# OPIOID PLANNING SUMMIT
# APRIL 16, 2019
# NOTES FROM PARTICIPANT DISCUSSION SESSIONS

The Arizona Department of Health Services worked with AHCCCS and the Governor's Office of Youth, Faith, and Family to convene a one-day summit to generate ideas and recommendations on next steps in addressing the state's opioid crisis. Fifteen breakout sessions were held to discuss challenges and potential solutions on a variety of topics. The notes below include the top challenges and recommended actions generated from each session, as well as all of the ideas identified by participants in the sessions.

| SESSION: IMPROVING UTILIZATION OF THE CSPMP | |
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| **TOP 3 CHALLENGES** | **TOP 3 RECOMMENDED ACTIONS** |
| • **Challenge 1: Lack of Education**<br>• **Challenge 2: Integration with daily workflow (EHR)**<br>• **Challenge 3: Enforcement** | • **Action 1: It is not only the law, but is the standard of care.**<br>• **Action 2: Collaborate with other governmental agencies, associations, licensing boards, and EHR vendors; regarding integration into the EHR**<br>• **Action 3: Better data analysis regarding compliance** |
| **BRAINSTORMED CHALLENGES** | **BRAINSTORMED RECOMMENDED ACTIONS** |
| • Lack of education<br>• Awareness of benefits – a positive vs. negative approach<br>• Messaging for use of CSPMP – mandatory vs. this is a useful tool<br>• Better understanding of PMP – education!<br>• Usability – user friendly<br>• Integration in EHR (lack of)<br>• EHR integration<br>• Ease of access (EHR, BOP, HIE)<br>• Lack of repercussion if not adherent<br>• Concern about enforcement accountability<br>• Doctors are not paying attention<br>• Staffing to follow up<br>• Not all prescriptions have to be entered<br>• Push notification for high risk patients<br>• Doctors and stuff forget to enter | • Focus on standard of care (not just law)<br>• Target as "problem you don't see coming" Doctor has role<br>• Start from bottom up (i.e. nurses and delegates)<br>• Simplify to "check it every time" policy<br>• Cross-education<br>• Work with EHR vendors (automation)<br>• Better data mining for compliance<br>• Know your target audience (who is not checking) |

| SESSION: IMPROVING REFERRALS TO OPIOID USE DISORDER AT HIGH IMPACT POINTS | |
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| **TOP 3 CHALLENGES** | **TOP 3 RECOMMENDED ACTIONS** |
| • **Challenge 1: Stigma & lack of education with providers, first responders, administrative individuals**<br>• **Challenge 2: Insufficient network** | • **Action 1: Integrate CHW/peer support into high impact settings**<br>• **Action 2: Community stigma reduction campaign. Focus on administrative** |

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| **capacity (24/7 access, waitlists, transport, timely response, workforce shortage/retention)**<br>• **Challenge 3: Perceived risks/liability and systems logistics** | **level for LE, EBP/Tx for providers**<br>• **Action 3: Reimbursement and tuition incentives (especially in rural and tribal areas)**<br>• **Action 4: Standardized protocols for navigation from high impact points** |
| **BRAINSTORMED CHALLENGES** | **BRAINSTORMED RECOMMENDED ACTIONS** |
| • Not matching persons need to referral: geography, insurance, transportation<br>• Lack of services readily available: tribal communities, waitlists, no 24/7 pharmacies<br>• Lack of personnel/ boots on the ground<br>• Lack of waivered doctors<br>• Transportation<br>• Gaps between touch points<br>• Insufficient # of facilities, capacity, 24/7 access<br>• First responders: fatigue, not social workers<br>• First responder: not in scope to refer to treatment criminalization, arrest then will do treatment, multiple numbers to call (OAR line, local #, etc.)<br>• Logistics in ED<br>• Risk management<br>• ED system changes: MOU get in ED's, HIPAA concerns<br>• Standardized discharged procedures do not exist: exit ED's and correction setting<br>• No co-prescription at naloxone i.e. hospitals, OD does not equal treatment<br>• People need connected where they are, not referred to somewhere else<br>• Stigma<br>• Breaking of silos and collaborate<br>• Education of law enforcement: navigation<br>• Stigma and lack of education<br>• Need for more harm reduction interventions<br>• Workforce training<br>• Insurance coverage<br>• Uninsured people / uninsurable: don't go for services can't be referred<br>• Continued unethical prescribing or entities | • Stigma reduction/from leadership (including doctors) OUD as brain disease and MAT gold standard<br>• Enhanced education that focuses on the administration for low employment (Quarterly? Bi-Yearly?)<br>• Education on harm reduction programs, Authorization of syringe service programs<br>• Compassion fatigue and secondary traumatic stress education and reduction efforts/education<br>• Community Education Campaign: OUD, Tx Centers, people with lived experience<br>• Increase network capacity: statewide peer support association/council/coalition<br>• Involving the community (layman) in the processes<br>• Public/Private partnerships for transportation<br>• Be mindful of the culture of the people you care for when implementing education strategies<br>• Integrate CHW's & peer support in all healthcare settings (hospitals, jails, detox centers, etc.)<br>• Implement reach in and reach out coordinators at all jails<br>• "Friends in the lobby"<br>• Reframing first responders roles as community problem solvers<br>• Thoughtfully design and ED pilot (MAT/ Peer supports)<br>• Require ED's to implement opioid Rx/discharge procedure guidelines<br>• Shared policy and procedures (centralized policies and procedures)<br>• Policies for quality care / coordination of care those offering detox<br>• RBHA cheat sheets of grant providers to |

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| • Over prescribing! Lack of accountability for pharma<br>• Political atmosphere state; federal; tribal etc.<br>• $<br>• Lack of awareness of what is available<br>• Personal want/desire/readiness<br>• (SDOH) Social Determinant of Health challenges<br>• Trying to make Tx linear process | eliminate thinking/memory use<br>• Standardized referral protocols at high impact settings<br>• Community/patient needs assessment<br>• Sharing data for evaluation of program effectiveness<br>• Approach providers with data<br>• Local strategic planning with focus on coordination/collaboration<br>• GME – tuition reimbursement – those prof. in rural settings<br>• Use payment to incentivize |

| SESSION: IMPROVING ACCESS TO NALOXONE | |
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| **TOP 3 CHALLENGES** | **TOP 3 RECOMMENDATIONS** |
| • **Challenge 1: Naloxone distribution/administration reporting/tracking gaps**<br>• **Challenge 2: Identifying areas of need (youth, homeless individuals, and other at risk populations.)**<br>• **Challenge 3: Dispensing naloxone to patients upon discharge vs. providing a script** | • **Action 1: PSA's to increase awareness and education which includes Good Samaritan Law, and additional messaging that targets prescribers, and youth**<br>• **Action 2: Implementation of needle exchange programs.**<br>• **Action 3: Include naloxone in AED stations, consider naloxone vending machines, consider naloxone replacement program**<br>• **Action 4: Dispense naloxone directly from the ED/Hospitals/Urgent Care facilities** |
| **BRAINSTORMED CHALLENGES** | **BRAINSTORMED RECOMMENDED ACTIONS** |
| • Patients refusing scripts<br>• Families refusing naloxone<br>• Naloxone administration methods<br>• Assembly<br>• Reporting Gaps<br>• Identifying areas of need (HS, stores, etc.)<br>• Cost<br>• Needle exchange / AED stations / vending machines<br>• Co-prescribing<br>• Discharge planning | • PSA's<br>• Needle exchange/vending machines/ AED stations<br>• Home health visits<br>• Follow-up services<br>• Outreach to shelters, convenience stores, skilled nursing facilities, etc. (ex. Circle K's)<br>• Increase education and awareness – target prescribers and youth<br>• Dispense directly from the ED via leg. Callout<br>• Increase training |

| SESSION: WORKING WITH PRIORITY ADULT POPULATIONS (JUSTICE-INVOLVED, VETERANS, PREGNANT/PARENTING, BEHAVIORAL HEALTH) | |
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| **TOP 3 CHALLENGES** | **TOP 3 RECOMMENDATIONS** |
| • **Challenge 1: Stigma – Who to train? Within the community and within the treatment profession**<br>• **Challenge 2: Education & Engagement non-traditional populations, meeting them where they are at (i.e. disabilities, brain injuries, co-occurring disorders, tribal)**<br>• **Challenge 3: Pregnancy and Parenting, fear related to DCS removing children, lack of providers willing or able to treat, OBGYN's not educated, services not following after birth** | • **Action 1: Stigma-Education, training services providers, public awareness campaigns, Addressing the punitive treatment model, denying people services due to relapse, defining clinical language**<br>• **Action 2: Education/Engagement (patient, family provider, payor, workforce) Develop a task force including peers and clients for best practices**<br>• **Action 3: Pregnancy/Parenting Engage, public campaign to educate on drug use/MAT when pregnant and parenting, actual practices of law enforcement, prosecution and child protection services similar to The Journey Project.com, more MAT treatment and recovery options for pregnant women, workforce development.** |
| **BRAINSTORMED CHALLENGES** | **BRAINSTORMED RECOMMENDED ACTIONS** |
| • Fear within PPW<br>• Education about using alone (how to reach target population)<br>• Stigma related to the treatment<br>• Residential Treatment Center that won't accept people on MAT or that expect residents to detox.<br>• Identification of addiction vs. chronic addiction<br>• Public persona vs. Private experience<br>• OB's and all providers not educated enough on all options – standard questions regarding opioid use<br>• PPW: fear of DCS becoming involved, which also lead to not engaging services at all<br>• PPW: Pregnant women are not engaging services because they are afraid of the stigma (WIC, supplies, community support) | • Trainings in best practice approaches (ASAM, Motivational Interviewing, CBT)<br>• Challenge 2: Brain injury – brain injury screening at intake, brain injury education for providers (general understanding BI, screening, appropriate accommodations), expanded intensive after care recovery support for persons with BI<br>• Health plans initiating continuity of assessments and care plans<br>• Mobile/home-based services (frequent)<br>• Community focus groups to gather insights on what works<br>• Prenatal support<br>• Community Health Workers from different backgrounds<br>• Technology assisted care (mobile apps, text messages, recovery coaches)<br>• Peer support. Relationship building. |

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| • Rural/Tribal treatment<br>• Stigma related to the disease<br>• Treatment availability in rural areas (wait time)<br>• Losing moms after birth<br>• Safe living environments<br>• Stigma around pregnancy and treatment<br>• Coordination of care<br>• Lack of peer support specialists<br>• Stigma surrounding addiction<br>• Previously incarcerated: handoff to existing resources, people getting lost in the gap between release, securing basic needs, and formal Tx services<br>• Release coordination model resistance (in CJ)<br>• Access to treatment within jails<br>• Partnership with state organizations<br>• How to engage those not in the system<br>• Accessibility to treatment centers for individuals with physical diabetes<br>• Persons with brain injury are more likely to develop an OUD and experience co. occurring mental health issues (depressions/anxiety) but have a diminished capacity to engage and be successful in treatment<br>• Lack of education regarding brain injury after experience | • Treatment centers must accommodate ALL abilities!<br>• Workforce development (quality workforce)<br>• Support of PSS (encourage AHCCCS to increase the rate)<br>• Expand education to include: family members, caregivers, children<br>• Training service providers as to head conversations<br>• Social change needed i.e. HIV shift because those with HIV came forward to share stories; people in recovery are more engaging, peer support: challenges/successes etc.<br>• Maternity providers performing MAT – transition to other MAT providers once delivered warm hand-off / connect to care<br>• Non-maternity providers treating women of childbearing age need to ensure reliable contraception and highly consider regular urine pregnancy testing<br>• Maternity provider – recommend urine drug screening be universal<br>• Maternity providers doing MAT providing or referring for behavioral services and also outreaching if person quits treatment/engaging in services<br>• Providers unaware of non-opioid alternatives for chronic pain as first line of treatment<br>• Public not aware of non-opioid approaches as 1st line of treatment for chronic pain |

| **SESSION: INSURANCE COVERAGE FOR CHRONIC PAIN TREATMENT AND SUBSTANCE USE DISORDER** | |
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| **TOP 3 CHALLENGES** | **TOP 3 RECOMMENDED ACTIONS** |
| • **Challenge 1: Lack of reimbursement strategies addressing the complexity of chronic pain management and substance use disorders.**<br>• **Challenge 2: Insurance design and clinical criteria evolving to reflect the complexity of chronic pain management, substance use** | • **Action 1: Organized effort to map out and document evidence-based treatments and ROI**<br>• **Action 2: Increase transparency in insurance design, coverage, and patient navigation**<br>• **Action 3: Create a value0based bundle around pain care and/or substance** |

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| **disorders, and evidence-based practices.** | **use disorder treatment** |
| **BRAINSTORMED CHALLENGES** | **BRAINSTORMED RECOMMENDED ACTIONS** |
| • Public not aware of what treatment is actually covered – barrier to seeking treatment<br>• Insurance coverage too complicated for providers to decipher as to what is covered<br>• Stigma by employers<br>• Lack of ROI insights by employer groups<br>• Step therapy<br>• Brand name only (3500 A Medform)<br>• Getting insurance to cover 2nd procedure without max results<br>• Mechanism for methadone reimbursement<br>• Transportation to appointments<br>• Coverage for transportation for patients to providers<br>• Case management<br>• Capitation on physical therapy visits (no chronic pain pitus therapy)<br>• Lack of provider accountability<br>• Telemedicine<br>• Providers may be challenged with having the time to have difficult conversations related to chronic pain (time-sensitive PCP offices ) (incentive for having the conversations)<br>• Patients that can't afford co-pays<br>• Not enough resources for mental health<br>• Where to send chronic pain patients<br>• Indian health Services – Providers not recognized for private insurance. Additional barriers for patients to receive referrals | • Reference sheet for providers of what's covered in plans (user-friendly)<br>• Transparency – how are decisions made<br>• Patient education<br>• Partnership for a pilot to align provider reimbursement and evidence-based treatments to show that it is cost saving<br>• CMS innovation grants to conduct ROI evaluations on alternative therapies<br>• Studies on alternative treatments<br>• Align payment to outcomes<br>• House Bill 2166 – copay excellator<br>• Do something similar to Oregon's HERC, here in AZ (Health Evidence Review Commission) |

| **SESSION: TRAUMA-INFORMED CARE** | |
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| **TOP 3 CHALLENGES** | **TOP 3 RECOMMENDED ACTIONS** |
| • **Challenge 1: Lack of training and education for general public around trauma including prevention services**<br>• **Challenge 2: Lack of proper screening** | • **Action 1: Training for all professionals with a uniform message, language, materials**<br>• **Action 2: Community wide education** |

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| **for trauma**<br>• **Challenge 3: Lack of time and resources including funding dedicated to addressing trauma** | **including public service announcements**<br>• **Action 3: Funding needs/codes to be opened up to include trauma** |
| **BRAINSTORMED CHALLENGES** | **BRAINSTORMED RECOMMENDED ACTIONS** |
| • Workforce not informed<br>• Engage & educate workers and public<br>• Trust building relationships<br>• Where to screen for ACE's (peds, primary care, etc.)<br>• Workforce development<br>• Educate adults on what Trauma-informed care really is<br>• Reaction time and funding<br>• Provider training<br>• Education and stigma reduction<br>• Time limits of treatment. Insurance companies/providers not recognizing time it takes to uncover and work through trauma. More than 30 days needed.<br>• We need adequate screens for trauma then we need to know what to with responses in practice<br>• Not understanding trauma – believing its only traumatic experiences<br>• Culture shift<br>• Timing/scheduling implemented training<br>• People/providers don't have a clear understanding of how training occurs and what it is<br>• Reimbursements for assessment and treatment<br>• Capacity and access of trained providers<br>• Denial<br>• Access to care<br>• Prevention vs. punishment<br>• Not knowing the resources<br>• Engagement – bringing the right people to the table<br>• Untrained clinicians<br>• Lack of education regarding trauma informed trainings<br>• Prioritization<br>• Implementation<br>• Staffing<br>• Education | • Training – free, mandatory, ongoing<br>• Can trauma be included in Governor's office stigma regarding campaign? Medical School trauma – info care training? (curriculum) Workforce development – in creative ways w/ access for rural areas for example<br>• Reimbursement for screening. Resources increasing opportunity for collaboration. Opportunities for stakeholder meetings and learning action networks. Collaborative learning opportunities.<br>• Partnerships of coalitions, direct service providers, PD, fire, etc. of implementing training & continued support<br>• Trauma informed care liaison embedded in organizations<br>• Education (insurance, providers, schools, parents, AD campaign)<br>• Increase the number of community health workers and peer supports with screening and then offer support and stigma reduction directly to those experiencing OUD. Also can help connect individuals into treatment at community health level<br>• Earmarking tax dollars to support funding for training and education<br>• Develop a tool kit for trauma informed that includes a "train the trainer" training (ensure consistency – speaking the same language)<br>• Identify a "State" champion to spear head the trauma campaign, to give it a voice and normalize it<br>• Create a media campaign/general education to explain what trauma is and address stigma. Find best practices to use<br>• Add trauma informed care training for all medical professionals and educators<br>• Statewide curriculum<br>• Tie current funding streams with |

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| • Stigma and shame<br>• Difficult to heal from trauma<br>• Lack of knowledge and education and education tailored to community and providers | education programs for state wide curriculum |

| SESSION: DIVERSION PROGRAMS | |
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| **TOP 3 CHALLENGES** | **TOP 3 RECOMMENDED ACTIONS** |
| • **Challenge 1: Lack of resources such as alternatives to MAT, funding, staffing, transportation, and specialty services, peer support, etc.**<br>• **Challenge 2: Lack of access to services and resources if they exist**<br>• **Stigma towards substance users and lack of awareness at all levels including political/legislative, tribal council, policy makers, the public etc.** | • **Action 1: To address access to services promote the OAR line as a single point of contact to be connected to services, improve transportation to get people to the referred services, and have the state agencies examine policies that increase barriers to care.**<br>• **Action 2: To address lack of resources train all members of the criminal justice workforce on the benefits of diversion and trauma informed care to improve utilization of available services.**<br>• **To address stigma towards substance users and raise awareness create public service announcements showing that drug use impacts all ages, cultures, ethnicities and promote MAT as the most effective treatment for opioid use disorder** |
| **BRAINSTORMED CHALLENGES** | **BRAINSTORMED RECOMMENDED ACTIONS** |
| • N/A | • N/A |

| SESSION: IMPROVING ACCESS TO MEDICATION ASSISTED TREATMENT | |
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| **TOP 3 CHALLENGES** | **TOP 3 RECOMMENDED ACTIONS** |
| • **Challenge 1: Lack of access to treatment in rural, frontier, tribal communities and correctional facilities**<br>• **Challenge 2: Lack of sufficient providers and/or waivered prescribers not prescribing**<br>• **Challenge 3: Myths/stigma around the MAT model and different medications** | • **Action 1: All-in-One clinics; co-location of services**<br>• **Action 2: Increase network capacity for peer support; for those OUD and prescribers (provider consultation)**<br>• **Action 3: State leadership messaging for OUD as a brain disease and MAT as a gold standard of treatment, to increase public awareness** |

| BRAINSTORMED CHALLENGES | BRAINSTORMED RECOMMENDED ACTIONS |
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| • Rural/frontier/ tribal – challenges to getting services<br>• Rural vs. urban, is funding sustainable, process for health providers to get MAT certified, nimby<br>• Access to MAT in jails<br>• Non-billable services for peer support<br>• Lack of consistency in PA for MAT<br>• Transportation<br>• Education around Tele-med laws for MAT<br>• Retention in MAT (2-4 weeks ending MAT is highest risk of death so ongoing retention and engagement is critical)<br>• Lack of provider awareness / knowledge of MAT (or lack of knowledge of where to refer patients) for OB and other providers<br>• Fear of providers to do service and data waivers especially for pregnant women<br>• Need to enforce training for providers around SUD and integration<br>• Workforce scarcity especially for specialty providers<br>• Lack of sufficient providers or lack of understanding of current provider capacity<br>• Lack of understanding of the barriers to providers prescribing MAT<br>• Waivered prescribers actually prescribing<br>• DATA- waivered prescribers not prescribing<br>• Underlying stigma for SUD<br>• Heavier regulations on MAT than on Narcotic painkillers, stigma<br>• Fragmentation of AA and MAT communities<br>• Lack of infrastructure and resulting in decline Rxs but driver to street drugs<br>• Blanket discussions and descriptions of MAT without nuance of differing types of MAT and different definitions of what constitutes MAT (e.g. when does it begin)<br>• Myths/lack of clarity around necessity of psychosocial care component of MAT (including among MAT providers) | • State sponsored public relations campaign on MAT – why needed, benefits, how it works<br>• Education – communities, providers, nurses, MA's, PSS<br>• MAT Boot Camp – toolkit for providers (post provider challenge survey)<br>• MAT guidelines that are flexible to the individual<br>• Peer to peer for prescribers (ECHO, OAR, mentors, etc. )<br>• Expansion of programs like Project ECHO (with addition of more social supports)<br>• Identify provider champions<br>• Expand and enhance capacity for telehealth for behavioral health services<br>• Examine DEA protocols regarding length of time in recovery before patient can take home his/her meds<br>• Expand loan forgiveness so student loans for medical staff will practice in rural areas<br>• All in one clinics – all services (including MAT) in one location<br>• Enhance role of PCP with psychiatrist as a consultant<br>• Examine rules around transportation to assure response to rural/frontier areas of community<br>• Model designs that address unique challenges in rural areas (including reimbursement)<br>• AHCCCS to examine MAT retention data to identify targeted strategies to improve it |

| SESSION: REGULATORY APPROACHES (FACILITY LICENSING RULES, ENFORCEMENT OF OPIOID EPIDEMIC ACT, ETC.) | |
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| **TOP 3 CHALLENGES** | **TOP 3 RECOMMENDED ACTIONS** |
| • **Challenge 1: Patient Abandonment – providers not prescribing opioids due to risk liability and IT challenges**<br>• **Challenge 2: Education Component – Technical assistance for providers to understand regulatory framework**<br>• **Challenge 3: Regulatory review of current rules, regulations, and application** | • **Action 1: Education from regulatory boards about abandonment issues. Ex: Substantive policy statement to provide clarification for clinicians on prescription guidelines**<br>• **Action 2: Standardized CME for opioids that address Arizona Opioid Epidemic Act**<br>• **Action 3: Conduct rule review as a result of the Opioid Act or licensing rules more frequently to address new laws and rules** |
| **BRAINSTORMED CHALLENGES** | **BRAINSTORMED RECOMMENDED ACTIONS** |
| • Informed consent in IP setting<br>• Lack of risk assessment (validated) in IP setting<br>• E-prescribing & connectivity in rural AZ<br>• Patient abandonment due to prescribing regs/reaction to regs<br>• Technical assistance for providers regarding regulatory requirements (MAT esp.)<br>• Properly addressing issues (what is the right avenue) – Board? Rule? Policy?<br>• Impact on patients (they are being abandoned)<br>• Communication & Education (what resources are available?) Need for uniformity to focus on AZ laws<br>• Facility regulation for pain management clinics? What about primary care facilities?<br>• What is DHS looking for? Stressing? Is there something that can be focused on?<br>• No 24/7 pharmacies in rural areas | • Education from regulation boards about abandonment<br>• Convene workgroup/focus groups prescribers to discuss “abandonment”<br>• Standard CME for opioid, reviewed/approved by boards – one and done<br>• Permit e-prescribing waiver if demonstrable IT barrier<br>• Conduct a rule review of any rules promulgated as a result of Opioid Act and any clean-up bill to identify any barriers or lack of clarity<br>• Reopen opioid prescribing and ordering rule to address compliance challenges<br>• Provide technical assistance (education) for providers beginning to provide OUD treatment services |

| SESSION: PEER SUPPORT & RECOVERY SERVICES, FAMILY SUPPORT | |
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| **TOP 3 CHALLENGES** | **TOP 3 RECOMMENDED ACTIONS** |
| • **Challenge 1: No one knows what is available and how to access it** | **Action 1: Awareness campaign addressing what is available how to access and to** |

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| • **Challenge 2: Workforce development issues: Finding qualified peers that meet hiring requirements; getting family supports; training needs – accessing qualifies peers, transportation & costs.**<br>• **Challenge 3: Limited reimbursement incentives not there** | **become a peer**<br>**Action 2: EBP in peer support training and formalized graduate placement services**<br>**Action 3: Increase in home telehealth services; encourage parity across payers** |
| **BRAINSTORMED CHALLENGES** | **BRAINSTORMED RECOMMENDED ACTIONS** |
| • Availability – hours of operation, limited to business hours<br>• Navigating the system, access to care, limited resources<br>• How do you contact a peer support?<br>• Capacity / accessibility<br>• Length of support available<br>• Family / support even knowing their person with a disability is taking / has been given opioids<br>• Access to services for persons with disabilities<br>• Transportation – including accessible transportation<br>• Lack of access – understanding how to access services for family / support systems for the person with a disability<br>• Lack of overall education provided t person with a disability and/or the family / support system<br>• Economics – increase the reimbursement rate for HB0038<br>• Finding individuals – to become peer supports, and funding for peer supports<br>• Hiring: qualified candidates, finger-print clearance, undocumented<br>• Workforce development – within peer supports there needs to be a supportive system for relapse situations – (have it be in the design, not stigmatized etc…., defined layers of peers i.e. family, etc.)<br>• Resources to support trainings: transportation, not enough providers, human capital,<br>• Design for peer support system<br>• Training for individuals/agencies for peer support: TOT's, few and far between | • Regression analysis – H0038 cost of care<br>• Cross training: community mental health workers u/PPS<br>• Peer career advancement academy<br>• Public awareness academy: social media, PSA's, Media<br>• Telehealth services or telemed for H0038<br>• Increase reimbursement rate H0038<br>• ATA resources (American Telemed Association): EBP's for telemental health, core operational guides for telehealth services (involving provider and patient), blueprint for telerehab<br>• Alternative services, telemed, accessing government programs, web conferencing<br>• Peer mentor, street level education, dedicated case manager services, home based MAT services<br>• Caregiver based support groups, possible naloxone education, vetting 24/7 centers<br>• Allow peer support services to access $ from opioid Epidemic Act for under or uninsured<br>• Informing PSS trainers about hiring requirements<br>• Advertising peer support services<br>• Counseling for peer counselors and BH counselors<br>• Partnership and collaborations with existing organizations<br>• Ongoing web based training updated resources<br>• SAMHSA TIP #39: SA treatment and family treatment<br>• SAMHSA TIP #60: Using technology – based therapeutic tools in BH services<br>• SAMHSA – HRSA "DIMENSIONS: peer |

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| • Rural community issues<br>• Lack of ;OUD support staff understanding how to work with persons with disabilities (current peer support persons knowing how to work with person with OUD)<br>• Stigma, cultural limited resources, time restraints, lack of awareness and education<br>• Referrals: warm hand-off, naloxone<br>• Understanding trauma for providers and community<br>• How do we engage those not in the systems? Shifting paradigms | support program took kit"<br>• Community groups: peer to peer teaching, education, interaction, reduce stigma, family/peers doing marketing, online forums<br>• Family support groups, family education, build a support circle<br>• One point of contact, centralized referral<br>• Networking or job board for trained PSS<br>• Increase rate for peer support services<br>• Create separate designation and training for family support specialists<br>• $ for peer support activities |

| **SESSION: ILLICIT DRUG USE/TRAFFICKING** | |
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| **TOP 3 CHALLENGES** | **TOP 3 RECOMMENDED ACTIONS** |
| • **Challenge 1: Identification of drug types delayed, especially outside of urban areas, leading to delays in prosecution**<br>• **Challenge 2: Being a border state leads to AZ to have a higher volume of drugs entering the state than in other parts of the country**<br>• **Challenge 3: Denial of problem and/or lack of awareness and stigma around drug use leads to lack of understanding of need for treatment services** | • **Action 1: Dedicated lab technicians for expedited drug testing at state and regional labs with own funding for positions**<br>• **Action 2: Modernized and expanded ports of entry to increase the amount of inspections**<br>• **Action 3: Increased education on the effectiveness of opioid treatment services and reduction of stigma towards treatment services in the community** |
| **BRAINSTORMED CHALLENGES** | **BRAINSTORMED RECOMMENDED ACTIONS** |
| • Dogs and officers have difficulty identifying Fentanyl<br>• Not sure what you are coming in contact with drug wise<br>• Testing on site for all drugs<br>• Man power, resources – equipment, limited education/training, individuals arrested not being ready or willing to seek treatment<br>• Education youth traffickers as to the dangers vs. benefit of money earned as a trafficker<br>• Lack of resources<br>• Knowing when to use law enforcement as | • N/A – NO NOTES ON PAPER |

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| tool or to refer to alternative resources<br>• Denial that "we" our community doesn't have a drug problem<br>• Paying kids as drug mules/carrying across border<br>• Border issues. Overwhelmed system<br>• Tribal and governmental relationship<br>• Border issues – difficult to keep eyes on all of the passage ways (Mexico – U.S.) | |

| SESSION: ADDRESSING DETERMINANTS OF HEALTH (HOUSING, JOBS, ACCESS TO FOOD, ETC.) | |
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| **TOP 3 CHALLENGES** | **TOP 3 RECOMMENDED ACTIONS** |
| • **Challenge 1: Lack of resources or education on available resources (i.e. supported/affordable housing, transportation, employment skills, food, medical insurance, income)**<br>• **Challenge 2: Stigma – Marginalized communities (i.e. LGBTQ, immigration status, justice involved, tribal, rural communities) not in my backyard**<br>• **Challenge 3: Lack of systems alignment, Billing for social determinants of health services, Standardized assessment for needs and services, Service availability at different points of engagement** | • **Action 1: Lack of resources – Central resource directory for 211, providers, and community, meet people where they are at, having electronic/in person communication outreaching individuals possibly in need of resources**<br>• **Action 2: Stigma – Advocate statute that limits employer liabilities for employing individuals with recent lived experience with SUD and those on MAT**<br>• **Action 3: Lack of systems alignment – aligning value-based payment models to improvements in SDoH and increase funding availability for reimbursable services addressing SDoH** |
| **BRAINSTORMED CHALLENGES** | **BRAINSTORMED RECOMMENDED ACTIONS** |
| • Syringe service programs are still illegal<br>• Access to care in rural communities<br>• Lack of LBGTQ+ specific services<br>• Lack of normalization of trauma and the potential for substance use in various cultural communities<br>• Historical and recent trauma associated with first responders and people of color and other marginalized communities<br>• Stigma against MAT in Housing<br>• Stigma against those suffering from OUD with employers<br>• Aligning the system towards achieving SDH | • Challenge 1 solution: Shift in funding to include issues related to SDH<br>• Challenge 1 solution: Online resources e.g. 211 Stewart Comm. Connections, Cat. By social determinants of health<br>• Challenge 1 solution: Invest in AZ 2-1-1 to make it 24 hours and coincide with the OAR line<br>• Challenge 1 solution: complete a gap analysis to assess current state of resources and needs assessment<br>• Adding housing projects<br>• Reverse hotline (for outreach) |

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| successes<br>• Tying payment to SDH improvements<br>• Lack of housing for those suffering from SUD<br>• Implementing workflows in provider agencies to help SDH<br>• Injecting hope<br>• Reducing scarcity<br>• Connecting or promoting resources<br>• Access to permanent supportive housing<br>• Transportation to appointments not covered by private insurance (or uninsured)<br>• Lack of dual services for those with co-morbidities (complex medical issues and substance use)<br>• Lack of knowledge of what to do resource-wise after assessed<br>• No funding/coding for assessing and case management type services for medical professionals<br>• Housing: There isn't enough supported housing<br>• Challenge- If providers only focus on the disorder, they may miss an opportunity to help someone find recovery<br>• Housing (affordable, supportive, stigma, access/availability) child care is limited, lack of housing<br>• Lack of workforce development, job placement, felony friendly employers, childcare, TIC – employers<br>• Diagnosis/identification – Z codes vs. F codes etc.<br>• Transportation challenges (distance, time, availability)<br>• Lack of providers in rural areas<br>• Bias stigma (personal/internal/external) family turns back or doesn't understand addiction<br>• Communalizing of people in treatment or that should be in Tx, fear of kids being removed | • Resource list (monitored and updated)<br>• List of felony friendly employers, adding employers, advertising at work better and expanding it<br>• Challenge 2 solution: Mental Health First Aid workforce development – targeted to population and providers<br>• Challenge 2 solution: invest in PSA's that normalize accessing treatment amid asking for help; varied to all cultural and gender identities<br>• Regulations encouraging employers to hire people with recent lived experience<br>• Change the title SMI<br>• Stigma campaign, humanize the concern<br>• Opening up billing codes, increase rates in rural community<br>• Challenge 3 solution: Solutions exist but people don't realize e.g. 211 or Stewart Community Connection<br>• Challenge 3 Solution: Implement value based purchasing based on evidence based practices<br>• Challenge 3 solution: incorporate CHW/CHR's and peer support specialists into hospital settings and be considered as part of the coordinated care team<br>• Aligning VBP with SDH outcomes |

| SESSION: PRIMARY CARE RESPONSE TO TREATING CHRONIC PAIN – PREVENTING PATIENT ABANDONMENT | |
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| **TOP 3 CHALLENGES** | **TOP 3 RECOMMENDED ACTIONS** |
| • **Challenge 1: Provider factors – Lack of knowledge about the law, lack of knowledge and application of the evidence and whole-person management of patients with chronic pain, mental health and substance use disorder**<br>• **Challenge 2: System factors – Lack of time and support in PCP setting to adequately address chronic pain and common comorbidities (mental health, other medical conditions), lack of availability of integrates care options and lack of coordination among existing specialty providers**<br>• **Challenge 3: Surveillance – Lack of quantifiable problem of patient abandonment, unable to track problem or progress** | • **Action 1: Prescriber-focused action – increase prescriber education on evidence/law/whole-person care of patients. (NOTE: This must be done in conjunction with systems changes)**<br>• **Action 2: Systems-focused action – Create a process to navigate the system more efficiently, increase care coordinators to enhance integrated care, payment reform – increase reimbursement to PCP's for chronic pain (for their greater time, counseling, etc.)**<br>• **Action 3: patient-focused action – Increase knowledge and capacity of OARLine, as it interfaces with providers and public 1:1, and can teach about chronic pain management** |
| **BRAINSTORMED CHALLENGES** | **BRAINSTORMED RECOMMENDED ACTIONS** |
| • Pseudo addiction – people are withdrawing they act angry or addicted so they are abandoned<br>• MMJ make you not eligible for Rx prescriptions<br>• Doctor transparency of why they taper down<br>• Enforcing guidelines promoting drug seeking patterns. Patients feel tribal health system is abandoning them<br>• Patient education<br>• Provider afraid to prescribe because of MME "capped" @ 90 MME/d<br>• Providers don't know law / recommendations using at as cover or misinformed.<br>• Person gets pregnant so just stops<br>• Retirement – provider<br>• Person started new medication by another provider that might interact so just stops<br>• Provider moves on or changes practice | • Education about law/recommendations (what's real) what results are<br>• Better educational effort to create awareness of OAR line<br>• Setting new norms/expectations regarding pain – physical and emotional<br>• Education about evidence based pain management alternatives<br>• People setting regulations put together 3-day comprehensive training for prescribers: philosophy laws/regs, alternatives, patient interaction. Big pharma foot bill for provider time to attend<br>• Provider education – warm hand off and appropriate pain management<br>• Transparency of treating guidelines<br>• Education about long term outcomes, be patient for Tx outcome and changes (it's okay to have some pain not "0" pain level)<br>• Education to use tools to the best advantage CSPMP, HIE, don't ignore alerts |

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| • Prescriber Report Reaction (prescriber quits writing opioids altogether)<br>• Provides afraid of losing license<br>• Providers being totally uncomfortable with any conversation regarding behavioral health or SUD because then have to respond to need.<br>• Provider refuses under any circumstance because of other substance use disorder despite severe pain (heroine, alcohol, etc.)<br>• "Time" in a primary care setting to talk about chronic pain treatment modalities/addiction<br>• Provider OAR line not familiar with<br>• Health system disconnect from acute management to long term management<br>• Providers don't know how to step down so just refuse to prescribe or takes too long<br>• Helpers being put in position where they feel they can't help – or – they feel they are doing harm<br>• Mixed signals messages conflict<br>• Removing Rx options without providing new options<br>• No evidence for opioid use in chronic pain – how do I get my patients comprehensive non opioid care where do I send them<br>• Provider refused due to history of SUD even if has not used for years because in their medical record<br>• Misappropriation of CDC guidelines<br>• No education regarding everything related to opioids, pain, psychiatric services, regulations Doctors and patients | from pharmacy, insurance companies, EHR<br>• Education about how to treat pregnant women on opioids and options – also once delivered transition<br>• Pain educators (like diabetes educators)<br>• Pain education materials in waiting rooms, patient rooms, and billboards<br>• Integration of pain management behavioral health SUD treatment<br>• More MAT providers and coordination of care<br>• Telemedicine for pain care between doctor visits<br>• Referral and warm hand off to treating provider to help: step down, treat pain<br>• Payment reform for alternative Tx and quantity of Tx (massage, chiropractor, aqua, PT, acupuncture, meditation)<br>• Paid case manager for pain care options<br>• Having truly integrated comprehensive care<br>• More behavioral health providers and coordination of care<br>• Extend a 30 day Rx to a 90 day Rx time management<br>• Single EHR per patient |

| SESSION: GETTING READY FOR E-PRESCRIBING CONTROLLED SUBSTANCES | |
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| **TOP 3 CHALLENGES** | **TOP 3 RECOMMENDED ACTIONS** |
| • **Challenge 1: Workflow & Technical Issues – inability to transfer CS prescriptions from 1 pharmacy to another; physicians that practice in multiple locations (restrictions around access within the same vendor); how to communicate exemptions (system downtime); using the same key fob** | • **Action 1: Technology – provide simple technology alternative (i.e., standalone prescribing modules)**<br>• **Action 2: Education & Communication – clarity around exemptions, deadlines, etc., especially with smaller counties; cross-training between groups** |

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| **with same system at different locations; software version issues**<br>• **Challenge 2: Communication & Education – how to ensure all providers that turned in waivers are ready by deadline**<br>• **Challenge 3: Patient Care & Safety – If provider refused to transition to EPCS, especially in areas with fewer resources** | • **Action 3: Enforcement & Investigation – clarify how enforcement will be handed; investigate possible potential solutions to technical workflow issues** |
| **BRAINSTORMED CHALLENGES** | **BRAINSTORMED RECOMMENDED ACTIONS** |
| Lack of resources:<br>• Diversion programs access in schools and in general<br>• Access to resources<br>• Funding, access, education, acceptance<br>• Lack of resources in rural areas – need more programs, ways to get to programs 24/7 access<br>• Lack of alternative treatments<br>• Limited warm hand-offs ; limited peer support<br>Access to services:<br>• Politics<br>• Lack of support from legislative council<br>• Program commitment – time, work, family (children)<br>Awareness and Stigma<br>• Stigma<br>• Prevention and education<br>• Better "targeted" advertisement<br>• Reduce stigma – increase options<br>• Stigma, prevention and education, implementation of alternatives to medication, lack of support from legislature, politics | Lack of resources:<br>• Training of CJ workers on Trauma informed care and the benefits of diversion – early interventions<br>Access to services:<br>• Central access point of info – opioid line<br>• More advertising – state reviews of policies<br>Stigma:<br>• Statewide media campaigns (social media, etc.) PSA on MAT and its use/success<br>• Diverse populations |

| **SESSION: UPDATING RX COMMUNITY TOOLKIT AND RESOURCES FOR COMMUNITY COALITIONS** | |
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| **TOP 3 CHALLENGES** | **TOP 3 RECOMMENDED ACTIONS** |
| • **Challenge 1: Gaps in education and awareness/marketing of the toolkit**<br>• **Challenge 2: Lack of user friendly material (Ex. You Tube videos, PPTs,** | • **Action 1: Create an implementation manual of the toolkit for various populations**<br>• **Action 2: Expand the toolkit to include** |

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| **marketing materials, expanding PSA's, resource cards, etc.)**<br>• **Challenge 3: Lack of hands on training/lack of access to other trainers** | **the 5 major AZ HIDTA threats.**<br>• **Action 3: Implementation of youth focused toolkit (peer to peer)** |
| **BRAINSTORMED CHALLENGES** | **BRAINSTORMED RECOMMENDED ACTIONS** |
| • Need hands on training<br>• Increase prescriber resources ease of use: links, videos, etc.<br>• Guided presentations<br>• Difficulty locating materials<br>• No list of toolkit trainers<br>• Language toolkit resources - to hit specific target populations | • Trainer database online<br>• Provide direct links<br>• You Tube/webinar directions on training<br>• Implementation manual<br>• Funding resources/stakeholders by county<br>• Coalition / peer to peer toolkit<br>• Aces/trauma informed care |