2019 COMMUNITY HEALTH NEEDS ASSESSMENT – FINAL IMPLEMENTATION STRATEGIES

The Patient Protection and Affordable Care Act (ACA) added requirements which nonprofit hospitals must satisfy in order to maintain their tax-exempt status under section 501(c)(3) of the Internal Revenue Service Code. One such requirement added by the ACA, Section 501(r) of the Code, requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) at least every three years and adopt certain implementation strategies to address identified health needs of the community, including public health experts, as well as residents, representatives or leaders of low-income, minority, and medically underserved populations. Banner Health's first submission, cycle 1, under this requirement was completed for the period ending December 2013. The second submission, cycle 2, was completed December 2016.

In accordance with IRS regulations, Banner Health has completed the third submission of the Community Health Needs Assessment (CHNA) for the 25 facilities due for the three-year period ending December 2019. The three remaining hospitals: Banner Goldfield Medical Center, Banner Casa Grande Medical Center, and Banner Payson Medical Center are on different cycles and will be completed for year-end 2020. In addition, we will be repeating the CHNA process for Banner Ironwood Medical Center in 2020, so that it is on cycle with its fellow Pinal County facilities. Because all Banner and non-Banner health facilities in Pima County worked together in 2018 to conduct a needs assessment along with implementation strategies and tactics, the Community Health Needs Assessments and implementation strategies for Banner – University Medical Center Tucson and Banner – University Medical Center South were completed last year but require board approval in 2019. Listed below are the facilities whose reports have been submitted for 2019.

Banner Baywood Medical Center	Banner Behavioral Health Hospital	Banner Boswell Medical Center	Banner Churchill Community Hospital	Banner Del E. Webb Medical Center
Banner Desert Medical Center	Banner Estrella Medical Center	Banner Fort Collins Medical Center	Banner Gateway Medical Center	Banner Heart Hospital
Banner Ironwood Medical Center	Banner Lassen Medical Center	Banner – University Medical Center Phoenix	Banner – University Medical Center South	Banner – University Medical Center Tucson
Banner Thunderbird Medical Center	Community Hospital (Torrington)	East Morgan County Hospital	McKee Medical Center	North Colorado Medical Center
Ogallala Community Hospital	Page Hospital	Platte County Memorial Hospital	Sterling Regional MedCenter	Washakie Medical Center

IRS regulations require that the CHNA should identify significant health needs within the community (particularly for the underserved populations), identify resources that exist within the community, and assess gaps that exist in meeting the health needs. The regulations also require that for each of the significant health needs identified, the facility prepare implementation strategies to address needs or articulate why the need is not being addressed. As part of the implementation strategies, the regulations also require that hospitals include in the Implementation Plan the anticipated outcomes and how hospitals plan to measure the impact of the strategies. There is no standard for measurement or criteria

for determining impact, nor is it imperative for the hospitals to solve for all of the identified needs or gaps in care. Regardless, many of the identified needs align with Banner initiatives and, in addition, Banner works with various community organizations to address needs where possible.

The CHNA Reports and Implementation Strategies must be:

- Approved by an authorized governing body
- Published on each facility's website upon approval by the Board; and,
- Be readily available to the community by the end of the taxable year in which the CHNA analysis was to be completed

While this is a facility level requirement, it was organized and overseen at the system level similar to our 2016 (and 2013) approach, to ensure a consistent, standardized approach that leverages resources related to both the process and implementation strategies. CEO-designated facility-level champions have reviewed and approved the reports. We identified three priorities in 2019, which were consistent with our findings in 2016 (and 2013): Access to Care, Chronic Disease Management, and Behavioral Health. It is important to note that the areas identified align with our organizational strategies and our mission of "making health care easier, so life can be better". We concentrated our efforts in 2019 in order to have a bigger impact on these three areas and to leverage efforts already underway. The following pages contain the system wide Implementation Strategies approved by the Board and the specific Pima County Implementation Strategies.

BANNER HEALTH IMPLEMENTATION STRATEGIES

Banner Health in partnership with the 25 Health facilities who had a CHNA Report due in 2019 and their community partners identified three significant health needs to focus on for the upcoming three years, listed below.

- Access to Care
- Chronic Disease Management
- Behavioral Health

To address the significant health needs Banner Health developed a systemwide Implementation Strategy to address the aforementioned three health needs. The strategies, tactics and anticipated outcomes of those strategies and tactics are listed below, as are the regions within Banner Health's system where the tactics will be implemented.

If you have any questions regarding the strategies and tactics you can reach out to CHNA.CommunityFeedback@bannerhealth.com

	Maricopa County	Pinal County	Pima County	NoCo	Rural
Significant Health Need: Access to Care					
Strategy #1: Increase access points and capacity for primary care services.					
Anticipated Outcome: Improved geographic coverage for primary care and non-emergent services in order to reduce unnecessary utilization of costly ED services.					
Tactic 1: Increase Primary Care Provider (PCP) and Advanced Practice Provider (APP) clinical FTE	X	X	X	X	
Tactic 2: Increase primary care visits at Banner locations	X	X	X	X	X
Tactic 3: Increase utilization of online scheduling	X	X	X	X	
Tactic 4: Increase utilization of virtual urgent care and virtual PCP (internal Banner offering)	X	X			
Tactic 5: Promote in-school clinics and mobile health clinics for pediatric patients.	X				
Strategy #2: Increase access to ambulatory care settings (diversified services- urgent care, outpatient surgery centers, outpatient imaging, and outpatient physical therapy).					
Anticipated Outcome: Improved access to and utilization of lower cost ambulatory settings for outpatient care.					
Tactic 1: Increase percentage of population with access to Banner ambulatory services in non-Rural markets	X	X	X	X	
Tactic 2: Increase the percentage of outpatient services done in ambulatory settings versus hospital-based settings	X	X	X	X	
Tactic 3: Partner with local transportation providers for discounted trip charges to and from medical services	X	X	X	X	X
Strategy #3: Deploy care models and tools that improve affordability of care for Banner Health Network (BHN) members.					
Anticipated Outcome: Cost reduction to both members and Banner Health Network for care that is provided.					
Tactic 1: Promote and increase utilization of "Nurse on Call"	X	X	X	X	X
Tactic 2: Expand outreach to BHN members regarding Banner Urgent Care utilization.	X	X	X	X	X
Tactic 3: Promote and increase utilization of Dispatch Health (Home Urgent Care)	X				
Tactic 4: Utilize population health team to identify patient care gaps and help patients address their care gaps.	X	X	X	X	X

	Maricopa County	Pinal County	Pima County	NoCo	Rural
Significant Health Need: Chronic Disease Management (Diabetes / Heart Disease / Cancer)					
Strategy #1: Continue to improve the coordination of care for patients with chronic disease diagnoses.					
Anticipated Outcome: Improved navigation through the continuum of care for chronic disease patients.					
Tactic 1: Continued focus on care coordination for diabetic patients, including: PCP coordination, endocrinology diabetic eye exams (if applicable), diabetic foot exams, and lab testing	X	X	X	X	
Tactic 2: Provide education and assistance with medication adherence, including financial cost of medication	X	X	X	X	X
Tactic 3: Utilize pharmacist resources, both virtual and in-house, to improve care compliance for: diabetes, hypertension, and medication adherence	X	X	X	X	
Tactic 4: Continue to collaborate with Banner MD Anderson to streamline oncologic care / referrals across the care continuum	X	X		X	
Tactic 5: Improve utilization of the advanced heart failure clinic run by B-UMCP and BHH, including Northern Colorado facilities	X	X		X	
Tactic 6: Offer cancer screening services through cancer screening clinics at select locations	X	X	X	X	X
Strategy #2: Growth of preventative care and wellness programs in the communities served by Banner Health.					
Anticipated Outcome: Encouraging healthy lifestyles and proactive individual ownership of one's health and wellness.					
Tactic 1: Offer wellness programs, including: community classes on pillars of wellness and disease prevention, Virgin Pulse App for BHN Members (in partnership with Aetna), CHIM Program (Cultivating Happiness in Medicine for Physicians)	X	X	X	X	X
Tactic 2: Offer individual support, including 1:1 health coaching and diabetic education, from Registered Dieticians and / or Registered Nurses for BHN members. Resource needs will depend on the members' health needs and complexity.	X	X	X	X	X
Tactic 3: Continue to deploy RNs to perform Medicare Advantage Annual Well Visit	X	X	X	X	
Tactic 4: Offer same-day mammography access in ambulatory settings (health centers and Banner Imaging locations).	X	X	X	X	

Strategy #3: Continued enhancement of measurement / oversight of clinical quality measures for chronic disease patients.					
Anticipated Outcome: Enhanced monitoring and utilization of practice-based evidence in the care of chronic disease patients.					
Tactic 1: Decrease HbA1cs and BMI through an increase in clinical measures for diabetic members.	X	X	X	X	X
Tactic 3: Create region-specific Quality Improvement specialists who meet monthly with practices leadership teams to discuss successes and opportunities for continued improvement.	X	X	X	X	X
Tactic 4: Maintain centralized population health management team for chart preparation and patient outreach on open care gaps.	X	X	X	X	X
Tactic 5: Enhance workflow and deploy hardware to eliminate patient barriers to quality care (e.g., Medicare Advantage strategies for blood pressure check and point of care A1c testing)	X	X	X	X	

	Maricopa County	Pinal County	Pima County	NoCo	Rural
Significant Health Need: Behavioral Health (Substance Abuse / Depression / Behavioral Health)					
Strategy #1: Provide services to increase awareness and access to address general psychiatric health needs.					
Anticipated Outcome: Improved identification of patients with psychiatric needs and improved connection to resources for patients with identified psychiatric needs.					
Tactic 1: Partner with community outpatient behavioral health providers to provide better coordinated care.	X	X	X	X	X
Tactic 2: Evaluate opportunities to increase inpatient behavioral health capacity in select markets.	X	X	X	X	
Tactic 3: Encourage patients to get initial screenings, provided at Banner Behavioral Health Hospital and all Emergency Departments.	X	X	X	X	X
Tactic 4: Provide population specific services, including outpatient support groups / treatment groups for LGBTQ+ populations.	X	X			
Tactic 5: Provide population specific services, including outpatient support groups / treatment groups for populations such as: veterans, first responders, and others with Post Traumatic Stress needs.	X	X			
Tactic 6: Promote availability of Banner Academy, a school for 4th-12th grade students, which provides behavioral health resources.	X				
Tactic 7: Implement a counseling and evaluation system using Banner Total Care, a PCP integration screening process (general wellness PROMIS®, depression PHQ-9 and anxiety GAD-7).	X	X	X		
Strategy #2: Utilize internal and external resources to address opioid addiction in Banner Health communities.					
Anticipated Outcome: Enhanced capability to identify and address the community needs created by and the health impacts of the opioid epidemic.					
Tactic 1: Partner and leverage relationships with opioid prevention organizations: CO-SLAW (Colorado Opioid Synergy - Larimer and Weld); ALTO, ADHS Opioid Action Plan, etc.	X	X	X	X	X
Tactic 2: Continue to conduct patient addiction assessments at Banner Behavioral Health Hospital.	X	X			
Tactic 3: Provide ways for education programs to be shared in schools to prevent opioid and substance abuse for youths.	X	X	X		
Tactic 4: Implement primary care strategy to identify patients with opioid use disorder, initiating / referring them for treatment.	X	X	X	X	X

Strategy #3: Utilize internal and external resources to improve clinical quality for suicide, depression patients in Banner Health communities.					
Anticipated Outcome: Improved awareness of signs and symptoms of depression and suicide ideation.					
Tactic 1: Provide education on how to access help and identify the signs for when a person is in crisis.	**X**	**X**	**X**	**X**	**X**
Tactic 2: Provide education and information to area high schools for National Depression and Suicide Prevention month.	**X**				
Tactic 3: Implement a counseling and evaluation system using Banner Total Care, a Primary Care Provider (PCP) and Pediatric Provider Clinics integration screening process (general wellness PROMIS®, depression PHQ-9 and anxiety GAD-7).	**X**	**X**	**X**	**X**	**X**
Tactic 4: Integrate TeleBehavioral crisis evaluation in Emergency Departments to determine need for psychiatric hospitalization for patients who exhibit risk of suicide or other psychiatric crisis.	**X**	**X**		**X**	
Tactic 5: Provide depression screening for oncology patients	**X**		**X**	**X**	

BANNER HEALTH - TUCSON IMPLEMENTATION STRATEGIES

Banner – University Medical Center Tucson and Banner – University Medical Center – South, in partnership with other acute facilities in Tucson, the Pima County Department of Public Health, Federally Qualified Health Centers and Tribal Nations contracted with a public health consultant team to conduct a Community Health Needs Assessment in 2018. From the Community Health Needs Assessment, Banner's Tucson facility leaders developed strategies and tactics to address the identified health needs in their community.

On the following page are the specific strategies and tactics for Banner's Tucson facilities and medical group.

	BUMCS	BUMCT
Significant Health Need: Access to Care		
Strategy #1: Expand BUMGT primary care services by adding at least 40 primary care providers across 8- 10 locations by 2021.		
Gap Identified: The Primary Care Score for Pima County is 34, where 10 of the Primary Care Areas (PCAs) have higher scores (are more underserviced) than the median; Arizona's population to PCP ratio is 424:1 while Pima County's is 373:1 and 16 of the PCAs have a higher population to provider ratio than this.		
A. Develop concept proposals and business plans specific to targeted geographies, based on provider need	X	X
B. Secure capital for each year's business plans through annual capital allocation process.	X	X
C. Implement plans for each location - recruitment, staffing, infrastructure.	X	X
Strategy #2: Provide resources to address the less than adequate transportation scores for Pima County residents.		
Gap Identified: Transportation scores determine the adequacy of transportation in a PCA where the higher the score, the less adequate the transportation; AZ's score is 110 while Pima's is 109 and 10 of the PCAs have a higher score than Pima County.		
A. Expand utilization of telehealth services in order to provide more services that do not require transportation to a healthcare facility.	X	X
B. Partner with Veyo transportation services to provide Medicaid patients with transportation to and from clinic appointments.	X	X
C. Partner with Lyft transportation services to provide patients with transportation services post-hospital discharge.	X	X
D. Provide full scope primary care, including prenatal services, preventative care, and chronic care to underserved, underinsured and uninsured populations through the Family Medicine Department Mobile Health Program.	X	X
Strategy #3: Develop specific methods for measuring baseline access to care within Banner's Tucson facilities, develop improvement interventions with goals, track progress toward meeting goals.		
Gap Identified: Improve overall availability/accessibility and affordability to providers, specialty care and behavioral care in particular.		
A. Audit provider CFTE compared to clinic availability and make corresponding changes to clinic availability.	X	X
B. Audit provider clinic schedules (availability of new appointments, duration of appointments) to create new capacity/ open new sessions wherever possible to grow new patient visits.	X	X
C. Measure lead time from appointment request to appointment date; Launch pilot program to reduce lead times for imaging authorizations.	X	X
D. Create "fast pass" programs for Banner & UA employees to improve access times.	X	X
E. Solicit feedback regarding appointment access in patient experience surveys.	X	X
F. Strategic referrals initiative: goal is to contact all patients within three days to schedule referrals.	X	X
G. Measure provider productivity against national benchmarks, actively recruit providers in specialties where current providers are highly productive/lead times are lengthy/continued volume growth is projected.	X	X
	BUMCT	BUMCS

Significant Health Need: Chronic Disease		
Strategy #1: Reduce cardiac deaths (170.6 deaths per capita), in Pima County through implementation of Phase 3 Multi-Risk Factor Reduction Program.		
Gap Identified: Heart disease has surpassed cancer as the leading cause of death in Pima County with 170.6 deaths per 100,000 people (Healthy People 2020 target = 103 per capita).		
A. Comprehensive exercise, nutrition, weigh management and education program designed to reduce cardiac risk factors. Education-Based classes available to the community focused on exercise, diet, weight loss, hypertension, hyperlipidemia, stress reduction, and medication management. Courses to be offered in wellness center/cardiac rehab at BUMCT but communicated community-wide and Banner-wide.	X	X
B. Increase access to general cardiology by recruiting additional providers in order to allow for appointment scheduling within seven days or less.	X	X
Strategy #2: Reduce cancer related deaths per capita in the county (currently 155 deaths per capita)		
Gap Identified: Cancer resulted in ~155 deaths per capita in 2016, which is higher than the rest of AZ (142.2 per capita).		
A. Increase awareness of cancer screening services through outreach activities using disease-site specific risk-reduction fliers for breast, lung, head/neck, melanoma, GU, GI, and hematologic cancers. Fliers include screening recommendations for the specific cancer type.	X	X
B. Create workgroup to address the cancer disparity of late stage diagnosis for colorectal cancer, spearheaded by colorectal oncology nurse navigator. Special focus to be given to the Hispanic and American Indian population, as their rates of late-stage diagnosis of colorectal cancer are highest in Pima County.	X	X
C. Reorganize and develop lung cancer screening program.	X	X
D. As part of our Commission on Cancer (CoC) accreditation, conduct the 2019 CoC Community Needs Assessment (completed Aug 2019).	X	X
Strategy #3: Decrease obesity rates in Pima County		
Gap Identified: In 2014, 25% of Pima County's residents were obese (22% increase from 2012), 26.3% of residents reported eating the recommended amount of fruits and vegetables; 18% report no leisure time and activity; 13% report no access to exercise activities.		
A. Provide 100% of Spanish-only speaking Hispanic patients (identified as highest risk) with education about the association of obesity and increased cancer risk during face-to-face Survivorship visits with oncology nurse navigators, translation services provided.	X	X
B. Department of Family Medicine is hiring a physician certified in Culinary Medicine who will focus on improving food and nutritional literacy for families.	X	X
C. Department of Family Medicine will be partnering with the Community Foodbank of Southern Arizona and the Western Region Public Health Training Center to create educational videos about nutrition and healthy eating, that is multilingual, and will be shared in Banner's PCP clinics.	X	X
D. Department of Family Medicine is looking to expand their clinical weight loss program (B-UMC Medical Obesity Treatment Service) by integrating with the BUMC's bariatric program, the integrated program plans to offer treatment scholarships for uninsured / underinsured patients.	X	X
Strategy #4: Reduce the rate of adults in Pima County's diagnosis of diabetes		

Gap Identified: 13.11% of adults in Pima County are diagnosed with diabetes, which is higher than the rest of AZ.		
A. Increase utilization of diabetes treatment services to members of the community diagnosed with diabetes.	**X**	**X**
B. Increase utilization of free diabetes prevention and self-management education to community members at the Diabetes Prevention & Education Center (DPEC) in Tucson and in other Banner clinic locations (DPEC is located at Banner's diabetes clinic, on the BUMCS campus).	**X**	**X**
C. Coordinate with state and local agencies, and coalitions focused on reducing the incidence of diabetes.	**X**	**X**
D. Increase the capacity of BUMG/BUMCT/BUMCS to accept federal reimbursement for diabetes education programming.	**X**	**X**
E. Improve access to diabetes prevention programming to members of the community at heightened risk for developing type 2 diabetes.	**X**	**X**
Strategy #5: Implement tobacco cessation programs		
Gap Identified: 14% of Pima County adults are tobacco smokers; Healthy People 2020 lists commercial tobacco use as a leading health indicator related to chronic disease, with a target to reduce adult smoking to 12% of the population.		
A. Department of Family Community Medicine will continue to medically supervise the tobacco dependence treatment program "Quit and Win" that offers intensive medical management of nicotine withdrawal and individual counseling services.	**X**	**X**
B. Establish working group to focus on smoking cessation assistance for oncology patients and education/awareness for the population at highest risk for oncology/highest percentage of smokers (18-24 year olds) in Pima county.	**X**	**X**
C. Department of Family Community Medicine will continue to implement the "Helpers Behavioral Health Program" - provides training and technical support to behavioral health agencies to develop and implement tobacco cessation programming that is integrated into existing services.	**X**	**X**

	BUMCT	BUMCS
Significant Health Need: Substance Abuse / Behavioral Health		
Strategy #1: Address poor mental health including undiagnosed or untreated mental illness.		
Gap Identified: The average days a county resident reports poor mental health (3.9 days); 12% of county residents reporting frequent mental distress, and 13.5% being treated for depression.		
A. Expand services for treating depression and Serious Mental Illness (SMI) provided at Banner's Whole Health Clinic (WHC) - specialized team ensures at least monthly contact with all SMI patients, and neurotherapy suite opens September 2019 for patients with treatment resistant depression (services include TMS, ECT and possibly esketamine).	X	X
B. Increase awareness of mental health services provided at Banner through "Psych Talks" - topics include sleep, adolescent suicide, mindfulness, women's health - purpose is to educate community on important mental health matters and reduce stigmatism so that community members feel comfortable seeking help.	X	X
C. The Family Community Medicine Department Mobile Health Program will be adding a clinic site dedicated to serving at-risk teens and reducing the stigma around mental health treatment.	X	X
D. Family Community Medicine Department will continue to implement Help & Hope for YOUth - a school based educational program addressing stigma of mental illness and reduce barriers to youth seeking mental health treatment. The program will have special focus on substance use and misuse, mental illness, and suicide prevention. Additionally, the program is working to develop an online directory for youth mental health resources.	X	X
Strategy #2: Address the shortage of mental health providers in Pima County/ increase the ratio of mental health providers to population in Pima County.		
Gap Identified: The ratio for mental health provides is 600:1 in Pima County where top performing communities have a 330:1 ratio; there is increased concern about the lack of pediatric & adolescent specialists, in the school system in particular.		
A. Complete Care Unit (CCU) - scheduled to open in September 2019 - to provide detoxification and suboxone induction services, addressing the inadequate amount of detox and treatment centers in Pima county.	X	X
B. Continue to train new mental health providers through residency and fellowship programs to grow the number of providers in Pima County and have them rotate through the community during training, providing vital services amidst a provider shortage.	X	X
C. Recruit more mental health providers - three new psychiatrists and one therapist starting summer 2019, looking to possibly add more specialized PhD or therapy services in 2020.	X	X
D. Develop Intensive Outpatient Services (IOP) in fall 2019 for the adult population, with plans to later expand to the pediatric population.	X	X
E. Continue to expand specialty clinics under the collaborative care model, in order to reach more patients across the Banner system who require mental health services - pediatrics, in particular.	X	X
F. Explore adding telepsychiatry options for patients who reside 75 miles or farther from the nearest psychiatry clinic - schedule initial appointment in clinic but follow up via telepsychiatry.	X	X
G. Once funding is secured for IOP pediatric/adolescent programming, integrate services into local schools if possible.	X	X

Strategy #3: Address the high level of suicide in Pima County		
Gap Identified: Suicide is the 10th leading cause of death in Pima County with statistically significant higher rates of suicide compared to the rest of Arizona. Pima County's suicide rate is 17.1 per 100,000, where Healthy People 2020's indicator is to reduce this to 10.2 per 100,000.		
A. Hiring psychologist who specializes in high-risk adolescents, to address increasing rates of youth suicide - entering into contract with Sonora Behavioral Health Hospital to provide attending and resident coverage for pediatric unit.	**X**	
B. Since suicide rate is notable in LGBTQ+ population, developing specific programming for this population, as programming/resources are scarce in the community - all residents and front desk staff are now Safe Zone trained.	**X**	
Strategy #4: Address high level of alcohol abuse		
Gap Identified: Alcohol is the 2nd cause of morbidity in Pima County; 14% of adults report binge or heavy drinking; 32% (496) of driving deaths were due to alcohol impairment between 2012- 2016.		
A. Implementing robust addiction treatment programing for Medicaid population at WHC and EPICenter clinics - consider implementing at BUMCS after successful rollout.	**X**	
B. Continue to train psychiatrists to prescribe Vivitrol.	**X**	
C. Psychiatry Department has a new ACGME Addiction Treatment Fellowship program to train psychiatrists as future addiction treatment specialists.	**X**	
D. Partnership with Lyft: "Save Lives, Don't DUI" campaign - discounted rides and promotion of ride-sharing services to reduce alcohol-related driving accidents.	**X**	**X**
Strategy #5: Address Opium and unspecified drug use		
Gap Identified: Opium and unspecified drug use are the 4th and 8th leading causes of morbidity in Pima County; drug induced death rates are statistically higher than the rest of Arizona for opioid, heroin and pharmaceutical use.		
A. Implementing robust addiction treatment programing for Medicaid population at WHC and EPICenter clinics - consider implementing at BUMCS after successful rollout.	**X**	
B. Provide services that address the complexity of chronic pain management in light of opioid crises - hiring a psychologist who specializes in pain and provides individual treatment as well as group therapy. Working with pain management team (anesthesiology department) to eventually integrate psychology services into their pain management clinic. Pain management clinic/procedures relocating to Alvernon to allow for expansion/improved access to care (providers are do not prescribe opioids)	**X**	
C. Complete Care Unit (CCU) - scheduled to open in September 2019 - to provide detoxification and suboxone induction services, addressing the inadequate amount of detox and treatment centers in Pima county.	**X**	
D. Psychiatry Department has a new ACGME Addiction Treatment Fellowship program to train psychiatrists as future addiction treatment specialists.	**X**	
E. Psychiatrists have all been trained in prescribing Vivitrol.	**X**	