State Targeted Response to the Opioid Crisis

California Strategic Plan

Prepared for the Department of Health Care Services
California Health and Human Services Agency

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UCLA Integrated Substance Abuse Programs

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Introduction

This Opioid Strategic Plan was compiled for the California Department of Health Care Services to document existing and planned activities to address the opioid crisis, and to fulfill a requirement of the SAMHSA State Targeted Response to the Opioid Crisis Grant awarded to California. Through the implementation of the California Hub and Spoke System and other prevention and recovery activities, California expects to increase the number of Medicaid and uninsured beneficiaries treated with MAT, leading to reduced overdose death rates.

The Opioid Crisis in California

California in Context: Opioid Painkiller Prescriptions in United States

In 36 California counties, opioid prescriptions exceeded[1] the national average of 640 MMEs per resident, which is itself enough opioids to medicate every resident around the clock for about three weeks every year.[2]

Counties and municipalities at a higher risk of Opioid Overdose Death Rates

The geographic distribution of the opioid crisis in California can be summarized in the following ways. For more information, see California State Targeted Response to the Opioid Crisis Needs Assessment Report.

- Past year non-medical use of prescription drugs is highest in northern California rural regions [National Survey on Drug Use and Health (NSDUH) - Region 1R (Humboldt, Lake, Mendocino, Plumas, Shasta) = 5.71%; Region 12R (Tuolumne) = 5.59%.]
- The number of opioid prescriptions per 1,000 residents is highest in the rural northern counties of California (DOJ CURES); and
- The rate of prescription opioid related deaths per resident is highest in these same rural northern California counties, in addition to Inyo County on the eastern border (CDPH Death files).
- While California's overall opioid related death rate is lower than that of some other states, individual counties in the state are experiencing prescribing rates and death rates that are among the worst in the country.

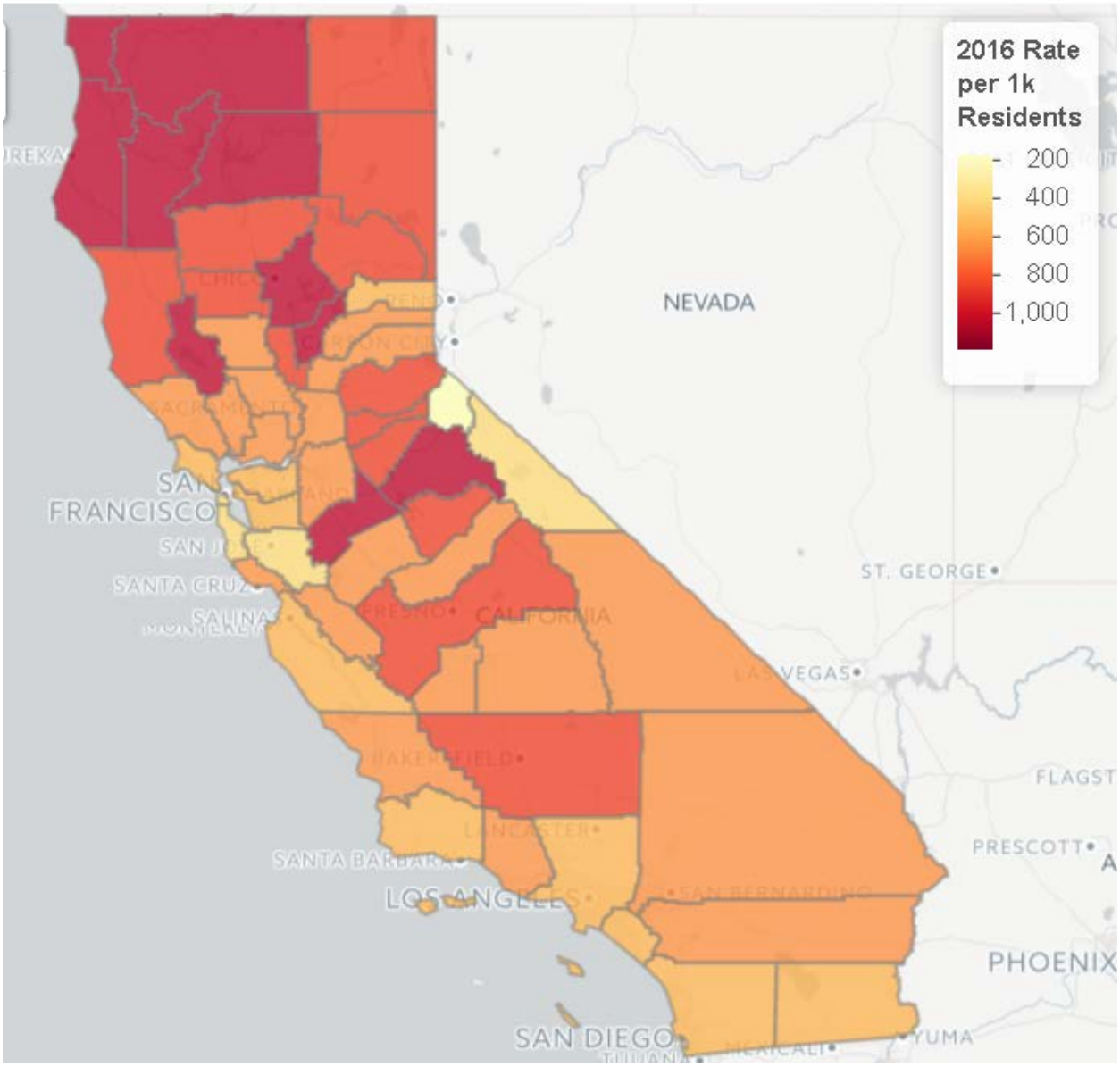
The maps below show the 2016 distribution of opioid prescriptions (excluding buprenorphine) and death rates from opioid overdoses across the state.

[1] California opioid overdose dashboard. https://pdop.shinyapps.io/ODdash_v1/

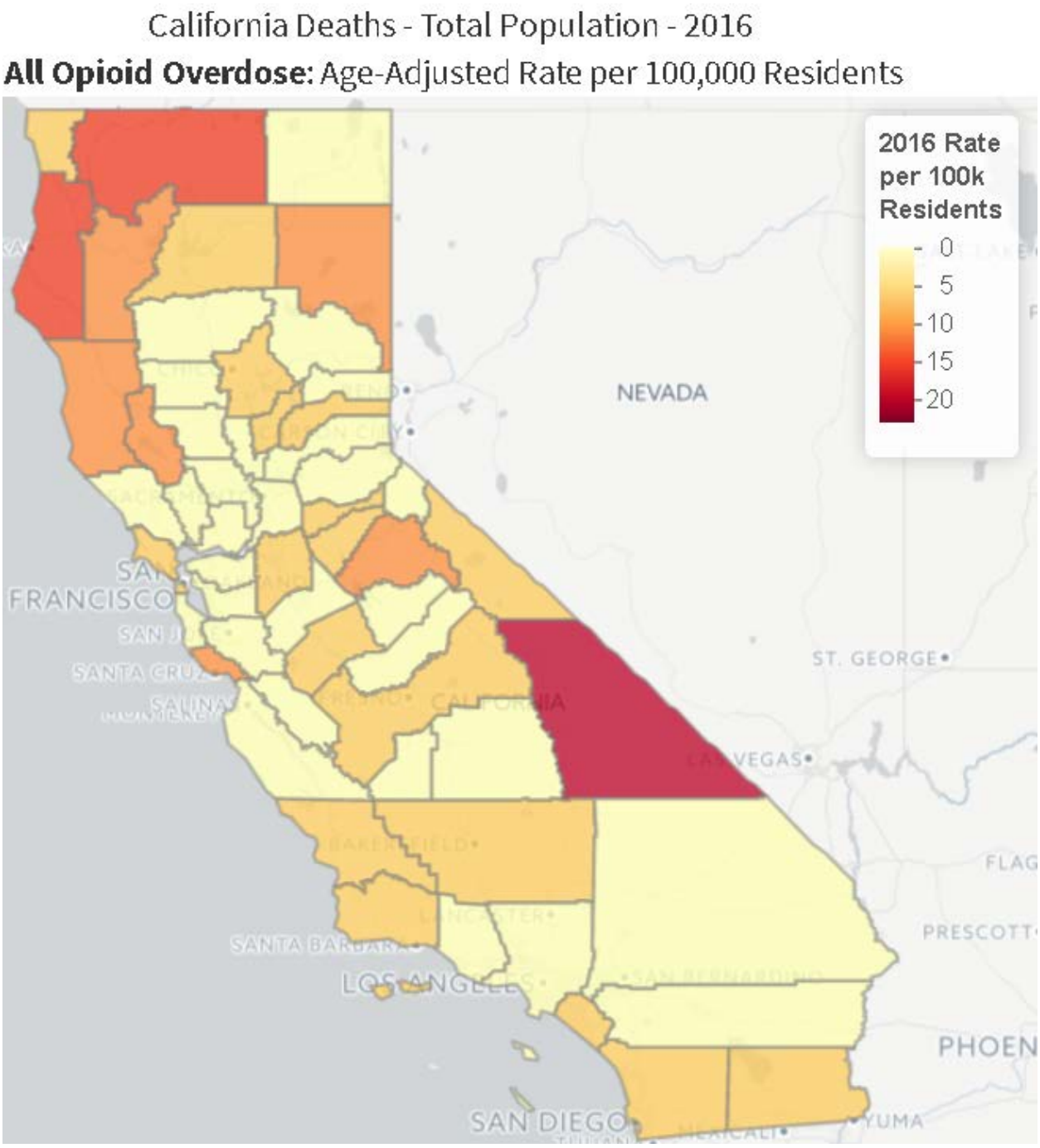
[2] CDC Vital Signs: Opioid Prescribing Where you live matters https://www.cdc.gov/vitalsigns/pdf/2017-07-vitalsigns.pdf

California Prescriptions - Total Population - 2016

Opioid Prescriptions by Patient Location: Age-Adjusted Rate per 1,000 Residents



Data Source: California Opioid Surveillance Dashboard.



Data source: California Opioid Surveillance Dashboard

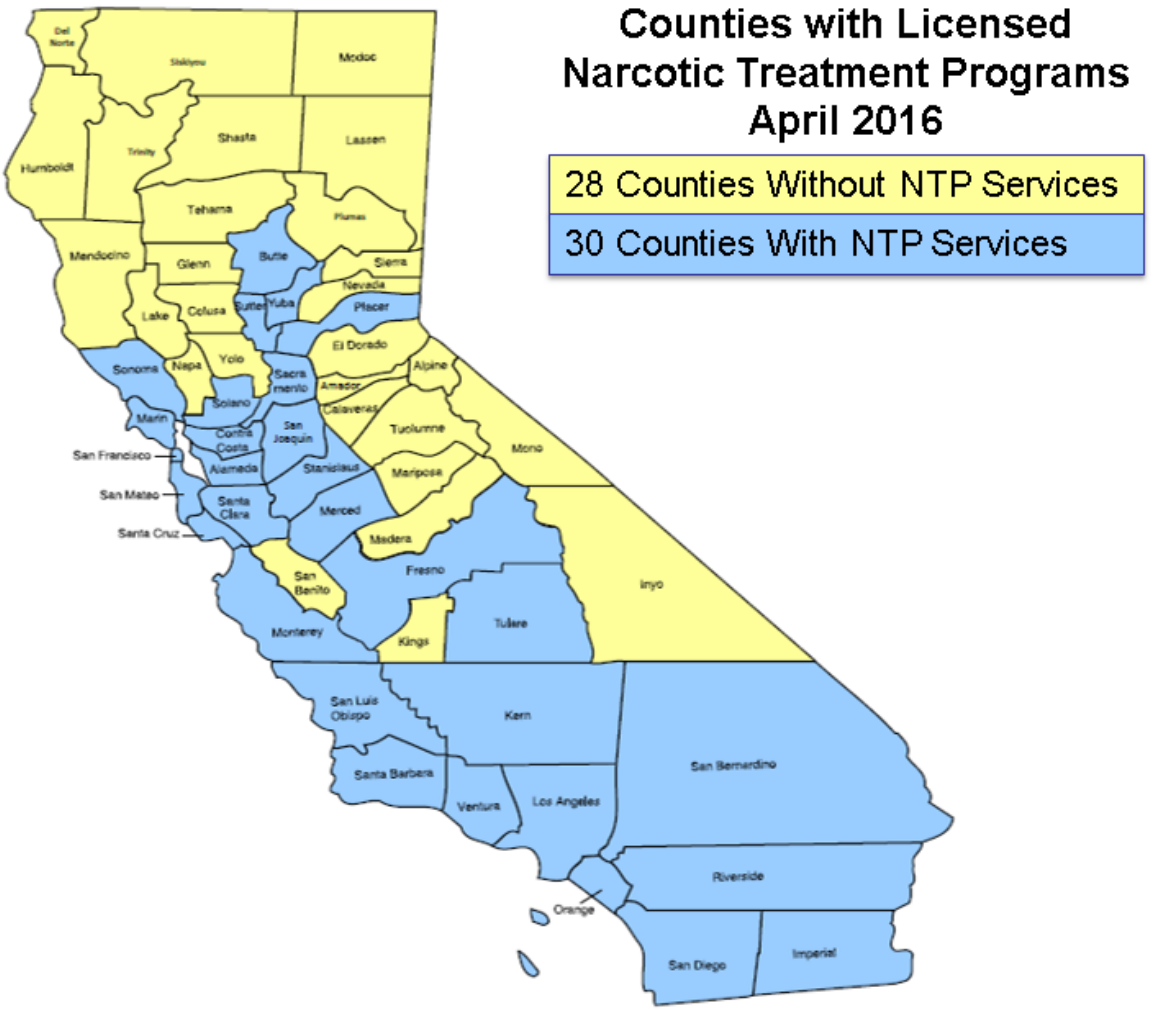
The three counties with the highest rate of age-adjusted opioid related overdose deaths per 100,000 residents in 2016 were Inyo, Humboldt, and Siskiyou.

Current availability of MAT

Number of certified Opioid Treatment Programs (OTPs), their location by county and average patient capacity

As of 2016, 48% of the counties in California do not have Narcotic Treatment Programs (NTP). The top eight counties in terms of opioid overdoses have no NTPs. These counties are located in Northern California and Central Eastern California (see Map xx).

In California, an estimated 70.8% of NTPs operate at 80% of capacity or higher.[3]

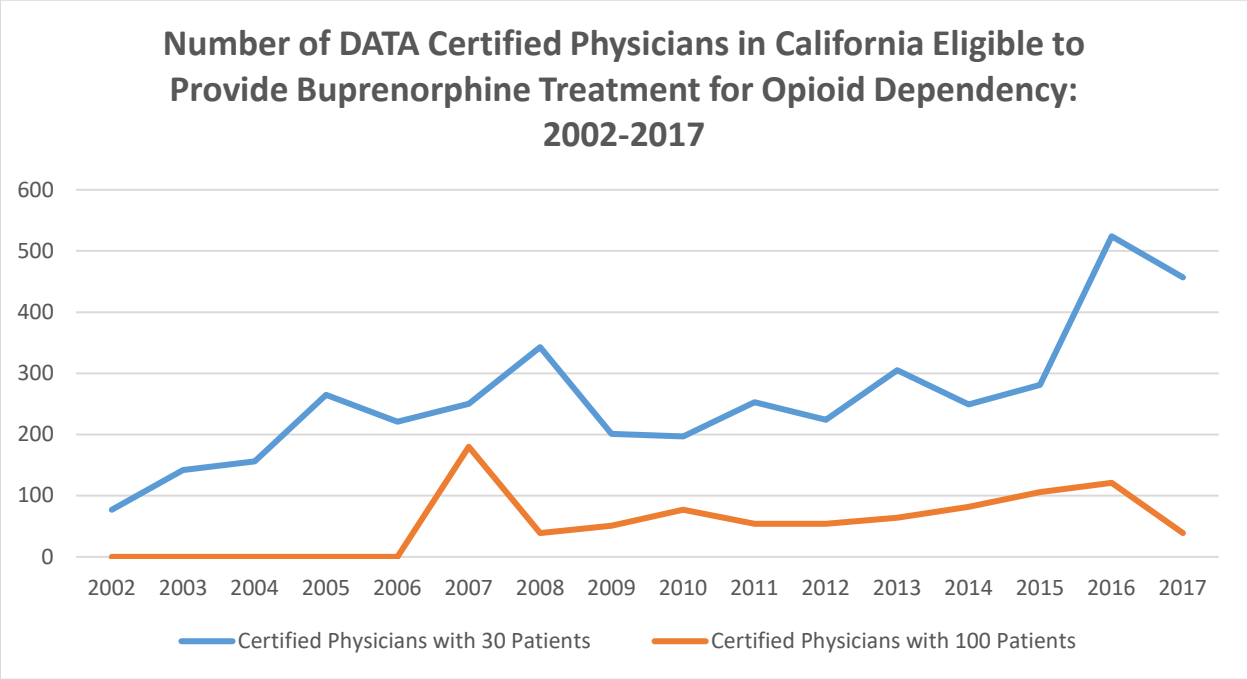


[3] Jones, C.M., Campopiano, M., Baldwin, G., & McCance-Katz, E. (2015). National and state treatment need and capacity for opioid agonist medication-assisted treatment, 105(8), e55-e63.

Number of Office-based Opioid Treatment (OBOT) certified providers (including MDs, DOs, PAs and NPs)

According to SAMHSA,[4] in California the number of physicians eligible to provide buprenorphine treatment for opioid dependency has gone up significantly by 493% for certified physicians with 30 patients from 77 in 2002 to 457 in 2017. However, for certified physicians with 100 patients the numbers have remained relatively low and stable. Between 2002 and 2006 there were no certified physicians to provide buprenorphine treatment for opioid dependency reaching the threshold of 100 patients per physician. In 2007, there were 180 certified physicians with 100 patients, with essentially no change in the last decade.

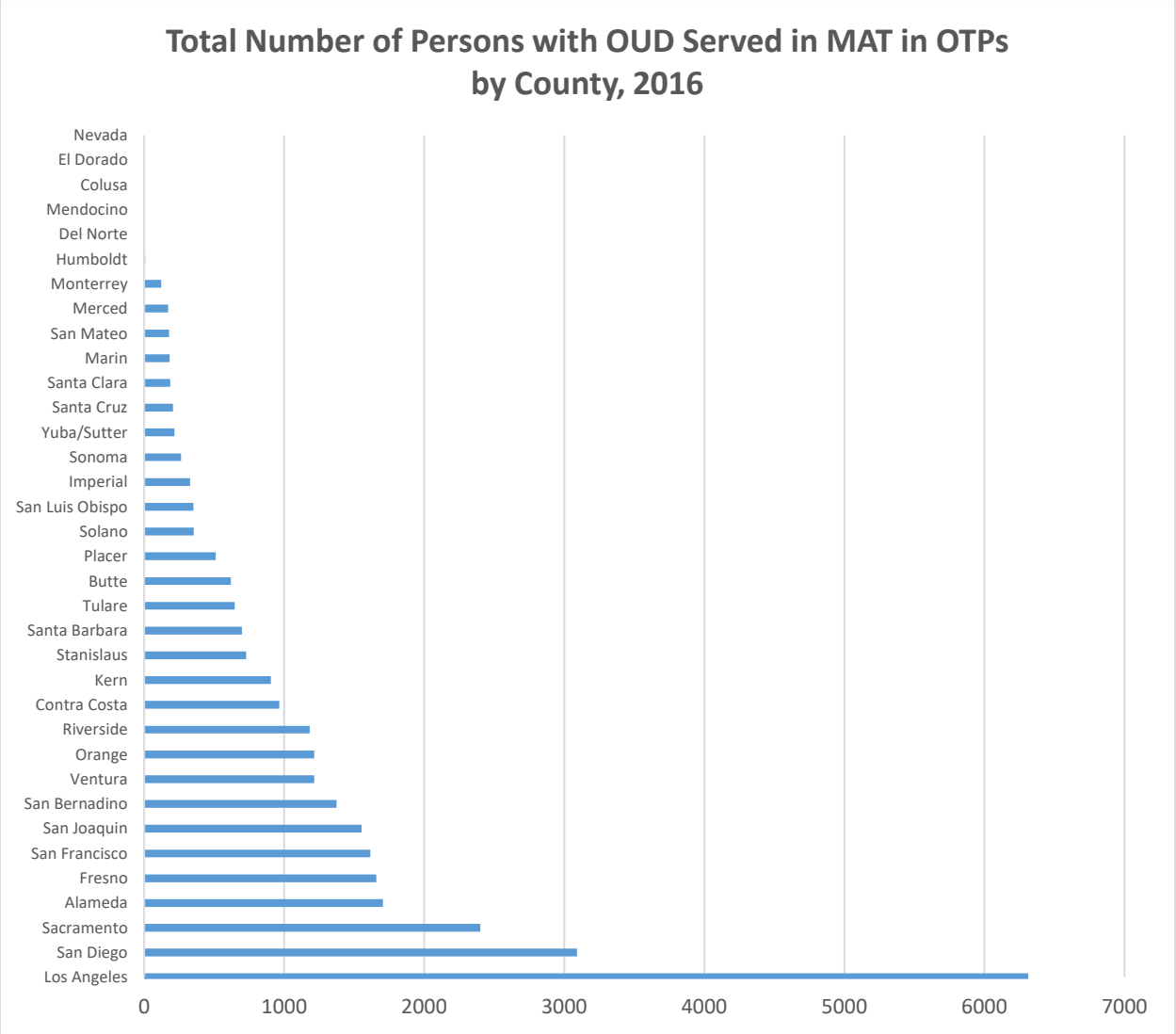
While buprenorphine is increasingly recognized as first line treatment for Opioid Use Disorder (OUD), in California one Medi-Cal beneficiary receives buprenorphine for every four patients receiving methadone. Despite Medicaid expansion, in California Medicaid pays for less than 20% of buprenorphine prescriptions.



Data Source: SAMHSA

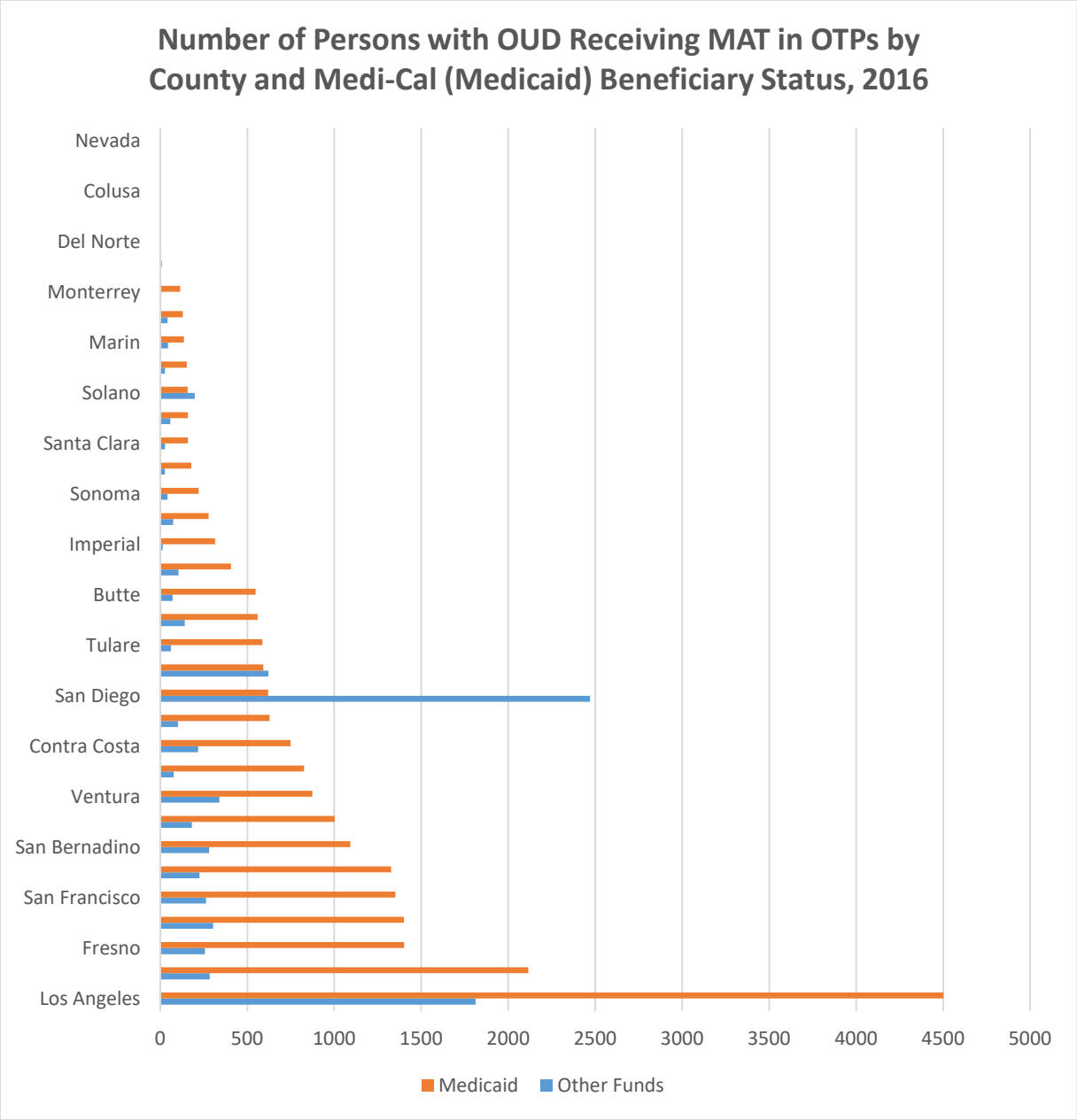
[4] https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/certified-physicians?field_bup_us_state_code_value=CA

Current Programmatic Capacity



Data Source: CalOMS-Tx, 2016.

In 2016 Los Angeles County had the highest number of OUD persons served in opioid treatment programs at 6,314 persons while Nevada, El Dorado, Colusa, Mendocino, Del Norte and Humboldt counties, which also have the highest overdose death rate, have less than 10 clients in opioid treatment programs.



Data Source: CalOMS-Tx, 2016.

While Los Angeles County had the highest number of OUD persons with Medicaid served in MAT in OTPs at 4,502 persons, San Diego had the highest number of OUD persons in OTPs who were not reported as Medicaid beneficiaries at 2,471 persons. It is unclear why San Diego is an outlier on this variable, and it is possible that data collection and reporting issues could play a role.

California's Response to the Opioid Crisis

MAT Expansion Project

For the next two years, an important component of California's response to the opioid crisis will be the state's STR-funded MAT expansion effort to adapt and apply the Hub & Spoke System (H&SS) Model from Vermont. This project will implement or expand access to clinically appropriate evidence based practices (EBPs) for OUD treatment, particularly the use of medication-assisted treatment (MAT) with all FDA-approved medications.

CA's H&SS will focus on populations with limited MAT access including rural areas, American Indian and Native Alaskan (AI/NA) tribal communities, and will also maintain a commitment to increase statewide access to buprenorphine.

Nineteen agencies in California will serve as hubs, each with several spokes, providing coordinated care to OUD clients requiring varying levels of care.

Hubs will serve as the regional consultants and subject matter experts to spokes on opioid dependence and treatment. Spokes will provide ongoing care for patients with milder addiction (managing both induction and maintenance). A Spoke will be comprised of at least one prescriber and a MAT team to monitor adherence to treatment, coordinate access to recovery supports, and provide counseling. Patients will be able to move between the Hub and Spoke based on clinical severity. The 19 hubs and the associated spokes that have been identified to date are shown in the map below. More spokes will be added as the project expands.

California's communities of focus at the highest risk for OUD fall into three categories:

Counties with no NTPs

The first community of focus is comprised of counties without a NTP in their geographic area. These communities currently have no access to methadone treatment services and very limited access to buprenorphine.

Counties with Low Buprenorphine Access

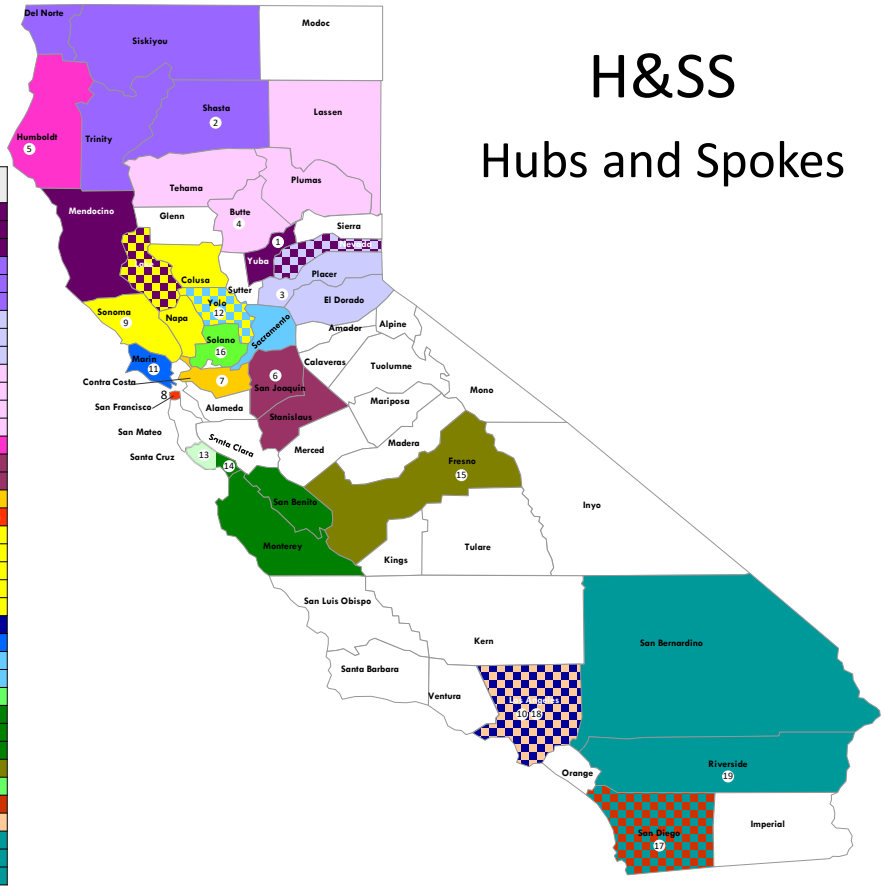
The second community of focus is inclusive of the entire state of California for improved access to buprenorphine services. California's overall rate of total dispensed prescriptions for buprenorphine is low compared to the rest of the nation.

American Indian and Native Alaskan Tribes

The third community of focus is comprised of the AI/NA tribes. The AI/NA communities have significant challenges in accessing MAT services and their issues with the opioid epidemic are also on the rise.

The death rate from unintentional drug poisoning is almost twice as high in the AI/NA population compared to the population nationally.

Network # & Hub location	Spokes
1	Lake County (1)
	Mendocino County (2)
	Nevada County (1)
2	Siskiou County (2)
	Trinity County (1)
	Del Norte County (1)
3	El Dorado County (1)
	Placer County (1)
	Nevada County (1)
4	Butte County (2)
	Lassen County (1)
	Tehama County (1)
	Plumas County (1)
5	Humboldt County (6)
6	San Joaquin County (1)
	Stanislaus County (1)
7	Contra Costa County (TBD)
8	San Francisco County (TBD)
9	Sonoma County (1)
	Lake County (1)
	Yolo County (1)
	Colusa County (1)
	Napa County (1)
10	Los Angeles County (10)
11	Marin County (8)
12	Yolo County (2)
	Sacramento County (1)
13	Santa Cruz - N County (6)
14	Santa Cruz - S County (4)
	San Benito County (1)
	Monterey County (1)
15	Fresno County (TBD)
16	Solano County (TBD)
17	San Diego County (7)
18	Los Angeles County (10)
19	San Bernadino County (1)
	Riverside County (6)
	San Diego County (2)



California is home to approximately 115 federally recognized AI tribes, with the largest population of individuals self-identified as AI/NA in the nation. Approximately 723,225 identify as AI/NA alone or in combination with another race, representing 14% of the national AI/NA population (T. Norris, P. Vines, E. Hoeffel, American Indian and Alaskan Native Population: 2010, 2010 Census Briefs, January 2012).

In Fiscal Year 2014-15, there were approximately 210,000 individuals (unique clients) served in California and of those, 3,640 reported being AI/NA (about 1.7%). The largest percentage of AI/NA clients served were in Inyo (14%), Mariposa (13.7%), Humboldt (12.7%), Mendocino (12.3%), and Del Norte (10.5%) counties. Drug overdoses accounted for 4.3% (450) of all deaths among Northwest AI/NA individuals and 1.7% (9,868) of all deaths among non-Hispanic whites (NHWs).

MAT Expansion Project Aims and Goals

The MAT Expansion Project will address the following aims, which build upon the priorities described in SAMHSA's State Targeted Response to the Opioid Crisis Grants Funding Opportunity Announcement.

Aim 1: Increase access to OUD treatment

Aim II: Reduce unmet treatment need.

Aim III: Reduce opioid overdose related deaths through access to treatment, prevention, and recovery activities.

Aim IV: Increase MAT Utilization for Underserved, Uninsured, Medicaid and Tribal Communities

Aim V: Track Progress of MAT Expansion Project

The strategic goals associated with each of these aims are described below.

Aim I: Increase Access to OUD Treatment

Goal 1) Implement Hub and Spoke model in various areas throughout California to improve access to Narcotic Treatment Programs (NTPs)

Hub Goals

Goal 1.1) Work with California counties without NTP facilities to overcome barriers related to limited access to MAT
Goal 1.2) Become true regional resources, serving as subject matter experts with broad public health missions.
Goal 1.3) Provide timely assessments and intakes of new patients.
Goal 1.4) Develop expertise to prescribe all FDA-approved medications for OUD.
Goal 1.5) Manage inductions (based on the need of the patient), provide timely consultation to Spoke prescribers, have the capacity to accept referrals for patients too complex to be managed at the Spoke, and transfer patients to Spokes when stable for medication maintenance.
Goal 1.6) Maintain and report data on patients in treatment.
Goal 1.7) Perform HIV and Hepatitis C virus (HCV) testing on all individuals who enter treatment.
Goal 1.8) Ensure capacity to assess and coordinate care for mental health disorders.
Goal 1.9) Provide basic case management services, including coordinating referrals for housing, insurance, entitlements (e.g. applications for food or income assistance and social security disability), and travel needs.

Spoke Goals

Goal 1.10) Employ a harm reduction approach
Goal 1.11) Manage ongoing signs of uncontrolled addiction while on buprenorphine treatment with intensive monitoring and behavioral health services, with referral to the Hub if the needs are greater than the Spoke can provide.
Goal 1.12) Collect minimal data elements such as numbers of patients in care and retention in treatment. These data elements will be reported to the Hub.

Hub and Spoke Goals

Goal 1.13) Provide counseling services to all OUD patients.
Goal 1.14) Provide recovery services onsite and/or make referrals to community providers.

Goal I.2) Establish Medication Units (MU) in counties with limited access to NTPs

Goal 2.1) Expand the creation of MUs and work in conjunction with licensed NTPs.
Goal 2.2) Expand MAT treatment to rural AND urban areas.
Goal 2.3) Expand MUs in non-NTP counties with the MAT Expansion Project.
Goal 2.4) Increase number of additional MUs in underserved areas especially where clinics are not located.
Goal 2.5) Increase access to NTP and/or MUs in underserved areas by at least three clinics.

Goal 3) Increase availability of buprenorphine and Naloxone statewide

Goal 3.1) Increase buprenorphine prescriptions to Medicaid population
Goal 3.2) Increase buprenorphine prescriptions as a proportion of opioid prescriptions.
Goal 3.3) Purchase Naloxone for distribution in high need communities and train first responders, substance use prevention and treatment providers and others on the use of naloxone.
Goal 3.3) Hubs to have both buprenorphine and methadone services
Goal 3.4) Hubs to help enable primary care providers to start managing patients with buprenorphine.
Goal 3.5) Create a robust infrastructure for the utilization of buprenorphine, since on average, California waivered physicians only manage five patients at a time.
Goal 3.6) Increase the number of patients served per physician.
Goal 3.7) In coordination with other statewide efforts, increase the total number of physicians and NPs waivered to prescribe buprenorphine.
Goal 3.8) Increase the statewide average of the number of opioid users served by each waivered physician/NP.
Goal 3.9) Increase the availability of counseling services for buprenorphine patients and a variety of support services for MDs in primary care settings.

Aim II: Reduce Unmet Treatment Need

Goal 4) Increase number of waivered physicians that can prescribe MAT

Goal 4.1) Support MAT as a best practice for OUD treatment
Goal 4.2) Expand upon current efforts to reduce the stigma associated with this disease, including promoting long-term maintenance treatment.
Goal 4.3) Improve access to MAT statewide
Goal 4.4) Improve access to MAT services in at least 30% of counties with the top ten highest overdose rates.
Goal 4.5) Expand access to integrated MAT services in urban areas.
Goal 4.6) Encourage local communities to support a long-term sustainable system to utilize MAT.
Goal 4.7) Improve infrastructure for providing MAT medications
Goal 4.8) Track and compare outcomes for clients that stay in MAT treatment for more than 90 days.

Goal 4.9) Track and compare outcomes for clients in MAT treatment that relapse based on length of treatment retention.

Aim III: Reduce Opioid Overdose Related Deaths through Access to Treatment, Prevention & Recovery Activities

Goal 5) Develop prevention and treatment activities

The MAT Expansion Project will promote prevention activities such as prevention specialists, provision of naloxone, coordination with local opioid coalitions, and training conducted by the University of California, Los Angeles (UCLA) and the California Society of Addiction Medicine (CSAM).

Goal 5.1) Reduce MAT stigma in the treatment community and concern by local elected officials and public safety organizations around SUD treatment
Goal 5.2) Provide education regarding effectiveness of MAT
Goal 5.3) Use data from Prescription Drug Monitoring Program (PMDP) to promote expansion of medically assisted treatment opportunities by region
Goal 5.4) Collaborate with the Statewide Opioid Safety Workgroup, comprised of all state agencies impacted by the epidemic (e.g. Medical Board, Pharmacy Board, Justice, Health Services, Managed Care, DEA, Public Health, etc.), along with other statewide leaders, to promote coordinated care and minimize the unintended consequences of increased heroin use
Goal 5.5) Conduct academic detailing to identify federal waivered prescribers that can become champions in their community to encourage other physicians, nurse practitioners (NPs) and physician assistants (PAs) to become waivered.
Goal 5.6) Collaborate with local partners such as Statewide Opioid Safety Workgroup, California Healthcare Foundation and others to map out treatment access and treatment gaps across the State of California, and create a strategy to ensure timely local access to all forms of MAT, to promote safe and effective prescribing and dispensing policies and practices, and to promote community dispensing of naloxone.
Goal 5.7) Promote the use of the National Clinician Consultation Center's (NCCC), Substance Use Warmline (SUW) which provides substance use evaluation and management advice to health care providers on behalf of the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC). The Warmline's goal is to provide "real time" education and clinical decision support via case-based telephone consultation to primary care providers. NCCC has established itself nationally as a clinical consultation and educational resource that helps clinicians of all experience levels across the U.S. deliver patient-centered, evidence-informed care for complex patient populations. Consultation is free and confidential, and the SUW can also link callers to expanded/"wrap around" consultation for human immunodeficiency virus (HIV) and viral hepatitis prevention and management as indicated.

Goal 5.8) Track number of calls received by SUW and evaluate its impact on MAT expansion.

Goal 5.9) Provide tailored technical assistance on addiction treatment in partnership with Treating Addiction in the Primary Care Safety Net (TAPC) created by The Center for Care Innovations and California Health Care Foundation

Goal 6) Establish a Learning Collaborative and provide trainings

The CA H&SS will establish a Learning Collaborative, which is a vehicle to create an effective network with bi-directional patient movement and team care.

Goal 6.1) The Learning Collaborative will be designed to increase training of addiction medicine within the Hubs, Spokes and other staff.
Goal 6.2) The Learning Collaborative will promote philosophy of harm reduction, and policies and practices that promote routine engagement and retention.
Goal 6.3) The Learning Collaborative will provide stigma-reducing education and training to all of California's SUD treatment facilities in addition to other stakeholders impacted by the opioid epidemic.
Goal 6.4) The Learning Collaborative will conduct monthly sessions with mandatory attendance from the participating Hubs and strongly encouraged for Spokes. The sessions covered will be developed from Vermont's model and will include but not be limited to the following topics:

- Step-up and step-down workflows and protocols (to manage referrals between Hubs and Spokes)
- Team-based care models, to decrease burden on prescribers and increase participation in treatment
- Drug screening
- Handling behavioral issues
- Effective treatment of cocaine, benzodiazepines, and alcohol use disorders
- Need for dose adjustments and induction protocols
- Integrating regular medical and psychiatric care into the office visit
- Overdose prevention with naloxone
- HIV and hepatitis education

Goal 6.5) Conduct Physician-to-physician training to access expansion efforts in both rural AND urban regions.
Goal 6.6) Find early adopters in the physician community that want to promote the change to treat patients with OUD.
Goal 6.7) Increase use of Prescription Drug Monitoring Program (PDMP) data
Goal 6.8) Provide Learning Collaborative deliverables:

- Conduct quarterly half-day seminars for the CA H&SS
- Design and implement CA H&SS implementation forums
- Deliver one-day statewide CA H&SS orientation training
- Provide quarterly statewide MAT trainings for the public, stakeholders, SUD providers and other entities on emerging trends pertaining to MAT and OUD

- Assist DHCS with the training and technical assistance functions for the CA H&SS Steering Committee
- Provide technical assistance for H&SS
- Collaborate with Vermont on CA H&SS implementation
- Conduct two, 6-hour clinical/skill development trainings per year in each H&SS region
- Coordinate with CSAM on training and mentoring projects
- Deliver one-day CA H&SS best practices training
- Design culturally specific training for the Tribal MAT Project
- Disseminate information statewide pertaining to Substance Use Warmline services
- Collaborate training with other CA initiatives such as academic detailing

Aim IV: Increase MAT Utilization for Underserved, Uninsured, Medicaid and Tribal Communities.

Goal 7) Improve MAT access for tribal communities.

Goal 7.1) Increase the total number of tribal waivered prescribers certified,
Goal 7.2) Provide expanded MAT services that include tribal values, culture and treatments.
Goal 7.3) Provide innovative telehealth in rural and underserved areas and increase community capacity to support OUD prevention and treatment.
Goal 7.4) Increase treatment engagement especially for underserved population by enhancing clinical decision tools using health information technology.

Aim V: Track Progress of MAT Expansion Project

Goal 8) Conduct program evaluation of H&SS Project

Goal 8.1) Conduct an evaluation of project efforts that include the required federal performance measures in addition to other data elements.
Goal 8.2) Report on the SAMHSA performance measures which include:

- Number of people who receive OUD treatment
- Number of people who receive OUD recovery services
- Number of providers implementing MAT
- Number of OUD prevention and treatment providers trained, to include NPs, PAs, as well as physicians, nurses, counselors, social workers, and case managers
- Numbers and rates of opioid use
- Numbers and rates of opioid overdose-related ED visits and deaths

Goal 8.3) Create data reporting structure and collect CA H&SS data elements
Goal 8.4) Conduct an evaluation of the CA H&SS project
Goal 8.5) Design the data reporting structure for the Tribal MAT Project
Goal 8.6) Develop and administer the CA H&SS Provider survey
Goal 8.7) Conduct Spoke Prescriber Interviews

Goal 8.8) Design and Conduct Patient Questionnaire and Interview Questions
Goal 8.9) Design and conduct the Tribal MAT Project evaluation
Goal 8.10) Coordinate with CDPH PDOP epidemiological team and data dashboard
Goal 8.11) Assist with the development and collection of the MAT Expansion Project performance measurement requirements

Allied Efforts

Although the previous sections have focused on the MAT Expansion Project, a number of other notable efforts are also underway in parallel. The MAT Expansion Project will coordinate with these efforts wherever possible.

Statewide Opioid Safety Workgroup[5]

The California Department of Public Health convened a Statewide Opioid Safety Workgroup in spring 2014. The goals for the Workgroup are to:

1. Promote safe and effective prescribing and dispensing policies and practices.
2. Guide appropriate patient use, storage and disposal of prescription drugs.
3. Support proper pain management methods.
4. Minimize the unintended consequence of increased heroin use.
5. Promote the expansion of medically assisted treatment opportunities.

Workgroup membership is representative of many agencies and disciplines, bringing diverse perspectives and valued content expertise. Taskforces, created to move forward on specific action plans, include communications, policy, data and monitoring, treatment, and maternal addiction access.

California Opioid Safety Coalitions Network[6]

Opioid safety coalitions bring together a broad group of stakeholders committed to decreasing opioid overuse and overdose deaths. Advocates and community leaders from public health, hospitals, addiction treatment, medical societies, law enforcement, health plans, and others come together to find creative ways to solve the opioid epidemic in their communities. Each coalition is charged with three priorities: lowering opioid prescribing rates, increasing access to MAT (specifically focused on buprenorphine), and increasing naloxone access. The California Health Care Foundation (CHCF) provided technical assistance to 16 of these coalitions in 24 counties across California from November 2015 through May 2017, and found that counties with CHCF-supported coalitions had almost double the increase of buprenorphine prescriptions (20% increase) compared to counties without CHCF-supported coalition (11% increase), along with statistically significant drops in opioid prescribing. Preliminary data will be published on the CHCF website by October 1, 2017. CHCF is now supporting the Public Health Institute to provide training,

[5] https://archive.cdph.ca.gov/Pages/OpioidMisuseWorkgroup.aspx
[6] http://www.chcf.org/oscn/about

technical assistance, and network support for all county coalitions (now including over 36 of California's 58 counties) through December 2019.

Smart Care California[7]

Smart Care California is a public-private partnership working to promote safe, affordable health care in California. The group currently focuses on three issues, one of which is opioid overuse. Collectively, Smart Care California participants purchase or manage care for more than 16 million Californians—or 40 percent of the state. Smart Care California is co-chaired by the state's leading health care purchasers: DHCS, which administers Medi-Cal; Covered California, the state's health insurance marketplace; and CalPERS. IHA convenes and coordinates the partnership with funding from the California Health Care Foundation. Specific actions related to the opioid epidemic include promotion of plan and purchaser checklist[8] of best practices shown to lower overprescribing, increase access to addiction treatment, and streamline access to naloxone (an overdose antidote). Smart Care CA aims to empower purchasers, plans and provider groups to take comprehensive and systematic action to reverse the harms of the opioid epidemic.

Treating Addiction in Primary Care learning collaborative[9]

The Center for Care Innovations, supported by the California Health Care Foundation, created the Treating Addiction in the Primary Care Safety Net (TAPC) program. The TAPC program provides tailored technical assistance on addiction treatment and change management topics to a group of 25 community health center awardees, all poised to either become Spokes in the system, or potentially to collaborate with hubs in management of complex patients. The goal of TAPC is to build more treatment infrastructure for MAT, integrated into primary care.

Treating Addiction in Emergency Departments learning collaborative

Recognizing that many patients with addiction only show up to the emergency department in distress, and are not engaged in primary care, CHCF is supporting the launch of MAT Emergency Department pilots in over eight hospitals in six counties, four of them in rural California. Based on the successful randomized controlled trial from Yale,[10] demonstrating that retention in treatment at 30 days doubled when buprenorphine was started in the emergency department, these pilots are aiming to increase access to MAT through another patient touch-point, the emergency department.

Treating Addiction in Correctional settings

As opioid addiction involves illegal behaviors, many patients with addiction end up in the correctional system – the place with the highest concentration of people with opioid use disorders, and the least access to MAT. CHCF is supporting Los Angeles County in their rollout of new programs offering all FDA-approved medications for addiction in all correctional settings, and is

[7] http://www.iha.org/our-work/insights/smart-care-california/focus-area-opioids
[8] http://www.iha.org/sites/default/files/files/page/pdf_healthplansopioidchecklist.pdf
[9] http://www.careinnovations.org/programs-grants/treating-addiction
[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4527523/

supporting a virtual learning network for local leaders interested in increasing access to MAT in corrections.[11]

Conclusion

In summary, the California Hub and Spoke system is a major component of DHCS's effort to increase treatment access across the State. The combined resources of CDPH and CHCF are also working with local coalition leaders to address local "not in my backyard" cultural barriers to increase MAT access, specifically working with primary care providers to increase the number willing to prescribe buprenorphine and expand their patient panel. CHCF is supporting community health centers, emergency departments, and jails, all to become key access points for patients to move from addiction to recovery. All of these projects depend on a robust Hub and Spoke System to ensure complex patients have access to specialty addiction care in opioid treatment programs, and new MAT access points can take advantage of learning opportunities in the rollout of the Learning Collaborative. Together, we can ensure that no patient needs to travel far to get addiction treatment, whenever they are ready for it.

[11] For more information, contact Kelly Pfeifer at CHCF, kpfeifer@chcf.org