

Dialogue4Health Web Forum

No Wrong Door for Opioid Safety: How to Build an Effective Response in Your Community

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Welcome to "No Wrong Door for Opioid Safety. How to build an effective response in your community." My name is Laura Burr, and I will be running this dialogue for Health Web Forum with my colleague Tonya Hammond. We thank our partners for today's event. The California Opioid Safety Network, the Center for Health, Leadership and Practice and the Public Health Institute.

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And now I am very happy to introduce Dr. Matt Willis, the moderator of this event. He is the clinical lead for the California Opioid Safety Network and Public Health Officer for Marin County. Matt comes on experience as a primary care physician and epidemiologist at the CDC to guide public health response to the opioid crisis. Welcome to Dialogue 4 Health, Matt.

>> Matt: Thank you, Laura. Good afternoon, everyone. I'm excited to be here with you today and our three amazing panelists to talk about forming partnerships to address the opioid epidemic. You are going to hear from three speakers who have worked really on the front lines doing that hard work that sits between silos at the local and state level. And hopefully the conversation will stay grounded in the realities they are facing every day, strengthening work across sectors. Our hope is that you will come away with some practical tools based on what you are hearing about how they approach the work and what they have accomplished. This webinar is part of a four-part series convening another Dialogue 4 Health. And hosted by the California Opioid Safety Network. After the conversation today about building partnerships, November we'll discuss data to answer the question: How is locally available data being used for measurable results to save lives? And then in December we will talk about what are the most effective messages for communications and means of communication to mobilize local opioid crisis results. In January, we will talk about how to sustain our efforts to make sure that our most effective strategies are secure for as long as they are needed. So we hope you will be able to join us for those conversations that will

be convened by myself or will will carbon though leads the lie dog for health series. A little bit about the California Opioid Safety Network coalitions.

People across California to our collective response statewide. COSN provides access to knowledge, training and resources to implement proven strategies. The network includes opioid safety coalitions in 38 of 58 total counties in the state of California. That are shown on this map. Which cover about 85% of the state or 33 million lives. Really a mechanism for identifying and accelerating best practices across the state. Our hope is because of the diversity and size of the state of California, with a lot of economic, racial, political, large, rural and urban communities we think that the lessons we are gleaning here in California can be helpful for others across the nation and also looking for opportunities to learn from you outside of the state.

So why are we talking about partnerships and building partnerships? I think we all recognize the value of partnerships in our work. But the institutes for healthcare improvement added important specificity to this and their report addressing the opioid crisis in the United States. They work with a panel of experts across sectors to identify some of the most important reasons why despite all of our best efforts the epidemic persists. And they included a lack of coordination of approaches and responses. Failure to engage with local communities and across multiple stakeholders, failure to spread promising practices. And lack of effective implementation of promising practices.

So the hope is that this webinar today will address multiple of these gaps to spread promising practices in building partnerships for coordinated community response.

This idea was echoed by the CDC in this info graphic that I won't share in detail but basically outlines the way in which multiple sectors need to engage. The local response to clusters of overdoses. What's important about this it calls out that acting independently within our silos is way less effective than acted in a coordinated way.

That coordinated response, I think we all know who are working in the space, doesn't happen automatically. Someone needs to make those connections and build protocols. So I think we are all engaged in trying to build new infrastructure. And there is not really a specific cookbook that we can follow. So today's webinar is partly about the art and the science of navigating the politics and the players in different settings to address the need for collaborative response.

I love this quote. Everyone has a plan until they get punched in the mouth. This I first heard Jerome Adams, our surgeon general a few months ago at the California opioid safety summit. And his point was, I think, I hope I'm getting it right, was that our plans are sometimes doomed if we don't develop them collaboratively across sectors. And that we, in public health, sometimes lean so far into what we see as the evidence-based or science that we can forget how political and relationship-based we need to be to have real practical impact in our communities.

So, how do we meet people where they are?

Here's some things to listen to. You are going to hear from a community member who is a grieving mother who turned into an advocate and organizer for our efforts. A state law enforcement officer, a lieutenant in New Jersey, an ER Doc working in rural California. Each of them are going to

share their story for 8 to 10 minutes and we will have a discussion together to finish out the hour. So listen for the ways that they work to understand what is in it for each partner as they try to form new coalitions, to identify that win-win space. You will hear how strategies were developed and defined collaboratively. Sometimes even before the plans were implemented. Listen for ways the different sectors are also different cultures and different words and terms and start with different assumptions. You will hear insights into personal and institutional relationships and how they were fostered and how important that is and how shared successes might have been celebrated. And then I would like to let most of you, our speakers observation simplifying perseverance and patience important to this work. They are also inspiring in their work and in their success. I think that's something we can all use as we address the challenges that we are facing nationally with the opioid epidemic.

We have asked each of the speakers to offer resources that connects to the work they are doing for you all that will be available after the call on the coast and website, under the resources tab. I would like to introduce April Rovero. April is the founder and executive director of the National Coalition Against Prescription Drug Abuse. April has been at the front of the opioid response for nearly a decade. I know when I, as a public health officer first pulled into this work it was partly due to April's local advocacy here in the Bay area. She was traveling around, sounding the alarm and we heard it. I am working with April as she has brought her message to a national audience over the past decade. We're honored to have April join us. April, you can take it from here.

>> April: Thank you, Matt. I appreciate the introduction and also the opportunity to share what I have learned along the way the past decade almost that I have been working in this space. So, on December 18th, 2009 was the fateful day that we got news that our 21-year-old son Joey had been found in his off-campus apartment where he was a student at the Arizona state university. He was living with a couple of his roommates who were fraternity brothers of his. And ultimately and pretty quickly, actually, we learned that he had died from the equivalent of a single pill of Xanax combined about a pill and and a half of oxycodone. He had been out with his friends that night before he passed away. And had a little bit of alcohol, but just over the legal driving level. And we learned that was all it had taken to shut down this young, healthy 21-year-old's life. Joey would have graduated about five months from the time he died. And so, you know, we really were happy and really focused on that opportunity to get him through his college experience and I have to say that this was the last thing we ever expected and, as you can imagine, we were absolutely devastated.

What I started learning though almost immediately what he had passed away from.

We weren't alone. Within two weeks of Joey's passing, another college student there at ASU died from an overdose. Another one died three weeks later. Within a year of his passing we have lost nine students that I became aware of at that one university alone. And we were starting to see other families in our own area be impacted by.

This we were very open and very forthcoming with what had happened to Joey right off the bat. Because, first of all, we were horrified and then the

second thought was what other families could be impacted by the same problem? We felt that if this could happen to our family, virtually no family out there, you know, was at potential risk. Need to make the difference. Sound the alarm to get the information out there that could potentially help other families from going through what we went through and continue to. This does not go away. Losing a child, I believe, is one of the most difficult things you could possibly deal with in life. So, the problem was as I started looking around and getting people's attention was there was a deep rooted and pervasive problem with stigma. People didn't want to even let others know what their loved one had died from.

They would often make up other reasons for it. And those with substance use disorder wouldn't admit they had a problem, that they needed treatment. So, we continue to battle that but I will tell you back then it was even worse. Far worse. So, that was something to move beyond and try to break through, you know, that part from. We learned that there really wasn't any true recognition of the problem. There was little-to-no data available to understand the level of impact that was happening in the local communities or at the state level or even federal level. It had risen to the state of emergency that I truly felt it was becoming. Prevention resources and programs weren't being applied to the problem. There was very little, if any, education about prescription drug safety in our K through 12 classrooms and even at the college and university levels. Recovery resources were limited. Especially for youth and that continues, of course, to be an issue that we are all battling. Back then it was even worse. Medication assisted training. Just starting to be introduced but not accepted yet as evidence-based treatment strategy. So a long way to go for that and certainly communication across State stockholder sectors it just wasn't happening. Individual sectors within communities will were kind of starting to get an idea what was going on. They weren't talking to each other. Individuals who had been impacted by this, like our family had been, they weren't starting to gather yet and talking and trying to do what they could collectively to do what they could. So it was pretty sad.

I started looking around and saying okay, hey, I'm a voice. I'm willing to speak out about this problem. Who can I side up with? Who can I come alongside and support, be a voice for? And I found there really wasn't anybody there. Coalitions that were out there doing prevention work, they weren't working on this issue. I really felt it was important to just go ahead and start my own nonprofit organization and I did.

So within just a few short months, I had a 501 c organization started. And I have led the organization ever since. We have continued to have a strong board of directors and that changes out of course over time. But a lot of great support.

The organization I felt gave credibility to my work that wouldn't have otherwise been there, just as an individual, and so I thought it was really important and has proved to be. Even naming the National Coalition Against Prescription Drug Abuse as I did, I found was the stroke of genius that I didn't even realize I had at the time come up with I almost immediately started getting contacts. The issue started to raise. And reporters looking for, a story that they could add to their indication,

you know, their bigger story about what was going on. I was contacted constantly. So, I really had to come up to speed quickly on the issue. I set up Google reports, you know. Alerts that would let me know what was going on across the country that helped to educate me. And I started reaching out to civic leaders and law enforcement and other coalitions, the educational community and just pretty much anybody that would listen to educate them to also get their attention and support which seemed to work really well. Key affiliations I established. At the federal level, I felt it was important to do what we could to alert others throughout the country about the issue gather to support and use that support to raise our voices in a big way. So the Fed Up Coalition forums. That was the original formers of that and I am still an executive steering committee member of that organization. We were looking to drive federal action. Top-down support. And then the California statewide RX opioid prevention work group. I was eventually a co-lead of that group. I am now a participant. We have other really good leaders. I was able to step away from that position. I also, though, in 2012 established the Contra Costa County MEDS Coalition. That was a direct response to the fact that's where I live and I felt in my own backyard we needed to have a coalition that was focused just on our multiple communities within the county. And so that was organized and I still lead that effort as well. And then, of course, we applied for and became a member of of the California Opioid Safety Network which has been a tremendous support and set of assets that we have been able to put to use very well. So moving on to action that you can take. I, again, want to reiterate what Matt indicated right off the bat. That is it is so important to work through community coalitions. We need to connect with the stakeholders across these multiple sectors to tackle this opioid problem. It's so multiple faceted. Each of these different sectors tend to be working on it in their own way. We have become so much stronger and capable and the result are so much better when we team up. I want to call out the public health folks here on the call. What I have seen and I will say within my own county I have seen this for sure and other counties as well. It seems that public health has really gotten the message. I they want to do something and putting all sorts of resources and doing some great work. But there tends to be a mission, I think, of connecting with outside of the public health environment community members. And sectors. And so, I think that that can help move the public health effort forward a lot better if those connections with made. And then community members, I think, especially those of us who have suffered, know, overdose deaths in our families or otherwise are dealing with substance use disorder are essential. We have firsthand perspective and we tend to be very passionate and dedicated members of any kind of coalition. So, I also see that more people with substance abuse disorder are willing to get involved and they are willing to stand up. The numbers are growing so they feel like they are supported and not that -- that stigma is breaking down. So, I think that's extremely important and then, of course, engaging and educate community members is just so important. Every single one of us on the call here today can do something to make a difference even without there being a formal coalition. So educating yourself and speaking out about just simple things like mixing medications and how dangerous that can be. Locking up and properly disposing of your

medications. Simple things and collectively we can do so much more. And then these are some of the key strategies I have gone with data gathering is extremely important. It points out the problem in your community and helps to determine what limited resources are and how they should be applied. Don't reinvent the wheel. We have wonderful coalitions operating throughout the country right now. The Opioid Safety Network here in California has a new website and it's a great resource for identifying other coalitions that may be already involved. In the type of work that you want to do in your environment. I CADCA is a really good resource also. You can find them in our resource link that was mentioned earlier. That they provide materials, training and support for newly forming coalition critical work across all coalitions and sectors who get wherever you want to go.

These are -- knowing about the issue and educating yourself at the highest level. Understanding what other sectors are dealing with and how they are tackling the problem. Seeing what you can do to help make successful. Gathering the data and also having good communication skills and being very, very persistent. Never giving up. Doing everything you can to work across those boundaries and break down hurdles is so important. These are just.

So successes we have had. Really proud to say we are now distributing Naloxone our coalition is with the support of the Costa County MEDS Coalition. Thanks to media engagement we have educated millions of youth and adults around the world literally and thousands of youth and adults in educational that include classroom, conference workshops, et cetera. Lots of -- actually, personally formed and led in Washington, D.C., lots of effort there actually establishing prescription drug abuse month in California through my work with local legislators. Anyway, I think that is it for me. So, resources that I am providing and I know will be on the resource link for you include these. Thank you very much.

>> Matt: Thank you, April. That was amazing. Again, your work is so impactful for us. Not just here locally but across the state and nation. We're going to hand it over now to officer Lieutenant Jason Piotrowski who is a unity head at the office of drug monitoring and analysis for New Jersey state police. Lieutenant Piotrowski's work I think exemplifies how partnerships at the state level between agencies can increase the impact and timeliness of our local efforts.

You can take it, lieutenant.

>> Jason: All right. Thank you very much, I appreciate it. Again, my name is Jason Piotrowski, I'm a lieutenant with the New Jersey state police and I have been working with our drug monitoring initiative since 2014.

I will get right to it. The problem we were seeing was that a lot of the people out there were being touched by different sectors and a lot of people suffering the substance use disorder. And not one entity could really understand what they were dealing with and specifically with law enforcement as well not really understanding addiction and not understanding what it takes to mitigate addiction. So, the -- for instance if you are working mental health capacity you may see the same patient that law enforcement sees, who EMTs may see and Department of Health may see. All this data comes together but everyone is only getting a little slice of that pie. Any one entity is only seeing what they see

and we need to expand everybody's perspective and so what we're, you know, essentially saying is the sector siloing of information and institutional boundaries were the problem. And they are a problem for several reasons. Not understanding the at risk populations, not understanding the actual at-risk people. The trends and the patterns and identifying drug -- bad drug batches. These were all things that we couldn't really get a handle on unless we could communicate across these sectors. So our solution in New Jersey anyway, we created a drug monitoring program and simply enough we just called it the drug monitoring initiative. It's been replicated through about 16, 17 other states across the country. On a law enforcement perspective. But the concept is to share drug intelligence and drug information with public safety and public health partners. We recognize that was a violate to the success of mitigating any drug harm and impacts.

In New Jersey, per day, we are looking at about 40 Naloxone deployments and eight fatal overdoses every day 2018-2019. That's what we are looking at. It's a pretty pervasive threat here in New Jersey. So, we had to come together and share this information. So, we got on board with our state Department of Health and like April kind of mentioned, you know, you have to be really persistent with these things and really be dogged to create these partnerships and get everybody on board. It's not easy to do. It's not easy to break down those barriers. And I would say the stigmas between sectors, a lot of times within law enforcement training about addiction awareness we talk about the stigma of addiction and when we try to educate law enforcement but we also have to talk about the stigma between sectors and that was something that we had to lock at. Anyway, I will talk more about that and push back. We did develop these relationships with law enforcement. Through the attorney general's directive, all law enforcement in New Jersey is now carrying Naloxone. We have in the last year alone over 5,000 Naloxone administrations in New Jersey potentially saving lives were administered by law enforcement officers. We partnered with the state Department of Health and to track their Naloxone information as well. So, any first responder and EMT administering Naloxone out there.

We combine that data with all the law enforcement administrations of Naloxone out there.

It gives us a pretty good picture of what the overruled environment and drug environment looks like in New Jersey and go on from there and look at the areas and population and demographics and the specific people.

Our Department of Human Services, they have a Division of Addiction Services there, which is a vitally important partner for us. And really we recognize how all law enforcement data was important to us. But it was also very important to these other sectors. And I will show you how that plays out in another slide.

All right. So we talked about the data use agreement with the Department of Health to share all that first responder and Naloxone administration data.

So, if you look at the bottom right there, that map, it's pretty interesting. But, our partnership with the Department of Human Services division addiction services, this is law enforcement data combined with essentially treatment data or treatment correlated data that we're showing so all those lines going to let dots there, those lines represent

somebody's residence and where they were arrested. They were arrested in those red dots for a drug offense but the other side of that line and red circles is where they lived. Now those purple shaded areas there, what we mapped out, we mapped out all the locations in New Jersey that had available treatment facilities within a 20-minute commute or 20-minute drive. So we could show you that in those red circle areas and we were able to show the Division of Addiction Services and our Department of Human Services that you had problems out there in those areas where you didn't have any readily available treatment services. Again, just an example of you who law enforcement data can inform one of these other nontraditional sectors and nontraditional partners in this public health problem. The other map down there is an overlay map. And for Naloxone administrations for the suspected overdoses, it's where the person resides is one shade and where the person overdose is another shade. So, if you are at the state level and you have limited resources like we all do, where are you going to get your -- where are you going to be most effective with your outreach and we can take all the data that we are receiving from all the law enforcement officers throughout the state and all of the other first responders through the Department of Health and we can overlay that data and point out the areas that are at most in need and where you will get the most benefit and impact for your outreach programs. Now, again, I kind of addressed this before the stigma that law enforcement is only here to arrest and doesn't understand the problem. That is something that I would say is not. True. In New Jersey and maybe it was at some point but it's something that we have held addiction awareness seminars throughout the state and really educating law enforcement about the problem. But really and truly law enforcement first and foremost are there to help. And I think that's something that we have done a good job in New Jersey with changing the mindset of law enforcement and I think it's been recognized through our other sectors here in New Jersey. And I do hear this a lot that it's a public health problem and law enforcement doesn't have a role in that. I obviously disagree with that as well. And, you know, I referenced before last year alone there were over 5,000 Naloxone administrations by law enforcement and I will talk about some of the other initiatives in the upcoming slides that we're engaged with as well. Law enforcement throughout New Jersey. And I'm trying to advance the next slide here. Am I advancing to the next slide?

All right. Lawyer lawyer hi, Jason, you are on slide 34 now.

>> Okay. Great. So the -- some of our successes retook all that data from all the law enforcement agencies throughout the state and all of the -- again, all of the Department of Health data from the Naloxone administrations and we were able to map out down to the block level of the most afflicted locations in the state where people were overdosing the most. By taking that information and sharing it one of these innovative partnerships between the Department of Human Services and Robert Johnson medical school at Rutgers through the Opioid Overdose Prevention Network we were able to show them exactly where they needed to go.

And what they would do is set up these community based trainings with the local county drug coalitions and law enforcement and they would open up trainings to the public obviously and the community. So people who either had an issue themselves or maybe a family member had an issue come to

these trainings and what they would get out of it was addiction awareness training but also understanding what the drug environment looks like and get a Naloxone kit most importantly. So to date there have been 400 trainings 700 and 7,000 Naloxone kits disseminated. I would argue to those most at need.

Also with that partnership as well the other thing we did is identify when bad drug batches are hitting the streets and again talking about these multi-sector collaboration. We have hospital systems that will call us now and say hey, we have a problem. We have 15 people in the last hour and a half come in on overdose and they can tell us exactly where they overdosed. Exactly what sample of drugs they were given. What the packaging was and all the details we need to mitigate that we will mitigate that through law enforcement purposes and work with the local law enforcement that minute and we will get them out on scene. We will get them to turn that operation giving out bad batches indoors to at least stop it right there.

We will notify all the other healthcare systems in the area. And then we will also notify Rutgers University in their Robert Wood Johnson Medical School they will be out there giving out free Naloxone. They know there is a bad drug batch out there.

That's another success story where we are combining law enforcement and Department of Health and hospital system and a university to have an impact there. All right. At this time it did move forward.

[Laughter]

I heard this as well again from April and I will reiterate it. Be persistent and I will add open-minded meaning we all need to work together on this.

It is a comprehensive problem that requires a comprehensive solution. And on our end we are very proactive in New Jersey with the law enforcement community with sharing data and it sharing drug intelligence and one other partner we work with all our forensic labs in New Jersey report all their information to us. So we know exactly what drugs are hitting the street and we will put out reports constantly. We will post the information. We have a very robust dissemination -- information dissemination capability and you can see there we have a web portal for our drug information. We have broken down by sectors for law enforcement, for health, for prevention, for treatment, for forensic sciences and we will post all this information up there and it's readily available there is a lot of feeds in there, drug-related feeds and grant feeds and things like that but anything we are seeing we will put it out there.

If you long to any of those sectors you will welcome to join in as well. One of the other things we would recommend is drug monitoring capability. Again that's what we did.

Just a collaborative information sharing platform where you can really understand the problem because you are collecting all the forensic lab data and seeing what drugs are out there and collecting the Naloxone data and public health harm data and really assess what areas are in need of assistance. What populations are in need of assistance. And they are going to differ by area, obviously. And how do you -- you know, that's going to dictate your approach, too.

Because not every area, not every population is going to have the same approach.

Identify the data stakeholders that will complement your initiative. That's probably an easy one. You know what data out there. You know what you would really like to see getting that data is a little bit hard, right? Identify multi-sector working groups. I sit on a few of them. Our statewide epidemiological outcomes group. I sit on a fatality review team. County driven right now. We sit on a lot of these groups. We work with our law enforcement against drug programs as well. But there are a lot of different initiatives out there and multi-sector working groups in New Jersey anyway and I'm a big advocate for the collaboration and for specifically for sharing law enforcement data to help in this problem. That's about all I have.

I thank you very much for listening to me. Do I have another slide here? Just my resources slide. There we go.

>> Matt: Thank you. What an amazing initiative. There were some great questions that came in for you, Jason, which we will get to in the Q and A at the end. I love just the example of, you know, a lieutenant sharing hard core epidemiologic data. I think it's a great example of the learning we are all doing across sectors how effectively you are able to summarize complex data for us. We have 10 minutes for Anne to summarize her amazing work in Bishop, California. And then we will get to 10 minutes of Q and A. I would love to introduce Anne Goshgarian. Anne is an ED Doc working in Bishop rural community in eastern California. Dr. Goshgarian has led a successful work in that area treatment for opioid disorder. Anne can summarize that for us now. Here you go, Anne.

>> Anne: Hi, everyone. I am an ER doctor in a small community in Bishop, California. For those of you who haven't been to Bishop, it's a beautiful small town on the eastern side of Sierra, Nevada mountain range. Here is a picture of the skyline in our area and some of the mountains I see on my way to work every day. Like I said a small rural community a town of about 3,000 people. We have about 10,000 people in the valley that we treat Bishop is known more widely in certain communities. We are called the mule capital of the world. Mules come from all over the country to drive down our Main Street during our Mule Day Festival and widely known amongst a small subset of rock climbers because we have large boulders right outside of town. But probably most of you may have heard of our county because we have both Mount Whitney the highest point in the contiguous 48 states as well as death valley national park lowest point. So kind of a special place here I really have only been involved with substance abuse work for a very short time. December of 2018. Last year I was working in our small 8 bed emergency department one day when I was called by the California president of the American College of emergency physicians, our governing body. It was kind of a big deal to get this cold call out of the blue. She asked us whether we were treating opiate withdrawal in the emergency department. I honestly told her no. But she told us we were missing an opportunity to save lives and she gave me some information about the California Bridge program. So I started to look into it at that point. Before then I was ignorant to the whole national crisis and the problem. But as I started to look into the issue, I realized that in Bishop we have extremely limited care for substance abuse treatment bordering on no care at all. At the time we only had one primary care provider who had a full primary care practice and treated just a very small number of patients for substance abuse disorder. In

addition to that we realized we are really isolated really far 2 and a half to four hours from any detoxification or rehabilitation program. We have a culturally diverse small community. We have a native American reservation in the center of our town and statistically we realized that native Americans have a high rate of substance use. We kind of thought we would probably come up with some stigma in our small community as we began to start treating substance abuse. Our solution we started taking all of that into account and came up with a plan by start having a meeting. We decided to invite everyone we could think of who might interact with people who use drugs. And that involved a lot of different entities. But we were surprised at the number of people who came to the table and started a conversation with us about what resources we had in the community already, which were minimal. But there was something and we learned what we were lacking and began to collaborate on all of our services, instead of duplicating services to help provide a more comprehensive approach to substance treatment. We also got involved with the California bridge program. This program provided us grant funding with the goal of increasing the number of wavered providers in our community and providing local education to destigmatize drug use. Most importantly though this provided us the opportunity to hire a Recovery Assistance Navigator. She is pictured in the pink sweater there in the middle. The ideal is to find a nonphysician person who could relate to the patients on a level that as healthcare providers we generally can't. Our Recovery Assistance Navigator her name is Arlene Brown and she has been the most incredible resource to us over the last 10 months. First of all she is a member of the Bishop Paiute Tribe and understands the struggles of the patients and really been able to communicate well with them. She has been tasked with breaking down any barriers to accessing care and she has really taken that job in stride. She has helped to arrange transportation for patients to make their appointments or sessions or therapy or whatever they need. She helps them find housing resources she even let's residents use they're computer and write resumes and get jobs. Most importantly she works with law enforcement. They call her whenever they arrest a patient for drug use or possession. She will go to the scene and talk to the patient about treatment options and talk to their family about substance abuse disorder and really try to destigmatize the issue for all of us. So she has really been the backbone of our program. And she was really made possible by the California bridge program. So, their slogan is treatment starts here. And that's a philosophy we really tried to adopt as we started our program. About a year ago, if a patient came to the emergency department and I was working and in withdrawal from opiates and asking for help. I pretty much would have said quit using drugs and told them to go to NA. I didn't even know the phone number for NA. I really didn't help them at all and I'm almost embarrassed to admit that today things are really different. These patients come to the emergency department. We treat that like an emergency like we would any other condition. They are treated with dignity and respect. They get offered Suboxone. They are started on treatment right in the emergency department. Our recovery navigator comes in, talks to them, links them into treatment and breaks down whatever barriers they have to accessing care. It's been a really incredible change.

While we did this we did encounter some adversity. We were extremely lucky because we had great administrative support from the hospital standpoint. We did get push back from the physicians and staff. I was impressed people would say to me why are we treating these patients which was extremely stigmatizing but also kind of sad when you think about anybody who comes into the emergency department to say why are we treating them. It made me realize that there is considerable fear and misunderstanding surrounding the whole issue of addiction and X waiver and treatment for addiction treatment. We felt the knowledge is power. So we educated the physicians and the staff really on every level to try to help destigmatize the issue and break down that barrier. I also realized as I was doing that most doctors really want to help people. For me some of my most rewarding patients are simple patients but have a problem that I can fix. Like removing ear wax. I mean, it sounds really silly, but when a patient comes in and they can't hear and I wash their ear out, and they leave with their hearing restored, they feel like a miracle has been done and I feel great. I get a little dopamine surge. I feel rewarded in my job. It's really because I made a small but measurable improvements on that patient. And we have seen sort of a similar culture change as our ER physicians began using medications to treat opiate use disorder and linking these patients into treatment. They went from saying why are we treating these patients? These patients are difficult and frustrating to saying these patients are easy and simple and walk out filling better with a hope and a plan. It's been a great culture change. We received some pushback from law enforcement as well. So the way we dealt with that is we had one sergeant show up to task force meetings. We made him our champion and asked him to educate his fellow officers and break down that barrier. Simultaneously our law enforcement officers started carrying Narcan in just the past few months but we used the opportunity of the Naloxone training as educational opportunity for them and really tried to stress to them that linking patients into treatment would mean less repeat offenders. And that makes their job easier.

We heard some community member concerns at the outset as we started to build the program. But unfortunately during that same time frame we had unprecedented number of overruled overdoses. In a small community a couple overdose deaths really hit home for community members. We hosted an awareness event with the intention of honoring those we lost and educating the community, destigmatizing substance use. At that event we provided Narcan training and handed out Narcan kits. I wanted to show a picture of our flier to the event because we put the event together in less than a week but the number of sponsors that are pictured at the bottom kind of demonstrates the collaborative nature of our program itself.

>> Matt: Thank you, Anne, this is awesome.

If can you summarize in the next minute or so you have some great questions coming in too.

>> Anne: Sure, sounds good. So as far as successes go in our program, it seems silly to talk about success right now because we have only been doing this for about 10 months and we have a lot of projects ongoing. Right now in less than a year we have been able to really start linking patients into treatment no matter how they encounter our system. We gave out 200 Narcan kits at our overdose awareness event. Weave continue to

hand out Narcan every day. Our law enforcement officers are linking patients into treatment. Primary clinic went to having almost no patients on treatment to over 70 and they really expanded their services. So. Yeah, so I guess the take home point for me would be if you are working in a rural community, having a small team can make a large impact. Especially if it's full of different organizations and mutually beneficial collaborations exist but it may be difficult to seek them out sometimes. So, if you come to Bishop, please stop by our clinic. Let me know. Say hi.

>> Matt: Thank you, Anne and thanks to all presenters. We are going to get to some of the questions. Some of them are actually similar in their theme. I will start with a question for Jason and any of the other panelists can jump in and it relates to the way it's worded what kind of strategies have you seen, Jason, in work in changing the narrative among law enforcement, especially people who are working on the front lines regarding the cultural law enforcement, especially beat officers and individuals who make arrests and are there to enforce the laws? What are the specific -- you know, the best talking points, the best pitch we might make if we are public health advocates reaching across to law enforcement, especially those on the front lines?

>> Jason: It's kind of two-pronged. On the one side of it is understanding that that the opioid problem drives a lot -- correlated into a lot of other crimes. Meaning in another life I did a lot of crime analysis, violent crime analysis. And, you know, we saw that all the shootings in the state were primarily drug-related. And to the tune of about 95%. And shootings are obviously very important and a lot of resources are dedicated to that. And it's kind of a sexy crime as well law enforcement officers investigating shootings and murders and things like that.

But, again, 95% were related to the drug environment. Now, that number is only about 150 to 200 per year and we are talking about 3,000 fatal overdoses per year. The things that you are looking at. Whether it's violent crime. Whether it's property crimes like theft and burglary, they are all related. They are all just a small subset of the drug problem, of the overall drug problem. And you are not going to arrest your way out of this with people, if there is no demand then there is no problem. So, demand reduction is key how can we assist that and other sector partners in reducing the demand. That's really the a big approach is everything you are looking at, your violent crimes and burglaries are all attributed to this bigger drug problem and arresting someone does not cure addiction. And putting them in jail does not, you know, is not going to magically cure addiction. These are just linking people to treatment and linking people that care can help. So we just have to stress that point to law enforcement in New Jersey. The other aspect that I will talk about is that it comes from the top, right? And our governor, former governor Christie did the overdose prevention act essentially there is immunity from conviction. Our current attorney general started the operation helping hand when he was a burden county prosecutor blue heart program which is an outreach program where they are targeting drug offenders for treatment and for mitigation. And our former governor, McGreevey, I saw one of the questions about the correctional system. He has a big reentry program where people coming out of prisons and how are we getting these

people back and making sure they are not going in to the same problems they had before. So, really, there is a lot of leadership at the top kind of dictating and a lot of law enforcement, education of law enforcement understanding it's a bigger problem and really demand reduction is key. That's how I would approach that.

>> Matt: Thank you. And thanks for making the link to both the front line law enforcement as well as the corrections setting.

Another question that came up more than once relates to the observation opiates were making progress on opioids and methamphetamine and other substances are on the rise as well. What opportunities do you see for kind of pivoting what we are doing in opioids base to methamphetamine use. Specifically I'm wondering whether bridge program and do -- are you doing any work with methamphetamine or Jason, whether you have any benefits from work laid out from the opioid work. Anne?

>> Yeah. We are definitely seeing a large amount of methamphetamine and, unfortunately, there is no medication assisted treatment to help with methamphetamine. We do some minimal in our primary care settle minimal contingency management. Linking those patients into treatment and keeping them in treatment help and allow for the cognitive behavioral therapy to work. Seeing a lot of that and a lot of methamphetamine use disorder, too.

>> Matt: Great. Real quick, I know there are more questions than we are going to be able to get.

To say there was one practical question, Anne, regarding how long folks are in the ED when they are initiated on Buprenorphine.

>> Anne: Not long at all. It's actually really interesting. It's kind of what we would call a fast-track patient, usually. The longest portion of their stay in the emergency department is usually the discussion with the Recovery Assistance Navigator. From the physician standpoint, these patients are usually pretty simple. They come in, they say they are in opiate withdrawal and typically if we see any objective signs that we believe them, and give them a dose of the sublingual Buprenorphine and oftentimes their symptoms get better in about 30 to 45 minutes and we you link them into treatment and they are out the door. No labs are done. You know, we let the primary care clinic do all the blood born pathogen screening and all that stuff. We just start them on medication. We don't do a long induction process. We just kind of give them the medication and usually they feel better quickly. It's amazing.

>> Matt: Great. Thank you. And those protocols and other resources that we'll address other questions that came up that we don't have a chance to get to today can be found on the resources that will be shared on the California Opioid Safety Network website. I want to thank all of our panelists so much for what they have brought to us today. Obviously one of the themes here is that the progress we're going to make collectively against this epidemic is so much of it is based on relationships and capitalizing on what each other can bring to the table and this is -- this group of panelists here and the sectors they represent, I think, are expanding that network across the nation of resources. So, hopefully we can stick together as a community of practice here and accelerate progress nationally. I will hand it over to Laura.

>> Thank you so much Matt and Jason and April for your presentation today. Also many thanks to today's partners and sponsors, the California Opioid

Safety Network, Center for Health Leadership and Practice and Public Health Institute. Thanks so much for being with us and that concludes today's web forum. Have a great day.