INTERGOVERNMENTAL AGREEMENT (IGA)

Amendment

ARIZONA DEPARTMENT OF HEALTH SERVICES
OFFICE OF PROCUREMENT
150 N. 18th Ave., Suite 530
Phoenix, Arizona 85007

Contract No.: CTR063847	IGA Amendment No: Three (3)	Procurement Officer: Nathaniel Thomas

Arizona's Prescription Drug Overdose Prevention Program

It is mutually agreed that the Intergovernmental Agreement referenced is amended as follows:

1. Pursuant to Terms and Conditions, Provision Six (6) Contract Changes, subsection 6.1 Amendments, the Contract is hereby revised with the following:

   1.1. The Scope of Work is revised and replaced.

   1.2. The Price Sheet is revised and replaced to increase funding from September 30, 2025 through September 29, 2026.

   1.3. Exhibit A is revised and replaced.

ALL CHANGES ARE REFLECTED IN RED

All other provisions of this agreement remain unchanged.

Cochise County Health and Social Services
Contractor Name:

1415 W. Melody Ln., Bldg. A
Address:

Bisbee	**AZ**	**85603**
City	State	Zip

County Authorized Signature

FRANK ANTENORI
Print Name

CHAIRMAN 12-16-2025
Title and Date

Pursuant to A.R.S. § 11-952, the undersigned public agency attorney has determined that this Intergovernmental Agreement is in proper form and is within the powers and authority granted under the laws of Arizona.

Bert Whitehead 11/26/2025
Signature Date

Bert Whitehead, IV
Print Name

This Intergovernmental Agreement Amendment shall be effective the date indicated. The Public Agency is hereby cautioned not to commence any billable work or provide any material, service or construction under this IGA until the IGA has been executed by an authorized ADHS signatory.

State of Arizona

Signed this _____ day of _____ 2025.

Procurement Officer

Contract No.: **CTR063847**, which is an Agreement between public agencies, has been reviewed pursuant to A.R.S. § 11-952 by the undersigned Assistant Attorney, who has determined that it is in proper form and is within the powers and authority granted under the laws of the State of Arizona.

Alice Perepech
Signature Date

Digitally signed by Alice Perepech
DN: cn=Alice Perepech, o=Arizona Attorney General's Office, email=Alice.Perepech@azag.gov, c=US
Date: 2025.12.29 13:08:00 -07'00'

Assistant Attorney General
Print Name

Denel M Pickering
Digitally signed by Denel M Pickering
Date: 2025.12.29 14:47:28 -07'00'

Scope of Work

1. BACKGROUND

1.1. The Arizona Department of Health Services (ADHS), through the Office of Injury and Violence Prevention (OIVP), administers funding provided by the Arizona Health Care Cost Containment System (AHCCCS) to operate the State Opioid Response (SOR) program. The primary objective of SOR funding is to assist Arizona in strengthening local capacity within counties to develop Overdose Fatality Review (OFR) teams. These teams bring together community agencies in a structured process to systematically share information on overdose events, identify risk factors, and develop actionable prevention strategies.

1.2. The abuse and addiction to opioids remain critical public health challenges both nationally and within Arizona. Drug overdose deaths have steadily increased over the past two decades, now representing the leading cause of injury-related death in the United States. According to the Centers for Disease Control and Prevention (CDC), overdose deaths surged to 92,452 in 2020—a thirty percent (30%) rise from 71,130 deaths in 2019—with opioids implicated in 69,031 of these cases, accounting for seventy-five percent (75%) of all overdose fatalities.

1.3. Historically, the opioid epidemic was driven largely by prescription medications. Arizona's Controlled Substances Prescription Monitoring Program (CSPMP) data show that in 2019, approximately 4.1 million Class II-IV prescriptions were written, resulting in the dispensation of over 240 million controlled substance pills statewide. This equates to around thirty-four (34) Schedule II-IV controlled substance pills per resident. Recent prescribing practices rank Arizona as twenty-eighth (28th) nationally for opioid prescriptions, with a rate of 44.1 prescriptions per 100 people, indicating that prescriptions are no longer the primary cause of overdose deaths.

1.4. Currently, fentanyl has become the leading driver of the opioid crisis. In 2019, synthetic opioids, mainly fentanyl, contributed to over 36,000 deaths in the United States, representing about seventy-three percent (73%) of all opioid-related fatalities that year. Most fentanyl-related deaths involve illicitly manufactured fentanyl, often found in counterfeit pills or combined with other drugs, such as heroin or methamphetamine. In Arizona, fentanyl's presence in overdose cases climbed significantly from nine percent (9%) in 2017 to fifty percent (50%) in 2021.

1.5. The financial toll of opioid misuse is substantial as well. In 2019, Arizona experienced 56,623 opioid-related hospital visits, costing an average of $11,942.00 per visit—totaling approximately $676 million in healthcare expenses attributed to opioids.

1.6. The escalating addiction rates and overdose deaths related to both prescription and illicit opioids underscore a growing national crisis. In Arizona, overdose fatalities are now the leading cause of preventable injury deaths, underscoring the urgency for interventions. ADHS is committed to collaborating with County health departments to build systems and enhance capacity to address substance misuse and abuse through community-based case management initiatives, thus fostering improved public health outcomes statewide.

1.7. Cochise County Health and Social Services (CCHSS) plans to use State Opioid Response (SOR) funds to establish and support local Overdose Fatality Review (OFR) teams, which aim to bring together community organizations and agencies in a structured process to review overdose deaths. These OFR teams analyze individual overdose events to identify risk factors and trends, enabling the development of targeted prevention strategies. Additionally, CCHSS intends to use SOR funds to strengthen local partnerships, improve data-sharing capacities, and implement prevention and intervention strategies that address opioid misuse and addiction, especially focusing on the rising impact of fentanyl in the community. Through these efforts, CCHSS aims to reduce overdose deaths, enhance community education on opioid risks, and provide supportive resources to individuals and families affected by opioid misuse.

2. OBJECTIVE

2.1. The objective of this Agreement is to enhance the County Health Departments' capacity to combat the opioid crisis by establishing local drug Overdose Fatality Review (OFR) teams and deploying community health workers, case managers, first responders, and peer navigators to support high-risk populations, improving access to care and reducing opioid misuse across communities.

3. SCOPE OF SERVICE

3.1. The purpose of this initiative is to strengthen CCHSS overdose prevention efforts through systematic reviews, data collection, and linkages to care (LtC). CCHSS shall designate a point of contact responsible for conducting systematic, multidisciplinary, and multimodal reviews of drug overdose fatalities to identify actionable, locally-implementable prevention recommendations.

3.2. CCHSS shall request and gather records for each case, including medical records, toxicology and medical examiner reports, behavioral health records, criminal justice records, prescription drug history records from the CSPMP, Department of Child Services records, Emergency Medical Services/Fire Department records, and next of kin interviews, when applicable. Based on these records, CCHSS shall use the designated data tool spreadsheet to document case demographics, methods of injury, substance use history, behavioral health history, healthcare utilization, stressors, childhood history, and chronic conditions relevant to each OFR case. All information from gathered records shall be entered into the data tool spreadsheet, and the completed document shall be submitted to the OFR Epidemiologist at ADHS. CCHSS shall respond to feedback from the OFR Epidemiologist to ensure all data aligns with standards for annual data analysis and statewide reporting.

3.3. Establishing LtC, a representative from CCHSS shall actively participate in the ADHS LtC workgroup to promote community-based support for those impacted by opioid misuse.

3.4. CCHSS shall develop or enhance case management systems to help individuals navigate pathways to care, focusing on identifying the needs of incarcerated individuals during assessments and follow-up sessions. CCHSS shall match individuals with local or the nearest facilities to ensure access to necessary treatment and initiate discharge planning. Care shall be coordinated with inpatient and outpatient behavioral health services, probation and court programs, and health plans. Additionally, CCHSS shall maintain a transportation program to support a "warm hand-off" transition for individuals upon release.

3.5. Through these comprehensive efforts, CCHSS aims to improve overdose prevention, promote life-saving overdose prevention and response services, and provide vital community-based care linkages for those impacted by the opioid crisis.

4. REQUIREMENTS

The County shall:

4.1. Participate in surveys, interviews (remote or face-to-face), and questionnaires developed and disseminated by ADHS' Evaluation Team or Consultant to collect data and information necessary to assess the state and local progress with meeting grant related goals, objectives, evaluation, and outcomes.

4.2. Prepare and submit annual budget(s) and work/ action plan(s).

4.3. Prepare and submit quarterly Contractors Expenditures Reports (CERs) with documentation.

4.4. Submit quarterly reports to ADHS detailing quarterly progress on funded activities.

4.5. Attend and participate in quarterly Contractor meetings with ADHS.

4.6. Assign at least one staff person to attend and participate in ADHS' LtC workgroup.

4.7. Attend and participate in any training, statewide Contractor's meetings, or professional development provided by ADHS or its contracted vendors, as necessary.

5. FUNDING RESTRICTIONS

In addition to 45 CFR Part 75, Subpart E's guidance regarding allowable/unallowable expenditures, Substance Abuse and Mental Health Services Administration (SAMHSA) funds shall not be used to:

5.1. Purchase, prescribe, or provide marijuana or treatment using marijuana. See, e.g., 45 CFR.75.300(a) (requiring Health and Human Services (HHS) to ensure that Federal funding is expended in full accordance with U.S. statutory and public policy requirements); 21 U.S.C. 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase, or distribution of marijuana).

5.2. Purchase, procure, or distribute pipes or cylindrical objects intended to be used to smoke or inhale illegal scheduled substances.

5.3. Pay for promotional items including, but not limited to, clothing and commemorative items, such as pens, mugs/cups, folders/folios, lanyards, and conference bags. (45 CFR 75.421(e)(3))

5.4. Pay for the purchase or construction of any building or structure to house any part of the program. Minor alterations and renovations (A&R) shall be authorized for up to twenty-five percent (25%) of a given budget period or $150,000.00 (whichever is less) for existing facilities, if necessary and appropriate to the project. Minor A&R may not include a structural change (e.g., to the foundation, roof, floor, or exterior or loadbearing walls of a facility, or extension of an existing facility) to achieve the following: increase the floor area; and/or, change the function and purpose of the facility. SAMHSA & AHCCCS must approve all minor A&R.

5.5. Provide inpatient treatment or hospital-based detoxification services. Residential services are not considered to be inpatient or hospital-based services.

5.6. Pay for housing other than recovery housing, which includes application fees and security deposits.

5.7. Make direct payments to individuals to enter treatment or continue to participate in prevention or treatment services. (See 42 U.S.C. § 1320a-7b).

5.7.1. A recipient or treatment or prevention provider may provide up to $25.00 non-cash incentive (for example, gift cards, bus passes, or gifts) to individuals to participate in required data collection follow-up. This amount may be paid for participation in each required data collection follow-up interview. Incentives cannot be provided for completing an intake or exit interview. For programs including contingency management as a component of the treatment program, each individual contingency must be $15.00 or less in value and clients may not receive contingencies totaling more than $75.00 per budget period.

5.8. Purchase firearms.

5.9. General Provisions under Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act Public Law 117-328, Consolidated Appropriations Act, 2023, Division H, Title V, Section 526, notwithstanding any other provision of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drugs. Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant state or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the state or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an human immunodeficiency virus (HIV) outbreak due to injection drug use, and such program is operating in accordance with state and local law.

5.10. Salary Limitation: Congress limits the direct salary for individuals under all federal grant and cooperative agreement awards not to exceed Executive Level II pay. The Executive Level II pay amount is an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to your organization. The salary limitation does not apply to consultants but does apply to subrecipients under a SAMHSA award or cooperative agreement. Note that these or other salary limitations will apply in future fiscal years, as required by law. The current salary limitation can be found in the most recent SAMHSA Standard Terms and Conditions posted on our website at:

5.10.1. https://www.samhsa.gov/grants/grants-management/notice-of-award/terms.

6. TASKS

The County shall complete the following tasks to achieve the program goals:

6.1. Designate a point of contact that shall be responsible for conducting systematic, multidisciplinary, and multimodality reviews of drug overdose fatalities and identify actionable prevention recommendations for implementation at the local level.

6.2. Request and collect records for each case, including but not limited to:

6.2.1. Medical, including toxicology and medical examiner.

6.2.2. Behavioral Health Records.

6.2.3. Criminal Justice Records.

6.2.4. Prescription Drug History Records (CSPMP).

6.2.5. Department of Child Services Records.

6.2.6. Emergency Medical Services/Fire Department Records.

6.2.7. Next of kin interviews (if applicable).

6.3. Review ten percent (10%) or at least twenty-six (26) cases provided by ADHS, whichever is greater.

6.4. Based on records received, use the data tool spreadsheet to document case demographics, methods of injury, substance use history, behavioral health history, healthcare utilization, stressors, childhood history, and chronic conditions of OFR cases.

6.5. Provide a Roster of the Local County Overdose Team to ADHS Overdose Fatality Review Program Manager.

6.5.1. CCHSS is responsible for creating a roster with representation from multiple sectors in your county. CCHSS should engage at least one member from each sector, including but not limited to:

6.5.1.1. Public Safety (Law Enforcement, EMS, and Fire).

6.5.1.2. Medical Professional (Hospitals, Nurses, MOUD Providers, Behavioral Health Specialists).

6.5.1.3. Community Organizations.

6.5.1.4. Public Member.

6.5.1.5. If applicable, Tribal Organizations.

6.5.2. CCHSS shall have a minimum of fifty percent (50%) attendance rate from their Local County Overdose Team at each OFR meeting.

6.6. Enter information from all records collected into the data tool spreadsheet.

6.7. Submit the completed data tool spreadsheet to the OFR Epidemiologist at ADHS.

6.7.1. CCHSS shall have a minimum of ninety percent (90%) of the cases reviewed added to the data tool spreadsheet. If more than ten percent (10%) are excluded from the data tool spreadsheet, CCHSS is responsible for explaining to the ADHS Epidemiologist why cases were excluded.

6.8. Respond to feedback from the OFR Epidemiologist to ensure data can be included in the annual OFR data analysis and statewide report.

6.9. Submit an annual report to the ADHS OFR Program Manager.

6.10. Establish LtC:

6.10.1. Have a representative from the County participate in the ADHS LtC workgroup.

6.11. Case Management:

6.11.1. By the end of FY26, implement a secure video communication system in the detention facility. Conduct at least two (2) pre-release video contacts per referred individual, expand access to all participants by the end of Q2, and begin monthly utilization reviews to support improved care transitions.

6.11.2. By the end of FY26, Public Health Social Workers will complete a comprehensive needs assessment and re-entry plan within fourteen (14) days of intake for at least ninety percent (90%) of referred incarcerated individuals. Community Health Workers will conduct at least two video sessions with seventy-five percent (75%) of participants during the thirty (30) days prior to release to reinforce plans and ensure community service linkage.

6.11.3. In FY26, ensure that eighty percent (80%) of referred individuals receive at least two tailored, community-based referrals. These referrals will be reviewed with the client at least five days before release, with staff following up within one (1) week post-release to confirm engagement with services.

6.11.4. In FY26, develop formal referral workflows with at least five (5) partners—including behavioral health, justice, and health plans—establishing 3 referral workflows by Mar 31, 2026, to improve transitions of care and strengthen system coordination.

6.11.5. Throughout FY26, improve responsiveness and adaptability within the transportation program by tracking the frequency and causes of canceled transports, maintaining a flexible task list for low-demand periods, and holding quarterly transport team check-ins to assess workload patterns and training relevance to improve operational efficiency and staff engagement despite unpredictable scheduling.

7. STATE-PROVIDED ITEMS

ADHS will:

7.1. Provide budget, CER, and quarterly report templates.

7.2. Provide a data tool template (Excel spreadsheet) for collecting and tracking case record data and prevention recommendations.

7.3. Provide death certificate data twice annually.

7.4. Coordinate quarterly Contractor calls with County staff to facilitate State and County updates and share resources.

7.5. Provide an annual virtual orientation training to County staff.

7.6. Provide technical assistance to County staff as needed.

7.7. Share resources and professional development opportunities with Counties to provide additional support for the implementation of grant related activities.

7.8. Arizona Opioid Epidemic webpage and Interactive Data Dashboard:

7.8.1. azhealth.gov/opioid.

7.9. Arizona Opioid Assistance and Referral (OAR) Line:

7.9.1. https://phoenixmed.arizona.edu/oar.

7.10. ADHS Injury Prevention website:

7.10.1. https://www.azdhs.gov/prevention/womens-childrens-health/injury-prevention/index.php#ofr-team.

7.11. ADHS Opioid Prevention website:

7.11.1. https://www.azdhs.gov/opioid/.

7.12. Substance Abuse and Mental Health Services Administration Opioid Overdose Prevention Toolkit:

7.12.1. https://store.samhsa.gov/product/opioid-overdose-prevention-toolkit/sma18-4742.

8. APPROVALS

8.1. Prior to publishing or recording any marketing materials including, but not limited to, brochures, posters, public service announcements, publications, videos, or journal articles which shall be developed and paid using funds awarded under this Agreement, a draft of the marketing material must first be approved by ADHS. The ADHS Communications Director must approve prior to the dissemination of such materials or airing of such announcements.

8.2. With prior written approval from the ADHS Program Manager, the County is authorized to transfer up to a maximum of ten percent (10%) of the total budget amount between line items. Transfers of funds are only allowed between funded line items. Transfers exceeding ten percent (10%) or to a non-funded line item shall require an amendment. The County should reach out to the ADHS Program Manager before the end of the third (3rd) quarter, so that a timely amendment can be processed by ADHS.

8.3. Requests for publication, student thesis or dissertations based on the work funded by this Intergovernmental Agreement must be approved in writing, in advance, by the ADHS Principal Investigator. The County shall submit the request to the ADHS Principal Investigator at least forty-five (45) days in advance of the proposed publication date. ADHS agrees to limit circulation and use of such materials to internal distributions with ADHS and agrees that such distribution will be solely for the purposes of review and comment. ADHS may require additional statements and will provide the statements when needed.

9. DELIVERABLES

The County shall provide:

9.1. A complete annual OFR data collection tool using the template provided by ADHS.

9.1.1. A complete data tool shall entail:

9.1.1.1. A death certificate number for each case.

9.1.1.2. At least one (1) standardized prevention recommendation for each case reviewed.

9.1.1.3. Each case has no more than four (4) columns with missing or "unknown" responses.

9.1.1.4. No missing data in required columns.

9.1.1.5. All cases submitted follow the State's case requirements of at least eighteen (18) years of age, not pregnant in the last year, Arizona resident, and not a suicide death.

9.1.1.6. Notation of medical records received for each case, including facility or provider requested from, date request sent, and date records received.

9.2. State Overdose Response (SOR) Grant Deliverables Timeline (September 30 – September 29)

DELIVERABLE TITLE	DUE DATE
1st Quarter Survey Completion and CER (October – December)	January 31st
2nd Quarter Survey Completion and CER (January – March)	April 30th
Local OFR Data Submission	May 1st
3rd Quarter Survey Completion and CER (April – June)	July 31st
Complete Local Annual OFR Analysis	July 1st
4th Quarter Survey Completion and CER (July – September)	October 31st

9.3. A complete annual report sent to the ADHS OFR Program Manager by July 1st.

10. NOTICES, CORRESPONDENCE, AND REPORTS

10.1. Notices, Correspondence and Reports and Contractor Expenditure Reports (CERs) from the County to ADHS shall be sent to:

Arizona Department of Health Services
Lauren Murphy
State Opioid Response Grant Manager
150 N 18th Avenue, Suite 310-B
Phoenix, AZ 85007-3242
Phone: (480)349-8539
Email: lauren.murphy@azdhs.gov

10.2. Notices, correspondence, and reports from ADHS to the County shall be sent to:

Cochise County Health and Social Services
Barbara Lang
Health Director
1415 Melody Ln. Bldg. A
Bisbee, AZ 85603
Phone: 520-432-9400
Email: blang@cochise.az.gov

	INTERGOVERNMENTAL AGREEMENT (IGA) **Amendment**		**ARIZONA DEPARTMENT OF HEALTH SERVICES** **OFFICE OF PROCUREMENT** 150 N. 18th Ave., Suite 530 Phoenix, Arizona 85007
	Contract No.: CTR063847	IGA Amendment No: Three (3)	Procurement Officer: Nathaniel Thomas

REVISED PRICE SHEET

Cochise County
State Opioid Response (SOR)
Cost Reimbursement Line Item Budget
9/30/2025 – 9/29/2026

Account Classification	Total Budget
Personnel Services*	$174,388.00
Employee Related Expenses*	$52,316.00
Professional & Outside Services*	$0.00
Travel*	$2,530.00
Other Operating*	$5,774.55
*Indirect Rate and Costs (10%)	$23,501.00
TOTAL (ANNUAL NOT TO EXCEED)	**$258,509.55**

The County is authorized to transfer up to a maximum of ten percent (10%) of the total budget amount between line items with the written approval from an ADHS Program Manager.

Transfers exceeding ten percent (10%) or to a non-funded line item shall require an Agreement Amendment.

*Indicated indirect rate calculation.

	INTERGOVERNMENTAL AGREEMENT (IGA) Amendment		ARIZONA DEPARTMENT OF HEALTH SERVICES OFFICE OF PROCUREMENT 150 N. 18th Ave., Suite 530 Phoenix, Arizona 85007
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Exhibit A – 2 CFR 200.335

eCFR eExhibit -§ 200.332

Prime Awardee: Arizona Department of Health Services
UEI# QMWUG1AMYF65
Requirements for pass-through entities.

Per § 180.300 the awarding agency must check that each subrecipient is not exclude nor disqualified. These checks can be perfomed in SAM.Gov.ADHS Procurement does these checks and uploads the results into APP or Euna Solutions (eCivis).

§180.300

Subrecipient name (which must match the name associated with its unique entity identifier):	Arizona Department of Health Services
Subrecipient's unique entity identifier (UEI #)	QMWUG1AMYF65
Federal Award Identification Number (FAIN, Sometimes it's the same as the Grant Number):	H79TI087838
Federal Award Date:	Contract Date 09/24/2024
Subaward Period of Performance Start and End Date;	09/30/2025-09/29/2026
Subaward Budget Period Start and End Date:	09/30/2025-09/29/2026
Amount of Federal Funds Obligated in the subaward:	$$1,925,824.00
Total Amount of Federal Funds Obligated to the subrecipient by the pass-through entity including the current financial obligation (how much is available for contracts):	$258,509.55
Federal award project description, as required to be responsive to the Federal Funding Accountability and Transparency Act (FFATA)	Overdose Fatality Reviews and Case Management
Name of Federal awarding agency, pass-through entity, and contact information for awarding official of the Pass-through entity	Substance Abuse & Mental Health Services Administration (SAMHSA)
Assistance Listings number and Title; the pass-through entity must identify the dollar amount made available under each Federal award and the Assistance Listings Number at time of disbursement	93.788
Identification of whether the award is R&D	No
Indirect cost rate for the Federal award (including if the de minimis rate is charged) per § 200.414	10%