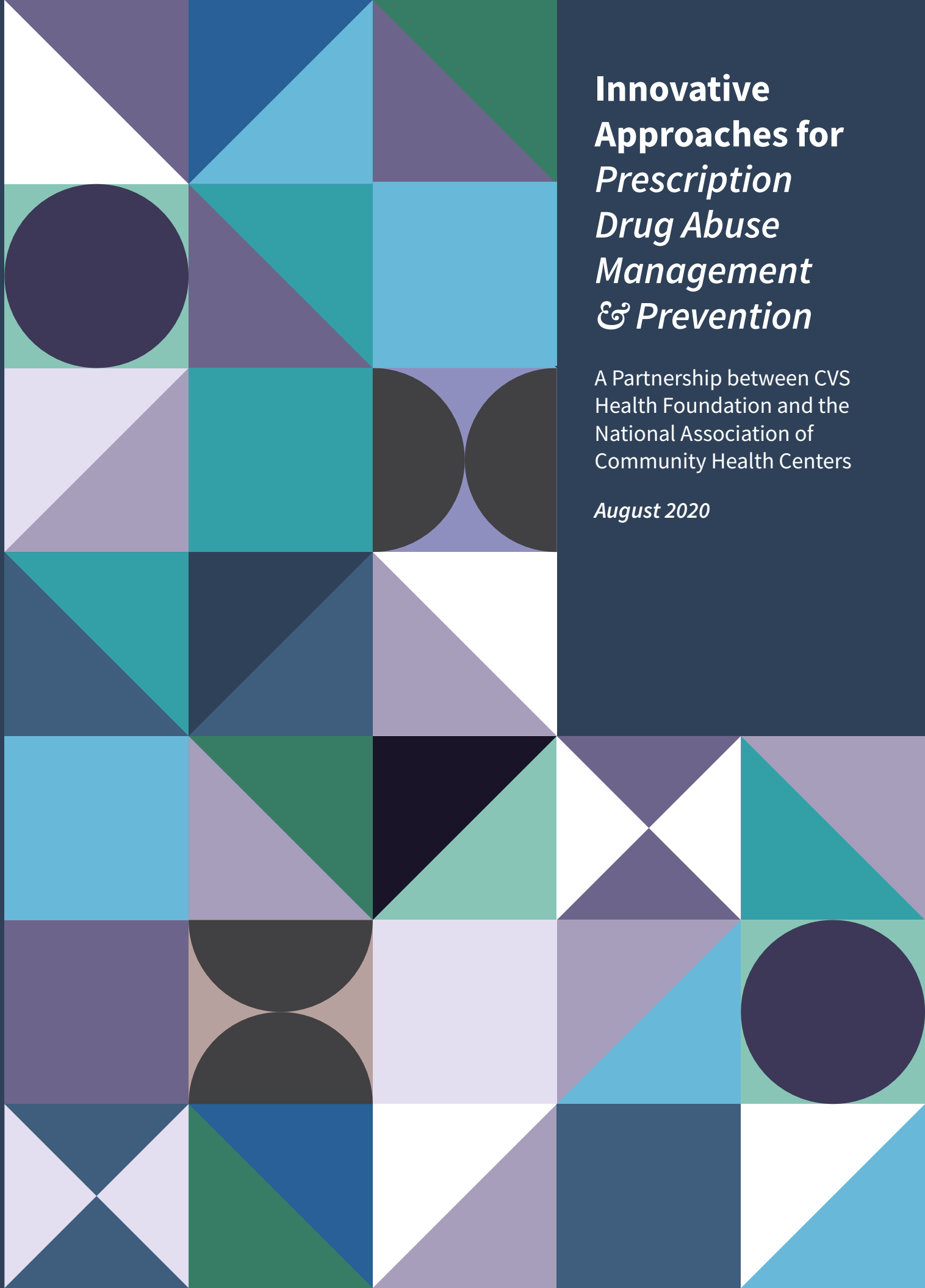


Innovative Approaches for *Prescription Drug Abuse Management & Prevention*

A Partnership between CVS Health Foundation and the National Association of Community Health Centers

August 2020

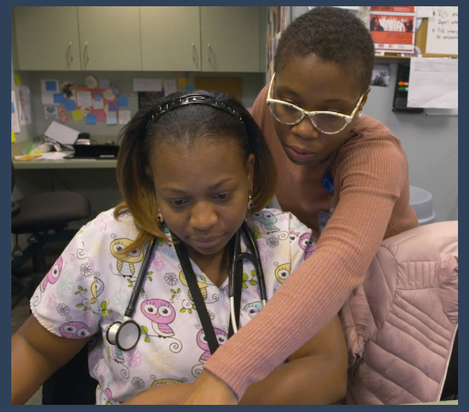
THE CVS HEALTH FOUNDATION is a private charitable organization created by CVS Health that works to build healthier communities, enabling people of all ages to lead healthy, productive lives. The Foundation provides strategic investments to nonprofit partners throughout the U.S. who help increase community-based access to health care for underserved populations, create innovative approaches to chronic disease management and provide tobacco cessation and youth prevention programming. We also invest in scholarship programs that open the pathways to careers in pharmacy to support the academic aspirations of the best and brightest talent in the industry. To learn more about the CVS Health Foundation and its giving, visit www.cvshealth.com/social-responsibility.

Established in 1971, the NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS (NACHC) serves as the national voice for America's Health Centers and as an advocate for health care access for the medically underserved and uninsured.

CVS Health FOUNDATION

NATIONAL ASSOCIATION OF Community Health Centers®

Quality improvement teams at each health center dedicated time, focus, and practical adjustments throughout the grant year to support changes in patient, family, community, and care team engagement.



The U.S. *Opioid* Epidemic

OPIOID USE DISORDER (OUD)* is considered a crisis in the United States, with opioid-related deaths at an epidemic level. The rate has been climbing steadily, with a six-fold rise in rates from 1999 to 2017 and a 9.6% increase in opioid-related deaths between 2016 and 2017. Over 70,000 people died of drug overdoses in 2017, an equivalent of 192 people per day. Of these deaths, 68% were due to opioids, including prescription opioids, heroin, and fentanyl. Economically, OUD is estimated to cost $78.5 billion per year: health care, lost productivity, addiction treatment, and criminal justice expenses contribute to the total.[1]

As OUD has come into the national spotlight, the health care community has urgently sought to develop, test, and implement practices that aim to limit the spread and severity of this epidemic.

*See glossary (page 32)

CVS Health Foundation & NACHC Collaborate to Find Solutions

IN 2017, CVS Health Foundation launched *Innovative Approaches for Prescription Drug Abuse Management and Prevention (Innovative Approaches)* in response to the opioid epidemic. The Foundation invited the National Association of Community Health Centers (NACHC) to partner with them, recognizing NACHC's role in supporting health centers that serve low income, minority, and underserved communities. There are over 1,400 such health centers funded by the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services (HHS). In 2019, more than 29 million people—1 in 12 nationwide—relied on a HRSA-funded health center for affordable and accessible primary health care. This included 1 in 3 people living below poverty, 1 in 5 uninsured people, and 1 in 5 Medicaid beneficiaries.

In 2018, health centers screened and identified over 1 million patients for substance use disorder (SUD)*, which encompasses the use of opioids as well as other substances. Medication-assisted treatment (MAT)*, the mainstay of OUD treatment, was given to approximately 95,000 health center patients by certified health center providers, commonly referred to as "DATA-waivered*" providers. Formal SUD services were available at 67% of health centers. Approximately 93% of health centers were able to provide on-site mental health treatment services to those in need through care delivery systems that integrate primary care and behavioral health (known as Integrated Behavioral Health)*.[2]

In 2019, more than 29 million people—1 in 12 nationwide—relied on a HRSA-funded health center for affordable and accessible primary health care.

NACHC supports health centers through advocacy, training, technical assistance, research, analysis, and partnerships and uses system transformation techniques and population health strategies to help health centers address emerging and critical health care issues. These techniques and strategies utilize clinical evidence, implementation science, standardized health measures, collaborative learning models, and community partnerships.

Innovative Approaches offered a competitive grant opportunity that would allow NACHC member health centers in targeted states to deepen their response to the epidemic. Health centers were selected through a rigorous review process based on demonstrated need, proposed program design, history of successful collaboration, leadership engagement, and capacity for sustained improvement in the prevention and management of prescription and non-prescription substance abuse. Geographic and population diversity were also considered. Over the first two years of the initiative (2017-2018 and 2018-2019), 24 unique health centers were selected to participate, with funding ranging from $50,000 to $85,000 per health center. Project periods were 12 months in length, during which health centers were tasked with creating at least one innovative approach within their systems, protocols, partnerships, or culture.

[1] Centers for Disease Control and Prevention (2020), accessible at www.cdc.gov/drugoverdose/

[2] Health Center Program Awardee Data (2018). Uniform Data System, HRSA, DHHS, accessible https://bphc.hrsa.gov/uds/datacenter.aspx?q=d

Focus Areas and Project Examples

Systems used to screen, identify, engage, and coordinate care for patients with SUD and OUD

- Across all funded health centers, expanded integrated care teams with dedicated SUD care managers, behavioral health consultants, psychiatric nurse practitioners, addiction specialists, clinical pharmacists, pain specialists, and peer recovery support specialists
- Used the electronic health record to flag patients on prescription opioids as high risk and refer them to an opioid use intervention, including pain management and tapering
- Conducted grief groups for children aged 6–17 who have lost a loved one to overdose death

Protocols for prescriber practices, with an emphasis on clarity, safety and effectiveness

- Across all funded health centers, provided a wide range of non-narcotic pain management services such as bio/neuro feedback, acupuncture, chiropractic services, cognitive behavioral therapy, anger management, meditation classes, and somatic therapy; and added DATA-waivered MAT providers
- Created six new clinical decision support tools in the electronic health record to implement best practices for opioid prescribing and identified the high benefit/low cost opportunities in the workflow
- Piloted a clinical pharmacist-led pain clinic, which guided clinic providers to tailor medicines for not just pain, but also for other co-morbid chronic conditions to taper patients off addictive medications and to optimize safe prescribing practices

Partnerships with specialty providers and community-based organizations

- Partnered with local emergency department staff to visit SUD patients while they were still in the hospital and enroll them in the health center's SUD services before discharge, making the most of the opportunity to initiate or resume treatment
- Partnered with a local prevention coalition to train youth group members on substance use and peer prevention methods; youth group members held a panel for community parents in which they addressed how to start a conversation with teens around substance use and gave parents tips on how to create an environment in which trust is fostered and built
- Established a peer network of MAT providers in the local community to share trainings, enhance provider wellness, and create a shared sense of responsibility of caring for community members impacted by SUD

A culture of safety, acceptance and inclusion for patients in need of SUD prevention and care services

- Trained all staff in trauma-informed care* and the importance of recognizing implicit, or unconscious bias*
- Created a language guide to help staff communicate in ways that respect the dignity of the person, name SUD as a disease, and eliminate blame from the treatment process
- Engaged a patient advocate (and former heroin user) to help staff understand more of the patient perspective

WITH EACH CENTER'S leadership and NACHC's guidance, innovations were responsive to the underlying circumstances of each health center's patient population, workforce, organizational and systems capacity, available resources, and community relationships. Quality improvement teams at each health center dedicated time, focus, and practical adjustments throughout the grant year to support changes in patient, family, community, and care team engagement. See pages 6-7 for key highlights.

As a central component of the grant, the 24 health center grantees became part of a learning community, implementing their individual initiatives in the context of a collaborative, iterative process that required frequent engagement with each other and with NACHC leadership. More about the learning community follows on pages 9.

Nine of the 24 health centers were selected for this publication, to represent a range of project experiences, a capacity for replicability and sustainability, and the diversity of health care settings. In-depth interviews with these nine health centers are summarized in the pages that follow. Three of the nine health centers are featured in an accompanying video documentary. The case studies, as well as the video, can inspire replication of this work, both within and without the health center system.

Key Highlights
2017–2019 Innovative Approaches

**Selected for case study*

Cherry Health *(Grand Rapids, Michigan)*

72% staff at one clinic site trained in opioid reversal (up from 6% at baseline and corresponding to an increase in patients receiving MAT)

Cornerstone Family Healthcare *(Cornwall, New York)*

28% of patients at the distant clinic site with a mental health and/or substance use diagnosis had a visit with an offsite provider via telemedicine (up from 26% at baseline)

Charles River Community Health *(Brighton, Massachusetts)*

66% of medical providers, nurses, and behavioral health providers trained in general aspects of opioid use disorder and outpatient-based treatment (up from 0% at baseline)

PCC Community Wellness Center *(Oak Park, Illinois)*

46% of patients aged 18 and older at one site screened using the PC-PTSD-5 tool (up from 0% at baseline)

Rocking Horse Community Health Center *(Springfield, Ohio)*

16 grief group sessions held with youth aged 6-17 who have lost a loved one to overdose death

Neighborhood Family Practice *(Cleveland, Ohio)*

98% of behavioral health, medical and nursing staff trained in motivational interviewing techniques (up from 0% at baseline)

East Boston Neighborhood Health Center *(Boston, Massachusetts)*

12% of eligible providers obtained DATA waivers to prescribe MAT (up from 6% at baseline)

Harmony Health Medical Clinic and Family Resource Center *(Marysville, California)*

81% of patients with SUD received case management (up from 30% at baseline)

Ryan Health *(New York City, New York)*

38% of eligible providers obtained DATA waivers to prescribe MAT (up from 25% at baseline)

Greater Lawrence Family Health Center *(Lawrence, Massachusetts)*

6 new clinical decision support tools created in the electronic health record to implement best practices for opioid prescribing

Sacramento Native American Health Center *(Sacramento, California)*

9% of patients who screened positive for substance use had at least one visit with an integrated behavioral health provider (up from 4% at baseline)

Brockton Neighborhood Health Center *(Brockton, Massachusetts)*

100% of pediatric providers trained to use the CRAFFT screening tool in primary care

United Community and Family Services *(Norwich, Connecticut)*

Increased the number of patients receiving MAT in primary care from 11 to 37

Marin City Health & Wellness Center *(Marin City, California)*

39% of patients in the MAT program received dental care (up from 10% at baseline)

Project H.O.P.E. *(Camden, New Jersey)*

81% of patients remained in SUD treatment with fewer relapses after 30 days (up from 71.4% at baseline)

La Maestra Family Clinic *(San Diego, California)*

Increased the number of patients receiving MAT in primary care from 4 to 27

CHEMED Health Center *(Lakewood, New Jersey)*

60% of women's health patients aged 18 and older received SBIRT screenings at new and well visits at the main clinic site (up from 7% at baseline)

AltaMed Health Services *(Los Angeles, California)*

85% of patients aged 18 or older on prescribed opioids who have a high-risk flag in the electronic health record received an opioid use intervention (up from 41% at baseline)

Family Care Health Centers *(St. Louis, Missouri)*

46% of patients receiving MAT had at least one visit with a behavioral health provider (up from 28% at baseline)

Shawnee Health Service and Development Corporation *(Carbondale, Illinois)*

10% decrease in the number of high-risk patients with multiple opioid prescriptions

Blue Ridge Health Services *(Hendersonville, North Carolina)*

Increased the number of patients receiving MAT in primary care from 18 to 97

Total Health Care *(Baltimore, Maryland)*

24% of patients receiving MAT attended all required scheduled visits (up from 2% at baseline)

El Rio Community Health Center *(Tucson, Arizona)*

94% of patients seen in the pain clinic completed the Adverse Childhood Events (ACE) screening (up from 88% at baseline)

Community Health Center of Pinellas *(Clearwater, Florida)*

99% of staff trained on identifying opioid overdose and administering life-saving Narcan (up from 0% at baseline)

Learning Community

A LEARNING COMMUNITY is built on an evidence-based model of systems change. Under NACHC leadership, all health centers engaged in *Innovative Approaches* actively participated in a learning community to facilitate standardized learning, peer sharing, resource acquisition, team development, data collection, reporting, and time management—all thoughtfully orchestrated to nurture successful health center projects. The learning community was activated mainly through virtual means such as monthly webinars and conference calls, and an online collaborative space. The learning community was enhanced with an in-person gathering, or Harvest Meeting, at the end of each funding year where all participating health centers presented their work as a storyboard poster display and engaged in group discussions.

NACHC engaged expert faculty for the *Innovative Approaches* learning community on subjects of interest, including OUD*, MAT, motivational interviewing*, peer recovery, trauma-informed care*, care team wellness, and pain management. NACHC staff and experts also served as coaches to help each project team innovate and clear hurdles over the course of the funding year. Perhaps most importantly, the learning community provided teams with emotional support, as caring for vulnerable patients with OUD and their families can be stressful and impact care team wellness.

LEARNING COMMUNITY OFFERINGS:

- Virtual Orientation Meeting
- Virtual Launch Meeting
- Virtual All-teams Meetings
- Group Presentations
- Learning Sessions with National Experts
- Coaching
- Monthly Data Reporting
- Face to Face Harvest Meeting

“It’s always so helpful to be in a room with other peers to get a perspective. Thank you so much for all of these transformational opportunities.”

Harmony Health Medical Clinic and Family Resource Center

case study
1

> It organically became this pharmacist-led approach, and it has worked wonderfully with the pharmacist's leadership.
>
> **Celia Vega-Herrera, MPH**
> *Project Manager*

AltaMed Health Services Corporation

Los Angeles, CA

AltaMed Health Services Corporation (AltaMed) is one of the largest independent health centers in the United States, providing over one million annual patient visits through 40 sites in Los Angeles and Orange Counties, California. These sites offer wrap-around services to entire families across the lifespan. ***AltaMed developed the Centralized Opioid Management and Behavioral Approaches to Treatment (COMBAT)*** *team to bring their medical, behavioral health, pharmacy, and healthy equity departments together to identify patients at risk for opioid use disorder (OUD), and develop better prescribing practices. The COMBAT team developed a pharmacy-based Chronic Pain Management Program (CPMP) for medication-assisted therapy (MAT), with non-opioid alternatives and counseling.*

Pharmacy Led Chronic Pain Management

ALTAMED HEALTH SERVICES CORPORATION (AltaMed) has been a leader in health care access for residents of Los Angeles for more than 50 years. Initially a small free clinic, it is now one of the largest health centers in the nation, serving more than 300,000 low-income Latino and multicultural clients in 40 sites throughout Southern California. Innovation is welcomed at AltaMed and is responsible for sustained improvements that include elder care programs, social services, nutrition support, health classes, and comprehensive medical, dental, and behavioral health services. AltaMed's pharmacy program places bilingual pharmacy staff in most of its clinic sites, including a mobile unit. These on-site pharmacies make **SAFE, AFFORDABLE, and TIMELY** prescriptions accessible for the health center's most at-risk patients.

AltaMed wanted to use the CVS Health Foundation grant to optimize care to a subset of its patients who still experienced limited access to services they needed most—its chronic pain patients. The Centralized Opioid Management and Behavioral Approaches to Treatment Advisory Board (COMBAT) was created to identify and support chronic pain patients and those with opioid use disorder (OUD). The advisory board, composed of leaders from many disciplines across the organization, realized that with an organization of its size, a centralized approach would have the most impact. At the center of all chronic pain care there were not only a multitude of health care providers, but also, in AltaMed's case, a much smaller number of pharmacists. Centralization could happen most effectively through pharmacist leadership.

The COMBAT team championed the hiring of a bilingual clinical pharmacist who would exclusively work on opioid management and its accompanying conditions, such as anxiety, depression, and diabetes. They found just the right person in Angela Villasenor, PharmD. She had extensive experience with patients who struggled with opioids as well as other substances, knew the community well, and had natural leadership skills. She started by creating an internal pain clinic that was pharmacy-led. It involved identifying eligible patients, enrolling of those patients into the pain clinic, training primary care providers, adjusting the electronic health record, and using standard protocols to monitor opioid use as and treat with medication-assisted therapy (MAT).

Angela's role bridged care between providers and patients. She used motivational interviewing techniques with both groups, helping them uncover root causes of chronic pain, unaddressed barriers to care, and resources available to provide safe, culturally acceptable, non-addictive relief. Patients saw the pharmacy team as advocates, not opponents, when their larger needs were recognized. For example, one woman in chronic pain struggled with a broken wheelchair. The pharmacy team talked to her insurance carrier and helped her quickly get coverage for a new chair—one that had a cushion, an extra piece she really wanted. Through recognizing the woman's deeper need and acting on it rather than referring her elsewhere for help, the pharmacy staff reduced the woman's stress, helped lower her pain triggers, and increased her trust in their commitment to her well-being.

As the pharmacists worked more specifically with chronic pain patients, they were able to help clinic providers tailor medicines for not just pain, but also arthritis, migraines, diabetic neuropathy, depression, insomnia, and anxiety. All of these interrelated diseases needed to be recognized in order to taper patients off addictive medications and optimize safe prescribing practices. Angela notes, "We're teaching providers how to have these conversations with a patient, how to see that meds are not the only option, and to see the patient as a whole person so they can address the body's pain response." Prescribing practices also covered the use of naloxone and MAT, with providers given opportunities to become waivered providers eligible to prescribe MAT. Pharmacy efforts challenged stigma in the treatment of OUD patients and privileged holistic care.

AltaMed's COMBAT approach has established the pharmacy as an integrated, essential leader in reducing and treating OUD. The pharmacy is involved in all aspects of care, much of which may seem outside of a pharmacy's typical scope. This includes patient scheduling, care coordination, clinical continuity, congruent treatment plans, health education, motivational interviewing, chart reviews, and eligibility assistance. Pharmacy interns help round out this approach, calling to check on patients, discussing a change in medication with another pharmacy, and advocating with insurance carriers. Such an approach requires dedicated time —not just for Angela, but for all pharmacy staff involved in this care. Approximately three hours per week are spent with each chronic pain patient as pharmacy staff act as case managers. Care is tapered as the patient improves. While this time commitment reduces provider pressures and increases patient safety, it also requires support from senior management at the organization.

Case Study *AltaMed Health Services Corporation*

Next steps for AltaMed include expanding provider training in alternative pain therapies, increasing waivered providers to oversee MAT, identifying the social determinants of health in chronic pain patients, and continuing to use the pharmacy as a surveillance system for diversion and prescription control. Community health workers will be added to facilitate care management. Partnerships with other area pharmacies used by patients are being strengthened and community resources broadened. Safety, trust, and quality of care will continue to be central to the mission of the AltaMed pharmacy as they work to "COMBAT" the opioid epidemic.

> We're teaching providers how to have these conversations with a patient, how to see that meds are not the *only* option.

Innovations & Interventions

- Established the Centralized Opioid Management and Behavioral Approaches to Treatment (COMBAT) Advisory Board
- Developed naloxone prescribing protocols and procedures, new opioid management workflows, and pain referral protocols; trained MDs and DOs
- Developed the COMBAT-inspired Chronic Pain Management Program (CPMP), led by a clinical pharmacist and physician champion
- Onboarded 5 MPH students and a pharmacy intern to support CPMP with patient follow-up, assess barriers to MAT and staff perceptions of OUD, and learn the social determinants of health for OUD patients
- Started MAT services and increased number of DATA-waivered providers from 0 to 5
- Developed a protocol for identifying CPMP patients
- Educated providers in cultural competency, better prescribing practices, and considering non-narcotic alternatives to pain (future training programs are in development)

case study
2

> **Families have to understand that just having the conversation is the first step.**
>
> **France Belizaire, MSW**
> *Behavioral Health Program Manager*

Brockton Neighborhood Health Center

Brockton, MA

Brockton Neighborhood Health Center (Brockton) started as a mobile medical van operating out of a church parking lot in Brockton, Massachusetts. It is now a large, multi-cultural center offering comprehensive services from primary, urgent, and obstetric care; to behavioral health, social services, and substance use disorder (SUD) treatment; to nutrition counseling and specialty care. Brockton has an on-site lab and a pharmacy with services for low-income patients. To address locally growing SUD problems, ***the center started "Brockton Cares" to reach beyond the clinic walls*** *and educate children and their families about substance use and how to prevent it.*

Preventing Youth Addiction Through Outreach

IT LOOKS LIKE A TYPICAL TEEN'S BEDROOM. The bed is messy, the laptop is open, there are empty glasses on the bedside table, a laundry basket holds some smelly socks, and a clothes drawer is full of candy. But this bedroom is set up in a school, and parents are filling the room searching for drugs. Most come up empty handed. They don't see the pills that have been hidden inside the Tootsie Roll candy, the alcohol in the gummy bears, the wastebasket with debris from a recent inhalation, the ping pong balls used for beer pong, or the belt with bite marks on it after being used as a tourniquet. The exhibit is part of a national project called "Hidden in Plain Sight," and it is just one of the many innovative ways that Brockton Neighborhood Health Center (Brockton) is working to prevent youth addiction in their Massachusetts community.

Brockton staff knew that drug abuse was a problem in this diverse city of just under 100,000 people. However, they had difficulty identifying risk factors for substance abuse as they screened adults and adolescents. Despite their efforts to uncover warning signs of addiction in those who came in for health care, few of their teen patients showed early signs of risky behaviors. The multicultural and low-income setting of Brockton challenged their efforts, as it required not just an understanding of stereotypical American teenagers, but also of those from Cape Verde, Haiti, Brazil, Ecuador, and other cultural backgrounds.

With their CVS Health Foundation grant, Brockton leaders were able to initiate the "Brockton Cares" campaign, aimed at engaging youth, parents, and the community to identify and address early signs of substance use in collaboration with health center efforts both inside and outside the walls of the clinic. "Brockton Cares" was comprised of three strategic efforts: an evidence-based screening tool used inside the clinic, known as CRAFFT*; parent and community outreach through the use of the "Hidden in Plain Sight" exhibit; and partnership with multicultural youth from Brockton's United Voices Youth Group (UV), who served as peer leaders. Input from staff, patients, parents, and community members shaped and reshaped their work as they endeavored to hone screening standards, community awareness, and cultural proficiency substance abuse among youth.

The CRAFFT tool examines youth behaviors when in a car, relaxing, and alone. It also asks if they have ever forgotten events associated with substance use, if family and friends have indicated they have a problem with substance use or if they have gotten in trouble because of substance use, (Car, Relax, Alone, Forget, Friends, Trouble). Initial use of the tool at Brockton yielded few positive results. Examination of workflow and electronic health record input identified system problems, such as patient confidentiality concerns, interpretation of terms and health literacy, timing of the screening tool, and provider use of the tool. Brockton leaders were able to train all providers to use the tool, incorporate it into the electronic health record, and optimize the screening process with adolescents. The CRAFFT tool is now a reliable part of the substance use identification and prevention program at Brockton and is used with all patients aged 11-18 years.

Brockton Cares leaders developed a mobile "Hidden in Plain Sight" model bedroom and exhibited it throughout the community. Schools, community centers, and parent groups were able to tour the bedroom and look for hidden signs of substance use. Through their presentations, staff also helped parents learn how to talk with their children about drug use and prevention techniques. As Behavioral Health Program Manager France Belizaire, MSW, LICSW, stated, "Families have to understand that just having the conversation is the first step." Adolescence is already a fraught time in many households, with difficult communication patterns between parents and their children. As parents saw evidence of substance abuse in the exhibit, they learned how changes in technology, peer culture, and popularity of certain substances have affected the world of their youth. They left the exhibit with new methods to monitor and to communicate with their adolescent children.

Brockton's United Voices Youth Group (UV) is composed of students aged 10-14 years who are learning to serve as peer leaders in their culturally distinct home environments. Over the past 10 years, this group has partnered in various ways with Brockton inside the clinic—learning how to talk about sexual health, self-esteem, and future planning. With the third arm of the Brockton Cares initiative, Brockton partnered with UV members in the community setting, equipping them with prevention education as well as methods to engage their peers in harm reduction. Using an opioid abuse prevention curriculum developed by another community partner, the Brockton Prevention Coalition, Brockton trained approximately 15 UV members on the dangers of substance use and the ways to avoid it. The youth also received training in motivational interviewing techniques so that they could better persuade their peers to consider the issue of prevention. The UV members noted that there is a lack of knowledge about the dangers of these substances, and that youth they know don't believe addiction will result from occasional use of illicit substances. As a result of the Brockton Cares initiative, UV members were able to present their own projects on prevention to the community and to hold a panel for parents to learn how to better engage their children on this topic.

What's next for Brockton? The health center now has plans to increase on-site case managers and therapists to care for at-risk and substance use disorder patients, and providers have regular training updates and improved methods to counsel their patients. Brockton will place ongoing emphasis on incorporating youth voices so that efforts are examined through the eyes of the patients. Better tracking, continuity of care, and team management will assist a comprehensive approach to addiction prevention both in health care settings and in the community.

Innovations & Interventions

- Created the "Brockton Cares" project to teach young people to identify and address early warning signs of substance use
- Improved the CRAFFT screening process by:
  - Building CRAFFT into the electronic health record
  - Revising CRAFFT workflow and policy
  - Building a CRAFFT training module on the health center's intranet platform and ensuring all pediatric providers were trained
- Added capacity in the health center's internal social services request system for pediatricians to request a Behavioral Health Clinician
- Built a traveling "Hidden in Plain Sight" exhibit to show an average teenager's room that has hidden signs of drug use, sparking conversations with parents and encouraging them to talk with their children about substances
- Educated United Voices Youth Group members on prevention methods and different kinds of substances using the Brockton Area Prevention Collaborative curriculum
- Worked with United Voices Youth Group to present youth-made prevention projects and hold a panel for parents to discuss how to start a conversation about substance use and build an environment of trust

case study
3

> **The same reasons that we learn CPR, are the reasons you may want to have Narcan in your home.**
>
> **Nichelle Threadgill, MD**
> *Medical Director*

Community Health Center of Pinellas

Clearwater, FL

Community Health Centers of Pinellas, Inc. (Pinellas) offers family and pediatric medicine, obstetrics and gynecology, dental, and substance use disorder (SUD) services in 12 clinics throughout Pinellas County, Florida. Pinellas County's overdose death rate has been increasing steadily. Pinellas ***embraces a holistic approach to managing this crisis,*** *and the staff now works seamlessly with a wide range of local partners to combine resources for a broader reach.*

Removing Stigma With Integrated Care and Naloxone

WE TEACH NEW PARENTS HOW TO RESCUE A CHOKING BABY. We examine their car seats to make sure they are properly fitted. While the vast majority of new parents won't ever have to rely on the Heimlich maneuver or a car seat to save their baby's life, we consider it good care to help everyone plan for such an emergency. In the same way, the Community Health Center of Pinellas (Pinellas) recognizes the role of providing access to naloxone, as well as training in its use, to the families served in their Florida county.

With over 55,000 patients and 12 clinic sites, Pinellas cares for low-income and underserved residents of Pinellas County. In 2016, Pinellas County had the highest rate of opioid-related deaths in Florida. As a comprehensive health center, most patients come to Pinellas to access primary medical, dental, or behavioral health services. Though substance use disorder (SUD) had been identified as a growing problem in the community, Pinellas staff were not sure how to best address it in their patients while also providing comprehensive primary care. The CVS Health Foundation grant allowed them to better understand their community needs, their health practices, and their resources. Naloxone provision through a team-based approach became a central aspect of their efforts to reduce and treat SUD.

Opioids slow your rate of breathing, lower your blood pressure, and sedate your brain. With overdoses, these effects become life-threatening. Naloxone*, commonly known by the trade name Narcan, quickly reverses these dangerous effects by preventing the opioids from attaching to the body's internal receptors for the drug. For many years, naloxone has been given as an injection in hospital settings to emergently treat these adverse drug effects. It has recently been made available in some communities to law enforcement, educators, shelter workers, and even the general public in an attempt to revive people as quickly as possible when an overdose is suspected.

There is some controversy about making naloxone available to the general public. Pinellas wondered if it would just serve to make people less fearful of opioid addiction, knowing they could reverse an overdose so easily. Would it just be a bandage over a deeper wound, keeping the source of the problem out of sight? Using grant funds, Pinellas was able to consult with a local expert in SUD care about these questions and its approach to SUD in organizational practices and protocols. Staff learned about trauma-informed care and the importance of an open, non-judgmental attitude as they earned the trust of patients with addiction histories. Staff saw that offering naloxone had the potential of being something that could open, rather than cover up, the channels of communication between health care providers, their patients, and their community.

Integrating SUD care with all of Pinellas' other services required a new approach to patient visits. All staff were trained in the general problems of SUD and the use of naloxone as a preventive tool to reduce overdose deaths. Emphasis was placed on the importance of reducing stigma surrounding SUD, and practice protocols were adjusted to incorporate screening patients seen at all service points—dental, medical, eligibility services, behavioral health, podiatry, or any other patient service. Information became easy to share across departments, and referrals streamlined. A new Integrated Care Manager was hired to specifically address the needs of OUD and SUD patients. "Warm hand-offs," the practice of taking a patient from one provider to another without interruption, allowed interventions to begin immediately after the patient was seen for primary care services.

High-risk patients were screened by clinical staff and offered naloxone. Staff also distributed information to family members on the availability of naloxone, and care teams trained clients in its use. Staff found that just bringing up the availability of naloxone initiated discussions about pain control, alternative treatments and adjustments of opioid prescriptions. Naloxone conversations normalized the topic of addiction and integrated it holistically into the comprehensive services offered by the center. With a SUD care manager on-site, referrals for SUD treatment became more secure, timely, and acceptable to the patient population.

Staff and patients feel the quality of care in the effort to prevent and reduce opioid deaths is much improved due to the CVS Health Foundation grant. Clinicians are better equipped to manage more complex SUD clients, and collaborations with community resources have been strengthened. Providing naloxone, adopting a culture of openness and acceptance, and having an integrated care team that can coordinate and collaborate to reach every patient in need is certain to positively impact the statistics in Pinellas County. Gloria Galston, the Integrated Care Manager, says it well:

Case Study *Community Health Center of Pinellas*

> **When our patients feel safe, they feel like they *can be* successful and sustain this. They know they can continue to see us.**

Innovations & Interventions

- Hired a substance abuse and rehabilitation specialist to review Pinellas' protocols and procedures
- Hired a new Integrated Care Manager specifically for opioid abuse and prevention
- Utilized the SBIRT* screening tool with enhanced CAGE-AID* screening and trained team members to use screening results for more integrated and holistic care
- Incorporated naloxone training for all clinical staff and new hires into daily clinical practices for high-risk patients and made naloxone available to any patient who requests it
- Trained all providers in "Controlled Substance Prescribing" through Florida's Medical Association
- Expanded non-narcotic pain therapy to include chiropractic care
- Revised clinical workflows for substance abuse services
- Fine-tuned referrals to vital substance abuse services for patients through warm hand-offs by the Integrated Care Manager
- Trained all staff to reinforce an affirmative and inclusive environment

case study
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Case Study *Harmony Health Medical Clinic and Family Resource Center*

> **Our choice was to either embrace it or fight it, and we chose to embrace it.**
>
> **Rachel Farrell, PA-C, LM/CPM**
> *Chief Executive Officer*

Harmony Health Medical Clinic and Family Resource Center

Marysville, CA

Harmony Health Medical Clinic and Family Resource Center (Harmony Health) is a Patient Centered Medical Home in Yuba County, California. The health center provides a holistic approach to care at three full-service medical clinics for families. For patients with opioid use disorder (OUD) or substance use disorder (SUD), Harmony Health has built a program that offers integrated behavioral health services, care management, 24-hour access to the care team medication-assisted treatment (MAT), substance abuse support groups and pain management that ***includes cognitive behavioral therapy, bio/neuro feedback, acupuncture, chiropractic care, and meditation classes.***

Going All In

CYCLES. We use that term to describe things that signify a never-ending circle, a motion that may have a beginning, but whose end is followed by another rotation in the same direction. Sometimes, our ideas about cycles indicate a sense of despair in their seemingly endless power to spin us in the wrong direction. Cycles of poverty and addiction are two such images.

Harmony Health Medical Clinic and Family Resource Center (Harmony Health) puts the brakes on those cycles. Instead, the health center promotes a wellness life cycle, from its family-centered birth center, to its youth explorations program, to its medical and behavioral health care services for underserved community members of all ages. Located in Yuba County, California, the health center was started with the idea that prevention and a focus on holistic care would result in harmony at the individual, family, and community level.

The opioid crisis challenged that idea of harmony, however. The crisis not only spread to Yuba County, it set up shop right in the midst of the center. Leadership became aware that a provider recently hired from the surrounding area was overprescribing opioids to his patients, some of whom followed him to Harmony Health. By the time the provider was confronted, staff realized that the opioid crisis was something they would need to either face head-on or ignore and hope that other organizations would respond to the growing need.

Harmony Health chose to face the crisis with all the resources it could muster. Being transparent in its own unwitting contribution to the epidemic was the first step. Next, all providers were trained in prescribing practices that would safeguard against dependence and overuse. The CVS Health Foundation grant allowed Harmony to develop the infrastructure to develop a comprehensive substance use disorder (SUD) program. A psychiatric nurse practitioner was hired as Harmony's first Addiction Specialist, teaching the care team to meet patients where they are as a first step in intervention. A care manager also became a part of the care team.

Through the Addiction Specialist, staff learned to approach SUD as a primary care and public health issue. They learned about the pace of treatment and recovery, and the importance of celebrating small steps rather than expecting full recovery to be imminent. For example, if a patient stopped using a substance on a daily basis, but now used about three days a week, staff learned to celebrate that change while also motivating the patient to continue toward full recovery. Trauma-informed care techniques helped staff work with patients as individuals, uncovering the complexities in their stories to develop strategies tailored to their individual needs. Harmony Health included all staff in this approach, from the front desk receptionists to the back office clerks.

By bringing SUD out into the open at Harmony Health, staff realized that not only was there a diverse array of patients in need of care, but there was also a diverse array of therapeutic options they could pursue. Medication-assisted treatment (MAT) was certainly a mainstay, but what about needs for pain control and lifestyle change? Staff investigated the use of several alternative treatments and developed new offerings for their patients both on- and off-site.

Alternative treatments now available at the health center include meditation groups, anger management classes, chiropractic care, and neurofeedback. Even the staff enjoy trying the neurofeedback machine, recognizing its power in real-time adjustments to stress and emotions through regulating breathing and heart rate. The CEO notes that the biofeedback machine is an example of making an investment in the future health of the community, even if it didn't initially look like a financially beneficial decision. *Going all in* means that Harmony Health pursues care modalities that will make a big impact, knowing that reducing the rate of SUD will in the long run save lives as well as health resources.

Acupuncture, physical therapy, and counseling are also available to patients. Every patient gets individualized care management, assisting them so they keep trying resources until they find what helps them the most. Clinicians report that the diversity in options results in a more positive response from their patients as they become willing to try something new. For some, chiropractic care is just what they need to feel well. For others, that therapy hasn't worked, but acupuncture relieves their chronic pain. The message the patients hear is that there are many ways that the health center can work with them to promote healing—they are in a cycle of care.

Every staff member at Harmony Health has been part of the response to the opioid crisis. All understand the importance of MAT, the ideas behind trauma-informed care, and the importance of recognizing implicit or unconscious bias*. Harmony relies on true collaboration and care coordination to manage patients with chronic pain, other chronic diseases, and potential SUD. They have made transparency in prescribing practices a core component of their program.

> **No one, including the patient, is part of the problem. *All are part of the solution.***

Innovations & Interventions

- Trained care teams in techniques to bolster SUD care, including trauma-informed care and implicit bias (future training will cover adverse childhood experiences (ACEs)
- Increased number of DATA-waivered providers from 5 to 9
- Developed workflows and policies for MAT patients, including a warm hand-off to a case manager for screening and referrals
- Offered SUD patients education and resources to become self-directed
- Provided more non-narcotic pain management/treatment modalities, including acupuncture, chiropractic care, neurofeedback, support groups, and meditation
- Hired specialty providers to treat pain with non-narcotic treatments
- Refined data collection processes and programs, including care plans
- Enhanced partnerships with local hospitals and the county mental health department

case study
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> They are not coming, "to treatment', they are coming for the atmosphere…we make the MAT patient special.
>
> **Dominique McDowell, BS RLPS-SUDCCII**
> *MAT Program Director*

Marin City Health and Wellness Center

Marin City, CA

Marin City Health and Wellness Center (Marin City) provides innovative health care for all, with the goal of African American health equity. The population the center serves includes people with poor health outcomes, the under-employed, residents of public housing, and the homeless throughout Marin City, Southern Marin County, and Bayview-Hunters Point in San Francisco, California. With the epidemic of substance abuse affecting many in its community, Marin City has created a ***culture of dignity around medication-assisted treatment (MAT)*** *within a comprehensive "whole person" medical-care program.*

A Whole Person Approach to MAT Patients

HEALTH EQUITY IS SOMETIMES A CATCH PHRASE. For the nation's Health Resources and Services Administration (HRSA) funded health centers, it is central to their mission. That is certainly true with Marin City Health and Wellness Center (Marin City), which named health equity for its African American community as a core value. But the center has changed the landscape on health equity with its CVS Health Foundation grant. Health equity has come to those in addiction treatment, a reality that many are experiencing for the first time.

Medication-assisted treatment (MAT) was well established at Marin City, thanks to support the center received in 2016. Counselors were in place, groups were meeting, and clinicians were trained in MAT care. But MAT Program Director Dominique McDowell, BS RLPS-SUDCCII, saw the need for a more holistic approach. What would success look like in the health center's MAT program? For Dominique, it would be that MAT clients received the same level of dignified comprehensive care as any other patient served by the health center. Compliance with MAT couldn't be the only measure of success noted.

Partnering in innovation, Marin City expanded the scope of its MAT services so that care management included ensuring patients had access to all needed dental, medical, behavioral, and social services. As a health center that serves public housing and homeless clients, Marin City knew that regular preventive care was often delayed while more urgent needs of food, shelter, and employment were pursued. Frequent address changes made eligibility for services more complicated. Transportation could be difficult for patients. For those in addiction treatment, they were sometimes juggling parole requirements, family reunifications, housing applications, and clinic appointments. When they came to their MAT appointments, did staff see them as "addicts" or as community members with health care equity needs?

Dominique trained every staff member in the biases and realities associated with addiction care. Patients feel welcomed and a part of Marin City's mission, with many noting they had lost family through addiction but now see staff treat them like family. Care management is personalized to each patient, avoiding stereotyping all MAT clients as "addicts" or drug-seekers. Dominique refers to these patients as "help-seekers"—they have a future with promise rather than a past with a problem.

As workflow changes were made to screen for patients' comprehensive needs, MAT clients were also empowered by learning ways to take charge of their own health. Nutrition classes, stress management techniques, and relationships with staff and other MAT patients strengthen self-efficacy. One patient remarks, "They give us tools so we can go into our lives and be productive without necessarily needing to go to the clinic." Transportation to job interviews, arrangement of dental appointments, and assistance with chiropractic pain management techniques are integrated into treatment plans.

By incorporating holistic care into MAT services, stigma is turned on its head. Patients feel valued for who they are, and they often seek ways to give back. One older man notes that his time in group sessions allows him to be the parent he never was, as he can support younger members and provide stability. Marin City offers multiple connections to build trust and integrate patients who are used to repeated failures and broken relationships back into a community setting. This idea is echoed by Quincy, a patient featured on the health center's website as a "face of an opioid user." Quincy states, "It's been such a long journey of failure. At Marin City I finally found a place where I can go back to school, have a relationship with my family, get any medical care I need, and not have the stigma I used to walk around with. Without this, there is a good chance I would have overdosed and died."

Part of advocacy in this holistic approach is the use of patient stories on Marin City's website. In addition to Quincy, who is a young Caucasian male, there are profiles of women and men of varying ethnicities and ages. No two stories are the same, a point Dominique emphasizes. The videos are striking as they show some of the group sessions attended by MAT patients. It's uncommon to see such a varied looking group gathered around a table, obviously enjoying each other and engaged in conversation. There is a real feeling of affection and support. Separately, one person shared that the program gave her new tools and allowed her to be comfortable enough to share why she turned to opioids as an antidote for anxiety and depression. "I found a place where I could speak my mind and have people give me honest responses," she said.

Group sessions are common across MAT programs. But relying on a web of support, whether from a dental hygienist, a nutritionist, or a front desk receptionist, is more uncommon. Everyone is invited to play a part in not just recovery, but renewal. Those cared for by Marin City look to an ever-growing inclusion in community, not as users, but as individuals with their own life stories to share.

Not everyone needs the same thing, but all need dignity, respect, and health equity.

Case Study *Marin City Health and Wellness Center*

> They give us tools so we can go into our lives and be productive *without* necessarily needing to go to the clinic.

Innovations & Interventions

- Added annual screening, brief intervention, and referral to treatment (SBIRT) for patients 18 and older to the electronic health record and built SBIRT into a dashboard to notify providers when MAT patients are due for screening
- Adjusted workflows for new MAT patients to screen for additional service needs, such as dental or behavioral health consults
- Hosts dental presentations for MAT patients on hygiene and to schedule assessments and cleanings
- Hosts regular health education seminars for MAT patients about healthy eating, lifestyle changes, and behavioral health topics that can positively impact recovery
- Developing a dashboard with custom reporting to capture preventative measures (e.g., diabetes, blood pressure) for MAT patients

case study
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> It's the many empathetic conversations over time that make a meaningful difference in people's recovery from addiction.
>
> **Erick Kauffman, MD, MPH**
> *Chief Medical Officer*

Neighborhood Family Practice

Cleveland, OH

Neighborhood Family Practice (NFP) originally filled a health-services gap in Cleveland's Cuyahoga County. It now provides primary care, behavioral health, dentistry, and midwifery at five locations, meeting the needs of 12 neighborhoods. In 2017, Cuyahoga County had a record number of drug overdose deaths, and it recorded some of the highest drug-related emergency room visits in Cleveland. ***NFP knew there was room to reinforce its behavioral health infrastructure for substance use disorder (SUD)****, especially for adolescents and Hispanic community members, so the staff has worked hard to build and strengthen these services.*

Changing Health Care Communication

NEIGHBORHOOD FAMILY PRACTICE (NFP) is situated in one of the epicenters of the opioid crisis—Cleveland, Ohio. In 2017, more than 30% of the emergency department visits in NFP's catchment area were substance use related. That statistic was accompanied by a record number of deaths due to overdose. As devastating as those statistics are, staff at NFP knew there were multiple troubling factors behind those figures. The factors leading to the use of opioids and illicit substances needed to be addressed.

The seeds of a substance use disorder (SUD) could be found not just in the community's stressed adults, but in the youth as well. Cleveland schools reported that 65% of adolescent Hispanic girls were showing signs and symptoms of depression. NFP cared for a large Hispanic population, and staff knew that they had to identify and treat these symptoms of distress as they were alarming risk factors for SUD and overdoses. Though the staff had experience screening and treating adults for depression, they had less expertise identifying and treating adolescents with mental health problems.

In its first year of receiving a grant from the CVS Health Foundation, NFP focused on care processes for adolescents at risk of anxiety, depression and substance use. The grant was used to expand staff, including adding a contractual child psychiatrist and additional bilingual therapists. The psychiatrist helped train all staff, from medical assistants to providers, in the use of the PHQ-A*, a standardized screening tool adapted for adolescents. Workflows were developed by implementing the PHQ-A at one NFP site, piloting it, and ensuring it operated smoothly before spreading it to other sites.

Recognizing the limitation of resources in child psychiatry, NFP developed an algorithm to help providers understand when a psychiatrist was needed as opposed to a primary care practitioner. All providers were trained in medication and therapy options for adolescents. Resources were also developed for the patients' Spanish speaking parents. This targeted approach to using resources thoughtfully allowed all staff to work to their limit of license while increasing NFP's capacity to recognize and treat mental health problems in youth before they developed a dependence on illicit substances as a coping method for their difficulties.

NFP received funding again in the second year of the CVS Health Foundation-NACHC partnership. With a staff that now was versed in using both the SBIRT screen and the PHQ-A, NFP wanted to make sure screening was followed with robust patient-centered care. The staff desired to make an impact in curbing the epidemic of SUD by individually recognizing the strengths and challenges faced by each patient they screened. Motivational interviewing (MI) was the technique they embraced to help them achieve their new goal.

Providers are typically accustomed to asking patients a series of yes or no questions from a list of concerns. Any problem with your vision? With your appetite? These are time-efficient ways to quickly gain information and stay in control of the interview. As appointment times get shorter and shorter, providers need to rapidly assess and diagnose their patients. Open-ended questions invite potential chaos in daily scheduling.

But patient responses to scripted questions may not yield helpful information for providers. The heart of the patient's struggles may not come to light. Or, they may choose not to answer truthfully because that would take more time, more emotion, and more explanation. MI counters these issues and still preserves the need for time-efficient patient care. It is something that can be used by all staff, not just providers, and it places the power in the patient's hands, shifting authority for change to the patients themselves.

The technique of MI is fairly simple. Using the acronym OARS, it asks open-ended questions, affirms strengths noted in the patient, reflects back on the patient's statements as an act of close listening, and summarizes what the patient has communicated about their capacity to change. MI quickly identifies how the patient feels about their ability to make a healthy change, the barriers to that change, and the actual steps needed for change to occur. Readiness for change is then understood by both patient and provider.

For example, a provider might ask a patient with SUD what challenges the patient faced during the week rather than ask if the patient felt more or less stressed than the week before. As the patient recalls the challenges, the provider can ask how that affected the patient's ability to stay in treatment, seek treatment, etc. Problem solving can then be focused on the specific need of the patient in that moment. What options does the patient have? This sort of question then opens up the possibilities for recovery even further. The provider can still share resources, but has a better sense of the patient's readiness for them.

MI can also be used to ask a patient about their degree of self-confidence to make the next change, as well as ask how important that change is, given everything else the patient is dealing with concurrently. Exploring the answers to those questions helps providers know how much support their patients need. Sometimes, they just aren't ready for the change that providers are trained to emphasize.

NFP chose to make MI a cornerstone of care and invested in a professional trainer for all staff. With leadership support and significant cross-divisional planning, the health center hosted a series of two-hour trainings every two months, which allowed staff to practice and reflect upon this method as they continually learned how to adapt their care. Videotapes of MI sessions not only gave helpful feedback to existing staff, but will also allow NFP to train future staff in this resource.

By anecdotal account, staff and patient confidence blossomed as MI became part of NFP's culture. Whether in phone calls, exam rooms, referral arrangements, or dental visits, MI is helping staff collaborate with patients in open, honest communication that is received as non-judgmental and supportive. NFP care teams are incorporating MI into their other primary and long-term care practices. Provider visits still last 20 minutes, but they yield a wealth of information that optimizes possibilities for health. Through this change in practice, NFP hopes to affect long-term change in Cleveland's statistics, reducing overdose deaths by understanding and impacting the root causes of SUD every single time a patient comes for care.

Through this change in practice, NFP hopes to affect *long-term* change...

Innovations & Interventions

- Developed workflows for MAT, PHQ-A and drug screening across the agency
- Provided treatment teams specialized training in PHQ-A and depression
- Trained all staff in MAT, SUD, and OUD
- Increased the number of DATA waivered providers from 1 to 12
- Coordinated organizational resources to launch a series of MI training sessions, including MI team leaders, human resources, marketing and communications, an external consultant, and permission to utilize all-staff meetings to host training sessions
- Established interdisciplinary care team collaboration goals as part of trainings
- Partnered with Cleveland Clinic to provide a seamless transition of care for patients being treated for SUD

case study
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PCC Community Wellness Center

Oak Park, IL

PCC Community Wellness Center (PCC) operates clinics in 11 locations throughout West Side Chicago and nearby suburbs. Anchored by family medicine, PCC serves all stages of life. For patients with substance use disorder (SUD), including opioid use disorder (OUD), PCC provides services in its Chemical Dependency Clinic (CDC) co-located in a local hospital. There, the staff offers whole-patient care, including counseling and medication-assisted treatment (MAT) to help reverse addiction, and ***they offer the uniquely helpful touch of a Peer Recovery Support Specialist.***

> **Talking with a living example of recovery is extremely powerful.**
>
> **Joanna Trask, LPC, CADC**
> *Chemical Dependency Clinic Team Lead*

Peer Recovery Support Specialists

IF YOU TAKE A TOUR of West Chicago's PCC Community Wellness Center's (PCC) clinic sites, you will be surrounded by experts. From certified nurse midwives assisting new parents in the birthing center, to medication-assisted treatment-waivered (MAT) providers available for patients with substance use disorders (SUD), to licensed counselors offering group classes in emotional health, PCC provides comprehensive, holistic primary care to those needing services in their community. No stranger to the epidemic of opioid addiction, PCC has its own Chemical Dependency Clinic (CDC), tailored mental health services for those with dual diagnoses of SUD and mental illness, and a high-risk chemical dependency program for pregnant women. Acupuncture and yoga are integrated into treatments for patients with chronic pain or drug dependencies.

Most would see what PCC has to offer and view it as a full response to the needs of anyone with SUD: care coordination staff who do outreach as well as enroll patients into care, a 1:1 medical provider to substance use behavioral specialist ratio, a fully-staffed CDC located within the local hospital and multiple group offerings tailored for a variety of needs. However, as PCC examined what they could do with the CVS Health Foundation grant, the staff realized another type of expert was needed for their SUD patients to realize the long-term goal of full integration back into the community. PCC employed experts in medical treatment, experts in counseling and experts in care coordination. Experts in recovery were missing.

An expert in recovery is, most accurately, one who has successfully recovered. Knowing that someone who was in a healthy state of recovery could conceivably be a coach to those in all phases of their SUD care, as well as a resource to those providing the treatment, PCC had to determine how best to find and collaborate with these potential peer supporters. Would they be volunteers? What specific responsibility would they have? What were the limitations of confidentiality and privacy if such a person were involved at any stage of patient care? Where would they be most useful?

After consideration of all these issues, PCC decided to design the role of a peer supporter as one of a fully integrated staff member, developing a new paid position known as a Peer Recovery Support Specialist (Peer). This was not a decision made lightly. Hiring policies had to be changed to make room for employing someone who had a criminal history. Most of those in recovery have faced charges related to illicit substance use and associated activities such as stealing. Consideration of staff safety and workplace culture had to be balanced with consideration of the impact of peer support on patient recovery. Risk management experts had to review issues associated with home visits and the availability of naloxone outside the clinic.

Leadership commitment to recovery underscored these personnel decisions. Hiring two Peers, PCC embedded peer support into multiple phases of care while also specifically targeting vulnerable periods in patient recovery. Patients were more likely to drop out of treatment at the induction phase and at the 30-day mark. The Peers became involved with all patients at these two critical times. They also developed home visits, emergency department rounds, and group session care.

The Peers know that when a patient is in the emergency department with a substance related incident, they are at a significant point in their lives. Some may already be in SUD treatment, while others are not. Law enforcement may be involved. The Peers recall their own experiences in an emergency department as often traumatic. Partnering with the emergency department staff, Peers visited SUD patients while they were still in the hospital, getting to know them and offering them enrollment in the CDC on-site. Such patients could be taken to the CDC before discharge, making the most of the opportunity to initiate or resume treatment. The Peers also helped emergency department staff understand the importance of naloxone prescriptions for patients before discharge as a mechanism to prevent overdose deaths.

The Peers also made home visits. Patients were surprised to see that the visits were friendly, involved care coordinators as well as peer support staff, and that they were not judgmental. Over and over again, patients stated that the home visits showed how important their recovery was to the health center, a factor that motivated the patients to continue on their journey toward health. During home visits, the Peers checked on a variety of needs, including unmet medical needs, social supports, and any unusual stressors. Advocacy and outreach are essential parts of these recovery specialists' roles.

In group sessions, PCC perceived that patients listened more fully to the Peers than they did to other staff. The Peers conveyed that they understood them, and that seemingly made the patients open up more and engage more deeply in problem-solving. Behavioral health staff helped the Peers by training them in the basics of motivational interviewing and making sure workflow practices included clear bidirectional communication about patients between behavioral health experts and peer experts. The Peers did not replace therapists and did not convey expertise outside of their scope. They did join in team huddles with providers as indicated, allowing providers to have more insight into their patients' struggles or successes.

Overall, patients appeared to see the Peers as witnesses to the benefits of continued treatment. Recovery is a long arduous process that typically includes setbacks. Patients could persist in hope as they heard encouragement from those who had been in their shoes. The Peers didn't pretend their own recovery had been easy, and this sort of transparency was invaluable in affirming that the patients' experiences were valid but were not barriers to continued recovery.

Going forward, PCC plans to sustain the Peer Recovery Support Specialist position. The health center's leadership notes that while it isn't a direct revenue source, sustained engagement in treatment has its own financial merit. Staff plan to measure rates of continued treatment engagement of their SUD patients before and after the peer support program as a measure of impact. They believe that rates at six months and one year will significantly differ based on peer presence.

They also plan to expand the peer support role to their high-risk Chemical Dependency Clinic (CDC) for pregnant women. As the only fully integrated MAT program with prenatal care in Illinois, the CDC has treated about a dozen pregnant women with opiate-dependence. The Peer will complement the comprehensive care pregnant women now receive, which includes prenatal care, ultrasounds, mental health and substance use treatment, mother-baby classes, labor and delivery, and follow-up care after birth. Pressures and risks are unique in this setting, as women often face the possible loss of their babies to foster care, new needs in housing, employment challenges, and changes in family composition. Seeing a successful mother who has navigated her course can be a powerful force for healing. And that gives everyone hope—what better way to change the course of the next generation than by removing SUD from their community?

Innovations & Interventions

- Revised PCC's hiring policy to decrease barriers for candidates with SUD backgrounds
- Recruited, hired, and trained two Peer Recovery Support Specialists (Peers) to provide increased support to patients and naloxone when needed
- Expanded the role of Peers to include home visits with a home encounter workflow to ensure Peers use best practices
- Added patient support groups co-led by Peers
- Trained staff in trauma-informed care and motivational interviewing, targeting pharmacy staff and medical providers
- Revised screening practices: all patients over age 12 screened with PHQ annually; all patients over age 18 screened with SBIRT; trauma screening tools (AUDIT, DAST, PC-PTSD)* are being validated for use
- Ensured all MAT patients receive a behavioral health visit
- Expanding peer support outreach to include high-risk women with chemical dependency who receive prenatal and new-infant care

case study
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Project H.O.P.E.

Camden, NJ

Project H.O.P.E. serves the medical and behavioral health needs of homeless patients in the economically depressed city of Camden, New Jersey. Project H.O.P.E. has a robust, integrated behavioral health department, and to address substance use disorder (SUD), all physicians are waivered to prescribe medication-assisted treatment (MAT). The health center also has clinical social workers, a psychiatric RN, case managers, substance abuse counselors, and a clinical RN to manage its MAT program. ***The staff at Project H.O.P.E. finds strength in their integrated care team approach.***

> **As practitioners, we have to help each other so no one works alone or gets burned out…to support our patients, we have to support each other.**
>
> **Brian Colangelo, LCSW, CADC**
> *Social Worker*
> *Director of Mental Health*

Language Guides And A Team Approach

CLOSE YOUR EYES and imagine you are sitting across from a teenage boy with recurrent cancer. What images do you see? What do you want to say? How are you feeling? Now close your eyes and imagine this same boy is a recurrent opioid user. Are you feeling the same? Does he look the same? What words come to mind?

This sort of exercise helps us understand our biases and approaches to patients with substance use disorders (SUD). Research shows that clinicians' perceptions of patients affects the patients' ultimate well-being. Even more forcefully, the language we use when speaking with and about them can either be healing or damaging. Years ago, clinicians were taught to stop referring to people as "diabetics" or "lepers," and instead to say, "a person with diabetes," or "a person with leprosy." The person was not the disease. Such an approach has been slow to enter the world of SUD care, though.

With their CVS Health Foundation grant, the leaders at Project H.OP.E. decided to help staff change some of the stigma their patients with SUD experienced when coming in for treatment. The health center already had a mission to help the marginalized since they care for the medical and behavioral health needs of a largely homeless population in a poor part of Camden, NJ. They are more aware than most that stereotypes alienate and distance us from providing real care. They had an established track record of compassionate, competent, holistic care to a population many hardly noticed. But even so, they needed help communicating with their SUD patients in a way that consistently promoted respect and inclusion.

Director of Mental Health Brian Colangelo, LCSW, CADC, knew that providers weren't purposely speaking to patients with words that hurt. Providers just didn't have the language tools they needed. So, he developed a language guide for staff, showing that a word like "addict" can be exchanged for the phrase, "person with a substance use disorder." Asking someone if they are "clean" can imply they are otherwise dirty. Instead, it is better to just ask how their recovery is going. Are they able to avoid using illicit drugs? We don't ask cancer patients if they are focusing on tumor growth. Why would we ask a patient with SUD if they are having cravings? Of course, they are! Rather, we can ask them what interests they are pursuing or if they are bored. The language guide helps all staff communicate in ways that respect the dignity of the person, name SUD as a disease, and eliminate blame from the treatment process.

Project H.O.P.E. has provided medication-assisted treatment (MAT) for more than 1,500 patients over the past 7 years. Every physician is waivered to provide MAT so that SUD care is an expertise that is a component of primary care. This way, patients aren't segregated by which clinician they see—this avoids stigma as well. Social workers are as numerous as physicians, emphasizing the role of case management and counseling in the treatment of people whose environmental needs are intimately related to their health care needs.

In this setting where team-approached care was already a standard, Project H.O.P.E. again innovated. They decided to incorporate training in SUD care into their weekly huddles. Huddles are quick meetings with a staff team—such as nurse, social worker and clinician—that assist planning for individual patient visits, anticipating needs and communicating potential difficulties. Infusing training into these huddles added value to staff and allowed regular small bits of learning to be integrated into weekly care. Topics included record keeping, communication, and motivational interviewing. Workload stress could be discussed and staff collaboration strengthened.

Burnout is a problem in health centers like Project H.O.P.E, where patients have so many needs, and resources can be so difficult to attain. Setbacks are an expected part of SUD treatment, but they can demoralize staff who are constantly trying to make an impact in disease eradication. In addition to internal efforts like huddles and care teams, Project H.O.P.E. reached out into the Camden community of MAT providers. They offered partnerships, trainings, and collaborations to help outside prescribers avoid burnout too. As support strengthens, providers are seeing more of their colleagues take on MAT care, sharing the responsibility of caring for all in need.

Lastly, Project H.O.P.E. includes the voice of the patient in their efforts to provide fully coordinated, collaborative care. A patient advocate, who is herself a former heroin user, serves to help the staff understand more of the patient perspective. Health centers are used to patient-led boards, but this effort drills down patient perspectives to get at the heart of integrated MAT care.

Where will Project H.O.P.E. and Camden, NJ be in the future? Close your eyes and imagine it. What do you see?

Case Study *Project H.O.P.E.*

Project H.O.P.E. includes the voice of the patient in their efforts to provide *fully coordinated* collaborative care.

Innovations & Interventions

- Built a collaborative, supportive team culture that encourages staff retention and lends itself to quality and consistency of client services
- Engaged staff by frequently soliciting feedback, answering questions, and providing regular trainings and care team meetings
- Developed a language guide to encourage two-way communication with patients and staff
- Offered more patient education with more staff, including a RN care manager
- Tracked more information about each patient for care management
- Collected more accurate reporting data, and expedited insurance authorizations to improve patient recovery, maintain abstinence, and improve retention
- Implemented a system for more intensive follow-up and connection with patients
- Created partnerships in the community with external medication-assisted treatment (MAT) prescribers and encouraged more prescribers to become involved in MAT treatment
- Hosted community opioid awareness events to engage neighbors and share free naloxone

**Project H.O.P.E. would be happy to share the language guide with any interested organization.*

case study
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> **When you are treating addiction, you don't just treat the individual who is suffering; you have to treat the children and community too.**
>
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Rocking Horse Community Health Center

Springfield, OH

Rocking Horse Community Health Center (Rocking Horse) operates four centers in Springfield, Ohio that provide primary care, behavioral health, substance use disorder (SUD) treatment, dental, obstetrics and gynecology, and chiropractic services to people of all ages. Situated in a state with the one of the highest rates of opioid deaths, Rocking Horse ***has tried to fight back by creating stronger community partnerships****, offering training in SUDs, and holding grief and loss groups for youth ages 6-17 exposed to the tragedies of substance abuse.*

Grief Groups for Children, Outreach with Schools, and Adaptability

ROCKING HORSES almost always bring a smile to the faces of old and young alike. They represent childhoods filled with play, imagination, and happy imitations of grown-up abilities. But as the opioid crisis rose in the state of Ohio, it shattered the lives of not just the addicted, but of the children who relied on them for nurture and support. At Rocking Horse Community Health Center (Rocking Horse), staff increasingly looked into the eyes of children whose parent had died, been incarcerated, or otherwise removed from their life because of substance use disorder (SUD). The heaviness of grief replaced the lightness of childhood.

With its grant from the CVS Health Foundation, Rocking Horse decided to reach out to the children in their Springfield, Ohio, community who had suffered losses due to SUD. They realized that though there were several prevention programs aimed at children in the area, there wasn't any resource that targeted children who had experienced the ultimate effects of addiction within their families. The health center's therapist and SUD educator provided general counseling and support, but she also wanted to provide these children with a mechanism to work through their grief in a structured, supportive peer environment.

Grief groups were born. Flyers were made announcing the program and inviting children aged 6-17 to attend. Gas cards were given to attendees to help with transportation costs. Restaurant cards were offered as an incentive for those who completed the eight-week program. Leaders in the Springfield area strongly supported this venture, sharing information in schools, daycares, gyms, and youth centers. Everyone working with the SUD epidemic knew that there were too many children who needed these groups.

Despite the heavy advertising, the initial two groups did not have many children enroll. Stigma still held many back. Some of the children in need didn't know their parent had succumbed to SUD—their guardians hadn't told them, preferring for them to think their parent's absence was due to a different cause. Other families just didn't want to talk about it, or felt so overwhelmed with their own cares that they didn't recognize how difficult it was for the children. Though those that did participate benefited from having a shared space to open up about their grief, Rocking Horse staff decided to try another approach.

As part of their work with *Innovative Approaches*, Rocking Horse joined Springfield's Substance Abuse Coalition. Through the Coalition, they found a network of educators, law enforcement personnel, health care professionals, and civic leaders who had resources and ideas that would benefit the children served by the center. The grief groups could be more acceptable—and more inclusive—if they were for any child who suffered a serious loss, regardless of the cause. Without stigmatizing SUD as a separate kind of grief, children could identify with each other's common concerns and struggles. Even if a child didn't know the real reasons behind their loved one's absence, they could still relate to the shared absence experienced.

Rocking Horse had also thought about doing prevention programs in the schools, but they found that the Coalition already had well-prepared curriculum being taught in the schools. They didn't want to replicate services. So, they approached the schools with a program that augmented what already existed, focusing on helping children learn to draw lean on the adult leaders in their lives to help them stay safe. Rocking Horse offered this resource back to Coalition members, strengthening the overall network of care.

Rocking Horse continues to adjust its offerings to the needs and responsiveness of the community. Staff want to offer grief groups for people of all ages. Peer-led youth groups are planned as the next phase of youth support groups, enabling the youth to develop some of their own leadership skills, and increasing opportunities for open communication about addiction. Mentorship programs are envisioned at the health center as the peer-led groups evolve.

All of these efforts are undergirded by the goals of reducing stigma and secrecy around SUD in the family. Whether in naming the disease, acknowledging the current crisis in the schools, or offering safe spaces to ask for help, Rocking Horse wants to be part of the solution to SUD. The health center will continually evaluate its efforts and change course when necessary to help where it is needed most. As they care for the grieving and mentor youth into the future, staff members anticipate a time when children will be more preoccupied by their toys than by the troubles of the adults around them.

Case Study *Rocking Horse Community Health Center*

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Innovations & Interventions

- Provided a grief group to support youth aged 6-17 who have lost a loved one to overdose death
- Developed a SUD educational prevention presentation for youth under age 18 and provided it in middle and high schools, church youth groups, and juvenile drug court – and used these experiences to learn from students about what they need
- Became an active member of the local Substance Abuse Coalition
- Built and strengthened relationships with community organizations to learn more about the children they serve and possibly offer a pipeline to behavioral health groups. Partners include child and family advocacy programs, boys and girls empowerment groups, and county juvenile court
- Held "Community Art Day" to positively engage youth and families in the community with the health center; taught children about healthy alternatives to substance use via a "learn through doing" approach
- Offered SUD training to court system staff
- Exploring peer-led group programming and mentorship programs for the future, and continually learn about resources within the community to enhance and align their services with local schools, churches, and other local treatment programs

Reflections & Recommendations *from the Health Centers*

Develop Meaningful Goals and Lean Into Organizational Change:

- Major goals often require an entire cultural shift for a health center, and the understanding that challenges ahead will pay off with positive health outcomes, positive patient experiences, and positive staff experiences.
- It's important to start by informing everyone involved about new goals and engage in ongoing communication about the steps required to get there.
- Often, when a major goal like the commitment to reduce opioid deaths in a community is made, it will take the entire health center staff as well as partners to be aware, engaged, and ready to pitch in and help.

Establish Open Communication and Engage All Providers and Staff to Identify Solutions:

- Staff are motivated to help when they've been engaged in reaching an important, clinic-wide goal early in the process.
- The leaders of any initiative should include people who are prepared, excited, and capable of completing the hard work of SUD care and treatment.
- Each team member should be allowed to contribute and identify solutions that will enrich programs and plans in meaningful ways.
- Encourage providers to participate in decision-making and trainings.
- Frequent communication among team members will be critical to success, as will the ability to adapt.

> It is vitally important to collaborate and draw on the strengths of all staff in the organization to propel goals and plans forward. When each member of the team has "buy-in," your success is limitless.
>
> **Community Health Centers of Pinellas**

Focus On Evidence-Based Treatment Approaches:

- Organizational goals are absolutely achievable when health centers can learn from proven, evidence-based treatment practices.
- Join a learning collaborative to become aware of and apply best practices without reinventing the path forward.
- Evidence-based tools such as motivational interviewing, trauma-informed care, and various screening tools have helped staff involved with opioid abuse prevention and care feel more confident in their work and experience immediate positive results.
- Learn from evidence-based practices about the best screening tools to use, when, and how.

Reflections & Recommendations from Health Centers

Invest In Training:

- Education, education, education!
- Training for both staff and peer or youth workers is essential to keep everyone well informed about clinical issues, programmatic changes and opportunities, but leadership must be mindful of staff burnout.
- Staff should be equipped with knowledge and resources to access evidence-based treatments that will help them with their work.
- To gain staff buy-in, training must be relevant, ongoing, and up-to-date.
- In particular, staff working with SUD patients must learn to view both mental illness and SUD as chronic conditions.
- It helps to find an Addiction Recovery Specialist, or someone experienced in this field to serve as a mentor for staff.

Know Your Patients:

- Consider and involve patients and those who care for them when developing a SUD program, since they're the ones who will use it.
- Try to facilitate as much patient communication as possible.
- Even resistant patients will be more successful when they're more engaged in care that is adapted to their needs and abilities.
- Explore ways to survey and understand what the target population needs and wants, and don't forget to consider the people who care for them.

Adjust Agency Policies, Workflows, and Protocols to Match Goals:

- Whether hiring a peer or youth educator, or creating new workflows for care teams, it's important to document changes and adjust policies and practices to formally implement these services.
- Update the electronic health record to remind doctors to screen and track opioid use and risky behaviors with targeted patients, or add insight about social determinants of health.
- Identify barriers within existing organizational policies, and make adjustments that make practical sense (e.g., when hiring a Peer Advocate).
- Budget additional time for hiring and training and build this time into work plans.
- Remember to be patient because creating the infrastructure for new services is a lengthy process.

Consider The Long Game:

- To achieve major health care goals for a challenging population like people addicted to opioids a long term, sustainable approach is required with consideration for each patient's social determinants of health.
- When incorporating changes that will shift an organization's culture around SUD care, consider how changes will impact the care team's work and consider how to fund and support those efforts over time.
- Connect with external partners at schools, churches, local emergency rooms, pharmacies, etc., for shared, whole-patient care.

Be Realistic About What You Can Accomplish:

- Be open to plan changes and delays.
- Working with SUD patients is difficult and it often takes a long time.
- Take care of providers by encouraging shared care – with strong care team partnerships as well as external partnerships for referral.
- Establishing new screening protocols and services often takes longer than anticipated.
- Obstacles are just part of the process.
- Be flexible and openly communicate wins with the care team, even if they take place after the initial deadlines
that were set.

Utilize Staff in New Ways:

- Pharmacists have a deep knowledge of drug interactions and insurance for medical equipment.
- Pharmacists can dive deep into the details of drug use.
- Having a pharmacist go beyond their standard job is something for health centers to think about.
- Treatment programs need someone with deep knowledge of brain chemistry, medication, and how to get it approved for payment.

> We understand the desire to impact as many individuals as possible, but health centers shouldn't forget that impacting just one person in a positive way makes doing this work worthwhile.
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> **Rocking Horse Community Health Center**

Collaborate! Don't Do It Alone:

- Work closely with community partners that have a shared vision.
- With shared goals, it's easy for partnering organizations to develop a strong rapport.
- Consider partnering with other agencies and MAT prescribers to gain strength from each other.
- Health centers will gain strength, knowledge, and excellent resources by participating in a learning community.

Potential Partners

Recommended by the Health Centers

- Consultants in trauma-informed care and SUD care
- Juvenile drug courts
- Local churches and religious institutions
- Local coalitions of health care providers
- Local family centers and recovery providers
- Local insurance companies
- Local medical centers and MAT providers
- Local mental health providers and organizations
- Local or community opioid task forces
- Local pharmacies
- Local public school systems
- Local youth groups
- State department of children and family services
- State department of job and family services
- State department of public health
- State or county child protective services
- University-based and community hospitals *(emergency department)*

Glossary

ACES (ADVERSE CHILDHOOD EXPERIENCES) SCREENING is a 10-question screening tool designed to collect information on childhood maltreatment, household dysfunction, and other potentially traumatic experiences that occur to people under the age of 18 and are associated with the development of substance use disorders.

ASSIST (ALCOHOL, SMOKING AND SUBSTANCE INVOLVEMENT SCREENING TEST) is a screening tool designed for the primary care setting to detect and manage substance use and related problems. ASSIST includes three different manuals: (1) to explain how to identify people who are using substances so that a brief intervention (or referral) can be provided; (2) to explain the theoretical basis for brief, effective interventions, and assist primary health care workers to conduct 5-15 minutes of counseling when a client's substance use puts them at risk; and (3) to help high-risk patients confront the problems of their substance use and give them ideas for change.

- NIDA (National Institute on Drug Abuse) Quick Screen is a modified ASSIST tool appropriate for patients age 18 or older. Quick Screen is delivered as an interview (read aloud and recorded in the medical records).

AUDIT (ALCOHOL USE DISORDER IDENTIFICATION TEST) SCREENING is a 10-item screening tool developed by the World Health Organization (WHO) to assess alcohol consumption, drinking behaviors, and alcohol-related problems. There is a clinician-administered version and a self-report version.

CRAFFT (CAR, RELAX, ALONE, FORGET, FRIENDS, TROUBLE) is a behavioral health screening tool designed for children under the age of 21. The CRAFFT keywords are used to identify at-risk teen substance abusers. It is a short 6-question tool intended to identify adolescents who may have simultaneous risky alcohol and other drug use disorders. It can assess whether a longer conversation about the context of use, frequency, and other risks and consequences of alcohol and other drug use is warranted. It is recommended by the American Academy of Pediatrics' Committee on Substance Abuse.

DAST (DRUG ABUSE SCREENING TEST OR DAST-10) DAST-10 is a 10-item, yes/no self-report instrument that has been condensed from the 28-item DAST. It should take less than 8 minutes to complete. It is a brief instrument to screen for drug abuse and treatment evaluation. It can be used with adults and older youth.

DATA (DRUG ADDICTION TREATMENT ACT) WAIVER of 2000 expands the clinical context of medication-assisted opioid dependency treatment so qualified physicians are permitted to dispense or prescribe specifically approved Schedule III, IV, and V narcotic medications (medications that have a lower risk for abuse, like buprenorphine) in settings other than an opioid treatment program such as a methadone clinic. A waiver is required to allow qualified physicians to prescribe Schedule III, IV, and V narcotic medications.

IMPLICIT BIAS or unconscious biases are learned stereotypes that are automatic, unintentional, deeply engrained, universal, and able to influence behavior. A critical component of implicit bias training helps people recognize and observe their own biases and learn how to overcome prejudices in the way we provide health care. This training is most effective when it's ongoing.

INTEGRATED BEHAVIORAL HEALTH is the practice of providing high-quality, coordinated health care by combining behavioral health services and medical services. According to HRSA, *"Integrated behavioral health results when a team of providers, including physicians, nurse practitioners, behavioral health clinicians, community health workers, home visitors, and other health care providers, work together to address patient needs to achieve quality outcomes for every individual in care."* With this approach, a range of health care needs can be addressed in a more patient-centered, cost-effective manner, from mental health and substance abuse conditions, to chronic medical illnesses, to stress-related illnesses, to education about better patterns of health care use, etc.

MEDICATION-ASSISTED TREATMENT (MAT) is *"the use of medications with counseling and behavioral therapies to treat substance use disorders and prevent opioid overdose,"* according to the Substance Abuse and Mental Health Services Administration. MAT is primarily used for the treatment of addiction to opioids such as heroin and prescription pain relievers that contain opiates.

MOTIVATIONAL INTERVIEWING is a counseling method that helps people resolve ambivalent feelings and insecurities to find the internal motivation they need to change their behavior. It is a practical, empathetic, and short-term process that takes into consideration how difficult it is to make life changes.

NADA (NATIONAL ACUPUNCTURE DETOXIFICATION ASSOCIATION) PROTOCOL is a non-verbal approach to healing using acupuncture. NADA involves the gentle placement of up to five small, sterilized disposable needles into specific sites on each ear.

NALOXONE is a drug that can be administered when a patient shows signs of opioid overdose from opioids such as heroine, morphine, and oxycodone. It blocks opioid receptor sites, reversing the toxic effects of the overdose to prevent death. The medication can be given by intranasal spray, intramuscular, subcutaneous, or intravenous injection. Training is offered to non-medical professionals to prevent death in non-clinical settings. The Substance Abuse and Mental Health Services Administration published the Opioid Overdose Prevention Toolkit – 2018 to equip communities and local governments with material to develop policies and practices to help prevent opioid-related overdoses and deaths.

NON-NARCOTIC MODALITIES FOR PAIN REDUCTION include prescription and over-the-counter aspirin, ibuprofen, and acetaminophen; nondrug remedies such as massages, acupuncture, chiropractic care, mindfulness, and Cognitive Behavioral Therapy (CBT) groups; and high-tech treatments such as biofeedback using radio waves and electrical signals.

OPIOID USE DISORDER (OUD) is a chronic, lifelong disorder with serious potential consequences including disability, relapses, and death. The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition describes opioid use disorder as a problematic pattern of opioid use leading to problems or distress, with at least 2 of the following occurring within a 12-month period:

1. Taking larger amounts or taking drugs over a longer period than intended
2. Persistent desire or unsuccessful efforts to cut down or control opioid use
3. Spending a great deal of time obtaining or using the opioid or recovering from its effects
4. Craving, or a strong desire or urge to use opioids
5. Problems fulfilling obligations at work, school or home
6. Continued opioid use despite having recurring social or interpersonal problems
7. Giving up or reducing activities because of opioid use
8. Using opioids in physically hazardous situations
9. Continued opioid use despite ongoing physical or psychological problem likely to have been caused or worsened by opioids
10. Tolerance (i.e., need for increased amounts or diminished effect with continued use of the same amount)
11. Experiencing withdrawal (opioid withdrawal syndrome) or taking opioids (or a closely related substance) to relieve or avoid withdrawal symptoms

PEER RECOVERY SUPPORT PROGRAMS are emerging as an important part of addiction treatment. They involve using peer specialists to model recovery by sharing their personal experiences and offering supports to help others who are experiencing similar challenges.

PHQ-9 AND PHQ-A (Patient Health Questionnaire with 9 questions or modified for adolescents) are multipurpose instruments for screening, diagnosing, monitoring, and measuring the severity of depression. The questionnaire is completed by the patient in minutes and is rapidly scored by a member of the care team. It can be administered repeatedly to reflect improvement or worsening of depression in response to treatment.

PRAPARE (PROTOCOL FOR RESPONDING TO AND ASSESSING PATIENTS' ASSETS, RISKS, AND EXPERIENCES) is a national standardized patient risk assessment protocol designed to engage patients in assessing and addressing social determinants of health. The tool was developed by the National Association of Community Health Centers, the Association of Asian Pacific Community Health Organizations, the Oregon Primary Care Association, and the Institute for Alternative Futures. For more information, visit www.nachc.org/prapare.

PTSD-5 SCREENING is a tool designed for use in primary care and other medical settings to screen for post-traumatic stress disorder. It includes an introductory sentence to cue respondents to traumatic events. If a patient responds "positive" or "yes" to any three items, appropriate care should be offered. The screen does not include a list of potentially traumatic events.

SBIRT (SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT) is a quick and simple method to identify patients whose patterns of alcohol and/or drug use put their health at risk, and conduct brief counseling or interventions to help. The typical screening process involves a brief 1-3 question prescreen designed to be given to all patients. If a person screens positive, they would then be given a longer alcohol or drug use screening tool such as AUDIT or ASSIST.

SUBSTANCE USE DISORDER (SUD) is *"a disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug or medication"* (Mayo Clinic). People who have SUD continue using the drug despite the harm it causes. OUD is one type of SUD.

TRAUMA-INFORMED CARE (TIC) understands and considers the pervasive nature of trauma and promotes environments of healing and recovery rather than practices and services that may inadvertently re-traumatize. TIC requires a change in organizational culture, where an emphasis is placed on understanding, respecting, and appropriately responding to the overall effects of trauma on patients and care providers.