts to end this epidemic, the Governor's Office of Youth, Faith and Family (GOYFF), in partnership with the Arizona Department of Education, and the Youth Prevention Sub-Team of the Governor's Goal Council on Healthy People, Places & Resources, conducted an inventory of substance abuse prevention programs that are currently being implemented in Arizona schools.

The purpose of this inventory is to assess potential gaps in these prevention services in order to make recommendations on prevention and afterschool programs for Arizona schools. The Arizona Substance Abuse Epidemiology Work Group and the Arizona Criminal Justice Commission facilitated the collection of this information with guidance and support from the members of the Youth Prevention Sub-Team and on behalf of the Governor's Office of Youth, Faith and Family and the Governor's Goal Council on Healthy People, Places & Resources.

The following charts and tables present statewide response trends on a number of metrics included in the Substance Abuse Prevention Program Inventory Survey (SAPPI). When applicable, results from this survey are compared to the 2016 Arizona Youth Survey (AYS) results. The following results are reported:

- Schools reporting substance abuse programs
- Risk factors targeted by schools
- Protective factors targeted by schools
- Additional programs provided by schools
- Mental health resources provided by schools

Survey Administration

The survey instrument (Appendix B) was developed by the Arizona Criminal Justice Commission's Statistical Analysis Center (AZSAC) in conjunction with the members of

the Youth Prevention Sub-Team. The survey was sent out to a list of Arizona schools[1] during the spring semester of 2018. Schools were then contacted by members of the Arizona National Guard's Counter Drug Task Force to facilitate participation in the survey.

Survey Participation

The survey instrument was distributed to a list of 3,978 individual contacts provided by the Arizona Department of Education. Included in the email was a letter from the Superintendent of Public Education, Diane Douglas, and Director of the Governor's Office of Youth, Faith and Family, Maria Cristina Fuentes (Appendix A), requesting participation in the study.

Table 1: Respondent Participation, Total and Percentage Relative to State

	Districts Participating[2]	Total Districts	% of District Participation	Schools Participating[3]	Total Schools	% of School Participation
Apache	4	11	36.36%	5	36	13.89%
Cochise	4	22	18.18%	4	67	5.97%
Coconino	5	10	50.00%	17	62	27.42%
Gila	6	9	66.67%	5	27	18.52%
Graham	2	9	22.22%	2	32	6.25%
Greenlee	1	4	25.00%	1	6	16.67%
La Paz	1	6	16.67%	2	12	16.67%
Maricopa	62[4]	58	106.90%	100	1145	8.73%
Mohave	4	14	28.57%	3	61	4.92%
Navajo	2	14	14.29%	3	76	3.95%
Pima	6	18	33.33%	7	336	2.08%
Pinal	2	21	9.52%	4	117	3.42%
Santa Cruz	3	6	50.00%	5	25	20.00%
Yavapai	5	25	20.00%	11	95	11.58%
Yuma	4	10	40.00%	3	71	4.23%

[1] A list of contacts was provided by the Arizona Department of Education.
[2] Schools and Districts that attempted to complete or completed the SAPPI Survey. Note that not all Schools and Districts reported here completed the survey in its entirety; please refer to the sample size listed for each table and figure included in this report.
[3] Numbers obtained from the Annual Report of the Arizona Superintendent of Public Instruction (Arizona Department of Education, 2017). The total of Arizona schools includes charter schools.
[4] The Annual Report of the Arizona Superintendent of Public Instruction (Arizona Department of Education, 2017) lists 58 districts for Maricopa County. However, there are an additional 281 charter holders in Maricopa County that have not been included in the State of Arizona numbers, as the AZSAC is unable to verify how many of those 281 represent individual school districts.

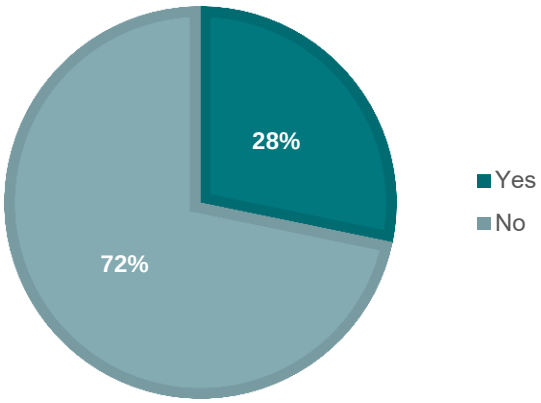
TOTAL	**111**	**237**	**46.84%**	**172**	**2168**	**7.93%**

The Arizona National Guard's Counter Drug Task Force was provided with the contact list, and members reached out to schools to encourage participation in the survey.[5] Table 1 presents the results of the survey administration, demonstrating that approximately 47% of districts and 8%[6] of schools in Arizona are represented in the survey findings presented in this report.

Substance Abuse Programs

Participating respondents were asked to report whether their school had a substance abuse prevention program currently available. As shown in Figure 1[7], the vast majority (n=122) of schools that participated in the survey reported that they do not currently have any form of substance abuse prevention programming available for students.

Figure 1: Schools Reporting Availability of Programming



Participants were also asked to report the number of prevention programs that were currently available to students at their school. Of those who responded (n=52), approximately 69% (n=36) indicated that they had only one prevention program, while 31% (n=16) reported they had two or more programs. Survey respondents were also asked to provide the name of the prevention program available at their school. Of those who responded, the most common programs listed include the Healthy Family Healthy

[5] As the National Guard called school across Arizona, many of the schools disclosed that they did not provide prevention programs but that they were greatly needed in their school and community.
[6] While the percentage of participating schools is low, the information cleaned from the survey give strong insights into the prevalence of substance abuse prevention programing in schools.
[7] 170 schools responded to this question in the SAPPI.

Youth program provided by the GOYFF (41%; n=56); a variety of programs funded through grant opportunities with the GOYFF, such as Botvin LifeSkills, Project SUCCESS, and Too Good for Drugs, among others (33%; n=45); and law enforcement partnerships and various other substance abuse programs (25%; n=34). Of the respondents who reported the length of time that their prevention program has been in existence, 46% (n=24) indicated that the program began in 2017 or later. It should be noted that of these programs, all are funded through grants provided by the GOYFF. These grants are provided on a three-year funding cycle, and as such, it can be expected that the programs will end between 2019 and 2020 without continued funding.

Schools were also asked to provide details about the substance abuse prevention programs that they are currently providing. Of the 40 respondents, 38 indicated that their substance abuse prevention programs were school-based, as opposed to an afterschool program (n=2). Of the 35 respondents for what the prevention intervention programs were offered[8], 30 indicated that their programs were universal prevention interventions, while 8 reported selective interventions and 3 reported indicated interventions.

Table 2: Top 5 Reported Risk Factors, SAPPI and AYS

SAPPI Survey		2016 AYS	
Risk Factor	**% of School Respondents[9]**	**Risk Factor**	**% of Student Respondents[10]**
Academic Failure	47.7%	Family Conflict	52.1%
Family Conflict	45.5%	Laws and norms favorable toward drug use	50.7%
Family history of antisocial, high risk or drug related behavior	45.5%	Low commitment to school	48.1%

[8] More than one response allowed.
[9] 44 schools responded to this question in the SAPPI.
[10] Percentages are based on 57,170 student respondents to the AYS in 2016.

Favorable attitudes toward drug use	45.5%	Early Initiation	48.1%
Friends' use of drugs	45.5%	Poor family management	47.9%

Risk Factors

Risk factors are personal and environmental factors that may increase a person's likelihood of engaging in problem behaviors (Hawkins et al, 1992). Survey respondents were asked to rank the top five risk factors that their school's substance abuse prevention program(s) sought to address. Table 2 reports the results of the top five most frequently reported risk factors by survey respondents.

In order to contextualize the risk factors that most schools are addressing, results from the 2016 Arizona Youth Survey (AYS) are included in Table 2. These results show the top five most prevalent risk factors among Arizona students. The composite 'risk score' represents the degree to which respondents are at risk for developing problem behaviors in a particular domain (i.e., peer-individual, school, family, and community) based on student responses on the 2016 AYS. These risk scores were then dichotomized into a variable that indicated whether the student responses were at high or low risk for each risk factor.

The results of the SAPPI indicate that most schools are addressing academic failure (47.7% of respondents); family conflict (45.5% of respondents); family history of antisocial, high risk or drug related behavior (45.5% of respondents); favorable attitudes towards drug use (45.5% of respondents); and friends' use of drugs (45.5% of respondents) within the substance abuse prevention program(s) available to their students. However, when compared to responses from 8th, 10th, and 12th grade students in Arizona in 2016, there appears to be a disconnect between what risk factors educators feel are most critical to address and those risk factors for which students report being a highest risk. For instance, while schools most frequently reported addressing academic failure, this risk factor did not rank among the top five risk factors reported from the AYS findings. Instead, AYS respondents indicated that they were at highest risk for family conflict, which is the second most frequent risk factor being addressed by Arizona schools. The second most prevalent risk factor among Arizona's youth was living in communities in which they perceive there to be laws and norms favorable towards drug use. While this may be difficult for schools alone to address, it should be noted that none of the top five risk factors being addressed by schools involved the community domain. Finally, it is worth noting that the third most prevalent risk factor among Arizona students was a low commitment to schools. This is indicative of a larger problem within Arizona schools in their ability to connect to students, beyond substance abuse prevention programs.

Protective Factors

Protective factors are personal and environmental factors that may decrease a person's likelihood of engaging in problem behaviors (Hawkins et al, 1992). Survey respondents were asked to rank the top five protective factors that their school's substance abuse prevention program(s) sought to address. Table 4 reports the results of the top five most frequently reported protective factors by survey respondents.

In order to contextualize the protective factors that most schools are addressing, results from the 2016 Arizona Youth Survey (AYS) are included in Table 3. The composite 'protective score' represents the degree to which respondents have protection against developing problem behaviors in a particular domain (i.e., peer-individual, school, family, and community) based on student responses on the 2016 AYS. These protective scores were then dichotomized into a variable that indicated whether the student responses indicated high or low levels of protection for each protective factor. The results in Table 3 show the top five protective factors for which most Arizona students indicate having the lowest levels of protection. Ideally, protection scores should be higher, indicating a higher level of protection. Lower scores indicate low levels of protection and thus areas where improvements can be made to further protect students from developing problem behaviors, such as substance use and abuse.

Table 3: Top 5 Reported Protective Factors, SAPPI and AYS

SAPPI Survey[11]		2016 AYS	
Protective Factor	**% of School Respondents[12]**	**Protective Factor**	**% of Student Respondents[13]**
Academic Skills	23.8%	Interaction with Prosocial Peers	52.9%
Healthy Beliefs and Clear Standards for Behavior	23.8%	Prosocial Involvement	52.3%
Belief in a Moral Order	21.4%	Rewards for Prosocial Involvement	51.1%
Bonding to Adults, Peers and Community	21.4%	Belief in the Moral Order	49.8%
Opportunities for Positive	21.4%	Family Attachment	49.4%

[11] "Academic Skills" and "Healthy Beliefs and Clear Standards for Behavior" are not protective factors found on the AYS or Communities that Care survey.
[12] 42 schools responded to this question in the SAPPI.
[13] Percentages are based on 57,170 student respondents to the AYS in 2016.

Involvement			

The top five protective factors being addressed by Arizona schools are academic skills (23.8% of respondents); healthy beliefs and clear standards for behavior (23.8% of respondents); belief in a moral order (21.4% of respondents); bonding to adults, peers and community (21.4% of respondents); and opportunities for prosocial involvement (21.4% of respondents). Similar to the results for risk factors in Table 2, there appears to be a disconnect between the protective factors being addressed by Arizona educators and the protective factors for which Arizona students report the lowest levels of protection. For instance, students report low levels of protection from interaction with prosocial peers (52.9%), prosocial involvement (52.3%), rewards for prosocial involvement (49.8%), belief in the moral order (49.8%), and family attachment (49.4%). While low levels of belief in a moral order were present among Arizona students, only 21.4% (n=9) of schools were attempting to address this issue among their students. Additionally, while two of the top five protective factors being addressed by schools are relative to the school domain (academic skills and opportunities for positive involvement), the school domain was not present among the top five protective factors for which students reported the lowest levels of protection. While schools would likely have a more difficult time addressing other domains, such as the family or community, it should be less problematic for them to institute prevention programming that addresses the peer-individual domain, which comprised the top four protective factors for which Arizona students report having the lowest levels of protection.

Additional Programs

While the primary focus of the SAPPI survey was to determine the availability and types of substance abuse prevention programming that are currently provided by schools in Arizona, additional information that is relevant to schools and students was asked to be provided by respondents for this report. A list of possible additional programming (see Table 4) was provided, and respondents were asked to indicate whether their school currently offered at least one program that dealt with each of the topics/issues. A number of schools indicated that they had at least one program available, even if they did not have a substance abuse prevention program in place. The most commonly reported programs were those addressing bullying (68%, n=73), youth with learning disabilities and/or academic difficulties (62%, n=66), homeless and/or runaway youth (42%, n=45), interventions related to parents/families/guardians (41%, n=44), and suicide prevention programming (41%, n=44). It is clear from Table 4 that while not all schools are able to provide substance abuse prevention programming to their students,

they attempt to address the same risk and protective factors that influence the likelihood of a student engaging in problem behaviors, such as substance use and abuse.

Table 4: Additional Programs Provided by Schools	
Program Description	**Number of Schools Reporting**
Bullying	73
Youth with learning disabilities/ academic difficulties	66
Homeless/ Runaway Youth	45
Parents/ Families/ Guardians intervention	44
Suicide Prevention	44
School Dropouts/ Truancy/ At risk of Dropping out	43
Economically Disadvantaged Youth	41
Mentally Ill/ Emotionally Disturbed Youth	34
Children involved in Child Protective Services (CPS)	32
Migrants	29
Adults/ families with children in the CPS system	28
Youth Tobacco Cessation	28
Pregnant Teens	27
Probation/ Parole/ Drug Offending Youth	26
Gay/ Lesbian/ Bisexual/ Transgendered Youth	25
Children in households receiving monetary assistance	24
Adults/ families receiving monetary assistance	23
Immigrants/ Refugees	22
Youth Victims of Physical/ Emotional/ Sexual Abuse	20
Incarcerated Youth	17
Youth in Rural/ Isolated Populations	17
Domestic Violence Offenders - Youth	16
Youth Sex Offenders	16
Gang Prevention/ Intervention	16
COSAs/ Children of Substance Abusers	15
Other Family (e.g. community mentorship, college prep, school counselor)	14
Other Youth (e.g. parent liaison programs, positive behavior intervention support, conflict resolution)	13

Note: 106 schools responded to this question, multiple responses allowed.

Mental Health Resources

The final topic addressed in the SAPPI survey was in relation to the type and availability of mental health resources in Arizona schools. Similar to the results of Table 4, it is evident that more schools are able to provide some form of mental health resource(s) to students than they are able to provide substance abuse prevention programming. Of the 157 respondents, 63% (n=99) indicated that they had some form of mental health

resource available to their students, while 37% (n=58) reported that they did not have any mental health resources available. Of the 99 schools that reported having mental health resources available, 88% indicated that they had a counselor or psychologist on staff (n=8); 17% reported that they had a social worker on staff (n=17); 9% indicated that they had a behavioral specialist on staff (n=9); and another 17% reported that they had some other kind of resources available, such as an outside agency, special education program, school nurse, or other tools and resources (n=17).

Table 5: Mental Health Resources in Schools

Type	# of Schools Reported
Counselor/Psychologist	87
Social Worker	17
Behavior Specialist	9
Other (e.g. Cultural Coordinator, Special Education Program, outside agencies, nurse)	17

Note: 99 respondents, multiple responses allowed

With recent violent events occurring in schools across the United States, it is clear that mental health resources should be available at all schools. Based on the SAPPI survey results, it appears that approximately 40% of Arizona students attend a primary or secondary educational institution that does not have access to these resources. Of those that do have mental health resources available, it may be for only a portion of the school week. Several schools reported having their resource (such as a social worker or counselor) only available to students "part-time," "2.5 days a week," "once a week," or on an "as needed" basis. While the majority of schools report having access to one or more mental health resources for their students, this may not include a trained professional who is available to students at all times.

Recommendations

Results of the SAPPI survey indicate that there is likely little substance abuse prevention programming being consistently offered to K-12 students across Arizona, yet there also appears to be a great need for such programming. Results from the 2016 AYS indicate that approximately half of 8th, 10th, and 12th grade students report being at high risk for several key factors that may lead to involvement with substance use and other delinquent behaviors. Empirically grounded, data-driven substance abuse prevention programming is one way to prevent youth from ever being involved in the cycle of substance abuse.

School-Based Programming

As this report has established, there is a clear need for substance abuse prevention programming in Arizona's primary and secondary schools. To that effect, a series of recommendations around school-based substance abuse prevention programming are included.

Program Selection Methodology

The Youth Prevention Sub-Team used the following methodology to select ten evidence-based programs to review for recommendation in this report. Programs were selected through a web-based search of the National Repository of Evidence-Based Programs and Practices (NREPP), Blueprints for Healthy Youth Development, the Office of Juvenile Justice and Delinquency Prevention Program (OJJDP), and the National Institute of Justice Crime Solutions. The initial search criteria screened for substance abuse prevention programs designed for youth 6-17 and that occurred within a school setting by trained school staff. The initial search results revealed more than 60 prevention programs. Programs were then reviewed to ensure that primary outcomes included a reduction in substance abuse or alcohol, tobacco and other drugs (ATOD) rates, could be delivered by school staff, and had a manualized curriculum with a defined number of lessons over a span of time. Remaining programs were evaluated based on programmatic outcomes associated with a reduction in substance abuse rates. If a program did not demonstrate a significant change in lowering substance abuse between the intervention and control group, it was eliminated.

One program was presented that is not listed in the aforementioned repositories. *Living in 2 Worlds* was included in this list due to the limited information available on school-based prevention program designed for American Indians. Many of the programs identified had marginal American Indian population sizes in their evaluations (around 1-10%). Since *Living in 2 Worlds* is a cultural adaptation of *keepin' it REAL*, it is being run in Arizona communities (primarily through the Phoenix Indian Center), and has significant research associated with urban Indian populations, it was included for programmatic review.

The following 10 programs[14] were selected according to the above listed criteria, and then presented to the Youth Prevention Sub-Team members to vote based on nine criteria:

- Botvin LifeSkills
- The Good Behavior Game
- Guiding Good Choices
- keepin' it REAL
- Living in 2 Worlds
- Positive Action
- Project SUCCESS
- Project Toward No Drug Abuse
- Strengthening Families
- Too Good for Drugs

The criteria for selection as a recommended program included:

- Youth- and/or parent-focused program which can be implemented in schools.
- Substance abuse focused; substance abuse must be a primary objective of the curriculum, although not necessarily the only objective.
- Curriculum-based program, with a specific curriculum (including lessons and manual) that can be implemented with fidelity.
- Rated as an "evidence-based" program by a recognized national rating system.
- Program is geared to a multi-cultural population (includes a cultural competency component).
- The cultural competency component can be adapted for other groups/cultures.
- The program is available for all grade levels (K-12).
- The program is available for only a subset population of students (e.g., 5-8th grades).
- The length of the program (both in terms of weeks and a number of lessons) will be suitable for schools to adopt.

Evaluators from the Youth Prevention Sub-Team were asked to provide feedback on each of the ten programs in accordance with how strongly (on a five-point Likert scale ranging from "Strongly Agree" to "Strongly Disagree") they perceived each program met each of the above listed criteria. While individual feedback varied, the group unanimously agreed that all of the ten programs be included as recommendations in the final report.

[14] More detail on each of the programs is available in Appendix C.

Of the ten programs, however, there were five that the group determined to be the preferred programs. These included: *Botvin LifeSkills, keepin' it REAL, Positive Action, Project Toward No Drug Abuse,* and *Too Good For Drugs*. These five programs were determined to have the greatest focus on substance abuse, evidence-based backing, and ability to be implemented in Arizona schools. It should be noted, however, that these programs are not necessarily the best fit for every school in Arizona. Educators and community stakeholders should first assess the needs of their population, and identify programs that are best suited to address those needs. In addition, prior to selecting a program, the prevalent risk and protective factors should be determined in order to select a program that will best address those factors.

One way for schools to obtain data on risk and protective factors, as well as substance use, is through the AYS. Conducted biennially by the Arizona Criminal Justice Commission, the Arizona Youth Survey (AYS) collects data on 8th, 10th, and 12th grade students across the state. The survey asks youth about their experiences with topics such as substance use, school safety, bullying, gang activity, and other problematic behaviors, as well as the risk and protective factors that influence the prevalence of these behaviors. The AYS is grounded in empirically driven and research-based theories of youth development, and provides a wealth of information that is used to improve the circumstances in which all Arizona youth live and learn. For years, the AYS has been utilized by a number of coalitions, non-profit agencies, government agencies, Regional Behavioral Health Authorities (RBHA), local school districts, and state universities in order to:

- Identify the nature and extent of various problem behaviors;
- Assess the performance of prevention and intervention efforts;
- Guide program and policy decisions that affect prevention and intervention efforts;
- Design and implement a new program and/or policy; and
- Apply for competitive funding opportunities to solve a variety of problem behaviors.

The Youth Prevention Sub-Team only recommended specific evidence-based prevention programs because of the extent of research available. There are also many short-term evidence-informed supplementary prevention programs that schools should consider incorporating in a systematic prevention effort. These programs include but are not limited to Healthy Families – Healthy Youth, Rx 360, and "Opioid Impact" lessons provided for School Resource Officers through the Arizona Bar Foundation. Schools should also partner with local coalitions and non-profits to provide additional prevention

programs and incorporate school-based prevention activities into a Strategic Prevention Framework[15].

After-School Programming

After-School Programs (ASP) vary in structure, focus, content, emphasis, and sponsoring organization (e.g., schools, religious institutions, libraries, Boys and Girls Clubs). Effective ASPs are unique in that they are a strong protective factor for a number of risky behaviors including substance abuse, but they also create prosocial protective factors. ASPs may be broadly differentiated by the following categories:

1. Team sports, sports clubs, or organized sports activities out of school.
2. Prosocial activities, such as participation in volunteering, service clubs, and/or religious service activities in the community.
3. Performing arts, including participation in band, drama, art, or dance.
4. Academic-oriented clubs and experiential/enriched learning programs.
5. School involvement, such as participation in student government.[16]

ASPs work best when they are thoughtfully incorporated into systematic prevention effort as demonstrated through The Icelandic Prevention Model. In Iceland, the Icelandic Centre for Social Research and Analysis (ICSRA) and researchers at Reykjavik University, along with policy makers and practitioners in the field, began collaborating in the 1990s in order to better understand the societal factors influencing substance use among adolescents and possible approaches to prevention. The evidence-based approach that was developed is commonly known as “The Icelandic Prevention Model.”

Components of the intervention involved but were not limited to parents signing contracts to agree to spend more time with their children and significant investment to provide greater opportunity for youth to engage in music, art, dance, and sports programs to keep youth engaged in prosocial activities after school hours.

Results from the implementation of The Icelandic Prevention Model show a steady decline in substance use, which is reported as being drunk during the last 30 days; smoking one cigarette or more per day; and having tried hashish once, from 1997 through 2007 among 14 and 16-year-old adolescents (Sigfusdottir, Thorlindsson, Kristjansson, Roe, & Allegrante, 2008). In addition, protective factors such as parental monitoring, time spent with parents, not attending parties, and participating in sports or clubs were all reported to have increased over time.

[15] A Strategic Prevention Framework is a comprehensive guide to plan, implement and evaluate prevention practices and programs and is discussed in greater detail beginning on page 17 of this report.
[16] See (McDowell Group, 2018) for additional information.

More current research indicates that the effort has continued to be effective over the last decade. In 1998, 42% of 15- and 16- year olds reported getting drunk in the previous month. In 2016, that number dropped to only 5%. A similarly drastic reduction in youth cigarette use occurred during the same time period, with those reporting use decreasing from 23% in 1998 to only 3% in 2016. The Icelandic Prevention Model exemplifies the use of ASPs in a strategic prevention model.

While research supports the impact ASPs can have, a major limitation to evaluating the best afterschool programs for Arizona schools is that they generally do not have an empirically based set of standards in which to operate. Additionally, a wider variety of options allows for youth to participate in after-school programs that appeal to their passions. While there is not a specific list of afterschool programs to be recommended in the context of this report, the Youth Prevention Sub-Team recommends using the standards set-forth by the Arizona Center for Afterschool Excellence (AzCASE) as a resource for schools to ensure quality and effective afterschool programming.

AzCASE created a set of quality standards for the state of Arizona's afterschool programs in 2013. These seven standards are designed to promote quality out-of-school time for students. It is crucial to consider the time spent outside of classroom hours as an opportunity to provide youth with additional services that may not be addressed in the classroom. Approximately 80% of a youth's waking hours are spent outside of the classroom. Research has shown that participation in afterschool programs can reduce misconduct in school, and reduce the use of drugs and alcohol compared to students that were unsupervised. The seven standards of quality afterschool programming are as follows:

1. **Safe and Healthy Environments:** Youth experience physically and emotionally safe, healthy and developmentally appropriate learning environments.
2. **Positive Relationships:** Youth benefit from the positive relationships and interactions that are promoted, developed, nurtured and maintained by the program staff and volunteers.
3. **Intentional Programming and Activities:** Youth experience a variety of fun and stimulating opportunities for engagement and learning that support positive physical, social, emotional and cognitive development.
4. **Equity and Inclusion:** Youth thrive in the program regardless of their background, including but not limited to race, color, religion, sex, income level, national origin, physical, mental and learning ability, sexual orientation, or gender identity and expression.
5. **Family, School, and Community Engagement:** Youth benefit when families, schools and communities are actively engaged in program development and implementation.
6. **Program Management:** Youth benefit from effective leadership, strong program management and sound fiscal management.

7. **Program Evaluation and Data:** Youth benefit from systems for continuous quality improvement that include measurable goals, aligned with children, youth and family needs.

ASPs provide a link between educators and community stakeholders, and allow schools to serve the needs of students outside of school hours. To ensure the effectiveness of ASPs as part of the substance abuse prevention model, they should be incorporated in and support the Strategic Prevention Framework and prevention programing established by the school.

Considerations When Selecting a Program

There are several important considerations that should be addressed when selecting a program, such as the cost per students, the needs of the population, and how well the program fits within the Strategic Prevention Framework.

Cost

Programmatic costs can vary greatly depending on the prevention program. For example, cost for the top ten evidence-based prevention programs identified in this report range from approximately $15.00 to $81.00 per student. When selecting a program for implementation, it is important to assess the costs associated with implementing and sustaining a program over the long term. Costs should, however, also be balanced against the return on investment in reducing negative outcomes for students. The Washington State Institute for Public Policy developed a standardized model using scientifically rigorous standards to estimate the costs and benefits associated with various prevention programs. Benefit-per-dollar cost ratios for evidence-based interventions ranged from $0.62 per dollar invested to more than $64 for every dollar invested (Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health, 2016).

Results from this survey indicate that there is a need for additional substance abuse prevention programming to be made available to students in Arizona. The Governor's Office of Youth, Faith and Family's High School Health and Wellness (HSHW) grant program can be used as a model to determine the approximate amount of funds needed to offer substance abuse prevention programming in schools that do not currently have some kind of program for students in place. The HSHW program is ideal for calculating approximate costs, because the funding model allows schools flexibility in the type of programming they offer and in how that programming is implemented. For instance, some schools may opt to hire an additional personnel in the form of a Prevention Specialist, while others may sub-contract with a community coalition that is experienced in delivering prevention programming.

Funding Sources

In 2017, GOYFF equipped 53 middle schools with the Healthy Families Health Youth prevention program and funded 38 high schools to run evidence-based prevention programs. Through the Arizona Parents Commission on Drug Education and Prevention, the GOYFF funds multiple non-profits and coalitions to provide community primary prevention programs. Many of these community organizations also offer programming to schools. The Department of Education provides competitive grant

funding that supports more than one-hundred School Resource Officers (SROs) in Arizona schools. The Arizona Attorney General's Office also provides some prevention program funding to community-based organizations. Other research has found that substance abuse intervention programs that address general risk and protective factors for substance abuse result in reduced risk for participants of between 20 to 65 percent (Spoth, et al., 2013).

There are also federal grant opportunities including but not limited to the Opioid State Targeted Response grant, Substance Abuse Block Grant, and the Partnership for Success Grants through the Substance Abuse Mental Health Services Administration (SAMHSA) that are able to fund school-based prevention programs. Other potential federal funding sources include, Formula 1 educational funds as well as the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Formula Grant. Some state agencies have also formed private-public partnerships to help fund prevention efforts. For example, the state of Massachusetts Attorney General's Office partnered with General Electric to provide two-million dollars in additional school-based prevention funding. This partnership provided funding for a select group of middle schools to run year-long evidence-based substance abuse prevention programs. Funds were also used to develop and disseminate a substance abuse prevention toolkit, which was made available to all middle schools in the state.

Strategic Prevention Framework

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides a resource for implementing substance abuse prevention programming, known as the Strategic Prevention Framework (SPF)[17]. The SPF is a comprehensive guide to planning, implementing, and evaluating prevention practices and programs. The SPF offers prevention professionals, community members, and educators a comprehensive process for addressing the substance misuse and related behavioral health problems facing their schools and communities. The effectiveness of the SPF begins with a clear understanding of needs and involves stakeholders in all stages of the planning process.

Figure 2: Strategic Planning Framework

[17] https://www.samhsa.gov/capt/

The steps of the SPF include:

Step 1: Assess Needs: What is the problem, and how can I learn more?

Step 2: Build Capacity: What do I have to work with?

Step 3: Plan: What should I do and how should I do it?

Step 4: Implement: How can I put my plan into action?

Step 5: Evaluate: Is my plan succeeding?

The SPF also includes two guiding principles:

- **Cultural competence:** The ability to interact effectively with members of diverse population
- **Sustainability:** The process of achieving and maintaining long-term results

Based on SAMHSA's vision of reducing the impact of substance use and mental illness on America's communities, the Framework applies to any prevention planning process that addresses substance use and mental health issues. It defines the essential traits of high-quality prevention strategies, lays out guiding principles and action steps, and offers tools communities can use to plan and build prevention programs that work. Through a long list of federal and national partners, the Framework provides broad support and access to many resources.

Conclusion

This report provided a current view of the availability of substance abuse prevention programming at both elementary and secondary schools in Arizona. Results indicate that there is a clear need for the expansion and continued funding of prevention programs. Recommendations from this report include:

1. Continuation and expansion of the use of evidence-based substance abuse prevention programs such as those recommended in this report.
2. Continuation and expansion of funding for school-based substance abuse prevention programs and after-school programs.
3. Continuation of back-to-school substance abuse programs such as the Healthy Families Healthy Youth program in conjunction with ongoing evidence-based and evidence-informed prevention programs throughout the school year.

4. Further equipping schools with tools and timely data in the determination of needs and measurement of outcomes.

Appendices

Appendix A

STATE OF ARIZONA
OFFICE OF THE GOVERNOR

DOUGLAS A. DUCEY
GOVERNOR

MARIA CRISTINA FUENTES
DIRECTOR

March 1, 2018

Dear Educator:

The health and wellbeing of our youth and families is and will remain a top priority for the state of Arizona. Each of you have seen, and in some cases, have been directly impacted by the drug epidemic that is sweeping our country and affecting all Arizona communities. This is why Governor Doug Ducey has taken action to improve access to substance abuse treatment, enact a Good Samaritan law, increase public messaging on the dangers of opioid misuse and abuse, and strengthen laws that limit the amount of opioids dispensed while protecting individuals suffering from chronic and debilitating pain.

As part of the continued efforts to end this epidemic, the Governor's Office of Youth, Faith and Family, in partnership with the Arizona Department of Education, and the Youth Prevention Sub-Team of the Governor's Goal Council on Healthy Citizens, is conducting an inventory on afterschool programs and substance abuse prevention programs currently being implemented in Arizona schools. The purpose of this inventory is to assess potential gaps in these prevention services in order to make recommendations. Your timely participation in this process is critical as it ensures an accurate representation of all Arizona communities.

The Arizona Substance Abuse Epidemiology Work Group and Arizona Criminal Justice Commission are facilitating the collection of this information on behalf of the entities listed above. Your time and investment in this work is of the utmost importance and greatly appreciated.

If you have questions about the Data Collection Form, please contact Catie Clark, Chair of the Arizona Substance Abuse Epidemiology Work Group and Director of the Statistical Analysis Center at the Arizona Criminal Justice Commission, via phone at (602) 364-1158 or through email at cclark@azcjc.gov.

Sincerely,

Maria Cristina Fuentes
Director
Governor's Office of Youth Faith and Family

Diane M. Douglas
Superintendent of Public Education
Arizona Department of Education

GOVERNOR'S OFFICE OF YOUTH, FAITH AND FAMILY
1700 West Washington Street, Suite 230, Phoenix, Arizona 85007
Phone 602-542-4043 * Fax 602-542-3423 * www.goyff.az.gov

Appendix B[18]

DISTRICT INFORMATION: Please ensure that the name of the district is indicated. Please use a street or highway address (not a P.O. Box as the information is used for mapping purposes).

District name:

CTDS Number:

Street Address:

City:

County:

Zip:

District Prevention/Title IV Coordinator:

Phone:

Email:

Fax:

SCHOOL INFORMATION: Please ensure that the name of the school is indicated. Please use a street or highway address (not a P.O. Box as the information is used for mapping purposes).

Please provide your name, phone and email so we may contact you if there are questions about the data you provide.

School Name:

[18] Note: The survey was provided to educators via the online platform SurveyMonkey. If you would like to receive the link to the survey instrument, please contact Catie Clark at the Arizona Criminal Justice Commission at cclark@azcjc.gov.

School CTDS Number:

Street Address:

City:

County:

Zip:

School Prevention/Title IV Coordinator:

Phone:

Form Completed By:

Phone:

Email:

Fax:

Do you have a substance abuse prevention program available in your school?

- Yes
- No

(If Yes, continue. If No, skip to page 24)

How many substance abuse prevention programs are available in your school?

RISK FACTORS: select the top five (5) core/main Risk Factors that your school addresses with substance abuse prevention program(s).

Consider the goals that your school has around substance abuse prevention. These goals should reflect specific risk and/or protective factors that identify the desired outcomes of participants once they have completed a prevention program. What are the factors the program is most designed to influence and/or change?

Begin with 1 as the highest ranked (most important) factor.

*Note: **Your school may be addressing fewer than five risk factors. In this case, please rank *only* the risk factors being addressed (if any).**

Academic failure

Community and personal transitions and mobility

Community disorganization

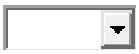
Early initiation of problem behavior

Family conflict

Family history of anitsocial, high risk or drug-related behavior

Favorable attitudes toward antisocial behavior

Favorable attitudes toward drug use



Friends' use of drugs

Interaction with antisocial peers

Laws and norms favorable toward drug use

Low commitment to school

Low neighborhood attachment

Low perceived risk of drug use

Parental absenteeism

Parental attitudes favorable toward antisocial behavior and drugs

Perceived availability of drugs and handguns

Poor family discipline

Poor family supervision

Rebelliousness

Rewards for antisocial involvement

Sensation seeking or risk taking propensity/Impulsivity

PROTECTIVE FACTORS: select the top five (5) core/main Protective Factors that your school addresses with substance abuse prevention program(s).

Consider the goals that your school has around substance abuse prevention. These goals should reflect specific risk and/or protective factors that identify the desired outcomes of participants once they have completed a prevention program. What are the factors the program is most designed to influence and/or change?

Begin with 1 as the highest ranked (most important) factor.

***Note: Your school may be addressing fewer than five risk factors. In this case, please rank *only* the risk factors being addressed (if any).**

Academic skills

Belief in a moral order

Bonding to adults, peers and community

Family attachment

Healthy beliefs and clear standards for behavior

Opportunities for positive involvement

Religiosity

Resistance skills

Rewards for positive involvement

School attachment

Social competence skills

PROGRAM NAMES AND DESCRIPTIONS: **Select the name of the program you are reporting on from dropdown box.** The following list of programs comes from SAMHSA's National Registry of Evidenced-Based Programs and Practices (NREPP) and may not be inclusive of all evidenced-based programs. **If the name of your program isn't listed, select "Other/Not Listed". You will be prompted to give the name of your program and a brief description of the program's overall purpose and goal. In 1-3 sentences, describe your program and what is strives to achieve. You may wish to mention if it is a research-based or "effective" program, or if it is based on research-based strategies.**

For example: "The XYZ prevention program is a school based program that seeks to increase the protective factors for at-risk students and to prevent, reduce, or delay the use of alcohol and

other drugs. Specific objectives include: 1) increasing the knowledge of health/substance use issues; 2) improved academic performance, school attendance, and behavior and attitudes toward school; and 4) enhancing problem-solving and decision-making skills."

Other/Not Listed: Please list name and brief description

PROGRAM TYPE: Please choose the Program Type that best matches the services your program is designed to address from the dropdown box. For the purposes of this inventory, the program must be either a school-based substance abuse prevention program or an after school program.

Programs may be designed to be implemented in school (implemented in the school setting) or after school (before school, after school, between school terms, or during the summer).

This should describe what the program is designed to do, not who the program serves.

☐ ***School-based substance abuse prevention interventions:*** Prevention interventions that are implemented in the school setting that aim to decrease risk factors and/or increase protective factors associated with youth substance use.

☐ ***After School Programs (ASPs):*** "[R]egular, structured or semi-structured activities for school-age (K-12) youth that occurs before school, after school, between school terms, or during the summer. Other terminology – out-of-school time or OST, extra-curricular activities, organized activities, expanded learning time, school-age-care – is synonymous in this context and use interchangeably."

PROGRAM START DATE: **Please provide the date (school year) that this prevention program was started in your school.**

(If Other/Not Listed selected, ensure they include name and description then continue to page 10. If Named program selected, skip to page 11).

TARGET POPULATION FOR INTERVENTIONS: **Please indicate the group of people (targeted population) you are serving in your program. If the actual population served is different from the targeted population, please describe your participant characteristics.**

☐ **Universal Prevention Interventions:** Universal interventions attempt to reduce specific health problems across all people in a particular population by reducing a variety of risk factors and promoting a broad range of protective factors.

For example: ***Strengthening Families Program: For Parents and Youth 10-14*** (SFP), which is a widely used seven-session universal, family-focused program that enhances parenting skills ”specifically nurturing, setting limits, and communicating” as well as adolescent substance refusal skills.

☐ **Selective Interventions:** Selective interventions are delivered to particular communities, families, or children who, due to their exposure to risk factors, are at increased risk of substance misuse problems. Target audiences for selective interventions may include families living in poverty, the children of depressed or substance using parents, or children who have difficulties with social skills. Selective interventions typically deliver specialized prevention services to individuals with the goal of reducing identified risk factors, increasing protective factors, or both.

For example: The ***Nurse-Family Partnership***, which uses trained nurses to provide an intensive home visitation intervention for at-risk, first-time mothers during pregnancy.

☐ **Indicated Interventions:** Indicated prevention interventions are directed to those who are already involved in a risky behavior, such as substance misuse, or are beginning to have problems, but who have not yet developed a substance use disorder. Such programs are often intensive and expensive but may still be cost-effective, given the high likelihood of an ensuing expensive disorder or other costly negative consequences in the future.

For example: Coping Power, which is a 16-month program for children in Grades 5 and 6 who were identified with early aggression. The program, which is designed to build problem-solving and self-regulation skills, has both a parent and a child component and reduces early substance use.

Other (please specify)

BREAKDOWN OF FUNDS: **Estimate the breakdown of funds received, number of children served, as well as the source of those funds.**

Include the name of the funding source (e.g., High School Health and Wellness - HSHW - grant; SAMHSA grant, Drug Free Communities - DFC - grant, etc.), as well as the estimated number of children served through the program, and the estimate of total funds received from that specific source directed towards the program.

Funds reported should be those dedicated to the specific prevention program reported on in this form.

Funding source:

Number of Children Served:

Estimated Funds Received:

Does your school have another substance abuse prevention program?

- Yes
- No

(If Yes, repeat questions on programs – no more than 5 programs may be detailed. If No, go to next question.).

ADDITIONAL PROGRAMS/SERVICES: **Indicate the number of the** school's programs/services **targeted to** families and youth **(not including substance abuse prevention programs). If your school does not implement a specific type of program, leave the space blank.**

Parents/ Families/ Guardians intervention

Adults/ families receiving monetary assistance

Adults/ families with children in the CPS system

Other Family (describe):

Probation/ Parole/ Drug Offending Youth

Incarcerated Youth

Children in households receiving monetary assistance

Children involved in Child Protective Services (CPS)

Economically Disadvantaged Youth

Domestic Violence Offenders - Youth

Gay/ Lesbian/ Bisexual/ Transgendered Youth

Youth Tobacco Cessation

Youth Sex Offenders

COSAs/ Children of Substance Abusers

Homeless/ Runaway Youth

Mentally Ill/ Emotionally Disturbed Youth

Youth Victims of Physical/ Emotional/ Sexual Abuse

Pregnant Teens

Migrants

Immigrants/ Refugees

Youth in Rural/ Isolated Populations

School Dropouts/ Truancy/ At risk of Dropping out

Youth with learning disabilities/ academic difficulties

Bullying

Suicide Prevention

Gang Prevention/ Intervention

Other Youth (describe):

Do you have mental health resources at your school?

- [ ] Yes
- [ ] No

If so, please list the type of mental health resources available to students (i.e., counselor, etc.).

Thank you for your participation in this survey!

The Arizona Youth Survey (AYS), mandated by A.R.S. §41-2416, is a biennial survey of youth in all 15 counties in Arizona. The survey asks youth about their experiences with topics such as substance use, school safety, bullying, gang activity, and other problematic behaviors, as well as the risk and protective factors that influence the prevalence of these behaviors. The AYS is grounded in empirically driven and research-based theories of youth development, and provides a wealth of information that is used to improve the circumstances in which all Arizona youth live and learn. For years, the AYS has been utilized by a number of coalitions, non-profit agencies, government agencies, Regional Behavioral Health Authorities (RBHA), local school districts, and state universities in order to:

- Identify the nature and extent of various problem behaviors;
- Assess the performance of prevention and intervention efforts;
- Guide program and policy decisions that affect prevention and intervention efforts;
- Design and implement a new program and/or policy; and
- Apply for competitive funding opportunities to solve a variety of problem behaviors.

If you would like more information about the AYS, please visit the Arizona Criminal Justice Commissions website: http://azcjc.gov/content/arizona-youth-survey or contact a member of the Statistical Analysis Center at AYS@azcjc.gov or (602) 364-1157.

If you would like to enroll your school in the Arizona Youth Survey, please complete and return the School Information Form. Administration for the 2018 AYS is open from February 1, 2018 to May 18, 2018. Please be advised that we require a minimum of **three weeks'** time from submission of the form to administration of the survey.

Appendix C

Prevention Program Descriptions

Botvin LifeSkills Training: LifeSkills Training (LST) is a classroom-based universal prevention program designed to prevent adolescent tobacco, alcohol, marijuana use, and violence. LST contains 30 sessions to be taught over three years (15, 10, and 5 sessions), and additional violence prevention lessons also are available each year (3, 2, and 2 sessions). Three major program components teach students: (1) personal self-management skills, (2) social skills, and (3) information and resistance skills specifically related to drug use. Skills are taught using instruction, demonstration, feedback, reinforcement, and practice.

Guiding Good Choices: Guiding Good Choices (GGC) is a family competency training program for parents of children in middle school. The program contains five-sessions, with an average session length of 2 hours each week. Children are required to attend one session that teaches peer resistance skills. The other four sessions are solely for parents and include instruction on: (a) identification of risk factors for adolescent substance abuse and a strategy to enhance protective family processes; (b) development of effective parenting practices, particularly regarding substance use issues; (c) family conflict management; and (d) use of family meetings as a vehicle for improving family management and positive child involvement.

keepin' it REAL: keepin' it REAL teaches youths to live drug-free lives by building on their existing cultural and communication strengths and the strengths of their families and communities. Using keepin' it REAL strategies, students learn how to recognize risk, value their perceptions and feelings, embrace their cultural values (e.g., avoiding confrontation and conflict in favor of maintaining relationships and respect), and make choices that support them. The curriculum includes 10 sequential lessons to be taught in class over a 2- to 3-month period. The curriculum has six core elements: 1) communication competence and ethnic variations thereof; 2) narrative-based knowledge to enhance identification with the prevention message; 3) different types of social norms (personal, injunctive, and descriptive) as motivators in substance use; 4) social learning of life skills and their key role in risk assessment and decision-making; 5) drug-resistance strategies most commonly and effectively employed by adolescents; and 6) the local social context. Distinct Mexican American, non-Latino, and multicultural versions of keepin' it REAL were developed so students could recognize themselves in the prevention message and see solutions that are sensitive to their unique cultural environments. There is also a Native American adaption of keepin' it REAL called Living in 2 Worlds.

Living in 2 Worlds: Living in 2 Worlds (L2W) is a substance use prevention program for urban American Indian (AI) middle school students. To create L2W, the SIRC research team partnered with the Phoenix Indian Center and two school districts to engage youth, families, elders, and Native community leaders in a community-driven participatory process to identify cultural sources of resilience that protect American Indian youth from substance use and other risk behaviors. L2W was adapted specifically for Native adolescents living in urban areas using the core components of the keepin' it REAL curriculum, an existing SAMHSA "Model Program" for substance use prevention in middle schools, retaining the original program's focus on teaching the effective drug resistance strategies (Refuse, Explain, Avoid, Leave [R-E-A-L]) used most often by youth. A cultural adaptation model (Castro, Barerra, & Martinez, 2004) guided the creation of the culturally grounded curriculum, with a pilot phase that was followed by a small randomized controlled trial in three Phoenix area middle schools. Despite the diverse tribal backgrounds of urban American Indian families, ten inter-tribal cultural elements identified by the community were found to resonate widely, and these were infused into the L2W curriculum. These included the imperative of knowing ancestry, embracing kinship, and emphasizing oral traditions (see Reeves, Dustman, Harthun, Kulis, & Brown, 2014). These elements were aligned and integrated with the core components of the original keepin' it REAL curriculum. L2W emerged with lesson goals, objectives, activities, and prevention messages solidly grounded in urban American Indian inter-tribal cultural values. Focused on strengthening resiliency, L2W teaches a wide range of drug resistance skills and strategies including risk assessment, decision making, and culturally specific prevention messages in ways designated by the Native community as culturally appropriate and reflecting the social and cultural context navigated by urban American Indian youth. To test the degree to which culturally grounding improved youth outcomes, American Indian students in two Phoenix area middle schools received the L2W curriculum and American Indian students in another school received the original, unadapted version of keepin' it REAL. Classroom lessons for both programs were delivered by Native facilitators in regular academic enrichment classes for Native youth. Participating students (N=107) completed a pretest questionnaire before the 12 manualized curriculum lessons were delivered, and a post-test (85% completion) one month after the final lesson. The adapted L2W intervention, compared to keepin' it REAL, was assessed with paired t-tests, baseline adjusted general linear models, and effect size estimates (Cohen's d).

Positive Action: Positive Action (PA) is a school-based program that includes school-wide climate change and a detailed curriculum with lessons 2-4 times a week—approximately 140 15-minute lessons per grade K-6 and 82 15-20 minute lessons per grade 7 and 8. Lessons for each grade level are scripted and age-appropriate. All materials necessary to teach the lesson are provided including posters, puppets, music, games, and other hands–on materials integrated into the lessons. Students' materials

include activity booklets, journals and other lesson aids. The content of the program is included in six units that form the foundation for the whole program. The first unit teaches the philosophy of the program and the Thoughts-Actions-Feelings about Self Circle, and provides an introduction to the nature and relevancy of positive and negative actions/behaviors. Units 2-6 teach the positive actions for the physical, intellectual, social and emotional areas. There are two school-wide climate development kits (elementary and secondary) and a Counselor's Kit. The contents delivered through the climate development and counselor kits reinforce the classroom curriculum by coordinating the efforts of the entire school in the practice and reinforcement of positive actions.

Project SUCCESS: Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) is designed to prevent and reduce substance use among students 12 to 18 years of age. The program was originally developed for students attending alternative high schools who are at high risk for substance use and abuse due to poor academic performance, truancy, discipline problems, negative attitudes toward school, and parental substance abuse. In recent years, Project SUCCESS has been used in regular middle and high schools for a broader range of high-risk students. The intervention includes four components: The Prevention Education Series (PES), an eight-session alcohol, tobacco, and other drug program conducted by Project SUCCESS counselors (local staff trained by the developers) who helps students identify and resist pressures to use substances, correct misperceptions about the prevalence and acceptability of substance use, and understand the consequences of substance use. Schoolwide activities and promotional materials to increase the perception of the harm of substance use, positively change social norms about substance use, and increase enforcement of and compliance with school policies and community laws. A parent program that includes informational meetings, parent education, and the formation of a parent advisory committee. Individual and group counseling, in which the Project SUCCESS counselors conduct time-limited counseling for youth following their participation in the PES and an individual assessment. Students and parents who require more intensive counseling, treatment, or other services are referred to appropriate agencies or practitioners in the community.

Project Towards No Drug Abuse: Project Towards No Drug Abuse (TND) is a drug prevention program for high school youth who are at risk for drug use and violence-related behavior. The current version of the Project TND curriculum contains twelve 40-minute interactive sessions taught by teachers or health educators over a 3-week period. Sessions provide instruction in motivation activities to not use drugs; skills in self-control, communication, and resource acquisition; and decision-making strategies. The program is delivered universally and has been used in both traditional and alternative, high-risk high schools.

Strengthening Families: Strengthening Families 10-14 is a seven-session program for families with young adolescents that aims to enhance family protective and resiliency processes and reduce family risk related to adolescent substance abuse and other problem behaviors. The weekly, two-hour sessions include separate parent and child skills-building followed by a family session where parents and children practice the skills they have learned independently, work on conflict resolution and communication, and engage in activities to increase family cohesiveness and positive involvement of the child in the family. Parents are taught how to clarify expectations based on child development norms of adolescent substance use, using appropriate disciplinary practices, managing strong emotions regarding their children, and using effective communication. Children are taught refusal skills for dealing with peer pressure and other personal and social interactional skills. These sessions are led by three-person teams and include an average of eight families per session.

The Good Behavior Game: The Good Behavior Game (GBG) is a classroom-based behavior management strategy for elementary school that teachers use along with a school's standard instructional curricula. GBG uses a classroom-wide game format with teams and rewards to socialize children to the role of student and reduce aggressive, disruptive classroom behavior, which is a risk factor for adolescent and adult illicit drug abuse, alcohol abuse, cigarette smoking, antisocial personality disorder (ASPD), and violent and criminal behavior. In GBG classrooms, the teacher assigns all children to teams, balanced with regard to gender; aggressive, disruptive behavior; and shy, socially isolated behavior. Basic classroom rules of student behavior are posted and reviewed. When GBG is played, each team is rewarded if team members commit a total of four or fewer infractions of the classroom rules during game periods. During the first weeks of the intervention, GBG is played three times a week for 10 minutes each time during periods of the day when the classroom environment is less structured and the students are working independently of the teacher. Game periods are increased in length and frequency at regular intervals; by mid-year the game may be played every day. Initially, the teacher announces the start of a game period and gives rewards at the conclusion of the game. Later, the teacher defers rewards until the end of the school day or week. Over time, GBG is played at different times of the day, during different activities, and in different locations, so the game evolves from being highly predictable in timing and occurrence with immediate reinforcement to being unpredictable, with delayed reinforcement so that children learn that good behavior is expected at all times and in all places.

Too Good For Drugs: Too Good for Drugs (TGFD) is a school-based prevention program for kindergarten through 12th grade that builds on students' resiliency by teaching them how to be socially competent and autonomous problem solvers. The program is designed to benefit everyone in the school by providing needed education in

social and emotional competencies and by reducing risk factors and building protective factors that affect students in these age groups. TGFD focuses on developing personal and interpersonal skills to resist peer pressures, goal setting, decision-making, bonding with others, having respect for self and others, managing emotions, effective communication, and social interactions. The program also provides information about the negative consequences of drug use and the benefits of a nonviolent, drug-free lifestyle. TGFD has developmentally appropriate curricula for each grade level through 8th grade, with a separate high school curriculum for students in grades 9 through 12. The K-8 curricula each include 10 weekly, 30- to 60-minute lessons, and the high school curriculum includes 14 weekly, 1-hour lessons plus 12 optional, 1-hour "infusion" lessons designed to incorporate and reinforce skills taught in the core curriculum through academic infusion in subject areas such as English, social studies, and science/health. Ideally, implementation begins with all school personnel (e.g., teachers, secretaries, janitors) participating in a 10-hour staff development program, which can be implemented either as a series of 1-hour sessions or as a 1- or 2-day workshop.

Appendix D

Arizona Coalitions and Community Partners[19]

Southern Arizona

Pima County:
4R Communities Alliance – Community@ourfamilyservices.org
Ajo HOPE – Norma Gomez; Norma@azyp.org
Amistades Substance Abuse Coalition – rmjasso@amistadesinc.org
Community Prevention Coalition (CPC) of Pima County – Amy Bass; Abass@ppep.org
Arizona Youth Partnership - lorim@azyp.org; Rebekah@azyp.org
Be Med Smart – gsicobo@pcoa.org
East Tucson Substance Abuse Prevention Coalition – Susie@HealthyYouth.com
Pima Prevention Partnership – darroyo@thepartnership.us
La Frontera – jchapelle@lafrontera.org
Liberty Partnership Kino Neighborhoods Council – lpknc1@gmail.com
Luz Southside Coalition – mornelas@luzsocialservices.org
notMykid – Kristen@notmykid.org
Northwest Regional Coalition – coalition.northwestregional@gmail.com
Pima County-Tucson Commission on Addiction Prevention and Treatment – roy@grmtucson.com
South Tucson Prevention Coalition – morduna@gmail.com
RISP-Net (Refugee and Immigrant Service Provider Network of Tucson) – jvillabaze@lafrontera.org
ADHS Prescription Drug Overdose Grant – raul.munoz@pima.gov
Healthy People Coalition – jpaxton@inaaf.org

Cochise County:
Arizona Youth Partnership – lorim@azyp.org; Rebekah@azyp.org
IMPACT Sierra Vista – IMPACTSierraVista@gmail.com
Sierra Vista Community Coalition – Melodi Polach svcommcoal@gmail.com
Douglas Area Substance Abuse Coalition
Copper Queen Community Hospital School Opioid Program – jogiba@cqch.org
Southern AZ Opioid Consortium - Hope.Thomas@tmcaz.com
Wilcox Against Substance Abuse (WASA) Coalition – Sally White, 520-384-4777; w-a-s-a.weebly.com

Santa Cruz County:
Arizona Youth Partnership – lorim@azyp.org Rebekah@azyp.org
Santa Cruz County LDSHIP Coalition – infor@circlesofpeace.us
Santa Cruz Community Action Coalition – aromero@cenpatico.com
Santa Cruz County Drug Free Communities – Sonia Sanchez; 520-205-4780
Douglas Community Coalition – Alexandra Boneo; ntdouglas@gmail.com

Northern Arizona

[19] This list should not be considered exhaustive. Please consult your local community, prevention, and substance abuse leaders in your area for more information.

Apache County:
Apache County Drug Free Alliance – dryan@lcbhc.org
Arizona Youth Partnership – lorim@azyp.org; Rebekah@azyp.org
Apache County Youth Council – Matrese Avila; avila_acyc@frontier.com

Navajo County:
Navajo County Drug Project – navajocountydrugproject@gmail.com; ncdp@ncdp.rocks
Arizona Youth Partnership – Lakeside - lorim@azyp.org; Rebekah@azyp.org
ADHS Prescription Drug Overdose Grant – amy.stradling@navajocountyaz.gov
Rx Stakeholders' Meeting – Michele.sgambelluri@navajocountyaz.gov
Nexus Coalition for Drug Prevention – vsncdp@gmail.com

Coconino County:
Coconino County Alliance Against Drugs – director@flagcasa.org
Sunnyside Neighborhood Association – 928-213- 5900
Page Anti-Drug Alliance – vida@cityofpage.org
Williams Alliance – joneill@tgcaz.org
Winslow Coalition for Strong Families – dtraylor@coconino.az.gov

Graham and Greenlee Counties:
Graham County Substance Abuse Coalition – Kathy_Grimes@seabhssolutions.org
Greenlee County Substance Abuse Coalition – Kathy_Grimes@seabhssolutions.org

Yavapai County:
ADHS Prescription Drug Overdose Grant – leslie.horton@yavapai.us
MATFORCE – matforce@cableone.net

Central Arizona

Gila County:
Payson Senior Prevention Coalition – Holly Crump, 928-474-3472
Copper Basin Coalition – nrutherford@gilacountyaz.gov; cturney@gilacountyaz.gov
DIG YA - adrianna@azyp.org
STOP Globe - juliec@azyp.org
San Carlos Suicide Prevention Task Force – mary.casoose@scatwellness.net

Pinal County:
San Tan Valley Coalition – stvcoalition@santanvalley.com
Apache Junction Drug Prevention – bplante46@yahoo.com
Casa Grande Alliance – cgadirector@gmail.com
Coolidge Youth Coalition – cycsharonboyd@gmail.com
Maricopa Youth Coalition – Priscilla Behnke; pbehnke@gmail.com
notMykid – Kristen@notmykid.org
Eloy Governor's Alliance Against Drugs (EGAAD) – tcruz@pinalhispaniccouncil.org
Fact Finders – Ak-Chin Indian Community – Hilary@eotb.org
ADHS Prescription Drug Overdose Grant – Rachel.zenuk@pinalcountyaz.gov
San Tan Valley Substance Abuse Coalition – stvcoalition@hotmail.com

Maricopa County:
ADHS Prescription Drug Overdose Grant - TracyCruickshank@mail.maricopa.gov

Be Awesome Youth Coalition – pbehnke@macaasa.org
Capital Neighborhoods Coalition – Shannon@capitolmall.org
Chandler Coalition on Youth Substance Abuse – melissa@icanaz.org
Chicanos Por La Causa – jose.malvido@cplc.org
Child and Family Resources – lmedina@cfraz.org
COPE Coalition – Torre.Valentine@terros.org barbg@terros.org
Fountain Hills Youth Substance Abuse Prevention – fhcoalition@me.com
Gila River Prevention Coalition – Gila River Indian Community, 480-326-7999
Guadalupe Prevention Partnership – Maria.R.Paisano@pascuayaqui-nsn.gov
HEAAL – lorengrizzard@tcdccorp.org
Isaac Community Coalition – frank.saverino@touchstonebh.org
notMykid – Kristen@notmykid.org
Maricopa County Urban Indian Coalition – pattih@phxindcenter.org
MEBHAC Coalition – Heidi.donniaquo@aaaphx.org
NOPAL – North Phoenix Prevention Alliance – vickeyE@valledelsol.com
Scottsdale Neighborhoods in Action – metinsley@spi-az.org
South Mountain Works Coalition – smworksinfo@gmail.com
Tempe Coalition – Hilary_Cummings@tempe.gov
Way Out West – carriem@sbhservices.org
Urban Indian Coalition of Arizona - pattih@phxindcenter.org
Teen Lifeline/Arizona Suicide Prevention Coalition – Nikki@teenlifeline.org
TERROS/Maricopa LGBTQ Consortium – barbg@terros.org
Touchstone/CARE Coalition – Erica.chavez@touchstonebh.org
Yavapais Against Substance Abuse – Ft. McDowell Yavapai Nation; rpilcher@ftmcdowell.org

Western Arizona

Mohave County:
MSAT – Kingman - Dr. Sarah Knievel sknievel@azkrmc.com. Chief Robert DeVries 928-753-2191 rdevries@cityofkingman.gov
Mohave Substance Treatment Education Prevention Partnership (MSTEPP) – tunforss@gmail.com
Arizona Youth Partnership – trish@azyp.org
Youth Adult Development Association of Havasu – trish@azyp.org
Coalition for Successful Youth Development – www.coalitionforsuccessfulyouth@yahoo.com
Mohave Area Partnership Promoting Educated Decisions – Karole Finkelstein; mapped2014@yahoo.com

La Paz County:
Parker Area Alliance for Community Empowerment – Duce Minor; duce@paace.org
Quartzsite Substance Abuse Prevention Coalition – Tracy Richardson; Trichardson4575@gmail.com

Yuma County:
Yuma County Anti-Drug (YCAD) Coalition – hilda.nordell@local.unitedway.org
South County Yuma Anti-Drug Coalition – hilda.nordell@local.unitedway.org
Yuma Coalition for Activism and Progress – Ycap.tucson@gmail.com

Statewide

Arizona Youth Partnership – trish@azyp.org Rebekah@azyp.org
notMykid – Kristen@notmykid.org
Urban Indian Coalition of Arizona – pattih@phxindcenter.org, 602-264-6768
Arizona Coalition for Military Families – info@arizonacoalition.org; 602-753-8802
AZ SADD – jessica@azsadd.org
Arizona Opioid Treatment Coalition – nick.stavros@additiontx.net

Appendix E

Definitions of Risk Factors

Academic Failure: Youth who experience academic failure are at a higher risk of participating in drug abuse and other problem behaviors throughout adolescence (Bryant et al., 2003; Catalano et al., 2002; Hawkins et al., 1999).

Family Conflict: Family conflict appears in the top 5 of both surveys. The importance of this risk factor can be described as Youth raised in families who experience high levels of conflict, whether or not the child is directly involved in these conflicts, are more likely to engage in delinquent behaviors and drug use (Szapocznik and Williams, 2000).

Family History of Antisocial Behavior: When youth are raised in a family with a history of problem behaviors (e.g. violence, alcohol, or other drug use), they are more likely to engage in these behaviors themselves (Corrigan et al., 2007).

Attitudes Favorable toward Drug Use: As youth grow older, they have a higher likelihood of being exposed to others who engage in drug use or have a greater acceptance of these behaviors. This exposure may influence a youth's attitude toward drug use and increase the likelihood of them engaging in a variety of problem behaviors (Arthur et al., 2002; Bahr et al., 2005; Bauman and Ennett, 1996; Beyers et al., 2004). This factor examines how wrong youth perceive it is to use four different substance groups: alcohol, cigarettes, marijuana, and LSD/cocaine/amphetamines/illegal drugs.

Friends' Use of Drugs: Youth who spend time with friends who engage in substance use are more likely to engage in the same behavior. Peer drug use has consistently been found to be among the strongest predictors of substance use among youth (Beyers et al., 2004; Iannotti et al., 1996; Yamaguchi and Kandel, 1984).

Laws and Norms Favorable toward Drug Use: Legal restrictions on substance use, such as raising the legal drinking age or restricting smoking in public places, may influence the degree to which youth consume these substances. Moreover, youth who live in communities that view substance use as "normal activity" have a higher chance of using substances themselves (Arthur et al., 2002; Cleveland et al., 2008; Hawkins et al., 2002). Participants were asked if adults in their neighborhood would think it is wrong for them to use substances, or if they were likely to be caught by law enforcement when using substances.

Low Commitment to School: Youth who do not feel connected to or have low commitment to school are more likely to use drugs and participate in other problem behaviors. Low school commitment is measured through items such as disliking school, spending little time on homework, and perceiving course work as irrelevant to one's future (Brown et al., 2005; Catalano et al., 2002).

Early Initiation of Drug Use: Early onset of drug use has been linked to increased drug use and abuse through adolescence and beyond, with later age of onset more likely to

lead to reduced drug involvement and a greater likelihood of discontinuation of use (Kandel, 1975; Miller et al., 2006). To assess the scope of onset among the sample, this factor looks at the age at which youth first tried cigarettes, marijuana, or alcohol, and when youth first began drinking regularly.

Poor Family Management: Parents' use of inconsistent and/or unusually harsh punishment with their children places their children at a higher risk for participation in substance use and other problem behaviors. This higher risk is also seen in youth whose parents do not provide clear explanations for expected behaviors and do not monitor their children's activities (Arthur et al., 2002; Dishion et al., 2004). Youth were asked if their parents usually know who they are spending time with, if there are clear rules in their household, and if their parents would be aware of the youth's participation in problem behaviors.

Definitions of Protective Factors

Belief in the Moral Order: Youth who have a belief in what is "right" or "wrong" are less likely to use drugs (Beyers et al., 2004; Catalano et al., 1996).

Bonding to Adults, Peers and Community: Rewards for positive participation in activities helps youth bond to their communities, and lowers their risk of participating in problem behaviors. When neighbors encourage them to try their best in various activities, talk with them regarding something important, and if community members ever inform the youth that they are proud of them for doing something well all lower student's risk of problem behaviors (Catalano et al., 1996; Cleveland et al., 2008).

School Opportunities for Prosocial Involvement: When youth are given opportunities to participate meaningfully in important activities at school, they are less likely to engage in drug use and other problem behaviors (Arthur et al., 2002; Beyers et al., 2004; Catalano et al., 1992). Youth were asked about having the chance to participate in school activities, being asked to work on special projects in the classroom, and being able to speak with their teacher one-on-one.

Interaction with Prosocial Peers: Youth who associate with peers who engage in prosocial behavior are more likely to participate in prosocial behavior as well.

Prosocial Involvement: Youth who participate in positive school and community activities are less likely to participate in problem behaviors (Arthur et al., 2002; Beyers et al., 2004; Catalano et al., 1996).

Rewards for Prosocial Involvement: Youth who are rewarded for working hard in school and the community are less likely to engage in problem behaviors. Rewards for prosocial involvement include being seen as cool for trying your best at school,

defending someone who is being bullied, or regularly volunteering in the community (Catalano et al., 1996; Cleveland et al., 2008).

Family Attachment: Youth who feel that they are close to or are a valued part of their family are less likely to engage in substance use and other problem behaviors (Arthur et al., 2002; Catalano et al., 1992). Youth were asked questions regarding if they feel close to their family members and if they share thoughts and feelings with their mother and father.

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Appendix I

Opioid Overdose & NAS Surveillance Data

Appendix I

Highlighted Opioid Surveillance Data: June 15, 2017– June 14, 2018

On June 5, 2018 under Governor Ducey's Emergency Declaration ADHS was tasked with developing an enhanced surveillance system to monitor the opioid emergency response. Rather than creating a new system, ADHS expanded two existing data collection systems, the Arizona Pre-hospital Information and EMS Registry System (AZ-PIERS) and the Medical Electronic Disease Surveillance Intelligence System (MEDSIS). AZ-PIERS collects information from EMS and law enforcement about suspect opioid overdoses. MEDSIS collects information from healthcare facilities and medical examiners about opioid overdoses and neonatal abstinence syndrome (NAS).

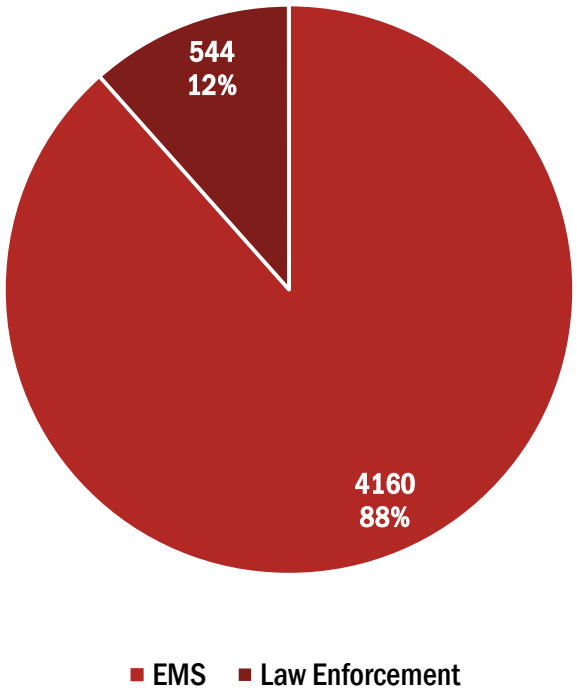
On June 15, 2017, ADHS began collecting reports of fatal and non-fatal suspect opioid overdoses and NAS. Reporting was required within 24 hours under the enhanced surveillance order, until October when rules went into effect changing it to a 5 business day reporting period.

Between June 15, 2017 and June 14, 2018, 1,382 suspect opioid deaths, 8,591 suspect opioid overdoses, and 809 NAS cases were reported. Data is updated weekly at www.azhealth/opioid.

June 15, 2017 – June 14, 2018

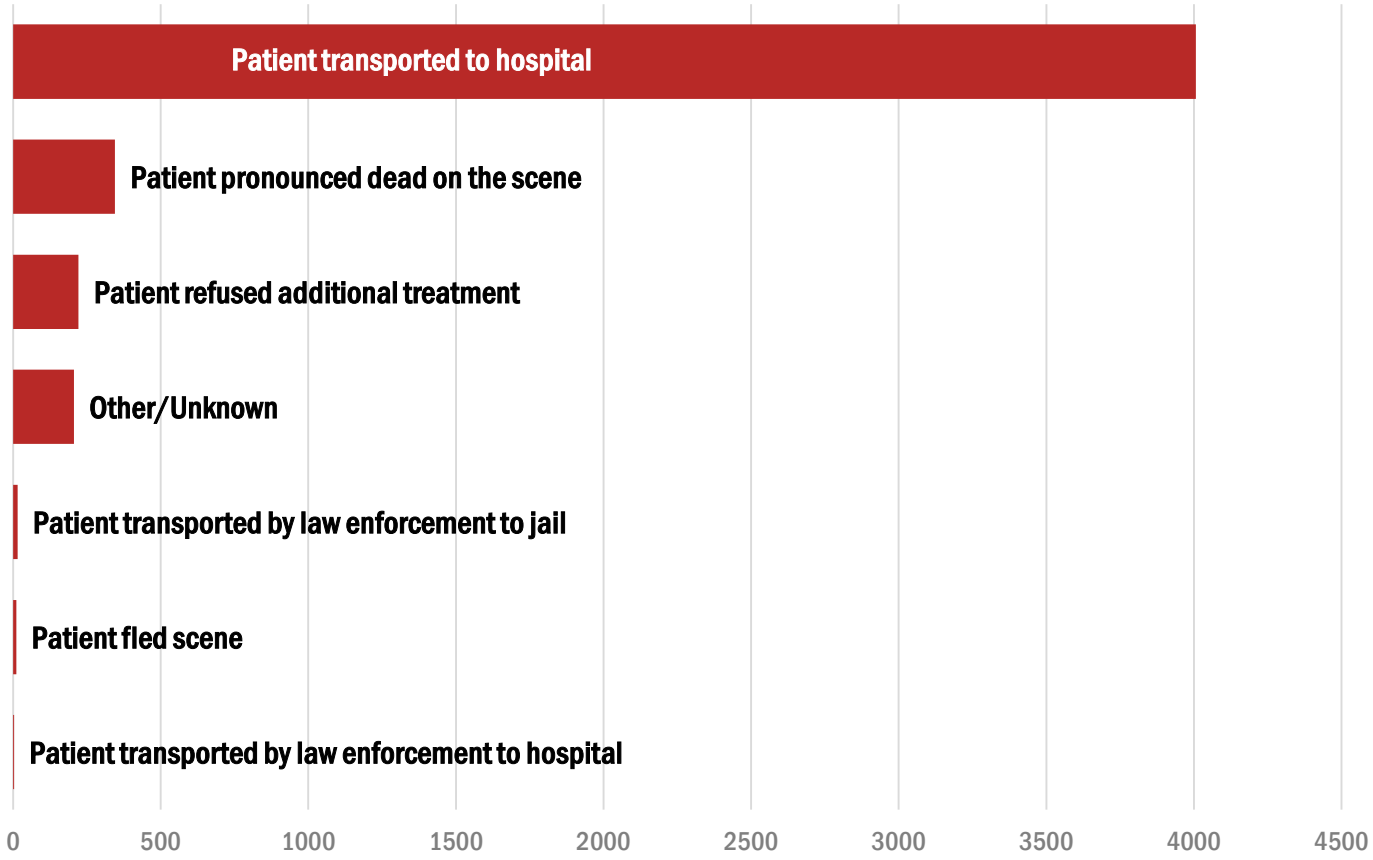
List of Figures

Figure 1: Which Agencies Reported to AZ-PIERS, June 15, 2017-June 14, 2018



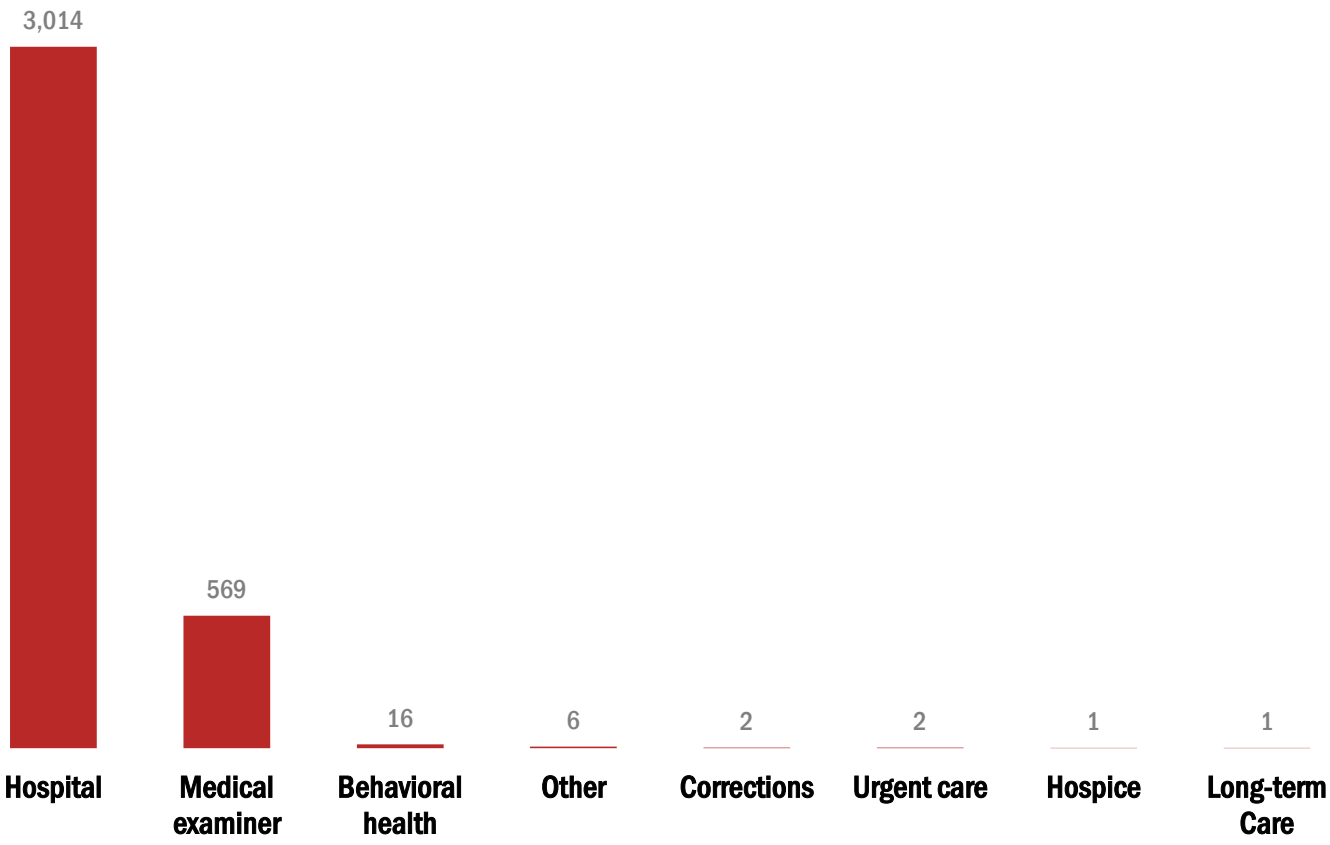
- The majority of overdose reports are made by EMS.
- Of the EMS reports, 99.8 percent were made by ground transport companies.

Figure 2: AZ-PIERS Patient Disposition for Suspect Opioid Overdoses June 15, 2017-June 14, 2018



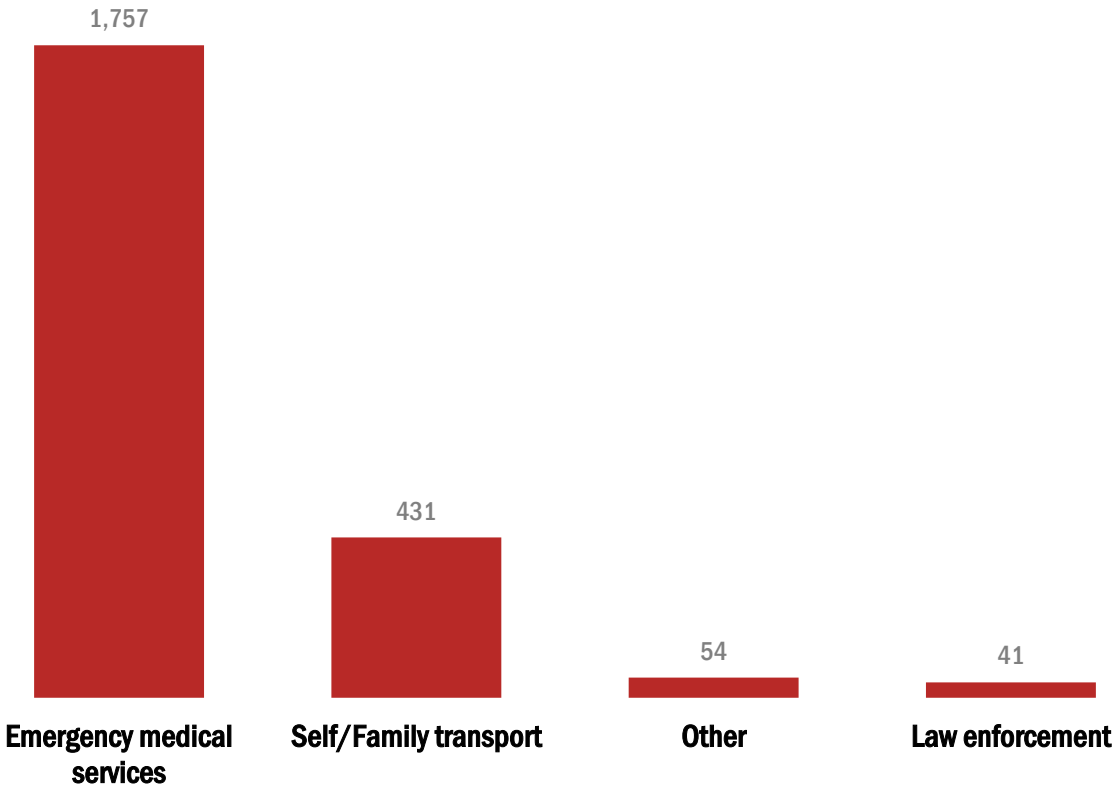
- The majority of patients were transported to the hospital by EMS.
- Five percent of patients refused additional treatment.

Figure 3: Type of Facilities that Reported to MEDSIS, June 15, 2017-June 14, 2018



- The majority of overdose reports are made by hospitals.
- Although medical examiner reports account for only 12% of all reports, they reported 78% of fatal suspect overdoses.

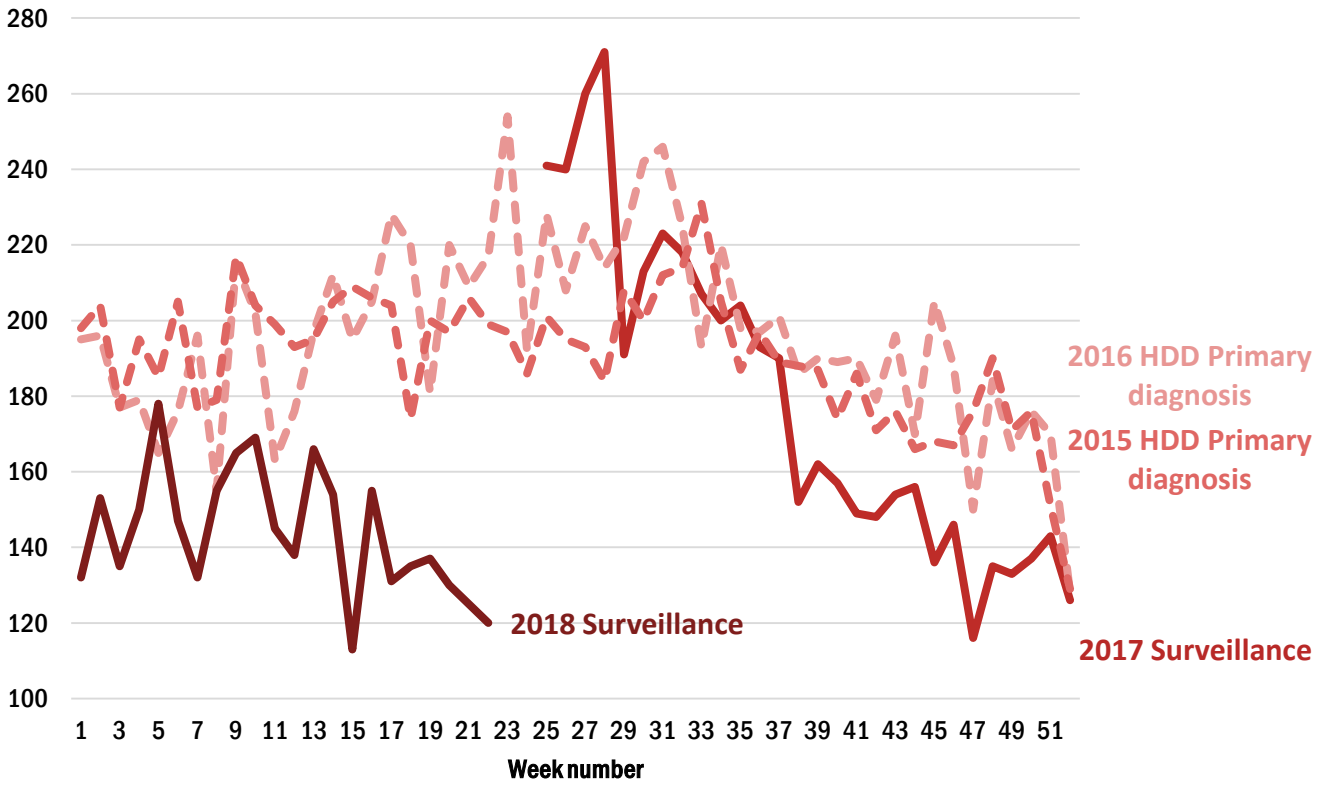
Figure 4: Modes of Transportation to Hospital for Suspect Opioid Overdoses Reported to MEDSIS: June 15, 2017-June 14, 2018



- The majority of patients were transported to the hospital by EMS.
- Transportation by self, family, or other private vehicle accounted for 19% of all transportation methods.

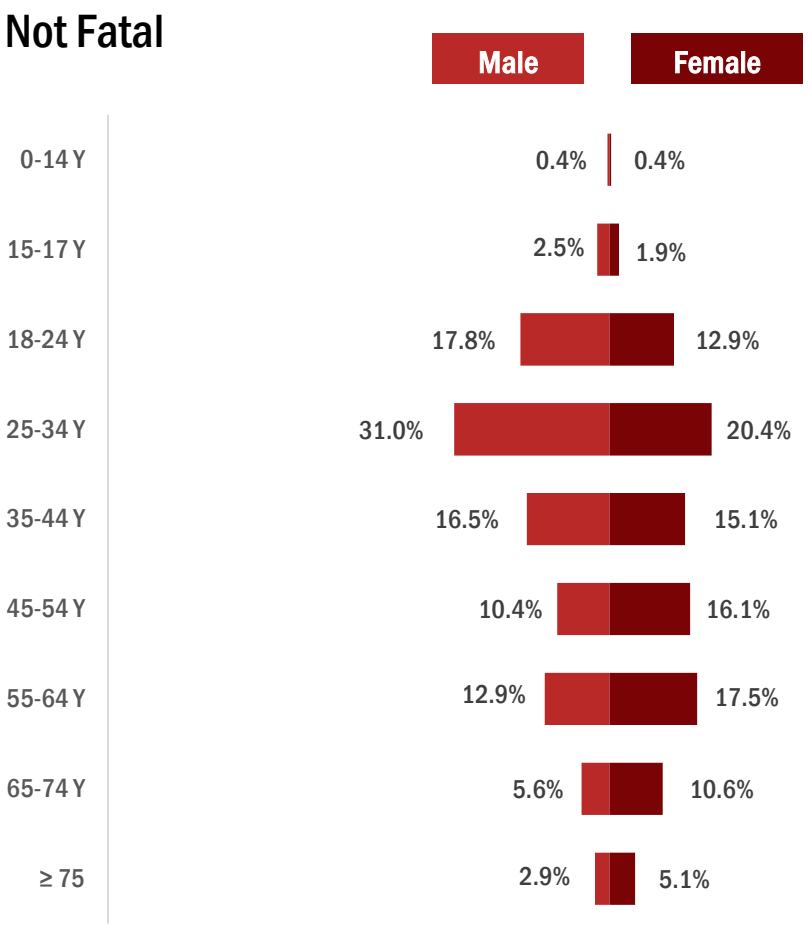
Figure 5: Year on Year Comparison by Week: 2015-2018

- Real-time opioid overdose surveillance data began being reported to ADHS on June 15, 2017.
- Hospital discharge data (HDD) is emergency room and inpatient information reported to ADHS by hospitals.



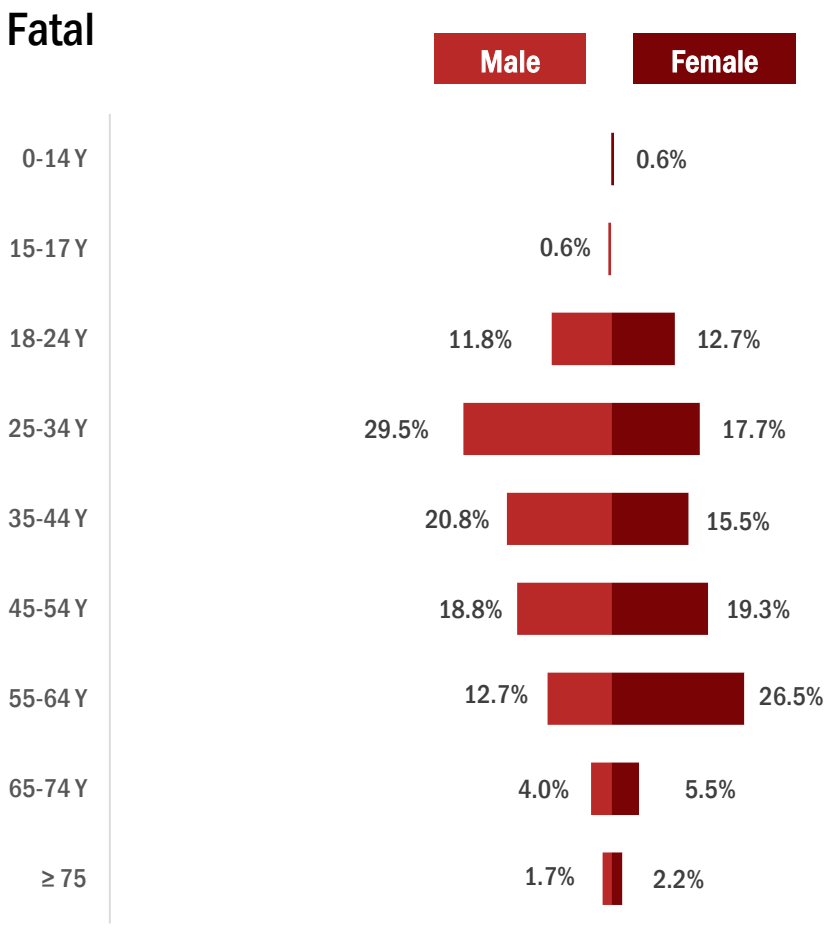
- Week to week comparison of opioid overdoses reported through the surveillance system with HDD data from 2015 and 2016 shows that overdoses in Arizona rise in the spring, peak in the summer and decline in the fall.
- Because real-time opioid overdose reporting is new, it is not yet as complete as HDD. Efforts are being made to improve it as the system matures.

Figure 6: Verified Not Fatal Opioid Overdoses by Age and Gender June 15, 2017-June 14, 2018



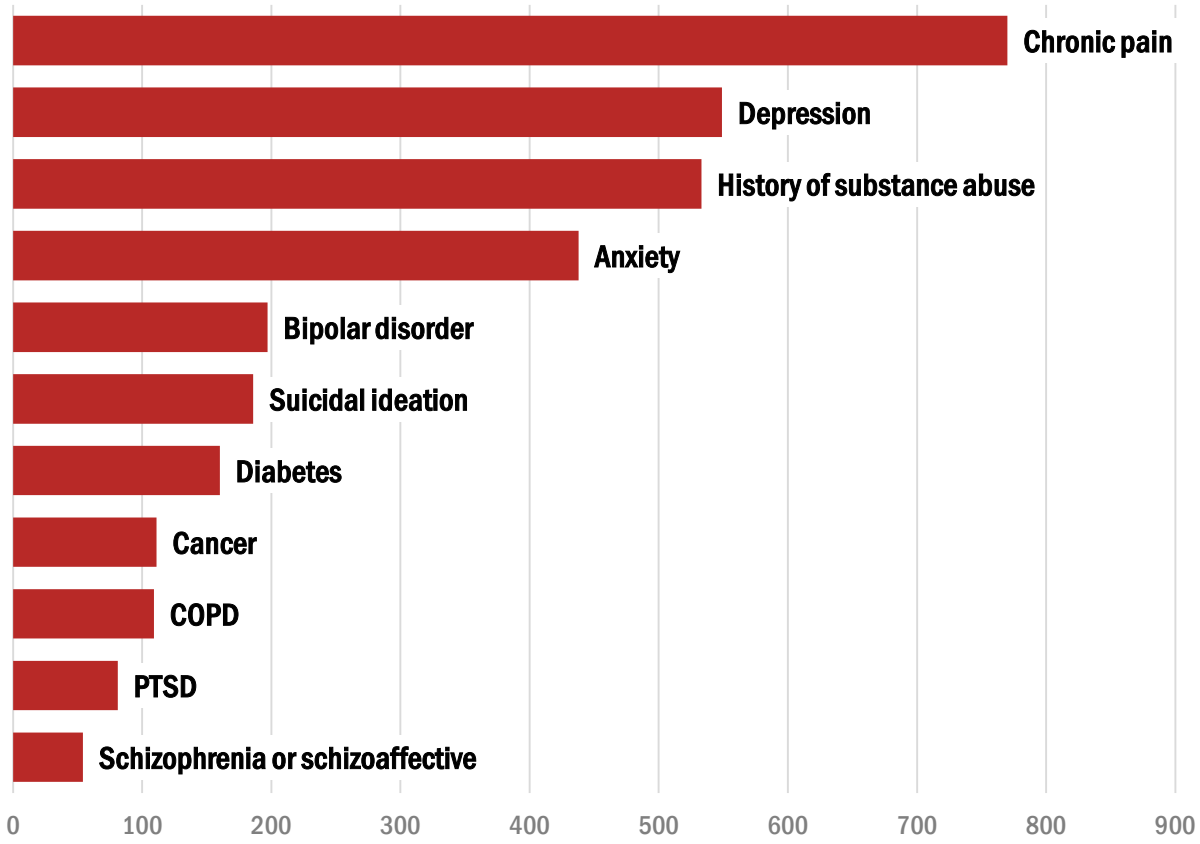
- A verified opioid overdose is one where the medical records have been reviewed and the cause of the overdose has been determined by ADHS.
- At the time of writing, 530 fatal overdoses and 2,459 non-fatal overdoses had been verified.
- Men 34 years old and younger have more non-fatal verified opioid overdoses than older men.
- Women 25-64 years old and younger have more non-fatal verified opioid overdoses than younger women.

Figure 7: Verified Fatal Opioid Overdoses by Age and Gender: June 15, 2017-June 14, 2018



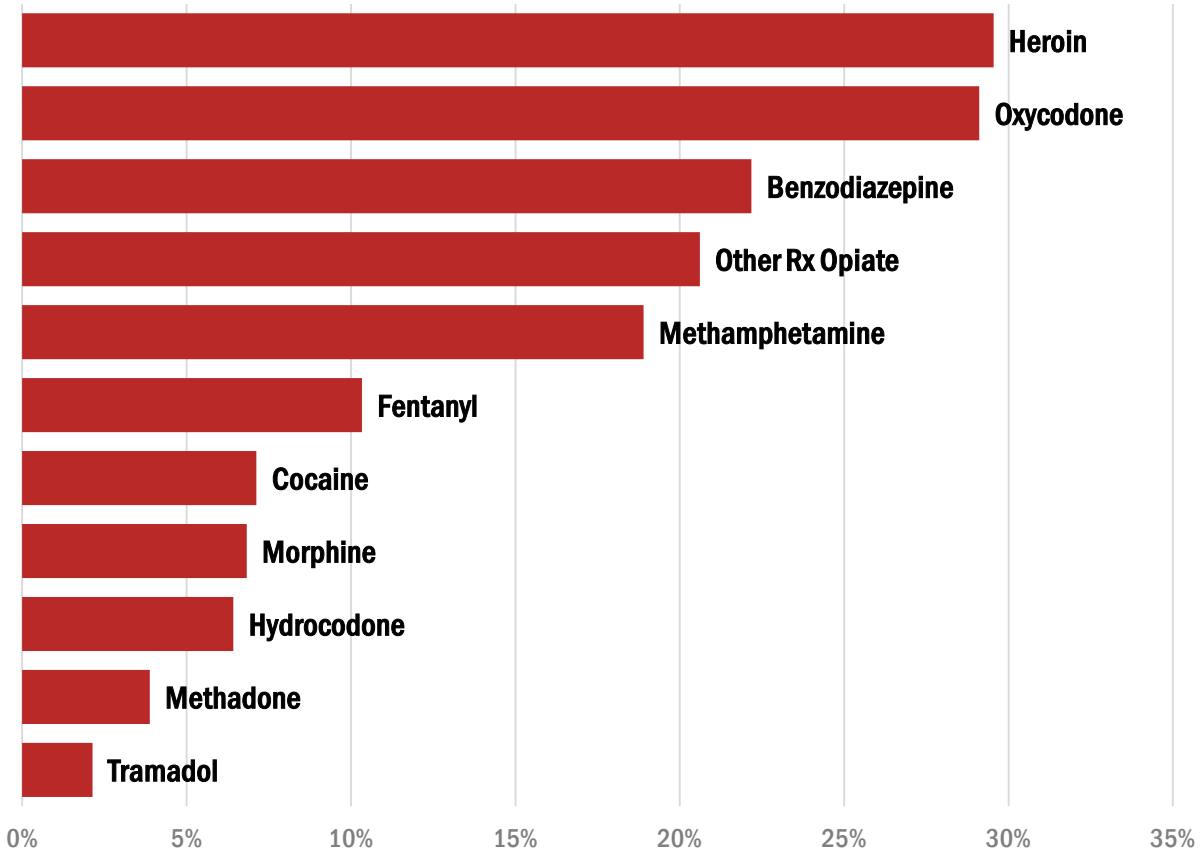
- A verified opioid overdose is one where the medical records have been reviewed and the cause of the overdose has been determined by ADHS
- At the time of writing, 530 fatal overdoses and 2,459 non-fatal overdoses had been verified.
- Women 45-64 years old are more likely to have a fatal verified opioid overdose than other age groups.
- Men 25-44 years old are more likely to have a fatal verified opioid overdose than other age groups.

Figure 8: Reported Pre-Existing Conditions for Verified Opioid Overdoses: June 15, 2017-June 14, 2018



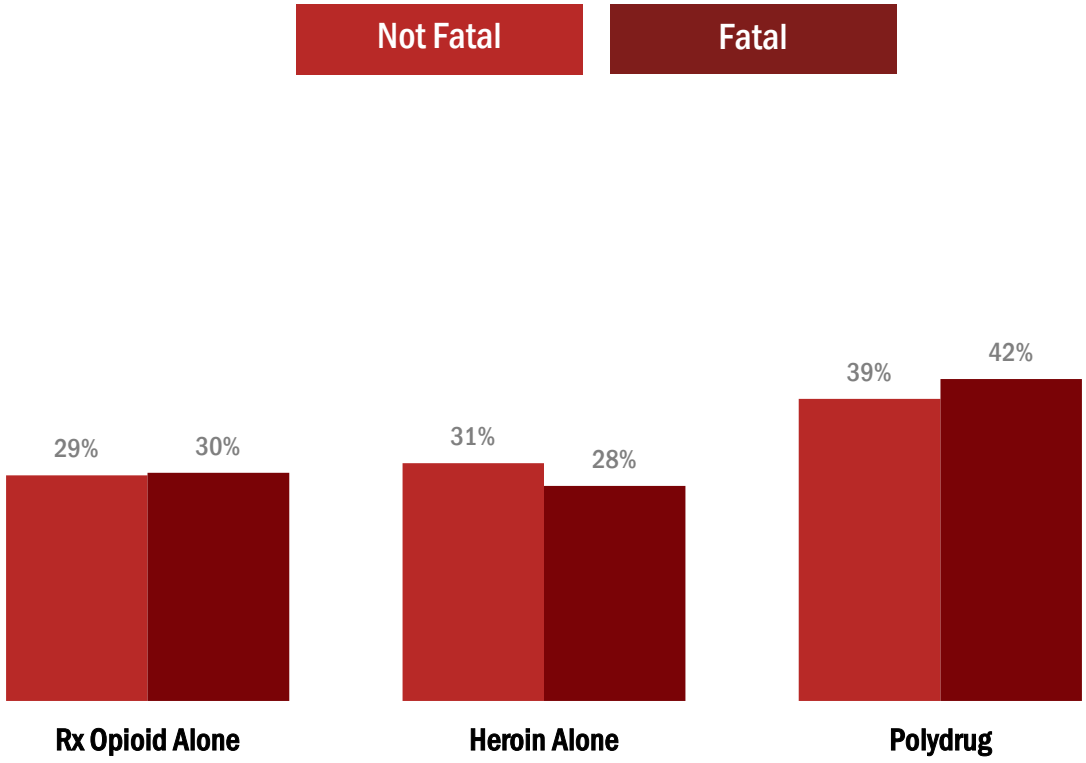
- A verified opioid overdose is one where the medical records have been reviewed and the cause of the overdose has been determined by ADHS.
- At the time of writing, 530 fatal overdoses and 2,459 non-fatal overdoses had been verified.
- Chronic pain (e.g. lower back pain, joint pain, arthritis) is the most common pre-existing physical condition reported for those who had a verified opioid overdose.
- Depression, history of substance abuse, and anxiety are the most common pre-existing behavioral health conditions reported for those who had a verified opioid overdose.

Figure 9: Drug Type Involved in Verified Opioid Overdoses: June 15, 2017-June 14, 2018



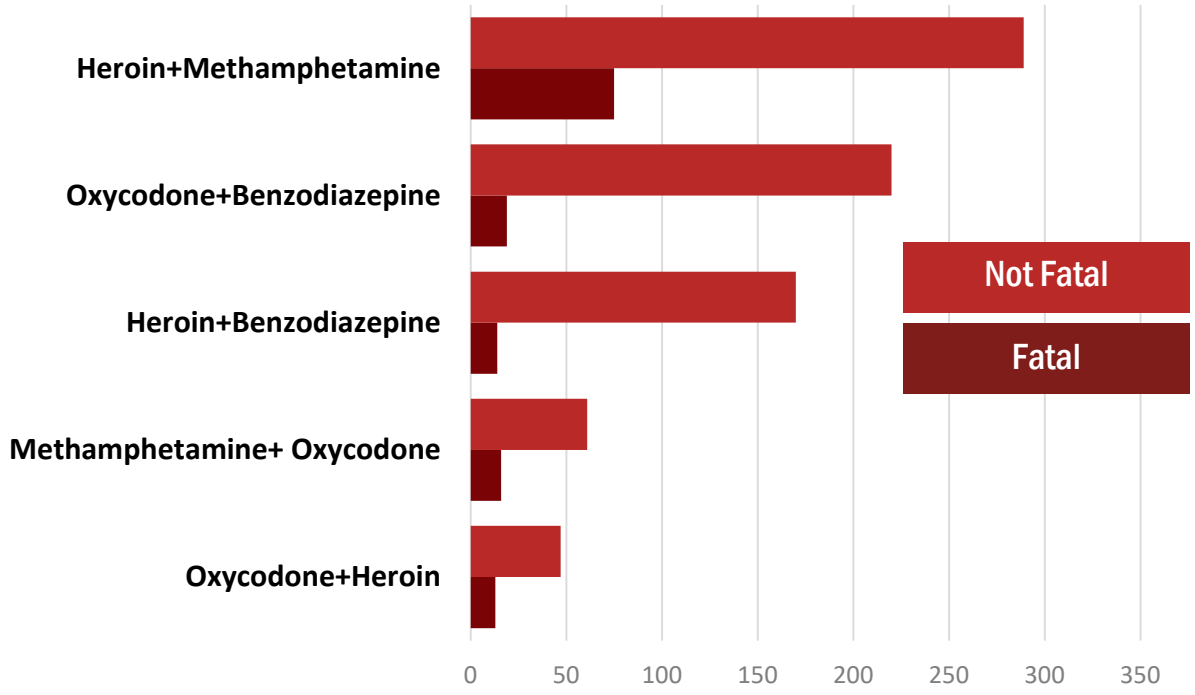
- A verified opioid overdose is one where the medical records have been reviewed and the cause of the overdose has been determined by ADHS
- At the time of writing, 530 fatal overdoses and 2,459 non-fatal overdoses had been verified.
- Heroin, alone or in combination with other drugs, was reported to be involved in 29% of verified opioid overdoses
- Oxycodone, morphine, and hydrocodone, alone or in combination with other drugs, were involved in 42% of verified opioid overdoses

Figure 10: Prescription Drug, Heroin, and Poly-drug Use in Verified Opioid Overdoses June 15, 2017-June 14, 2018



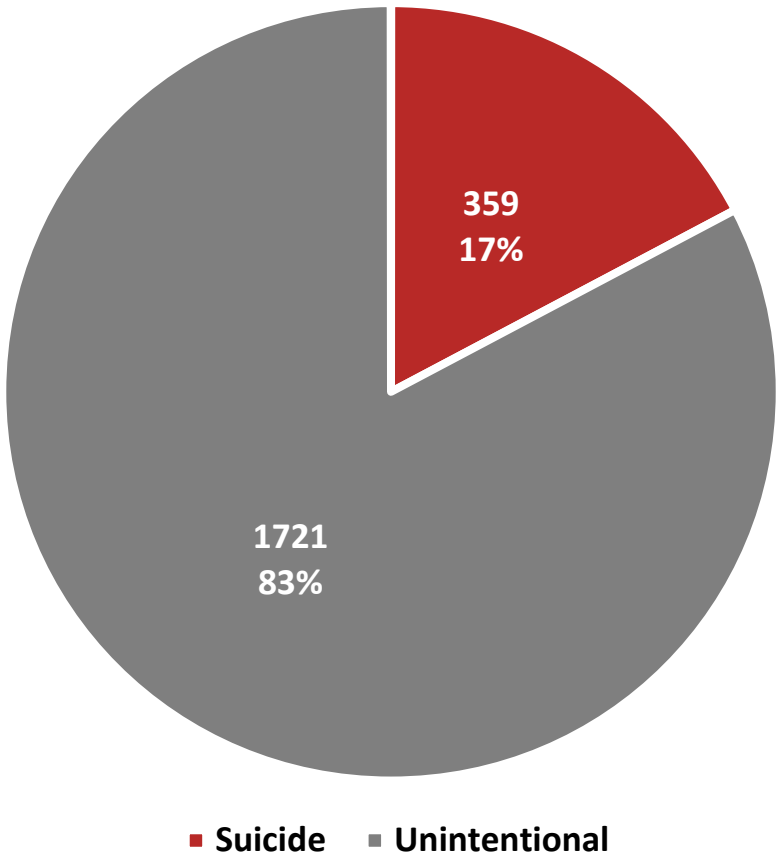
- A verified opioid overdose is one where the medical records have been reviewed and the cause of the overdose has been determined by ADHS
- At the time of writing, 530 fatal overdoses and 2,459 non-fatal overdoses had been verified.
- A "polydrug" overdose is when there was more than one drug identified.
- 42% of verified *fatal* opioid overdoses and 39% of *non-fatal* opioid overdoses involved polydrug use of at least one opioid and at least one other type of drug.

Figure 11: Common Drug Combinations in Verified Opioid Overdoses June 15, 2017-June 14, 2018



- A verified opioid overdose is one where the medical records have been reviewed and the cause of the overdose has been determined by ADHS.
- At the time of writing, 530 fatal overdoses and 2,459 non-fatal overdoses had been verified.
- The most common drug combination in fatal & non-fatal overdoses was heroin and methamphetamine.

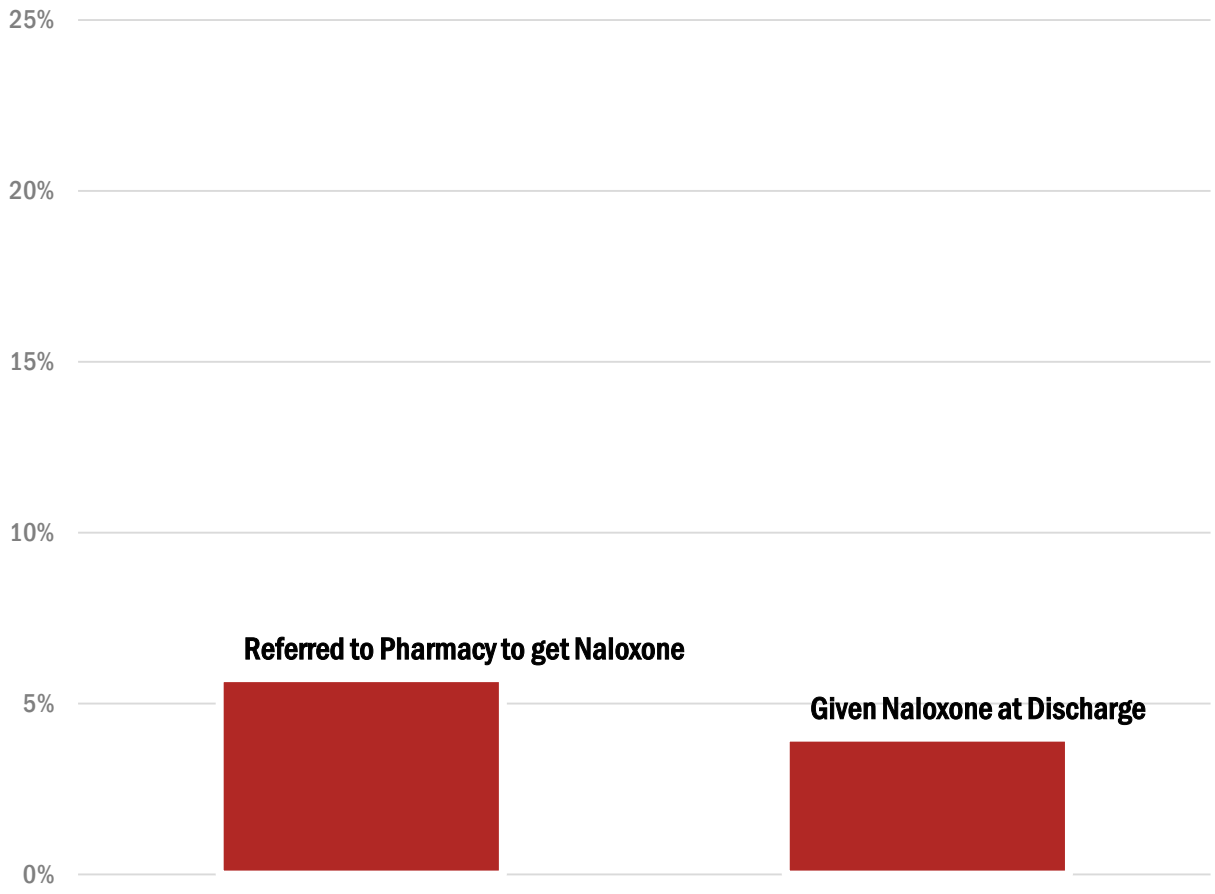
Figure 12: Intent of Verified Overdose: June 15, 2017-June 14, 2018



220 (9.5%) of cases did not have information about suicide available.

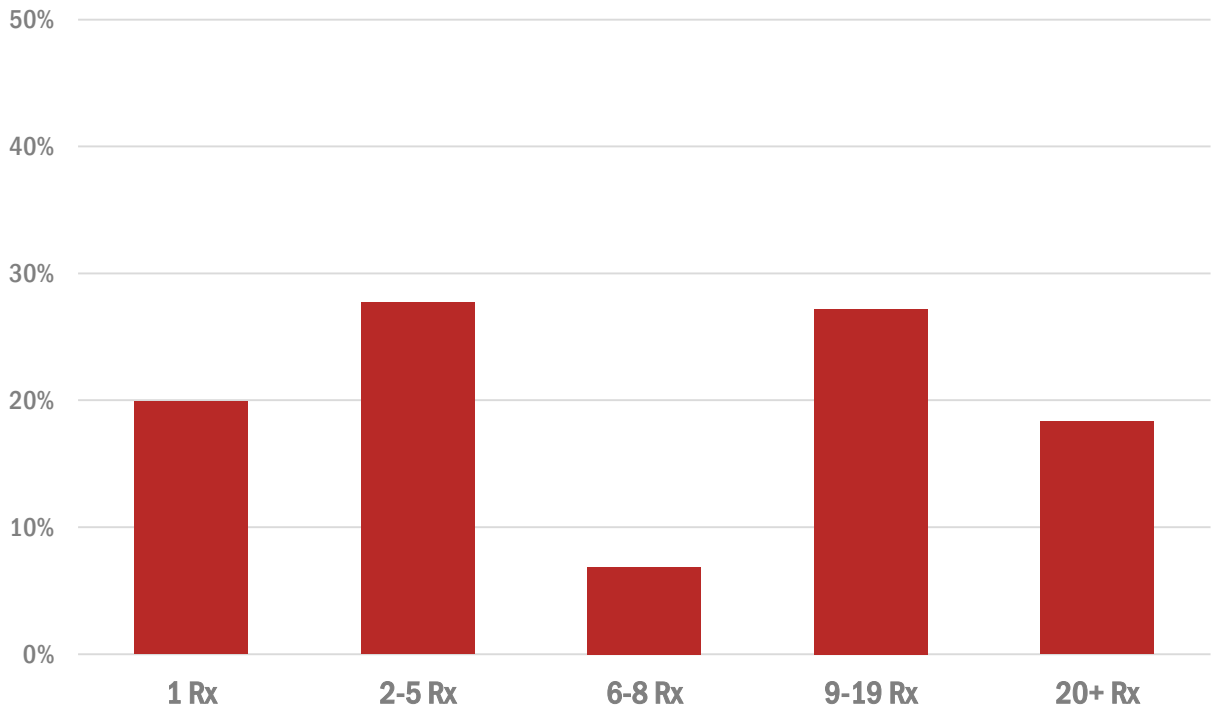
- A verified opioid overdose is one where the medical records have been reviewed and the cause of the overdose has been determined by ADHS.
- At the time of writing, 530 fatal overdoses and 2,459 non-fatal overdoses had been verified.
- The majority of verified opioid overdoses were not intentional.

Figure 13: Recommended After Care for Verified Non-Fatal Overdoses that are Discharged Home: June 15, 2017-June 14, 2018



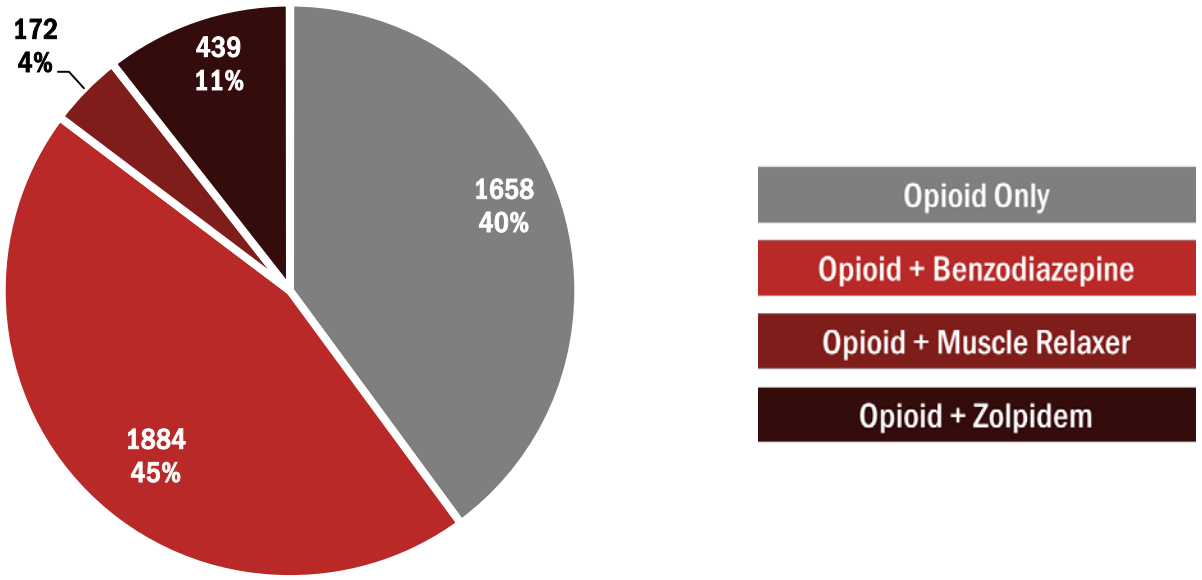
- A verified opioid overdose is one where the medical records have been reviewed and the cause of the overdose has been determined by ADHS.
- At the time of writing, 530 fatal overdoses and 2,459 non-fatal overdoses had been verified.
- Fewer than 10% were given naloxone at time of discharge or referred to a pharmacy to obtain naloxone.

Figure 14: Number of Opioid Prescriptions Filled January 1, 2017- June 12, 2018 by People who had a Suspected Opioid Overdose June 15, 2017-June 14, 2018



- 3,719 people (80%) who had a suspect overdose between June 15, 2017 and June 14, 2018 had one or more opioid prescriptions between January 1, 2017 and June 12, 2018.
- Approximately 40% of the people who had a suspected opioid overdose between June 15, 2017 and June 14, 2018 had nine or more prescriptions filled between January 1, 2017 and June 12, 2018.

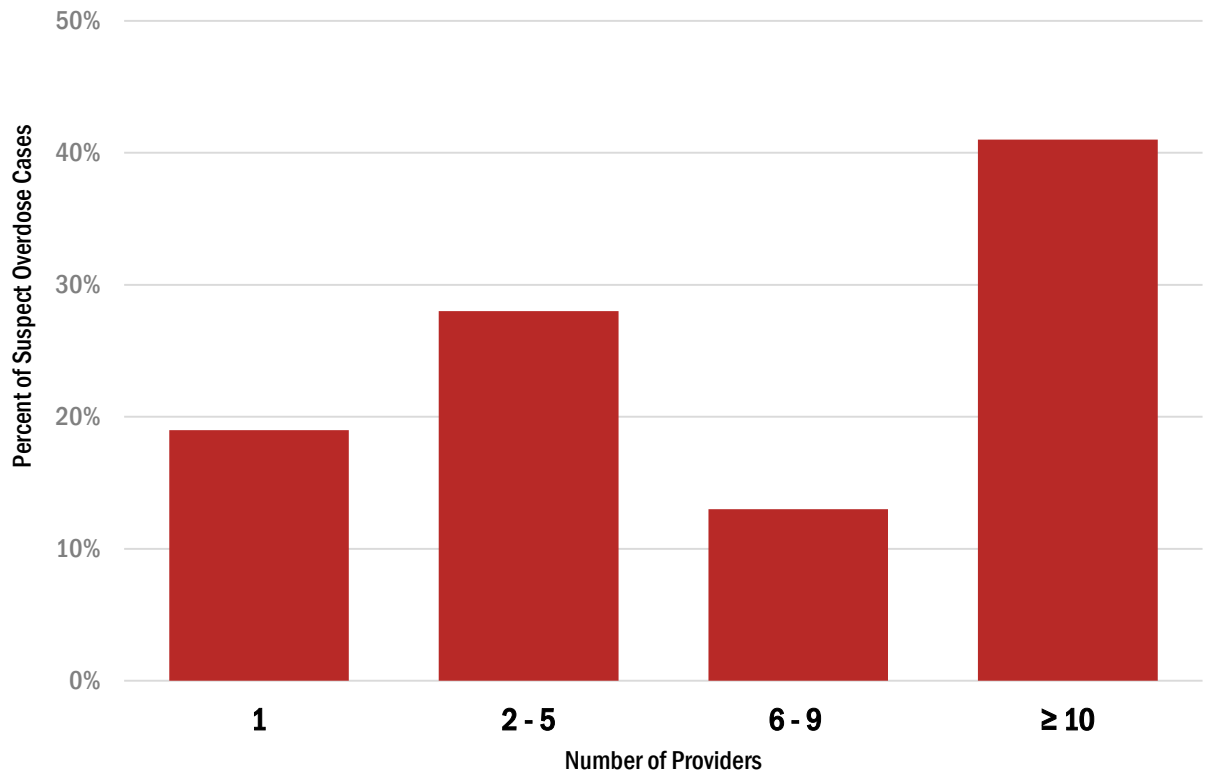
Figure 15: Drug Combinations Prescribed to People Who Had a Suspect Opioid Overdose between June 15, 2017-June 14, 2018



Prescription Drug Monitoring Program (PDMP) data from January 1, 2017 – June 12, 2018

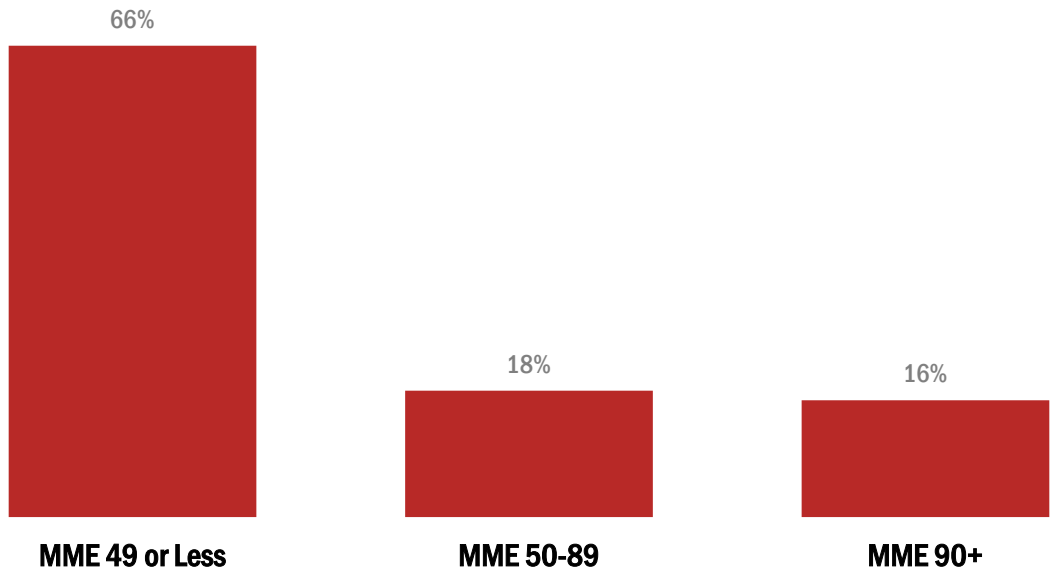
- 3,719 people who had a suspect overdose between June 15, 2017 and June 14, 2018 had one or more opioid prescriptions between January 1, 2017 and June 12, 2018.
- Taking opioids with certain other drugs increases the chance of overdosing.
- 45% of the people who had a suspect opioid overdose were prescribed opioids and benzodiazepines.

Figure 16: Number of Opioid Prescribing Providers per Suspect Overdose Case June 15, 2017-June 14, 2018



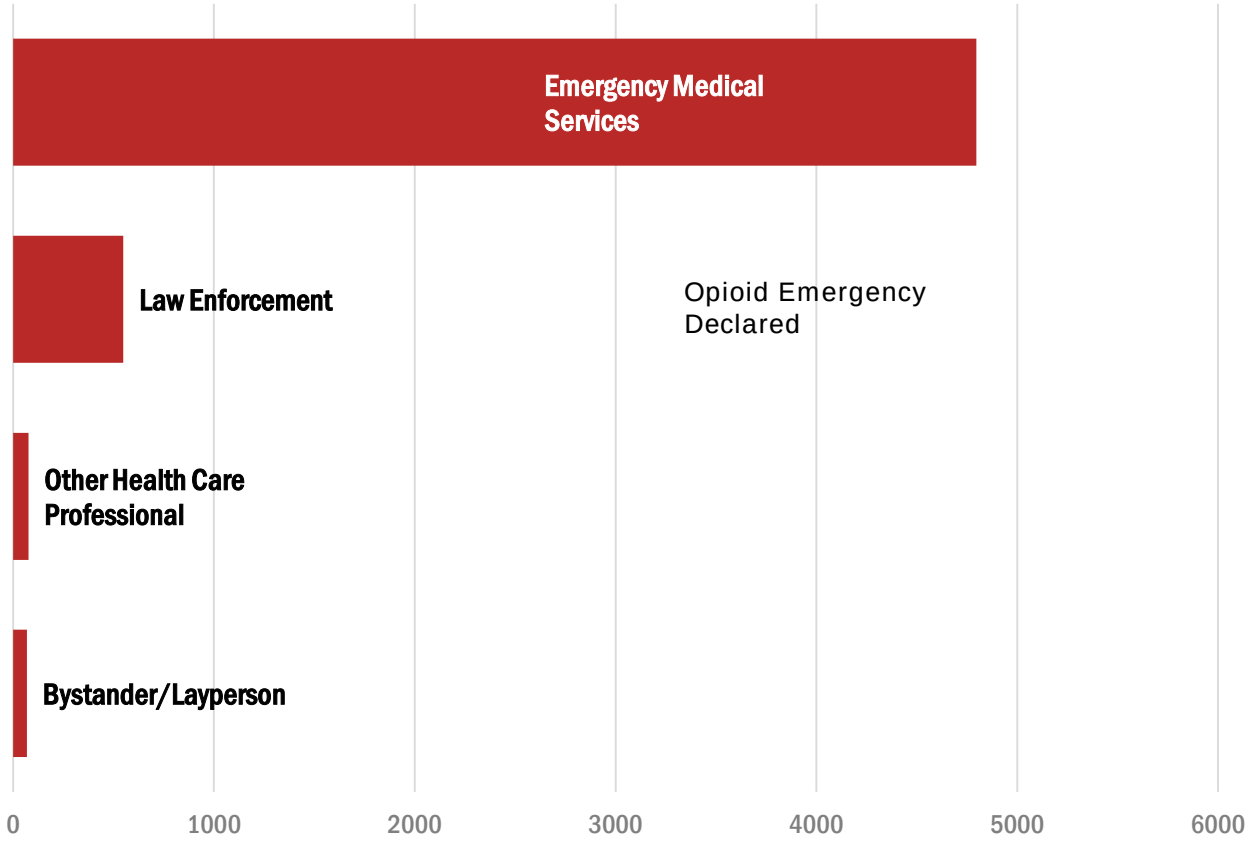
- 3,719 people who had a suspect overdose between June 15, 2017 and June 14, 2018 had one or more opioid prescriptions between January 1, 2017 and June 12, 2018.
- 80% of people who had a suspected opioid overdose and had a prescription for opioids were prescribed opioids by more than one provider.
- 36% were prescribed opioids by 10 or more providers.

Figure 17: Morphine Milligram Equivalents (MME) for Prescriptions Filled January 1, 2017-June 4, 2018 by People Who Had Verified Opioid Overdoses June 15, 2017-June 14, 2018



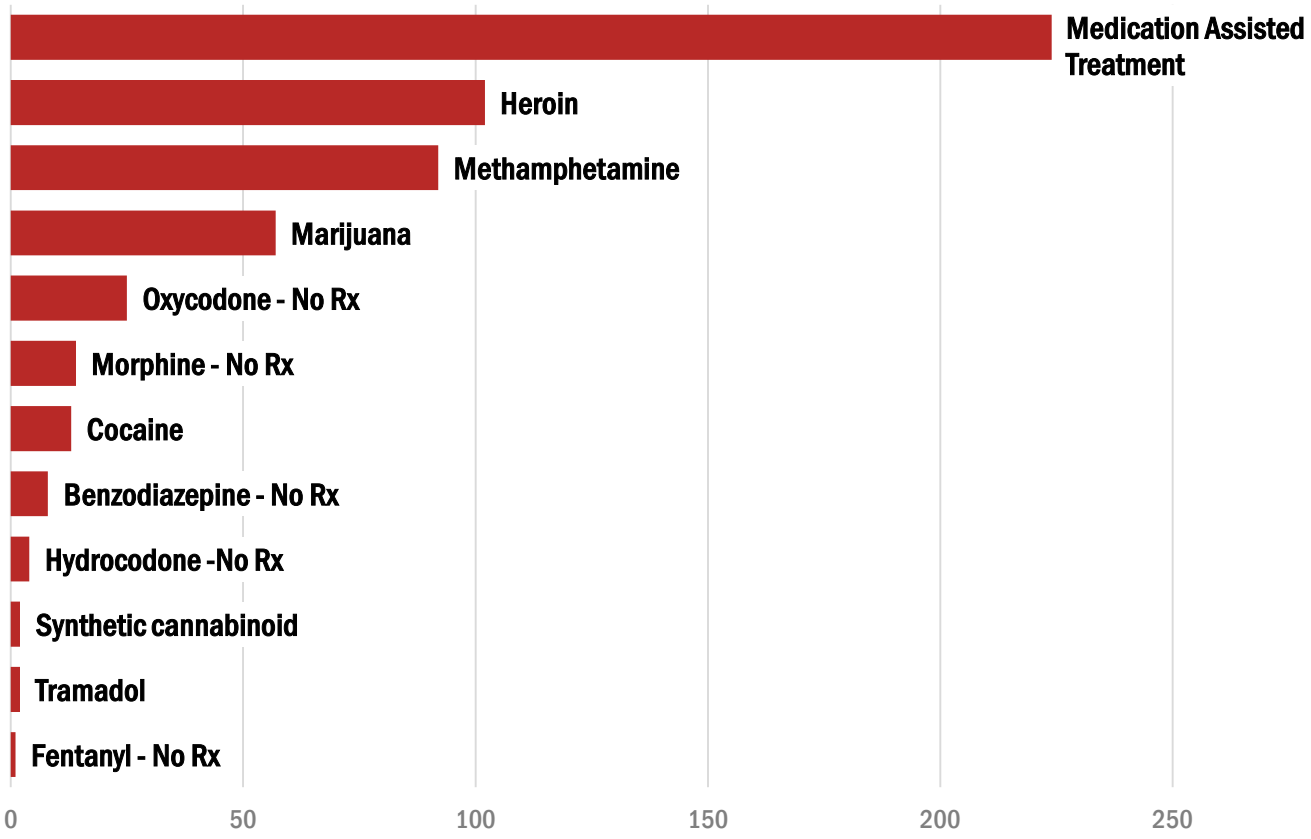
- 3,719 people who had a suspect overdose between June 15, 2017 and June 14, 2018 had one or more opioid prescriptions between January 1, 2017 and June 12, 2018.
- MME is a measure of the strength of a patient's daily opioid dose.
- Approximately 35% of people with verified opioid overdoses had prescriptions for doses of 50 or more MME filled prior to their overdose.

Figure 18: Entity that Administered Naloxone to Suspect Opioid Overdoses June 15, 2017-June 14, 2018



- Naloxone is a medication designed to rapidly reverse opioid overdose.
- In Arizona you can get naloxone from any pharmacy without a prescription.
- EMS administers the majority of the naloxone to people who experienced suspected opioid overdoses.
- Law enforcement officers administered naloxone 549 times since June 2017.
- Bystander/layperson naloxone administrations are undercounted since only those with a law enforcement or EMS response are captured in AZ-PIERS.

Figure 19: Drugs Used by Women Who Gave Birth to Infants Who Developed Neonatal Abstinence Syndrome June 15, 2017-June 14, 2018



- Numerous drugs can cause neonatal abstinence syndrome.
- The majority of women giving birth to infants with neonatal abstinence syndrome were reported to have received medically assisted treatment during their pregnancies.
- Methamphetamine and heroin were the most common drugs used without medical supervision.

Table 1: Possible Overdoses Reported by County Where They Occurred June 15, 2017-June 14, 2018

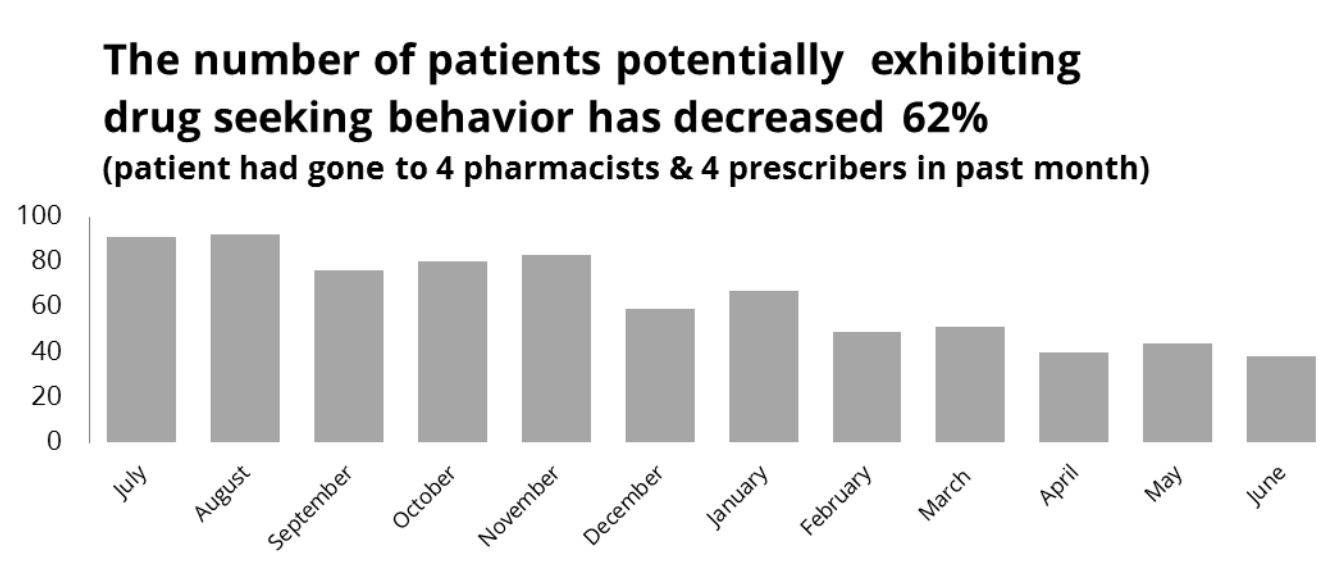
County	Number of Possible Opioid Overdoses Reported
Apache	<10
Cochise	61
Coconino	75
Gila	55
Graham	55
Greenlee	<10
La Paz	27
Maricopa	5317
Mohave	260
Navajo	123
Pima	1431
Pinal	378
Santa Cruz	17
Yavapai	369
Yuma	202
Out of State*	<10
Missing	207

* Arizona EMS and law enforcement agencies will respond across state lines if they are closest to the scene

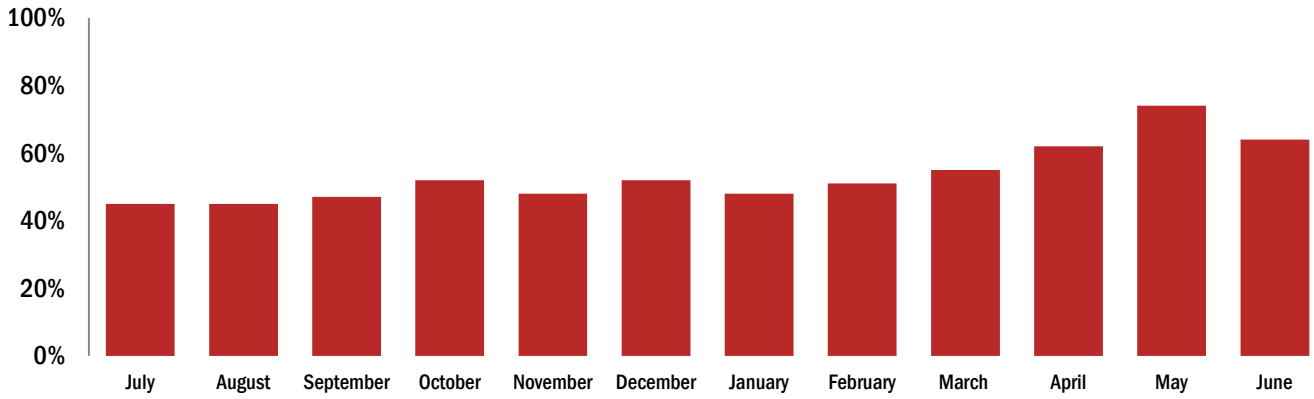
- Maricopa County reported the most possible opioid overdoses, followed by Pima County, and Pinal County.
- Yavapai County had the highest number of possible overdoses reported out of all rural counties.

Indicators of Progress

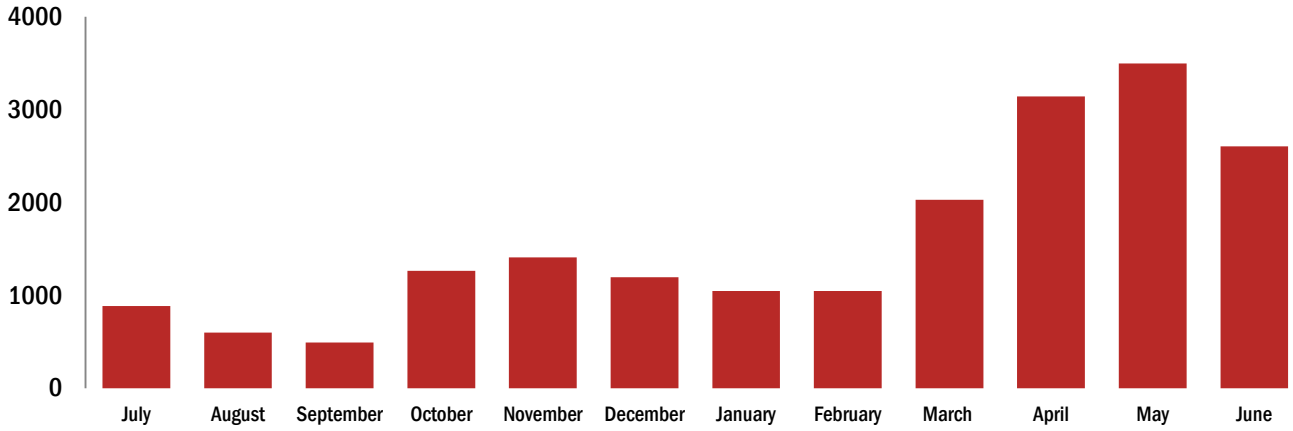
As part of the Governor's Opioid Breakthrough Project, ADHS and state agency partners tracked a number of metrics to assess progress over the course of the year. With many new state policy and initiatives just going into place in 2018, outcome measures such as numbers of overdoses and deaths will not demonstrate progress immediately. However, other indicators, such as number of opioid prescriptions dispensed, are showing clear movement into a positive direction. The following are some additional metrics indicating progress.



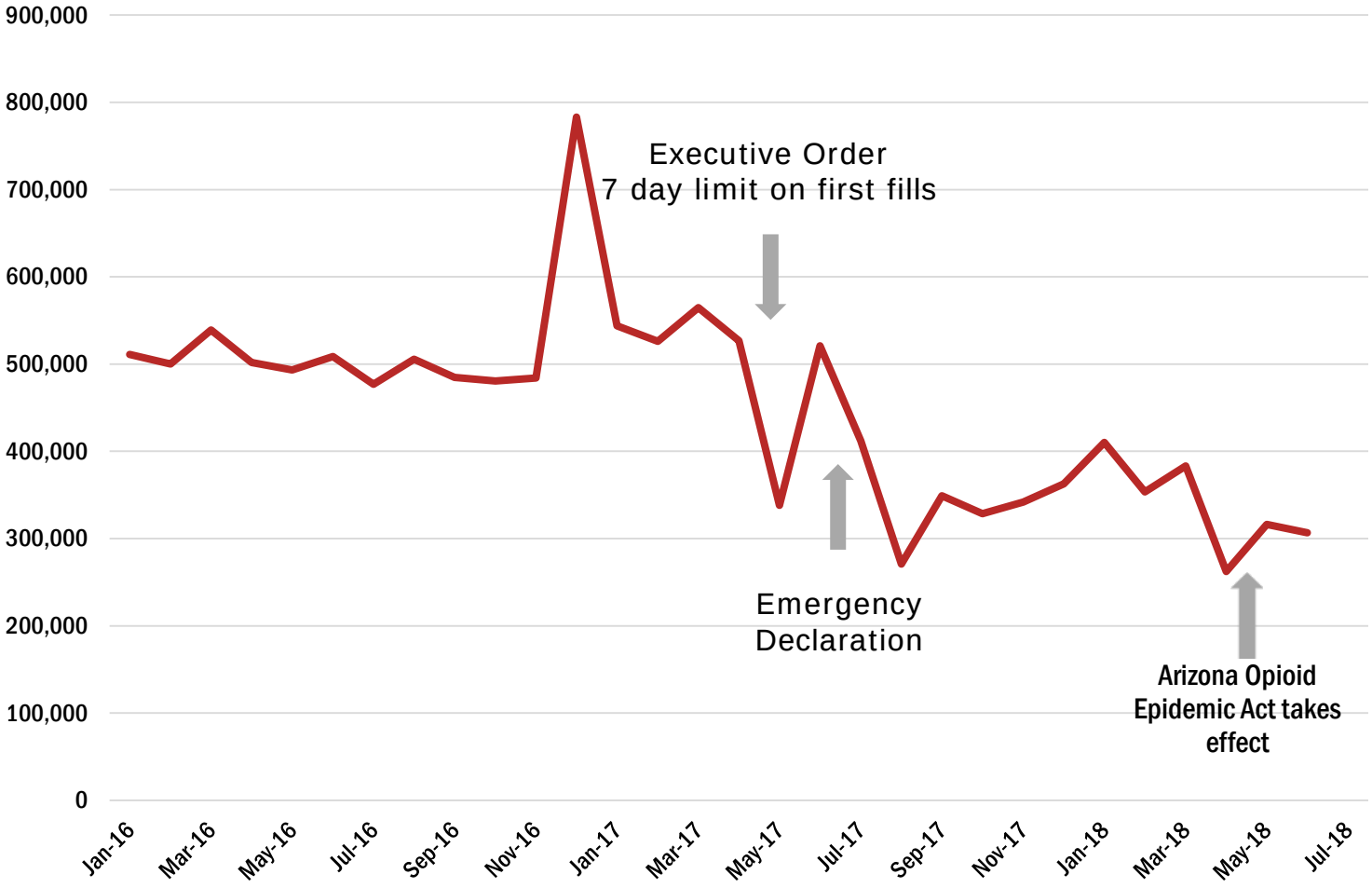
The percent of people with suspected overdoses referred by hospitals to behavioral health increased 42%



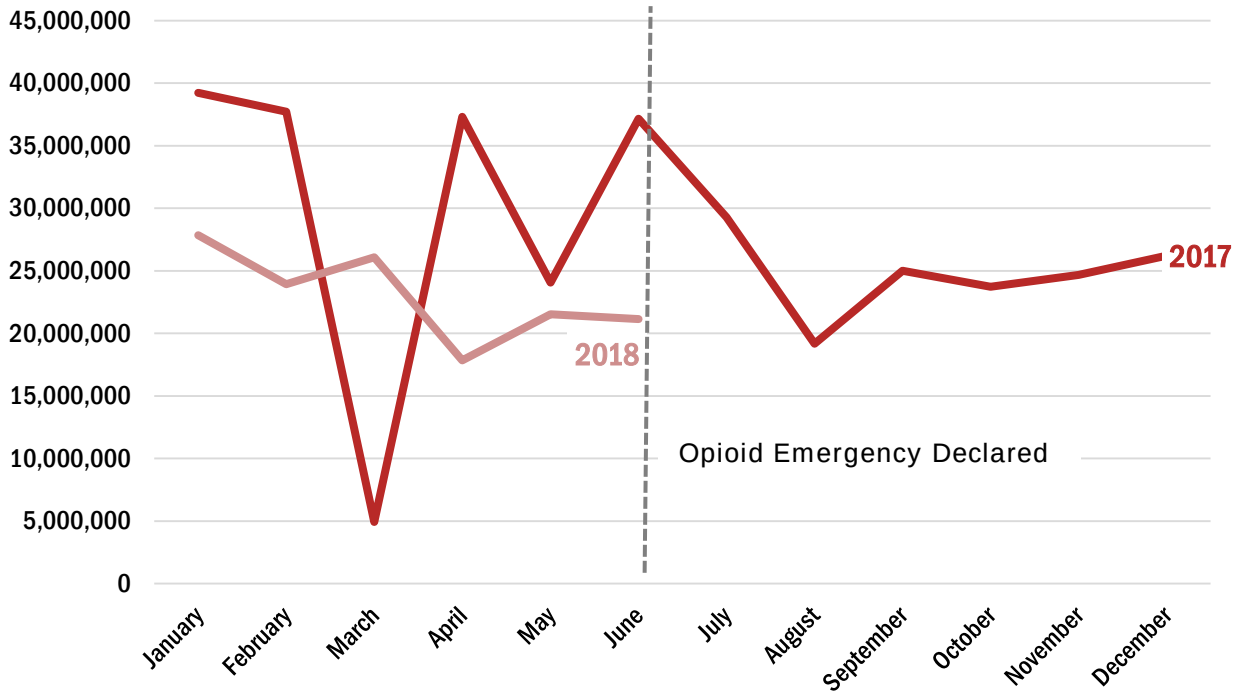
The number of naloxone doses dispensed by pharmacists has tripled



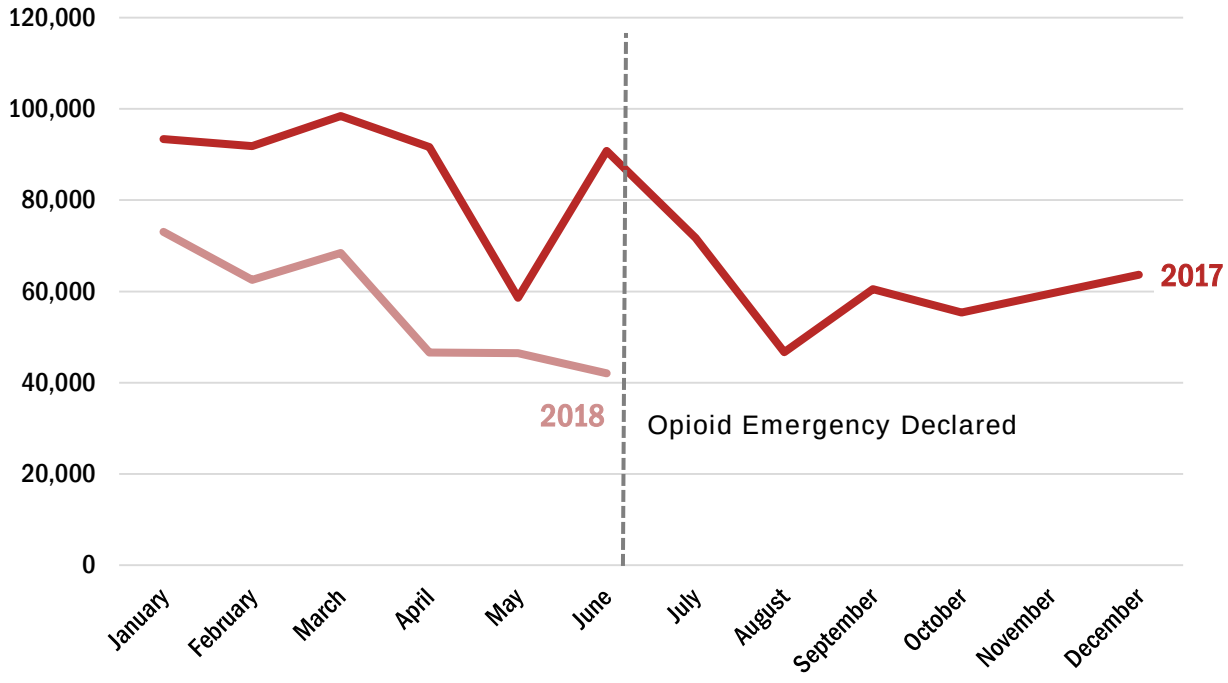
The number of opioid prescriptions filled has decreased 40% between January 2016 and June 2018



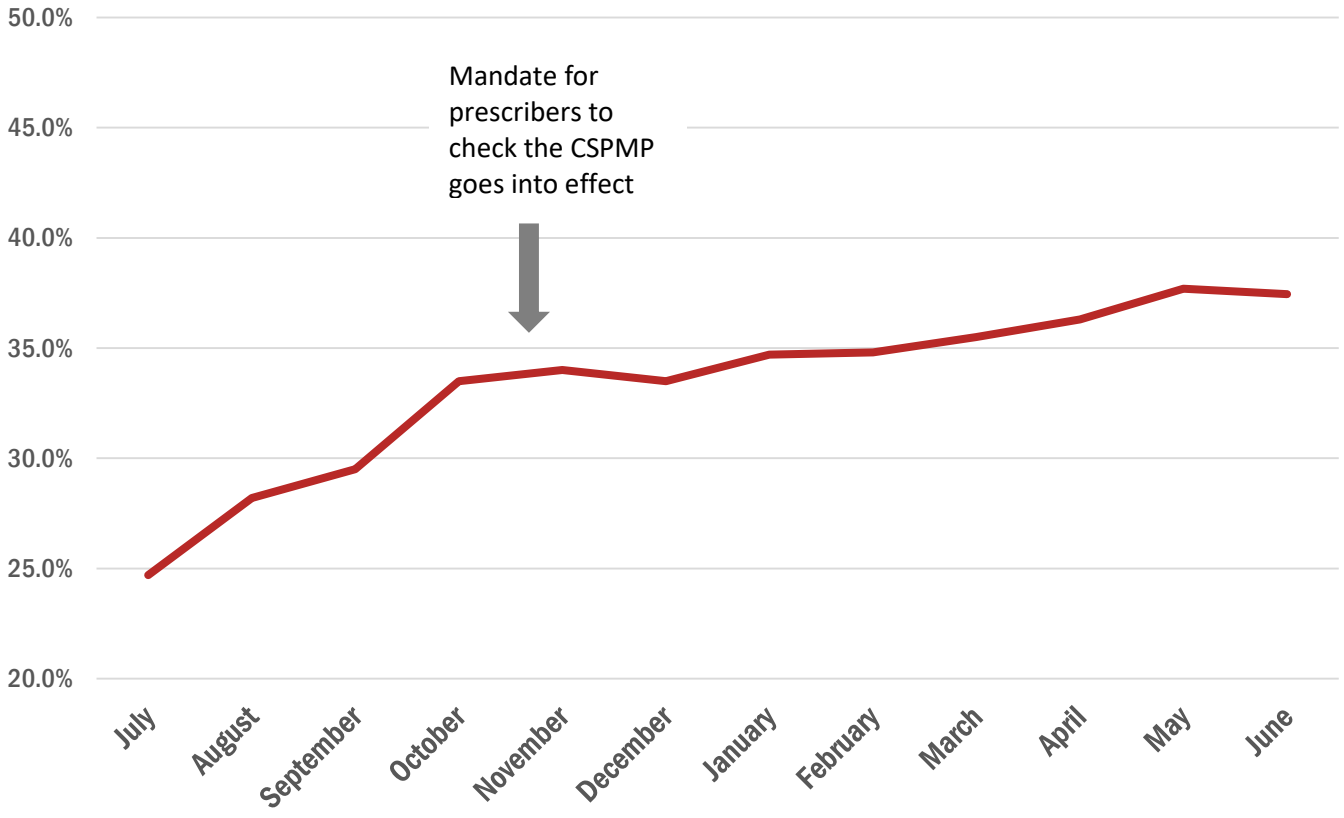
The number of opioid pills dispensed per month decreased 43% between June 2017 and June 2018



The number of opioid prescriptions for MME 90 or above filled per month has decreased by 54% between June 2017 and June 2018



The percentage of prescribers who had "lookups" in the Controlled Substances Prescription Drug Monitoring Program (CSPMP) increased 51% between July 2017 and June 2018



- This data represents the percentage of prescribers who checked a patient's record in the CSPMP prior to prescribing a controlled substance to a patient in that month. It does not reflect how many times they checked the CSPMP nor how often the provider was in compliance with the mandate to check.
- While the percent of prescribers checking the CSPMP has been slowly increasing, there remains substantial room for improvement to ensure patient safety.

Appendix J

2017 Opioid Deaths & Hospitalizations

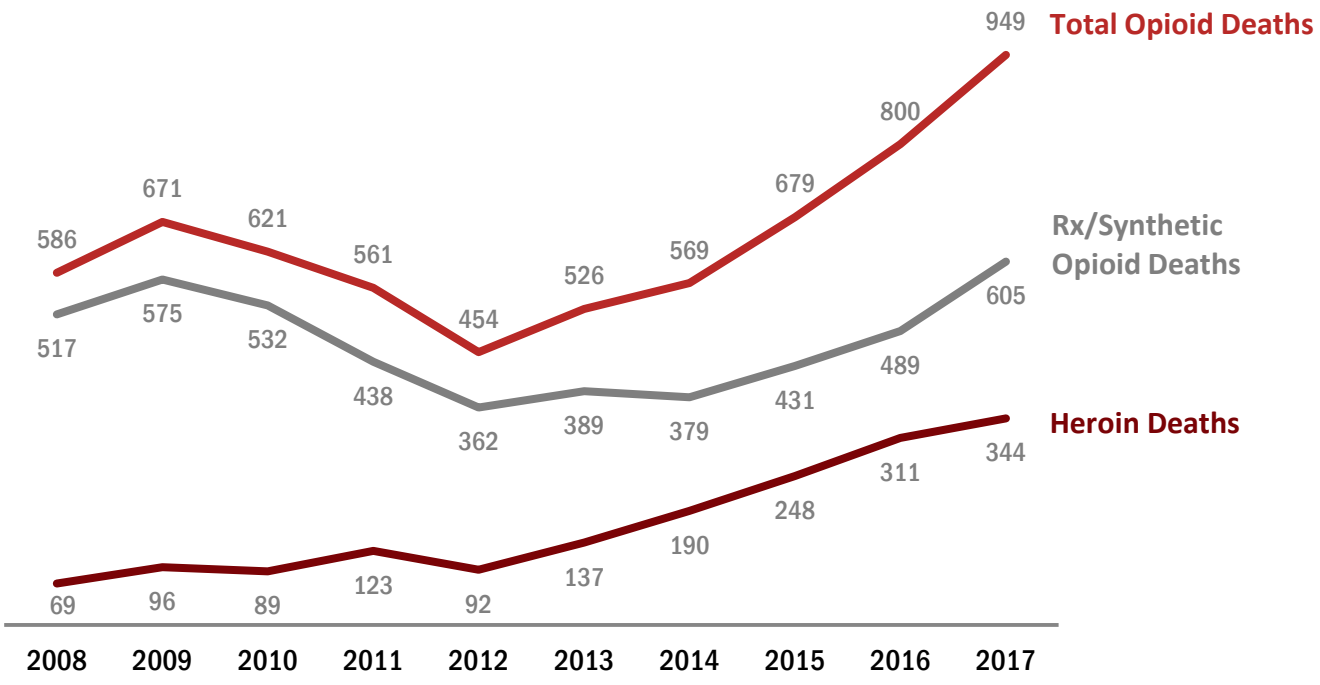
2017 Opioid Deaths & Hospitalizations

ARIZONA DEPARTMENT
OF HEALTH SERVICES

azhealth.gov/opioid

Opioid death events reported in Arizona are based upon final determination of cause of death as reported in the official certificate of death. The underlying cause code used in opioid overdose deaths may not always be specific to opioids. General codes for drug poisonings are interpreted to be opioid deaths when the general code occurs together with an opioid-specific external cause code in any of the external cause code fields. Underlying causes coded F110 – F115, F117-F119 are always opioid deaths. Underlying causes coded Y11-Y14, X41-X44, X61-X64, X85 together with an external cause code of T40.0-T40.4, or T40.6 are also opioid deaths. These definitions align with opioid coding definitions published by CDC.

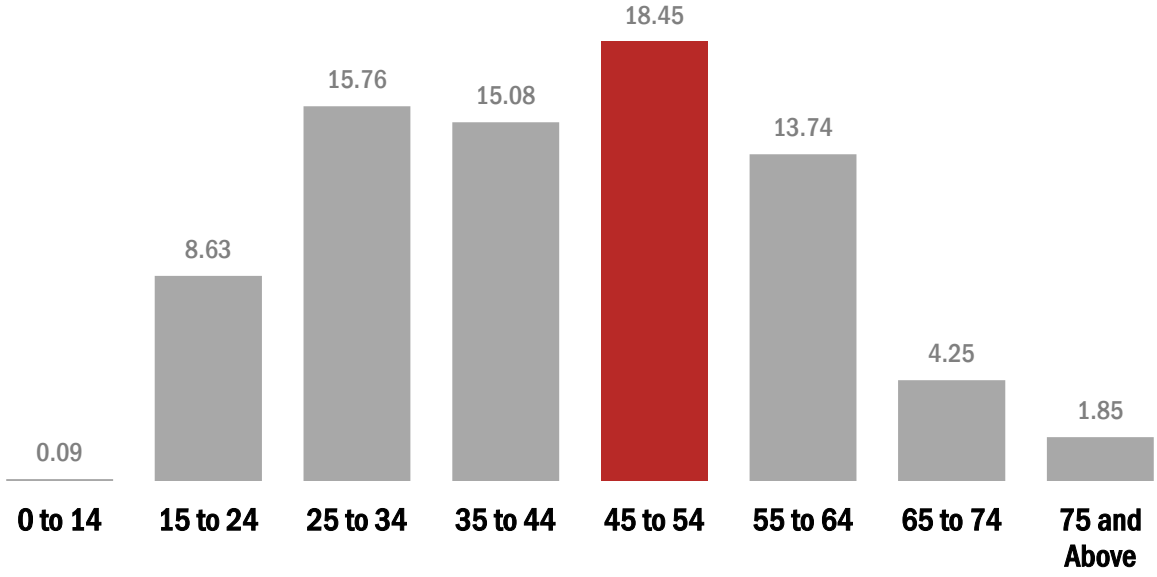
The number of reported 2017 deaths directly attributed to opioids among Arizona residents, or non-residents in Arizona is 949. This represents a 20.1% increase in opioid deaths since 2016, and a 109% increase since 2012. Fifty one percent of the growth in opioid deaths over the last 5 years, and 36% over the last two years have been growth in heroin deaths. Heroin had increased from 11% of opioid deaths in 2007 to 39% in 2016, but dropped to 36% in 2017. Data also show increasing deaths due to prescription/synthetic opioids since 2014, reversing a declining trend since 2009. If current trends are sustained, the number of opioid deaths in Arizona will exceed 1,000 in 2018.



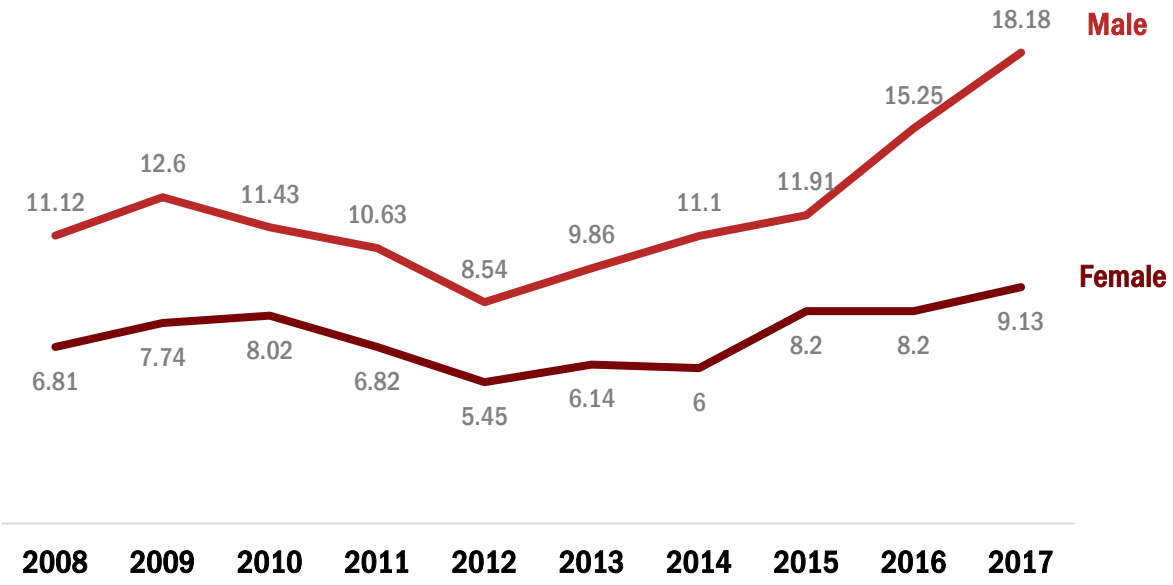
These trends are not explained by changes in the Arizona population since 2007. Due to well established factors delaying reporting, new opioid death reports continue to be received as of 6/15/2018, and the full number in 2017 will likely increase beyond 949.

Opioid deaths are not uniformly distributed among different population groups in Arizona. By age, opioid death rates rise beginning in the late teens until they peak at age 55-64. Above age 65 the opioid death rate drops significantly. Deaths due to opioids among persons under age 55 have constituted 79% of all opioid deaths in Arizona during the last 10 years.

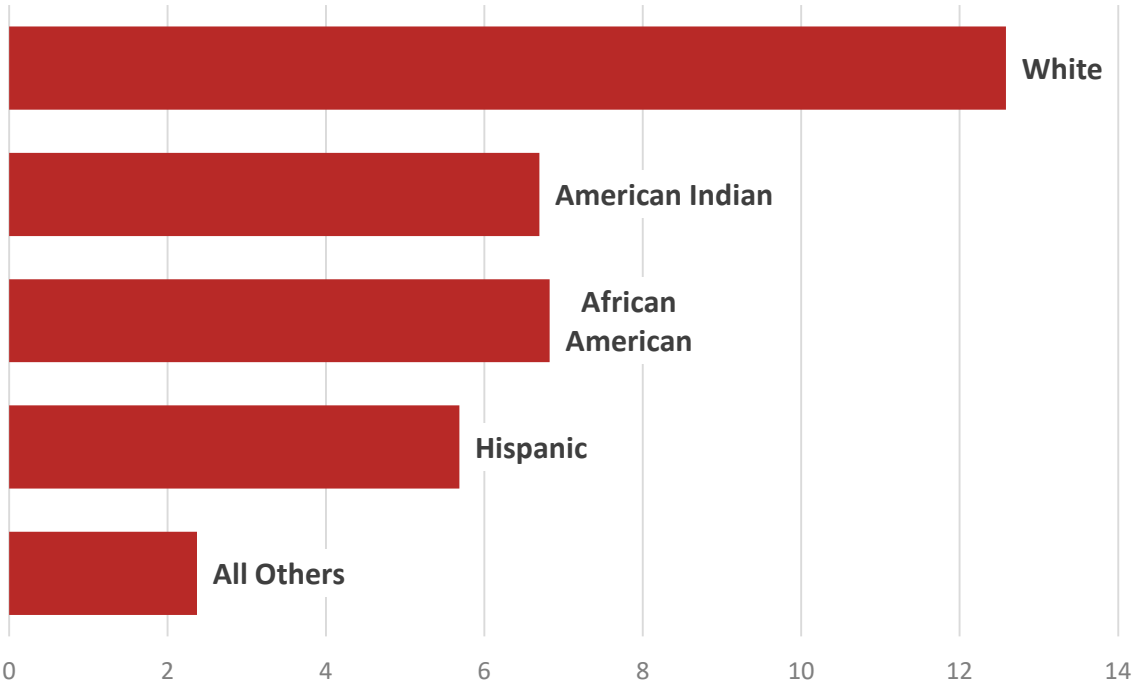
Arizonans aged 45 to 54 years of age have the highest highest rates of opioid deaths over the last 10 years.



The opioid induced crude death rate for males has been higher than females over the last 10 years and has increased faster than for females



Among different race/ethnicity groups, rates of death from opioids differ greatly. From 2008-2017 75.7% of all opioid deaths were among White non-Hispanics, among whom the rate of death is nearly twice that of any other race/ethnicity group.



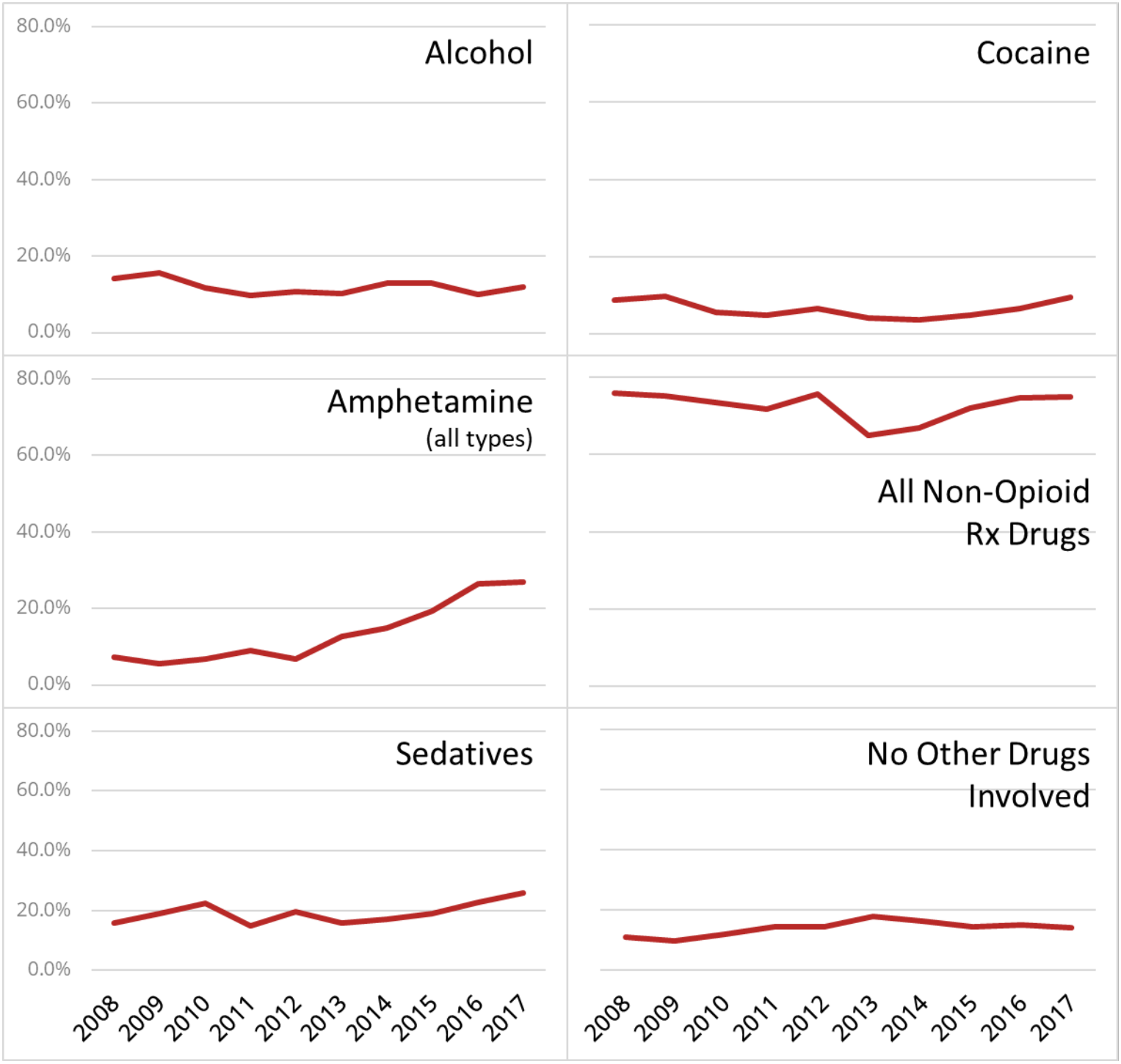
County	Number of Opioid	Rate of Opioid Deaths

	Deaths, 2017	per 100,000, 2017
Apache	< 10	N/A
Cochise	17	13.2
Coconino	10	6.9
Gila	< 10	N/A
Graham	< 10	N/A
Greenlee	< 10	N/A
La Paz	< 10	N/A
Maricopa	576	13.6
Mohave	31	14.8
Navajo	< 10	N/A
Pima	176	17.1
Pinal	33	7.7
Santa Cruz	< 10	N/A
Yavapai	19	8.4
Yuma	< 10	N/A

Arizona death certification includes a single underlying cause, and can include up to 20 additional secondary causes of death. The description of the causes of death is determined by the person certifying death, such as a physician, or medical examiner. The causes of death are coded to ICD-10 standards by the National Center for Health Statistics based upon the underlying and secondary causes described in the death certificate. A particular death may be determined to be caused by an opioid, but usually secondary causes of death and external cause codes will also mention other drugs as well. The role that these other drugs played, and the extent to which they contributed to the death is a complex matter. The Department relies upon the determinations of the medical professional who certified the death, because they are best qualified to evaluate the medical and physical evidence. But the frequency of the involvement of other drugs together with opioids can also be informative if for no other reason than to demonstrate how complex the dynamics of opioid induced death can be.

Other drugs, including multiple other drugs, are a significant factor in deaths from opioids. Eighty six percent (86%) of all opioid deaths in 2017 involved other non-opioid drugs, or alcohol. The category of drug most frequently involved were other non-opioid prescription medications which were involved in 75% of all deaths due to opioids. Other commonly involved drugs included cocaine, amphetamine (all types), and sedatives. Drugs such as cannabis, or hallucinogens were infrequently involved. 67.3% of all persons who died of opioids in 2016 and 2017 had an opioid prescription within six months prior to their death.

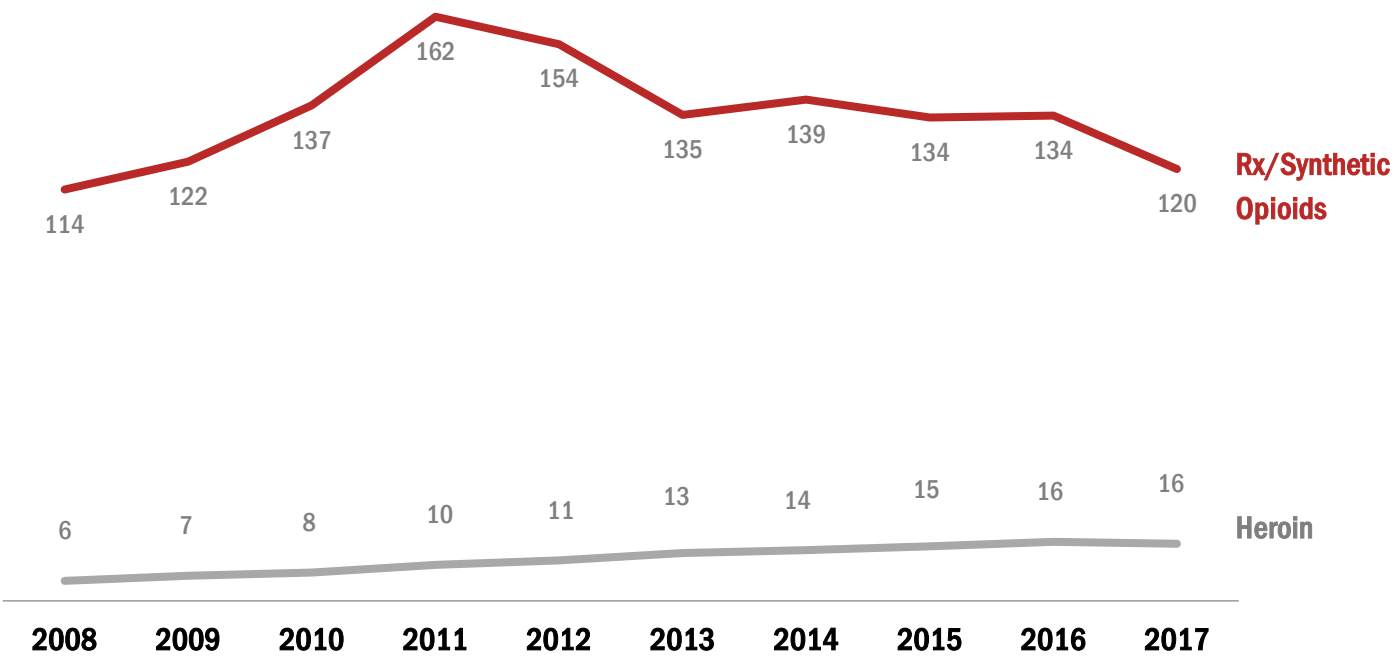
Percentage of opioid deaths that had other substances in their system



Other significant factors include the patterns of prior medical history among persons who die from opioid overdose. Historical analysis completed in 2017 found that just 36% of persons who died from opioids had any prior opioid-related encounter at a hospital or emergency medical provider during the 5-year period prior to their death. An additional 46% of those who died from opioids had some kind of hospital or emergency medical encounter not related to opioids.

Opioids have a significant impact upon Arizona's medical care system due to the volume of encounters involving opioids. Unique encounters are events for a single person involving either hospital admission, or an emergency department encounter without admission. The rate of unique encounters due to prescription/synthetic opioids as the principal diagnosis has declined since 2011, while the rate due to heroin has increased. However the disparity between these two categories of opioids is very large, with prescription/synthetic opioids having a much greater burden upon the healthcare system.

Unique Opioid Hospital Encounter Event Rate Per 100,000 Population.



The best comprehensive measure of the economic cost of opioids in the healthcare system is to consider all encounters involving opioids, not just those in which the opioids are the principal diagnosis. The cost of all such encounters may be reasonably estimated using national cost to charges adjustments provided by the U.S. Department of Health and Human Services. These indicate that the cost of all opioid-related encounters in Arizona from 2008 – 2017 has increased by 300%.* Hospital data indicates that in 2017 there were 51,473 unique opioid-related encounters in Arizona hospitals, totaling an estimated $431 million in healthcare costs, an average of $8,374 per opioid-related unique encounter. In 2008 there were 18,592 unique opioid encounters, costing $143.6 million - only marginally less per encounter than in 2017 ($7,726). The observed increase in cost is not primarily due to rising healthcare costs, but the increasing numbers of opioid-related encounters.

Year	Number of Opioid-Related Encounters	Estimated Costs for Opioid-Related Encounters	Net Annual Change
2008	18,592	$143,639,592	N/A
2009	20,365	$151,535,815	5%
2010	23,437	$161,172,385	6%
2011	30,865	$198,374,505	23%
2012	32,751	$226,127,368	14%
2013	32,684	$231,131,469	2%
2014	36,459	$260,725,158	13%
2015	41,434	$305,408,447	17%
2016	51,532	$402,596,263	32%
2017	51,473	$431,054,043	7%

*Actual cost for encounters are calculated by applying the annual cost-to-charges ratio (produced by the Agency for Healthcare Research and Quality, Healthcare Cost Utilization Project) to reported encounter charges for each reporting facility. The encounter charges are adjusted to estimate the actual cost paid to the provider for the healthcare services received. For this report, 2017 costs were estimated using the 2016 cost-to-charges-ratio by facility because 2017 ratios were not available. If facility-specific ratios were not provided, the facility group ratio was used for that facility. If a facility group ratio was not able to be defined, the state-wide average ratio was used. These estimated costs are therefore reasonable, not precise, estimates of actual cost, and a far more accurate measure than reported charges.