DEFLECTION, STABILIZATION, & SUPPORT:

A MIDPOINT LOOK AT THE PIMA COUNTY SAFR CENTER PILOT

JANUARY-MARCH 2026

April 13, 2026

Prepared by:
The University of Arizona
RISE Team

for the Regional Opioid
Settlement Advisory Committe

College of Agriculture, Life & Environmental Sciences

Table of Contents

Author's Note

The SAFR Center's external evaluation is provided by the University of Arizona Responsive Insight, Strategy, and Engagement (RISE) team. We thank the following partners for supporting this evaluation:

Community Bridges, Incorporated
Pima County Health Department
City of Tucson Community, Safety, Health and Wellness Team
City of Tucson Police Department

Executive Summary

"SAFR opens the door to people who didn't think there was a door to open."

-SAFR Staff

Background & Program Overview. Pima County faces a sustained substance use crisis, with opioids as a central driver and persistent gaps in care leaving individuals without appropriate support during acute intoxication episodes. In response, the Regional Opioid Settlement Advisory Council (ROSAC) awarded $1.8 million in opioid litigation settlement funds to Community Bridges, Inc. (CBI) to launch the county's first sobering center. The Sobering Alternative for Recovery (SAFR) Center opened in January 2026 as a 15-bed, 24/7 facility at 250 South Toole Avenue in Tucson. Operating as a low-barrier deflection point for law enforcement, emergency services, and community partners, SAFR provides short-term medical monitoring, clinical assessment, medications for opioid use disorder (MOUD), and referrals to ongoing treatment and community resources.

Who SAFR Serves. Between January 1 and March 22, 2026, the SAFR Center served 138 unique patients across 149 admissions. Patients were predominantly male (66%), aged 35–44 (36%), and identified as White (54%) or Hispanic (30%), with Black/African American (13%) and American Indian/Alaska Native (11%) patients also represented. Three-quarters of patients held Title XIX insurance. Social determinants data collected beginning in March (n=30) reveal the acute intersecting needs of the individuals SAFR serves: 97% were unsheltered, 100% were unemployed, and 67% reported food insecurity. These findings underscore that SAFR patients arrive amid compounding social circumstances that shape their ability to engage in and sustain treatment.

Clinical Findings & Service Delivery. All 149 admissions received urinary drug screening, with 31% testing positive for opiates and 28% for fentanyl. Seventy-three percent of patients received a formal clinical assessment, and 40% of those with a documented diagnosis presented with polysubstance use involving opioids. SAFR has established capacity to initiate Buprenorphine (MOUD) on-site, with 11 patients initiating and 8 continuing MOUD in February and March combined, though MOUD tracking continues to be refined. Referral rates reached 96% of discharged patients, just below CBI's 100% target. Median length of stay increased substantially across the pilot period, rising from 10.7 hours in January to 89.3 hours in March, with 46% of patients staying beyond the 96-hour target by March. Patient satisfaction data collected in March was incomplete, but for those who completed a survey rated the center very highly across all domains (4.7–4.9 on a 5-point scale), with respondents describing SAFR as a safe space to rest, recover, and access support.

Operational Progress & Costs. Launched on an accelerated timeline, the SAFR Center has demonstrated meaningful organizational adaptability. CBI has filled 11 of 19 allocated staff positions as of late March 2026, established a partnership with Pima Animal Care Center to accommodate patients with pets, implemented social determinants screening, and

formalized quality improvement processes. Several challenges persist. Gaps in documentation quality affect the reliability of key metrics, including triage timing, TPD deflection tracking, and MOUD initiation rates. The facility's location has been identified by community stakeholders as a structural barrier, both due to proximity to drug access points and CBI's brand perception among some unhoused community members. A lack of pet-friendly residential treatment options continues to create a gap in post-SAFR continuity of care. Regarding costs for care, the two-month average per patient stands at $1,706, with $184,251 billed through February and $1.68 million in budget remaining.

Key Recommendations

1. **Complete staffing and consider a dedicated benefits enrollment specialist.** Eight of nineteen positions remained vacant as of late March, including nursing and behavioral health roles.
2. **Strengthen documentation practices.** Addressing gaps in data quality for key metrics will likely improve the reliability of future reporting.
3. **Standardize referral tracking to accurately measure deflections.** Coordinated data entry guidelines can ensure that the program fully demonstrates progress on this central goal.
4. **Enhance MOUD initiation capacity and opioid use disorder metric tracking.** The low initiation rate in February relative to opioid-positive testing suggests an opportunity for additional clinical guidance, metric tracking and post-discharge continuity.
5. **Integrate Social Determinants of Health data into individualized patient care planning.** This data could be systematically embedded into discharge planning to connect patients with the community resources most relevant to their long-term stability and recovery.
6. **Address transportation as a needed support.** Lack of non-medical transportation is associated with shorter lengths of stay, suggesting an impact on clinical outcomes.
7. **Track patient incident patterns over time.** Tracking incident trends data over the coming months can inform understanding around the relationship between incidents, patient engagement and length of stay.
8. **Establish a formalized partner communication strategy.** Standardized marketing materials and regular partner updates would support consistent messaging about the SAFR model.

The Opioid Crisis in Pima County

Pima County has experienced a sustained and escalating substance use crisis over the past decade, with opioids as a central driver. Substance Use Disorder (SUD) has been identified as a priority health issue in the county, reflecting broad recognition that the structural drivers of this crisis, including stigma, housing instability, and the widespread presence of fentanyl demand a coordinated, community-centered response (APRC, 2025; PCHD, 2024).

At the individual level, Pima County residents experiencing intoxication-related crises present with overlapping medical, behavioral health, and other needs. In the absence of an immediate medical or psychiatric emergency, they have limited care options and are frequently routed to emergency departments or jails, settings that are underequipped to address their unique health needs (Hawk & D'Onofrio, 2018).

In July 2024, LeCroy and Milligan Associates (LMA) conducted focus groups and interviews with individuals who have lived experience of substance use and with healthcare providers. Their report documented persistent barriers to care such as provider-level stigma, a lack of low-barrier monitoring options for individuals at overdose risk, and an inadequate continuum of care that leaves people without support during critical transition points (LMA, 2024).

The consequences of this gap are well-documented: inappropriate utilization of acute care resources, unnecessary contact with the criminal justice system, and reduced access to appropriate services (Smith-Bernardin et al., 2017; Engel et al. 2023; LMA, 2024). Key strategies to bridge this gap are deflection and the sobering care model.

Deflection and Sobering Centers: Mitigating Acute Needs for Those in Crisis

Deflection

Deflection represents collaborative intervention connecting law enforcement, other first responders, and community responders with public health systems. This creates pathways to treatment and services for individuals with SUD, mental health, or co-occurring conditions, before those individuals enter the criminal justice system (LAPPA, 2023).

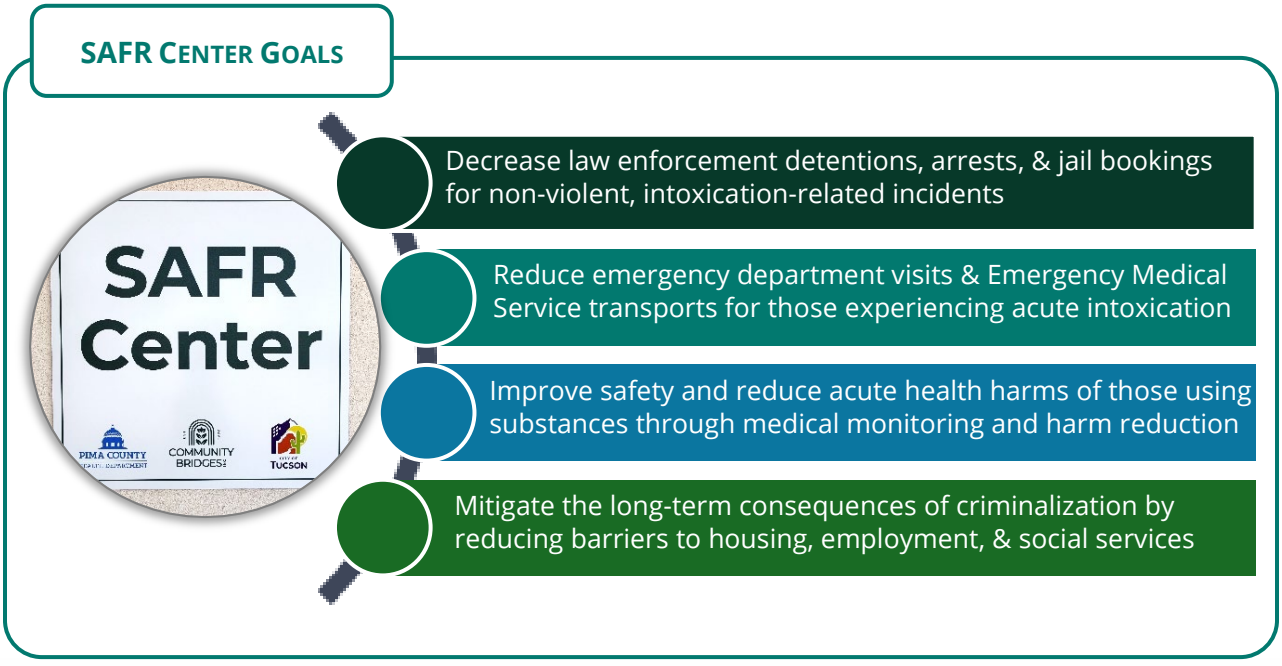
Sobering Centers

Sobering centers offer short-term, 24/7 care facilities providing medical monitoring and support to adults experiencing substance use intoxication, with lengths of stay typically ranging from four to 96 hours. They function as deflection points for first responders and as a bridge to longer-term care, offering screening for SUD, co-occurring conditions, and social determinants of health, alongside brief behavioral health support and referrals to treatment and community-based services (NSC, 2023).

Piloting a Sobering Alternative for Recovery (SAFR) Center

To address the county's co-occurring substance use and mental health needs, the ROSAC was established by the Pima County Board of Supervisors in 2024. ROSAC is a multi-jurisdictional governance body developed to guide the allocation of opioid litigation settlement funds within the Pima County region and includes representatives from Pima County, the City of Tucson (CoT), the City of South Tucson, and the Town of Marana, and operates within the One Arizona Agreement framework. Its own decision-making draws on expert consultation, peer-reviewed evidence, community-based surveys, and perspectives from individuals with lived experience of substance use and recovery.

Among ROSAC's early funding decisions was to establish the county's first sobering center. Following a competitive request for funding proposals, Community Bridges, Incorporated (CBI) was awarded $1.8 million to launch the 15-bed SAFR Center as a pilot at 250 South Toole Avenue in Tucson, using opioid settlement funds designated for harm reduction and recovery support.



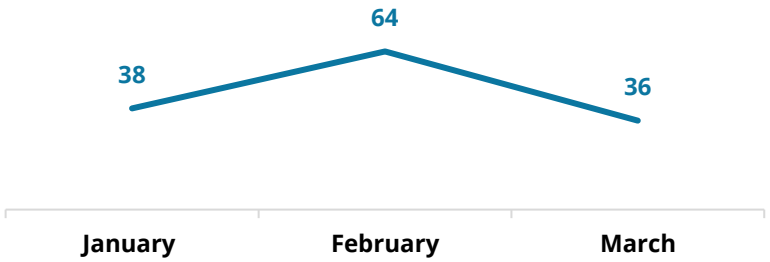
Founded in 1982, CBI is a private, nonprofit 501(c)(3) organization providing integrated behavioral health and recovery services across Arizona. CBI is responsible for SAFR's clinical service delivery, electronic health record documentation, staff training, quality improvement activities, and the coordination of referrals that connect individuals to ongoing recovery support, including through its subcontractor CODAC Health, Recovery, and Wellness, Inc.

Patient Demographics & Characteristics

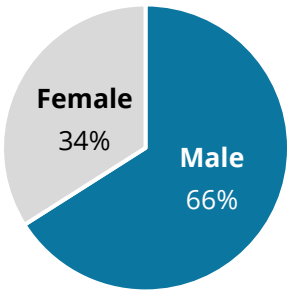
138
UNIQUE PATIENTS FROM JANUARY 1-MARCH 22

149
NON-UNIQUE PATIENTS FROM JANUARY 1-MARCH 22

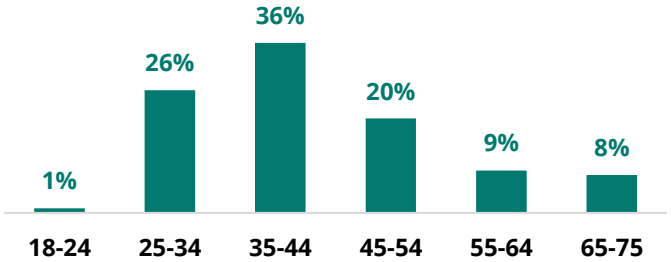
Number of monthly unique patients admitted to the SAFR Program. Data reflect admissions from January 1 through March 22, which may contribute to the lower count observed in March.



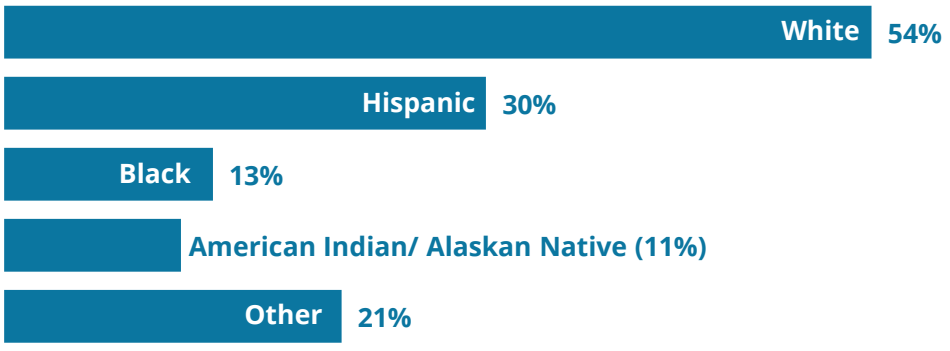
Gender of Patients



Age of Patients



Race and Ethnicity of Patients



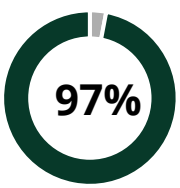
2 patients were **veterans**

5% of non-unique patients had a **Severe Mental Illness (SMI)**

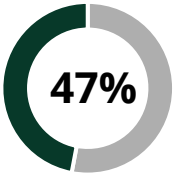
76% of non-unique patients had **Title XIX Insurance**

Patients with complex health and social needs. Social Determinants of Health (SDoH) such as employment, food security, housing stability, educational attainment, access to healthcare, and social support play a substantial role across the life course of individuals with SUD. These factors can influence substance use initiation, progression to SUD, participation in treatment, and long-term recovery (Lin et al., 2024). The Protocol for Responding to & Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is a standardized, evidence-based screening tool used to assess patients' SDoH **(Appendix A)**. In March, SAFR initiated use of the PRAPARE assessment during intake (n=30 patients). Findings highlight the range of complex health and social needs among the first wave of patients completing the PRAPARE, which may directly impact a patient's ability to engage in and continue treatment after leaving SAFR. Moving forward, all patients seeking care at the SAFR Center will be screened with the PRAPARE assessment.

The PRAPARE assessed patients' needs across four domains (n=30):
NEIGHBORHOOD ENVIRONMENT, ECONOMIC STABILITY, EDUCATION, SOCIAL CONTEXT

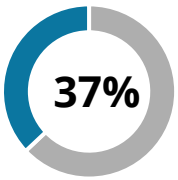


of patients were **unsheltered**

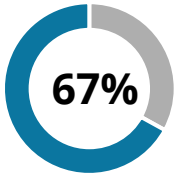


of clients have missed appointments or work due to **lack of transportation**

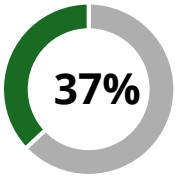
of patients were **unemployed**



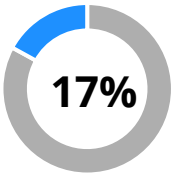
of clients were unable to get a **phone when needed in the past year**



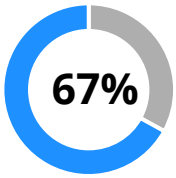
of clients were unable to get **food when needed in the past year**



of patients have less than **a high school degree**



of patients reported being **involved with the criminal justice system in the past year**



of patients reported talking to others **less than once a week**

Referrals to the SAFR Center

Patients come to the SAFR Center through various referral pathways:

- Family, Friends, or Self
- CBI
- Tucson Police Department (TPD)
- City of Tucson Community Safety, Health & Wellness Program (CSHW)
- Behavioral Health Agencies
- Hospitals

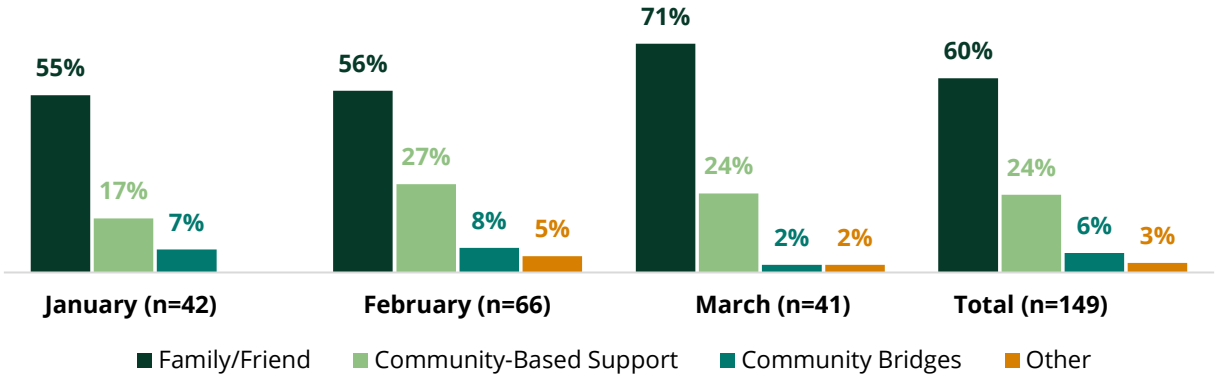
SAFR staff emphasized the importance of multiple outreach pathways, noting that awareness of the SAFR Center has increasingly spread through word of mouth. Families, friends, and outreach teams enter through a general Patient Drop-Off entrance. An alternative entrance is available for patient drop-offs from TPD and other first responders, aimed to minimize waiting times.

Figure 1 demonstrates the percentage of referrals by type, excluding TPD referrals (though the sample size from each month still represents the number of non-unique patients referred to the SAFR Center). Most referrals came from Family, Friends or Self (60%). Almost a quarter came from community-based support (24%), including the CSHW Outreach Team. A smaller share came from other CBI programs including the Toole Outpatient Clinic and the Crisis Mobile Team (6%). The smallest percentage of referrals came from medical and behavioral health agencies including Banner University Medical Center and La Frontera (3%).

Patient Drop-Off Entrance

PD and First Responder Drop-Off Entrance

1. Primary referral types to the SAFR Center included Family and Friends, Community-Based Support, and Community Bridges. "Other" includes Medical and Behavioral Health Agencies.



TPD Referrals. Referral data from TPD were excluded from analysis due to inconsistencies in documentation. TPD referrals can occur through two pathways. First, a deflection from jail may be recorded when a law enforcement officer transports a patient directly to the SAFR Center. Alternatively, TPD co-responders (a team of peer support specialists who conduct community outreach), may facilitate a referral to the SAFR Center. During the pilot period, feedback suggests that SAFR intake staff may have faced challenges distinguishing between these referral sources. Although both pathways would be considered TPD referrals, co-responder referrals may have been recorded under other categories. Future efforts to accurately differentiate these referrals will enhance the county's ability to measure progress toward SAFR's deflection goals.

CBI 23-Hour Crisis Unit. Patients entering CBI's 23-Hour Crisis Unit may transfer into the SAFR Center for further care. Current SAFR data processes suggest that a portion of referrals from the 23-Hour Crisis Unit are currently being documented under the Family/Friend category or the Community-Based Support category.

"The behavioral health community is small and it is common to see familiar faces in this field. ***Now, there are new faces coming into SAFR every day. [They are] getting resources and support. The outreach is working."***

-SAFR Staff

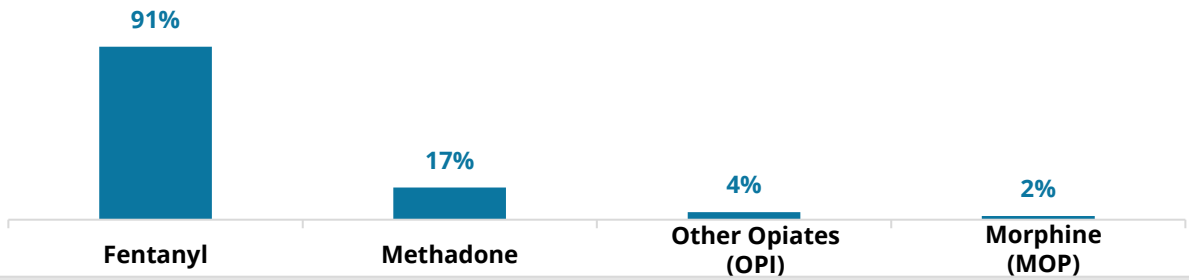
Patient Intake and Assessment

After a patient is admitted to the SAFR Center, they are triaged and receive a series of formal clinical assessments, including a psychiatric evaluation, urinary drug screen (UDS), and a screening for opioid use disorder (OUD) and other substance use and/or behavioral health diagnoses. These assessments help prioritize patient needs and guide appropriate care and referrals.

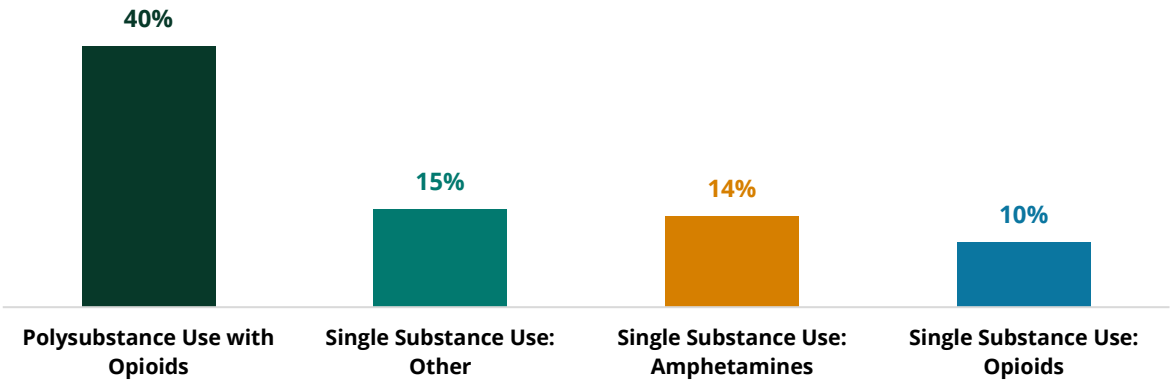
Triage Time. The target goal time from patient arrival-to-triage is ten minutes. Initial monthly data reviews suggested potential data quality issues. For example, in January, arrival-to-triage time was recorded as zero minutes for all patient intakes, suggesting a documentation issue. Following this, CBI added a data entry field to capture more accurate arrival-to-triage time measurements. Between February and March, only 14 patients had documented arrival-to-triage times, indicating a need for further staff support collecting data on this metric for each patient. On average, the time for these 14 patients exceeded the ten-minute target. At the same time, SAFR staff have noted challenges in meeting the target goal time during the intake process as meeting patients' needs and pace in the moment are prioritized.

Clinical Evaluations. From January through March, most patients admitted to the SAFR Center were documented as receiving a formal clinical assessment (73%). In addition, all patients (n=149) were screened via UDS for opioids **(Figure 2)** and other substances. More than a third of patients were positive for opiates (n=46), though this may be an underestimate due to UDS reporting gaps that CBI has been addressing. **Figure 3** presents the number of patients diagnosed with OUD only, Amphetamine Type Use Disorder, use of a single other substance (i.e., Alcohol Use Disorder or Cocaine Use Disorder), and polysubstance use involving OUD (i.e., Amphetamine Type Use Disorder and OUD).

2. Fentanyl was the primary substance found in patients who were positive for opiates via UDS (n=46).



3. Among patients with a documented diagnosis (n=105 unique patients), most with OUD had a co-occuring substance-related diagnosis.



MOUD. Patients who screen positive for OUD may initiate MOUD, specifically Buprenorphine, during their stay. Patients already prescribed Buprenorphine prior to admission may also continue their treatment. Due to data gaps in January, it is unclear how many patients who screened positive for OUD initiated or continued MOUD during that month. Data on these metrics have since been collected for February and March (**Figure 4**).

Additionally, CODAC, a contractor in the pilot project, will play a crucial role in measuring the long-term outcomes for SAFR patients discharged to their care. CODAC, CBI, PCHD, and the evaluation team have collaborated to define metrics for measuring MOUD initiation, continuation, and SDoH outcomes. These metrics are expected to be finalized in the coming weeks and will be incorporated into future monthly reports.

4. In February and March, more than half of patients who screened positive for opioids (n=31) either initiated or continued Buprenorphine.

SAFR Referrals and Discharge

During stays at the SAFR Center, staff support patients in developing discharge plans focused on continued care and resources aligned with each patient's identified next steps. Upon discharge, patients may transition to residential treatment, outpatient treatment, or other supportive services. Overall, most patients were provided with a referral (96%), just below CBI's target of 100%. Of the number of non-unique patients, 81% remained at the center for at least four hours. All of these patients received a referral for additional stabilization, community services, and/or substance use counseling, meeting CBI's target of 100%.

Treatment Referrals. Between January and March, most patients were referred to treatment to other CBI sites **(Figure 5)**, with the majority directed to outpatient services **(Table 1)**. Treatment referral patterns shifted over time, with initial referrals geared primarily to family and friends, and later transitioning toward CBI sites. Referrals to community-based support services were highest in January and declined in subsequent months.

5. Between January and March, most SAFR patients were provided treatment referrals to Community Bridges clinics.

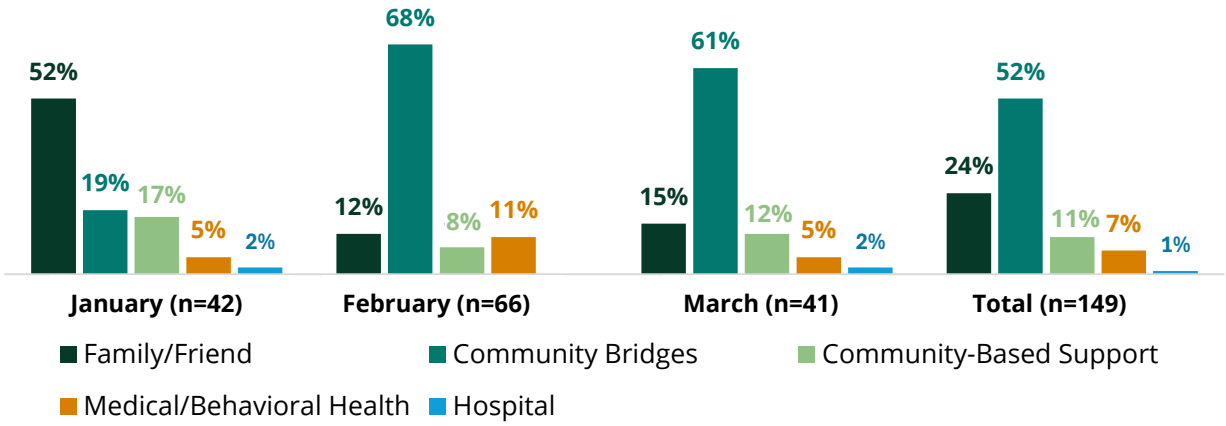
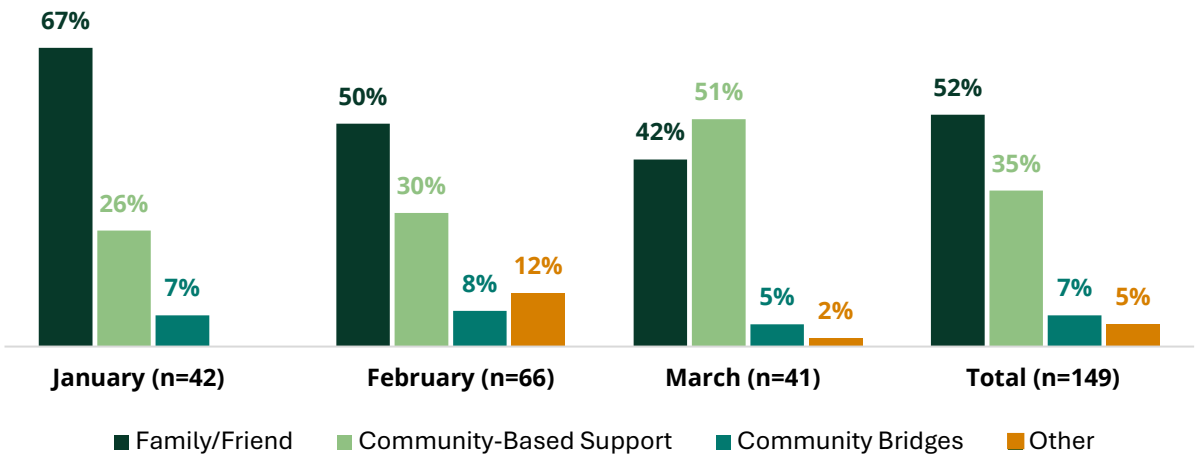


Table 1. Treatment Referral Sites for transitioning SAFR patients

Community Bridges (n=78)	Family/Friends (n=36)	Community-Based Support (n=17)	Behavioral Health (n=11)	Hospital (n=2)
Toole Outpatient: 73% **Toole Transition:** 10% **Toole Crisis:** 5% **Toole UE:** 6% **Toole Shelter:** 1% **Toole Inpatient:** 1% **Dodge Residential:** 1% **Women Transition:** 1%	**Self:** 69% **Family:** 22% **Friends:** 6%	**Other:** 77% **Casa de Vida:** 6% **Teen Challenge:** 6% **Cornerstone:** 6%	**La Frontera:** 36% **COPE:** 27% **CODAC:** 18% **Other:** 18%	**Banner Medical:** 100%

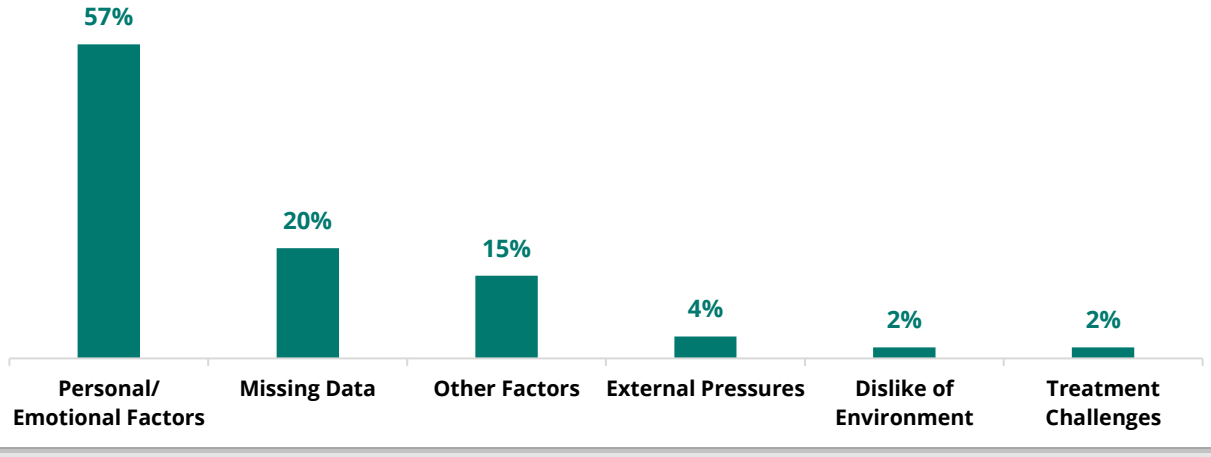
6. Between January and March, half of SAFR patients were provided placement referrals with family or friends.



Placement Referrals. Patients were primarily provided with referrals to family or friends, followed by community-based support **(Figure 6).** In addition, other patients were referred to a behavioral health agency, hospital, or shelter. Throughout the pilot period, placement referrals to family or friends have decreased and community-based support referrals have increased, potentially pointing to expanding community partnerships with the SAFR Center.

Discharge. Discharge completions refer to patients who completed treatment, which were documented by both placement and treatment referral type. For both referral types, 66% of discharges were recorded as "complete" for all patients. Other patients may have been discharged due to the need for a higher level of care, personal circumstances, or external pressures. Among incomplete discharges associated with treatment referral types (n=46), the most common reason for discharging without completing treatment was related to personal and emotional factors **(Figure 7)**. Notes from SAFR's weekly reports suggest that these factors often reflect a patient not being ready for treatment. Additionally, weekly reports indicate that "other factors" refer to other needs required for a patient, such as a different level of care from Banner University Medical Center, other CBI clinics, or other behavioral health providers.

7. The most common reason for incomplete discharges among referral types (n=46) was due to personal and emotional reasons.



Naloxone Education and Distribution.

Upon discharge, patients are intended to receive naloxone along with education on its use. While SAFR staff have noted that this process is carried out by nursing staff, current data documentation from the pilot period indicates that no patients have been recorded as receiving naloxone. This discrepancy between practice and documentation should be addressed in the coming months, potentially through additional training for nursing staff on data entry procedures.

Challenges of Referrals and Discharges.

SAFR staff noted several challenges to continuity of care, including long wait times for insurance enrollment. Staff emphasized the current need for a dedicated team member specialized in insurance to support enrollment processes. Additionally, staff described time constraints as a barrier to discharge planning. With at least half of a patient's stay dedicated to detoxification, only a short window remains to develop a discharge plan and coordinate connections to ongoing treatment, particularly if a patient has a pet and requires specialized referral sites.

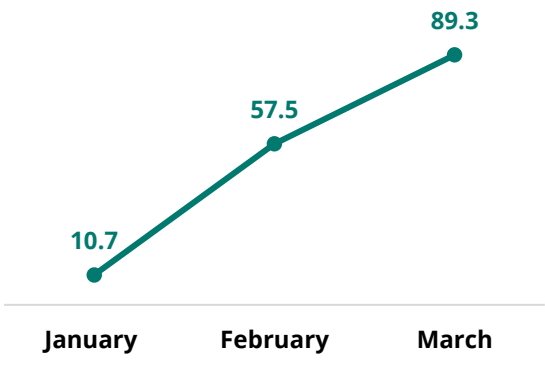
> *"People come here to get resources. We had an uninsured patient come in and SAFR was able to get him signed up for insurance. Now I see him at the CBI outpatient [clinic] five days a week...[but]* ***there's a gap in getting people to residential treatment because of [insurance], and that's so important for follow-up care*** *after SAFR."*
>
> *-SAFR Staff*

Patient Length of Stay

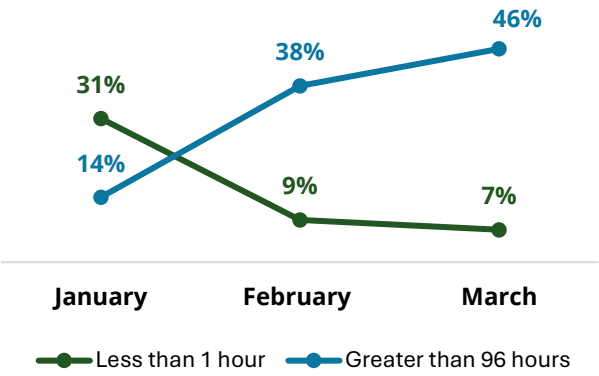
Length of Stay (LOS). Since the opening of SAFR, the median LOS for patients has increased each month **(Figure 8)**. By March, the median LOS was just under the target 96-hour stay. This trend may partly reflect SAFR staff observations regarding the effectiveness of multiple outreach pathways in connecting patients to the SAFR Center. In addition, staff have noted that some referring partners may have described the SAFR Center as a shelter or other model of care during outreach efforts. As a result, some patients arrived to the center with different expectations and chose to leave early upon learning the program structure. Quality Improvement (QI) plans from the SAFR Center have noted increased education and site tours for referral partners, which may have improved their understanding of the center's model of care. Therefore, patients may now be arriving with a clearer understanding of what to expect, which may contribute to greater engagement and length of stay at the center. By March, just under half of patients stayed at the SAFR Center beyond the target 96-hour stay **(Figure 9).** This may reinforce SAFR staff's previously noted observations around the challenges of planning discharge care in collaboration with a patient within a limited timeframe.

Additionally, the number of patients staying at the center for less than an hour decreased. Again, this may contribute to efforts addressing patient expectations about their stay at the SAFR Center.

8. Between January-March, patients' median LOS (hours) at the SAFR Center increased.



9. The percent of patients staying at the SAFR Center beyond the 96-hour stay increased. Patients staying less than one hour decreased.



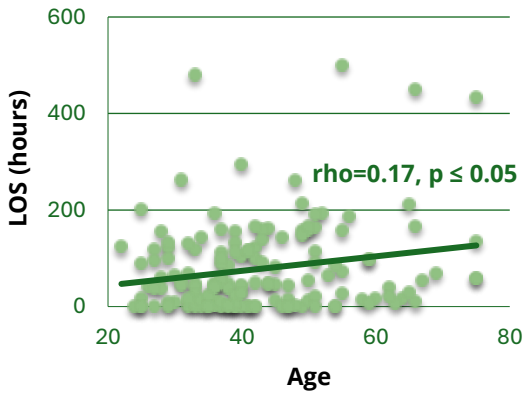
Factors Impacting LOS. Additional analyses[1] were completed to explore factors associated with patients' LOS (n=149). Because the pilot is still in its early stages, these analyses will be repeated as larger sample sizes become available to better understand emerging data patterns. Data from January through March are combined to increase sample sizes.

LOS AND AGE. Results showed a significant positive relationship between age and LOS (*rho=0.17, p≤0.05*), suggesting that an increase in the age of SAFR patients was associated with an increase in LOS **(Figure 10)**. Further subgroup analyses between age and LOS within each gender showed a near significant positive relationship among age and males (*rho=0.20*), *p=0.054*). This suggests that an increase in age of male SAFR patients may be driving the relationship between LOS and age.

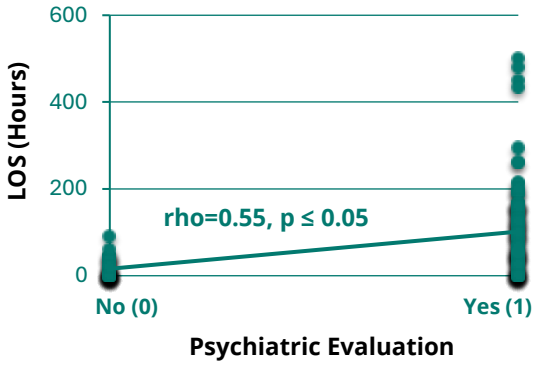
LOS AND GENDER. No statistically significant difference in the median LOS was found between male (n=98) and female (n=51) patients.

LOS AND PSYCHIATRIC EVALUATION. Analyses demonstrated a statistically significant relationship in the LOS between patients who received a psychiatric evaluation and those who did not (*rho= 0.55, p≤0.001*) **(Figure 11)**. Patients who received a psychiatric evaluation were strongly associated with

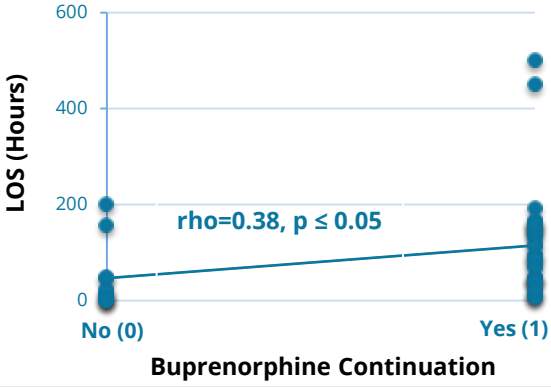
10. Older patients tended to have a longer stay (n=149)



11. Patients who were given a psychiatric evaluation tended to have a longer stay (n=149).



12. Patients who continued buprenorphine tended to have a longer stay (n=149).



[1] Spearman's correlation was used for correlation analyses, where the Spearman coefficient (rho) measured the strength of association between different factors and LOS. The Mann-Whitney U test and Kruskal Wallis tests were used to measure the difference in medians between different factors and LOS.

a longer stay at SAFR.

LOS and Buprenorphine Continuation. Results showed a significant positive relationship between patients that continued buprenorphine and LOS (*rho=0.38, p≤0.05*) **(Figure 12).** This suggests that patients who continue the medication during their stay tend to have a longer LOS.

LOS and Race. No statistically significant differences in the median length of stay were observed across racial groups, including White (n=81), Black/African American (n=20), American Indian/Alaska Native (n=16), and Other (n=31). One patient identified as Native Hawaiian/Pacific Islander and was excluded from the analysis due to the small sample size.

LOS and PRAPARE Items. Patient data gathered from the PRAPARE tool were explored to understand how SDoH influences LOS. Initial analyses suggest that a lack of non-medical related transportation was significantly associated with LOS (rho=0.5, p ≤ 0.05), indicating that this barrier tended to reduce the length of a patient's LOS. Analyses also suggest that other PRAPARE items, such as social connection indicators, may influence a patient's LOS. However, a larger sample size is needed to better understand and interpret these relationships. These analyses will be conducted in future reports as sample sizes increase.

Incidents

Incidents related to safety, elopement, and behavioral issues also present barriers to referrals and may lead to early discharges and shortened LOS. No incidents were reported in March, though 25 cases were documented between January and February. Those cases (n=25) were characterized as:

- Against Medical Advice or Refusal of Services **(52%)**
- Suspected Criminal Activity **(12%)**
- Physical Abuse **(8%)**
- CPI Administered **(8%)**
- Med Error with Adverse Reaction **(4%)**
- Abuse Towards Staff **(4%)**
- Injury, Property Damage or Loss **(4%)**
- Suicide Attempt Offsite **(4%)**
- Code of Conduct Violation **(4%)**

Patient Experience

Pets Challenges and Progress. Pet ownership can play a significant role in supporting individuals with SUD. For example, pets have been shown to offer emotional support and serve as a confidant during stressful times, provide companionship to combat social isolation, and instill a sense of responsibility and purpose (Kerr-Little et al., 2025; Kosteniuk & Dell, 2020). Progress narratives from SAFR staff and external partners noted initial challenges in navigating pet care, such as lack of facility policies on pets, vaccination services, limited crate access, resistance to pets from other SAFR patients, and staff allergies. Since receiving the first pet in February, facility operations, policies, and community partnerships have evolved to help address these challenges and accommodate patients seeking care with their pets.

7 **UNIQUE PETS, INCLUDING 6 DOGS AND 1 CAT,** HAVE BEEN HOUSED AT THE SAFR CENTER BETWEEN JANUARY 31ST-MARCH 30TH

POLICIES AND GUIDANCE. SAFR staff initially experienced challenges navigating pet care due to the need for operational guidance. Since the facility opened, formal policies have been implemented, including requirements for vaccinations, limits on center capacity, and pets allowed per patient.

VACCINATIONS. CBI executed a contract with the Pima Animal Care Center (PACC), ensuring all pets have access to rabies vaccinations during business hours prior to entering the SAFR Center, addressing patient safety, and a potential barrier for discharge referrals.

CRATES & RESOURCES. Additional crates were purchased to increase capacity for pets and safely house them with their owner. A pet waste bag dispensing station was also installed outside the facility and additional leashes were obtained as a resource to patients.

STAFF ADAPTABILITY. Staff with pet-related allergies were relocated to other CBI facilities. As this occurred, new staff were trained on SAFR-specific protocols and documentation processes.

DATA QUALITY. CBI leaders integrated an additional data field into the EHR system to track pets and reconciled past monthly reports to improve accuracy and consistency.

Looking Ahead:

Pet Status Data quality. Improvements are needed in tracking vaccinations, certifications, and spay/neuter information to better understand how pet status may impact a patient's LOS at the SAFR Center. Data quality standards for all staff related to pet policies and guidelines are being incorporated into a SAFR Program Guide. In addition, CBI, PCHD, and the evaluation team will continue to meet every week to ensure weekly pet information is up to date.

24- Hour Vaccinations. Access to pet vaccination services outside of PACC's business hours remains a challenge. For the remainder of the pilot, coordination with community partners to identify and implement potential solutions may be beneficial.

Dog Run Construction. Plans for a dog run are planned and identification of a dog run vendor is in progress.

Pet- Friendly Referrals. Although the facility accepts pets, SAFR staff identified a significant challenge in supporting continuity of care due to the limited availability of pet-friendly residential treatment options. This gap creates a direct barrier for patients who wish to continue treatment without being separated from their pets. Next steps could focus on coordinating with community partners and identifying options for patients.

> *"There is a lack of residential treatment centers [after SAFR] that accept non-service animals.* ***If people have to choose between their pet and getting treatment, they are always going to choose their pet."***
>
> *-SAFR Staff*

Pets and LOS. Additional analyses were completed to explore pet status and its association with patients' LOS, including whether a patient had a pet, type of pet, vaccination status, and spay/neuter status. Results indicated no statistically significant associations. It is important to note that the small sample size of patients with pets (n=7) may limit the ability to detect meaningful associations. These analyses will be repeated as additional data are collected throughout the pilot period.

> *"The population of dogs at SAFR has been a success. For [this population], there is a huge social emotional component to having pets. This is especially a big barrier for the unhoused population."*
>
> *-SAFR Staff*

Patient Feedback Surveys. Upon discharge, patients were invited to complete a brief survey **(Appendix B)** to share feedback on their experiences at the SAFR Center. The data presented in this Midpoint Report reflect only surveys collected in March, as responses from previous months could not be distinguished from those of patients receiving other CBI care at the Toole location. The survey included six rank-based measures of satisfaction, along with one open-ended question. In March, 25 patients were provided the survey; 16 completed the survey, while the remaining eight were returned with no responses.

In the following months, efforts will focus on improving patient completion of the survey. This may involve shortening the survey or exploring alternative approaches with the CBI, PCHD, and the evaluation team to ensure feedback is gathered in ways that meet patients' needs at the time of discharge. Overall, patients who completed the survey had positive attitudes related to their experiences. One patient noted the need for better food, while others emphasized staff warmth and the ability to rest and recover in a safe space.

> *"A comfortable place where they are always attentive to your health and well-being, helping you achieve balance in your mind and body. Thank you very much for the excellent experience and for the food!" [translated from Spanish]*
>
> *-SAFR Patient*

> *"I was able to get sober in a good environment."*
>
> *-SAFR Patient*

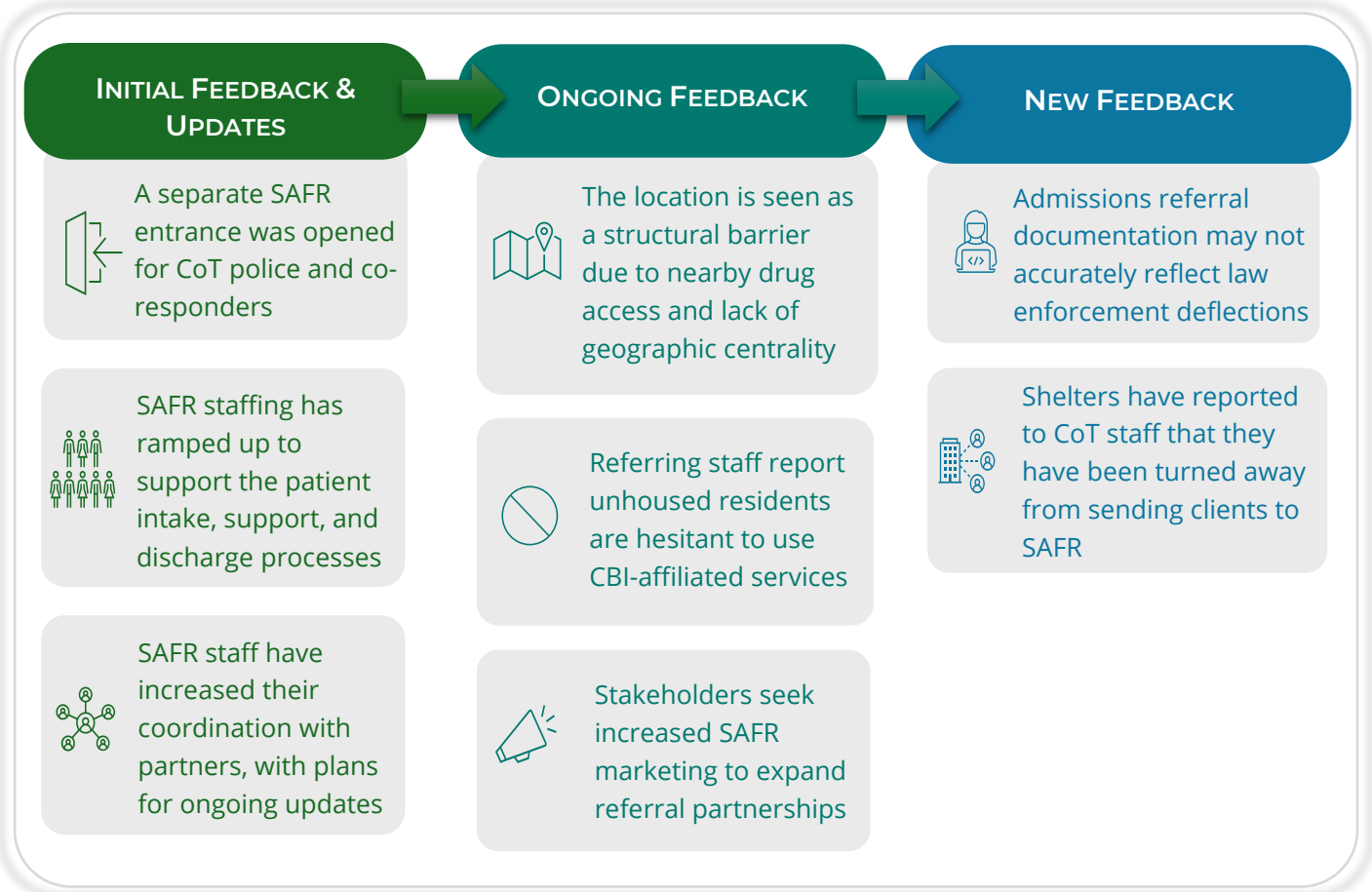
On average using a 1 (Strongly Disagree) to 5 (Strongly Agree) scale, patients had a positive attitude towards their experiences at the SAFR Center (n=16).

Stakeholder Experience

On February 9 and April 3, 2026, the evaluation team collected feedback from CoT PD officers and CSHW staff. These stakeholders' SAFR touchpoints occur via their roles as community responders engaging with substance-use impacted residents in Pima County. Seven staff attended the first in-person session, and four joined in-person or remotely for the second.

Perspectives on early strengths of the SAFR Center included its low barrier to accessing care, as the center accepts patients regardless of considerations such as pet or insurance status, or prior offenses. Stakeholders expressed that strong community interest in SAFR bodes well for the intentionality that will inform next steps for the pilot.

As is the case with multidimensional interventions addressing the complex intersection of substance use, mental health, and homelessness, there have also been challenges or barriers reported by these first and co-responders in their experiences with SAFR. Challenges reported here include those described initially with progress to date noted, those that have persisted, and those that have recently emerged. Recommendations based on these and other findings can be found at the end of this report.



Quality Improvement

Quality improvement (QI) in clinical settings refers to systematic, data-guided efforts to improve patient care through iterative cycles of change, measurement, and learning (Batalden & Davidoff, 2007).

SAFR and its stakeholders have identified several quality improvement domains consistent with CBI's January and February 2026 QI plans. Status to date on key issues is reported here, based on those plans as well as qualitative data that was collected through key informant interviews and stakeholder consultations between January and April 2026. Domains are organized thematically below, describing the initial issue, what has been addressed, and where gaps or challenges remain.

Pet Support

Issue: SAFR's commitment to accepting pets created significant early operational challenges.

Progress: CBI has established a vaccination partnership with PACC, through which clients with pets can be connected to free rabies vaccination prior to arrival. Crates are now available on the unit, and leashes and harnesses have been obtained. A formal pet policy has been developed, and SAFR staff reported that operations around pets have improved considerably.

Remaining gaps: A dog run remains in development and is not yet operational. CBI noted it will not be suitable for outdoor use during summer months due to heat. Most significantly, staff consistently identify limited residential treatment options that accept non-service animals.

Patient Experience

Issue: The day room generates elevated noise levels. The aesthetic environment at intake has been noted as a potential barrier to patient retention, with stakeholders citing limited visual appeal and an institutional atmosphere that may discourage clients from engaging with services. Additionally, the Center's tobacco policy prohibiting the sharing of cigarettes has generated frustration for some.

Progress: Acoustic panels for the day room are planned to mitigate noise levels in this high-traffic space, reflecting recognition of the issue and a step toward resolution.

Remaining gaps: Acoustic panel installation has not yet occurred. The intake room's aesthetics are an area to consider enhancing further to offer an even more welcoming space for potential patients upon arrival.

Oversight & Coordination

Issue: SAFR launched in January 2026 under an accelerated timeline, requiring CBI to operationalize all components of a sobering center simultaneously. This placed significant demands across the organization. Stakeholders have noted some coordination gaps between CBI and the funder, including delayed responses, key staff absences from meetings, and meeting postponements, likely tied to staffing constraints during the launch period.

Progress: Over more than three months, CBI staff and leadership have demonstrated sustained, intensive efforts to launch a complex care facility including weekly meetings with the funder. This reflects a strong organizational commitment to SAFR's successful implementation.

Remaining Gaps: Establishing shared expectations around communication and responsiveness may strengthen the coordination progress made to date, particularly as staffing stabilizes and operational demands shift.

Data Quality

Issue: The January QI plan identified data quality concerns reflected in this report, such as incomplete UDS documentation, patient satisfaction surveys not collected or SAFR-categorized, the PRAPARE not yet implemented, and inconsistencies in other data.

Progress: The PRAPARE was implemented starting in February, and patient surveys are now collected. CBI leaders re-educated nursing staff and prescribers on UDS documentation, and CBI key staff have been meeting weekly to review data quality.

Remaining Gaps: MOUD reporting still requires refinement. The report logic for capturing UDS screening is pending further clarification. The IT infrastructure supporting SAFR documentation has proved more resource-intensive than anticipated and may require additional staffing.

Partner Communication

Issue: Stakeholders have asked for more ongoing communication from CBI about program updates.

Progress: CBI has created a SAFR program flyer, a dedicated SAFR phone line, and CBI has begun receiving SAFR program inquiries through the CBI website. CBI has met with a variety of partners, including the Crisis Response Center, El Rio, CODAC, and The Haven to promote the program while determining a formal process for ongoing updates.

Remaining gaps: A formalized partner communication loop has not yet been established. CBI staff interviews have noted instances where referring partners' inaccurate descriptions of the SAFR Center have contributed to patients' mismatched expectations upon arrival, reducing the likelihood of successful engagement.

Staffing

Issue: At launch, SAFR was significantly understaffed. Hiring for a six-month pilot period was challenging in key roles including the Quality Assurance (QA) Specialist.

Progress: As of late March 2026, CBI has filled 11 of 19 allocated positions.

Remaining gaps: Several nursing and behavioral health positions remain vacant and are actively being recruited. The QA Specialist has not yet been filled; however, additional QA staffing has been dedicated from within CBI. Navigating AHCCCS applications can take up to 30 days, and the lack of a benefits enrollment specialist can create a barrier to treatment upon discharge.

The SAFR Center has demonstrated meaningful progress in many of the QI domains identified during its initial months of operation. The issues that remain most consequential going forward involve structural and systems-level challenges, gaps and solutions, which warrant continued attention from CBI leadership, staff, as well as partners to ensure that SAFR remains successful as the program matures.

"Staff is amazing."

"Friendly staff and food [are what I liked most]."

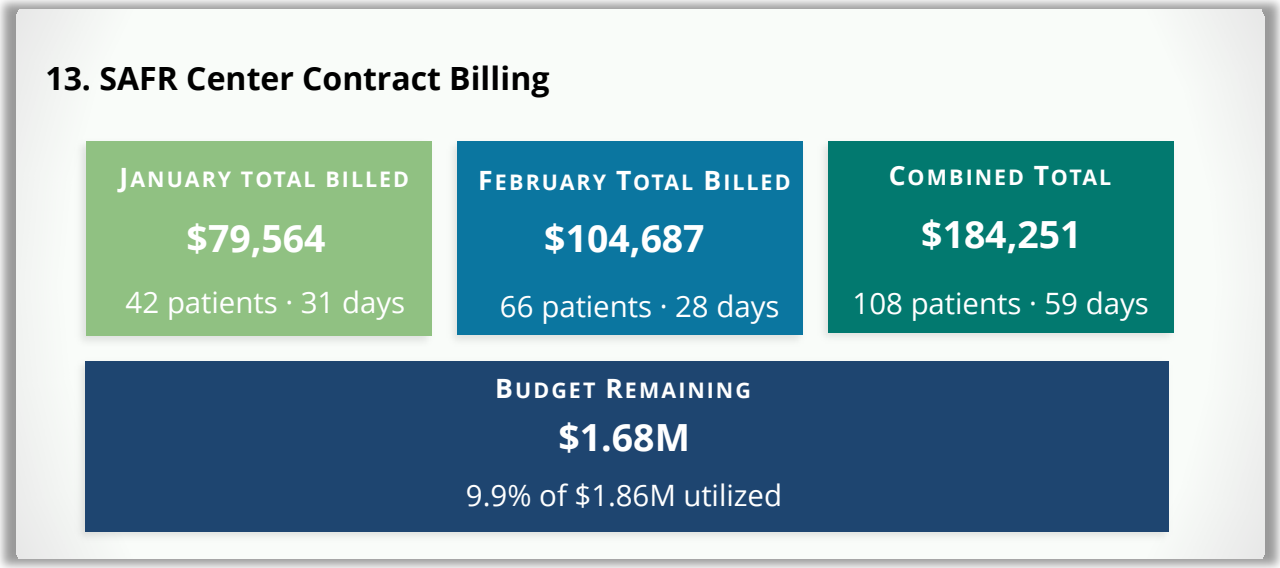
"Thank you for the support."

-SAFR patient survey comments

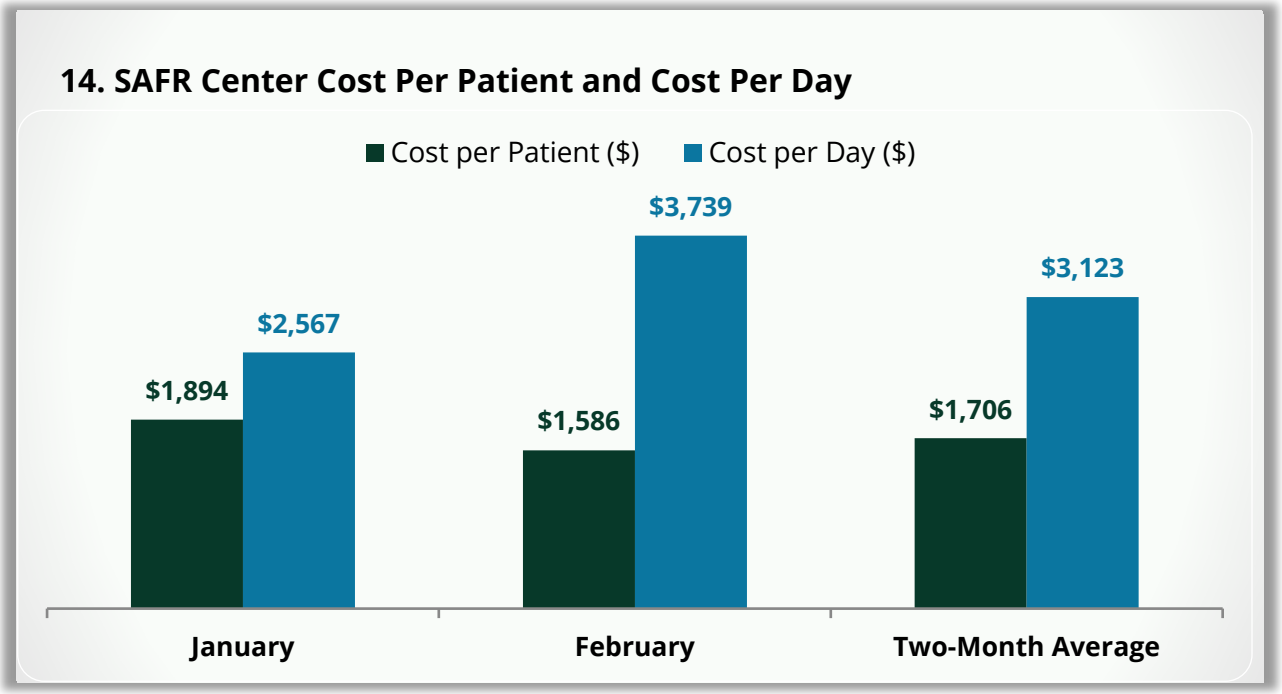
SAFR Center Costs to Date

One key consideration during the pilot period is the county's cost for SAFR Center care. The analyses presented here only reflect CBI's submitted contract expenditures from January and February 2026, the months available at the time of publication. **Figures 13** and **14** should be interpreted with a caveat: operations and staffing were in the earliest stages of ramp-up during this period and are unlikely to represent true monthly costs once billing for ongoing operations and subcontractors are fully established.

13. SAFR Center Contract Billing



14. SAFR Center Cost Per Patient and Cost Per Day



Recommendations

The SAFR Center represents a community-driven effort to offer something different to individuals in crisis and to the first responders and outreach workers who encounter them. What has emerged in the months since opening is a program that is learning in real time, adapting its staffing, its workflows, and its relationships with partner organizations in response to challenges that no planning process could have fully anticipated. The recommendations that follow reflect the collective insight generated by CBI staff, CoT stakeholders, and the individuals the SAFR Center was designed to serve.

Each recommendation is grounded in what the data and conversations have revealed about where targeted investment is most likely to matter. Taken together, they point toward a clear set of priorities: strengthening communication, stabilizing staffing, and improving the physical and relational environment so that SAFR can reliably do what it set out to do, which is provide a genuine alternative that meets people where they are.

Staffing

1. Complete staffing and consider a dedicated benefits enrollment specialist.

As of late March 2026, 8 of 19 allocated positions remained vacant, including nursing, behavioral health, and the QA Specialist role. The absence of a staff member dedicated to AHCCCS enrollment is notable: with applications taking up to 30 days, insurance delays represent a barrier to post-SAFR treatment access.

Data & Documentation

2. Strengthen documentation practices.

Data quality gaps persist for key metrics. Improved documentation training for all clinical and intake staff, coupled with systematic data quality reviews, will likely improve the reliability of future reporting and the county's capacity to measure SAFR's progress toward its core goals.

3. Standardize TPD referral tracking to accurately measure deflections.

The challenge around consistently distinguishing law enforcement deflections from co-responders and other referrals has created barriers for an accurate accounting of SAFR's deflection impact. Coordinated data entry guidelines between CBI intake staff and TPD partners can ensure that the program fully demonstrates progress on this central goal.

4. **Enhance MOUD initiation capacity and opioid use disorder metric tracking.**

SAFR has a unique opportunity to initiate and sustain MOUD within its patient community. The low initiation rate in February relative to opioid-positive testing suggests an opportunity for additional clinical guidance, metric tracking and post-discharge continuity in partnership with CODAC.

Patient Care

5. **Integrate PRAPARE data into individualized patient care planning.**

Early PRAPARE findings reveal intersecting social needs among SAFR patients: 97% were unsheltered, 100% were unemployed, 67% were food insecure. PRAPARE data could be systematically embedded into discharge planning to connect patients with the community resources most relevant to their long-term stability and recovery.

6. **Address transportation as a needed support.**

Early data on the lack of non-medical transportation was found to be significantly associated with reduced length of stay, suggesting that it may have a meaningful impact on clinical outcomes. Beyond PRAPARE screening, SAFR could explore transportation support options such as ride vouchers, partner coordination with mobility programs, or proactive transportation planning as part of the discharge process.

7. **Track patient incident patterns over time.**

Twenty-five incidents were documented at SAFR between January and February, with "against medical advice" departures representing the most common category. Tracking incident trends data over the coming months can inform understanding around the relationship between incidents, patient engagement and length of stay.

Community Partnerships

8. **Establish a formalized partner communication strategy.**

A standardized set of SAFR marketing materials, accompanied by regular partner updates, can support consistent and accurate messaging around the SAFR model and help expand the referral network, including among shelters.

The Months Ahead

In January 2026, the SAFR Center was rapidly deployed by CBI in partnership with the Pima County Health Department and other partners. In a span of 3 months, CBI has established a specialized sobering treatment and transition model, conducted hiring and onboarding of additional site staffing, established data protocols and transferring practices, developed QI processes, and integrated coordinated community support services, including pet care. Within the next three months, county leaders will determine whether the SAFR center pilot will continue with a one-year extension.

The months ahead represent a critical window. With staffing continuing to grow, data systems becoming more reliable, and relationships with community partners deepening, the program is approaching a level of operational maturity that was not yet possible during the first several months following launch. CBI staff, CoT stakeholders, and ROSAC partners have each brought their perspectives to this work, and the result is a quality improvement process that is genuinely iterative.

The PRAPARE data now being collected will shed light on the social determinants shaping SAFR patients' needs, and improving documentation practices will allow the evaluation team to more accurately characterize who the program is reaching and what success means for the SAFR care model. These developments reflect a program becoming more able to make intentional, evidence-informed decisions about how it serves its community.

The SAFR Center was created with the conviction that people in substance use crisis deserve a more effective and dignified response than what the existing system has historically offered them. The work now is to keep building the needed systems, communication, and infrastructure so that SAFR can reliably deliver on its mission: to improve individual and community safety, reduce strain on first responders, and support the health of every Pima resident, everywhere, every day.

"I'm most proud of being able to support even more of the community through SAFR. ***Individuals coming here are more vulnerable, because if they hadn't been picked up [through a referring partner], then they wouldn't have been able to come to the facility.*** *It gives them insight into what the SAFR opportunity is, whether they participate now or keep SAFR in mind for later."*

-SAFR staff

References

Arizona Prevention Resource Center. (2025). *Arizona opioid surveillance report*. Arizona Department of Health Services. https://www.azdhs.gov/opioid/documents/opioid-report-2023.pdf

Batalden, P., & Davidoff, F. (2007). What is "quality improvement" and how can it transform healthcare? *Quality and Safety in Health Care*, *16*(1), 2–3. https://doi.org/10.1136/qshc.2006.022046

Engel, R. S., Isaza, G. T., Cherkauskas, J. C., Corsaro, N., & Motz, R. (2023). *Evaluating the utility of sobering centers: Analyses of police and sobering centers across five jurisdictions.* National Policing Institute. https://www.policinginstitute.org/publication/evaluating-the-utility-of-sobering-centers-analyses-of-police-and-sobering-centers-across-five-jurisdictions/

Hawk, K., & D'Onofrio, G. (2018). Emergency department screening and interventions for substance use disorders. *Addiction Science & Clinical Practice*, *13*(1), 18. https://doi.org/10.1186/s13722-018-0117-1

Kerr-Little, A., Bramness, J. G., Newberry, R. C., & Biong, S. (2025). Dog ownership for people with substance use disorder: Self-reported influence on substance use and mental health. *Substance Abuse Treatment, Prevention, and Policy*, *20*(1), 27. https://doi.org/10.1186/s13011-025-00653-x

Kosteniuk, B. M., & Dell, C. A. (2020). How companion animals support recovery from opioid use disorder: An exploratory study of patients in a methadone maintenance treatment program. *Aporia*, *12*(1), 91–108. https://pdfs.semanticscholar.org/3639/ba3c072070662d46729ffd3885609afaf8a7.pdf

LeCroy & Milligan Associates. (2024). *Pima County opioid response needs and assets: Recovery and medication focus.* Pima County Health Department. https://content.civicplus.com/api/assets/90ce2a35-86b6-4434-81f2-c3c272ce64b5?cache=1800

Legislative Analysis and Public Policy Association. (2023). *Deflection and the deflection pathways.* https://legislativeanalysis.org/deflection-and-the-deflection-pathways/

Lin, C., Cousins, S. J., Zhu, Y., Clingan, S. E., Mooney, L. J., Kan, E., Wu, F., & Hser, Y. I. (2024). A scoping review of social determinants of health's impact on substance use disorders over the life course. *Journal of Substance Use and Addiction Treatment*, *166*, 209484. https://doi.org/10.1016/j.josat.2024.209484

National Sobering Collective. (2023). *Recommended standards for sobering care for alcohol and/or other drug intoxication* [Public summary]. https://nationalsobering.org/wp-content/uploads/2023/10/StandardsofCare_Sobering_PUBLIC_2023-10.pdf

Pima County Health Department. (2024). *Community health improvement plan.* Pima County. https://content.civicplus.com/api/assets/f6e824d1-9d45-4a08-88d7-7b4e2bcb7a80

Smith-Bernardin, S., Carrico, A., Max, W., & Chapman, S. (2017). Utilization of a sobering center for acute alcohol intoxication. *Academic Emergency Medicine*, *24*(9), 1060–1071. https://doi.org/10.1111/acem.13219

Appendix A.

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) Tool

The PRAPARE is a national, evidence-based, standardized patient risk assessment tool designed to identify and address SDoH.

PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question

2. Which race(s) are you? Check all that apply

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	White		American Indian/Alaskan Native
	Other (please write):		
	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

	Yes		No		I choose not to answer this question

5. What language are you most comfortable speaking?

Family & Home

6. How many family members, including yourself, do you currently live with? _____

	I choose not to answer this question

7. What is your housing situation today?

	I have housing
	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
	I choose not to answer this question

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

9. What address do you live at?
Street:_____
City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

	Less than high school degree		High school diploma or GED
	More than high school		I choose not to answer this question

11. What is your current work situation?

	Unemployed		Part-time or temporary work		Full-time work
	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
	I choose not to answer this question				

12. What is your main insurance?

	None/uninsured		Medicaid
	CHIP Medicaid		Medicare
	Other public insurance (not CHIP)		Other Public Insurance (CHIP)
	Private Insurance		

13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

_____

	I choose not to answer this question

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
Paper Version of PRAPARE® for Implementation as of September 2, 2016

14. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
	I choose not to answer this question				

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

	Yes, it has kept me from medical appointments or
	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
	No
	I choose not to answer this question

Social and Emotional Health

16. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

	Less than once a		1 or 2 times a week
	3 to 5 times a week		5 or more times a
	I choose not to answer this question		

17. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

	Not at all		A little bit
	Somewhat		Quite a bit
	Very much		I choose not to answer this question

Optional Additional Questions

18. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

	Yes		No		I choose not to answer this

19. Are you a refugee?

	Yes		No		I choose not to answer this

20. Do you feel physically and emotionally safe where you currently live?

	Yes		No		Unsure
	I choose not to answer this question				

21. In the past year, have you been afraid of your partner or ex-partner?

	Yes		No		Unsure
	I have not had a partner in the past year				
	I choose not to answer this question				

Appendix B. CBI Patient Survey

The Patient Survey was developed by CBI and is offered to SAFR patients at the time of discharge.

COMMUNITY BRIDGES INC

Patient Survey

YOUR OPINION MATTERS TO US

Date: **Facility:** EVARC Crisis

What did you like best about your CBI experience?

Rating Scale: (5) Excellent (4) Very Good (3) Good (2) Fair (1) Poor	**5**	**4**	**3**	**2**	**1**
How satisfied were you with the cleanliness and appearance of the facility?					
How satisfied were you with the overall care you received?					
How satisfied were you with your staff experiences?					
How satisfied were you with your medical practitioner experience?					
How satisfied were you with your discharge plan?					
How likely are you to recommend our services to a family or friend who is in crisis?					

Community Bridges, Inc. Administration Office | 1855 W. Baseline Road, Suite 101 Mesa, AZ 85202 | 480.831.7566 |
TTY 480.962.7711 | info@cbridges.com | communitybridgesAZ.org