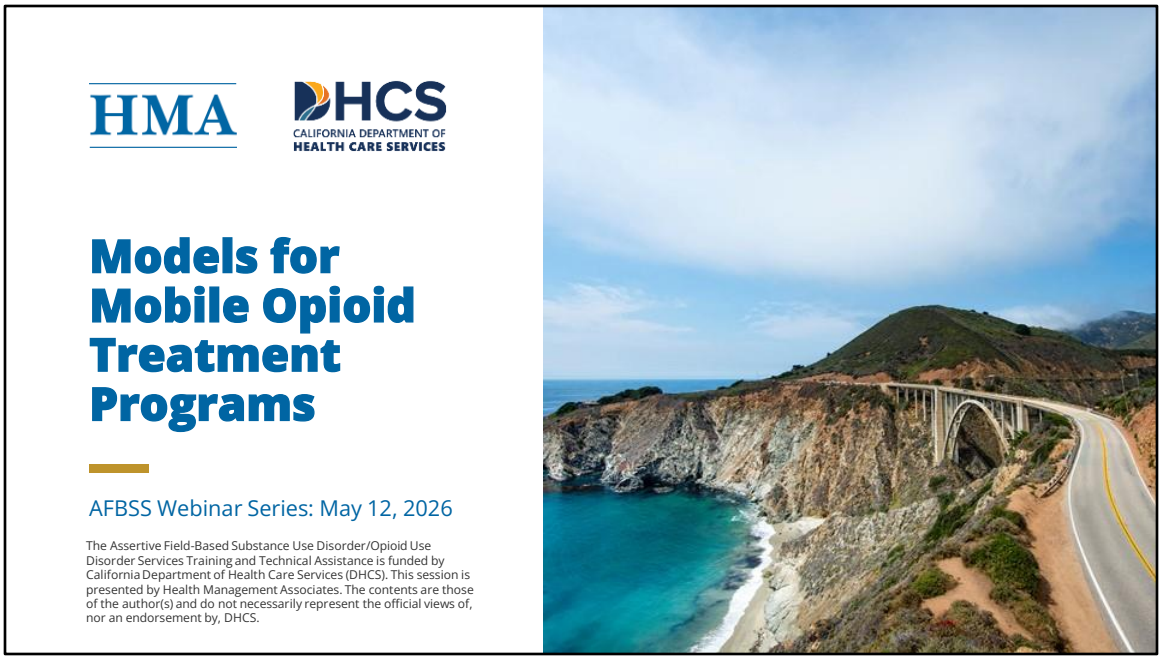

[Slide Image Description: This cover slide introduces the title of this webinar. It contains the logos for Health Management Associates.]

Disclaimer: This session is presented by Health Management Associates. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, California Department of Health Care Services.

Disclosures

Faculty	Nature of Commercial Interest
Anika Alvanzo, MD, MS, DFASAM, FACP	Dr. Alvanzo discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.
Debbi Witham, JD, LMSW	Ms. Witham discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients. Ms. Witham conducted research and analysis for Indivior.
Jeanene Smith, MD, MPH, CME Reviewer	Dr. Smith discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.

HMA discloses all relevant financial relationships with companies whose primary business is producing, marketing, selling, re-selling or distributing health care products used by or on patients.

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[Slide Image Description: This slide shows Continuing Education disclosures.]

- Anika Alvanzo, MD, MS, DFASAM, FACP: Dr. Alvanzo discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.
- Debbi Witham, JD, LMSW: Ms. Witham discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients. Ms. Witham conducted research and analysis for Indivior.
- Jeanene Smith, MD, MPH: Dr. Smith discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.

Presenters

Anika Alvanzo, MD, MS, FACP, DFASAM
Physician Principal
Health Management Associates
(HMA)

Debbi Witham, JD, LMSW
Principal
Health Management Associates
(HMA)

HMA

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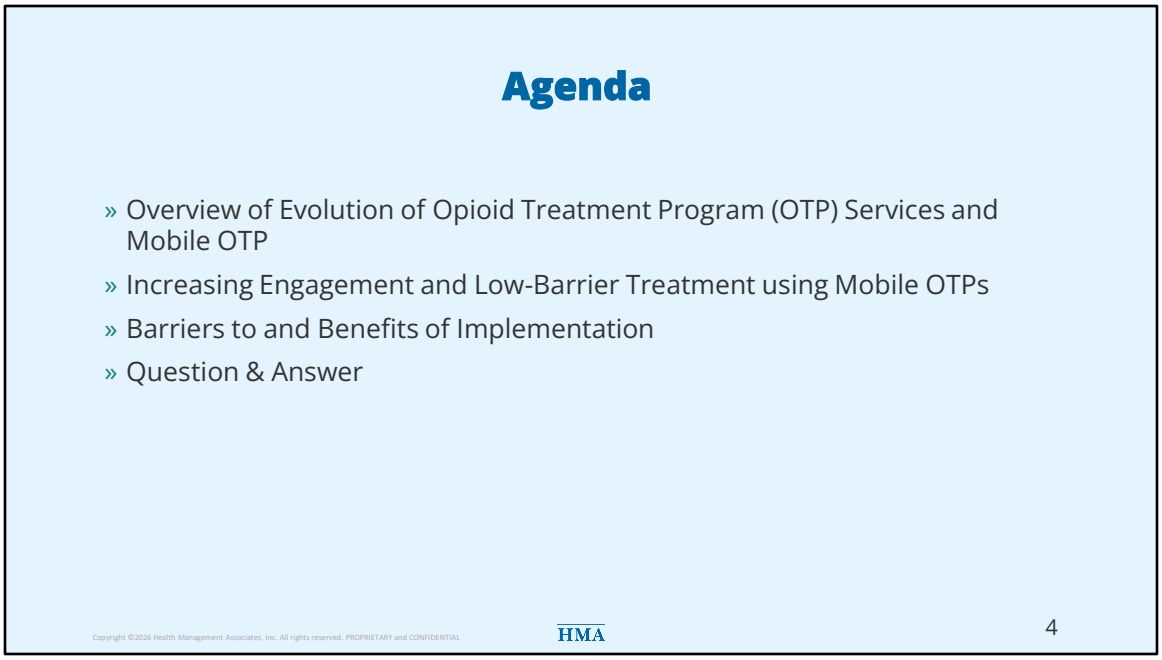
[Slide Image Description: This slide includes images of the presenters of this webinar on a light blue background.]

Dr. Anika Alvanzo is a distinguished health care executive with over 15 years of experience in specialty addiction treatment, behavioral health integration, and quality improvement. At Health Management Associates (HMA) Dr. Alvanzo's consulting has focused on supporting state and local jurisdictions in community needs assessment and strategic planning for behavioral health service delivery; provision of training, technical assistance and coaching to behavioral health providers; implementation of the American Society of Addiction Medicine (ASAM) Criteria; and advancing cultural humility in addiction treatment.

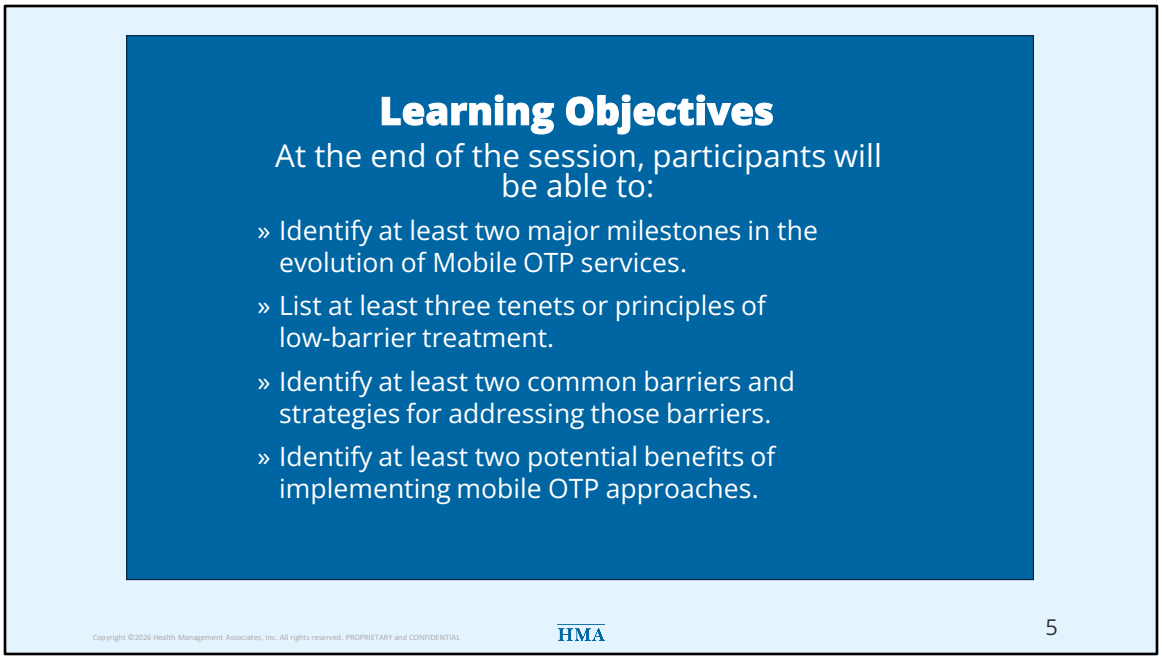
Debbi Witham is a seasoned executive with experience delivering high-quality, mission-driven healthcare and human services. She focuses on behavioral health, including mental health and substance use disorders; the integration of primary and behavioral health services; services for people living with HIV/AIDS; housing and social services; and child welfare.



[Slide Image Description: This slide shows the major sections of this webinar on a light blue background.]

Agenda:

- Overview of Evolution of Opioid Treatment Program (OTP) Services and Mobile OTP
- Increasing Engagement and Low-Barrier Treatment using mobile OTPs
- Barriers to and Benefits of Implementation
- Question & Answer



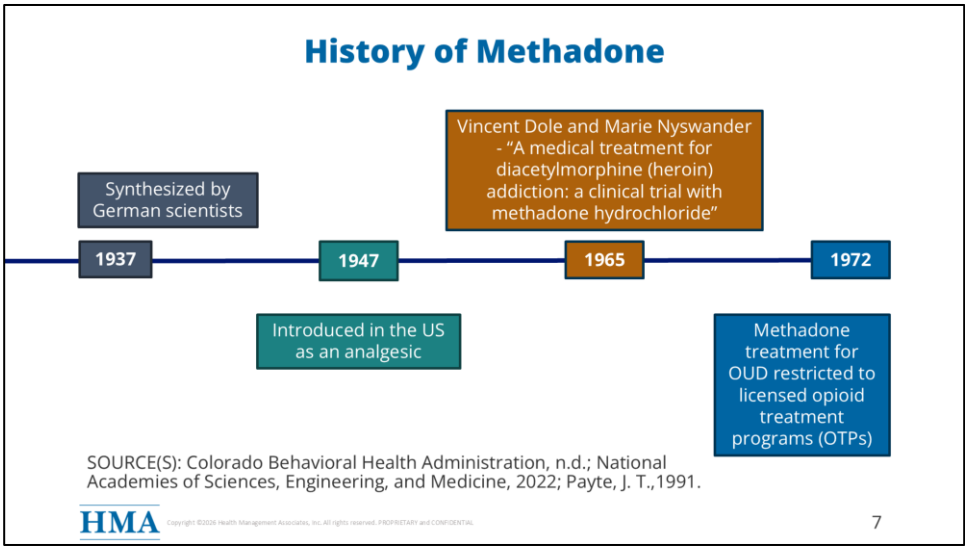
[Slide Image Description: This slide shows the learning objectives for this webinar with a light blue background.]

At the end of the session, participants will be able to:

- Identify at least two major milestones in the evolution of Mobile OTP services.
- List at least three tenets or principles of low-barrier treatment.
- Identify at least two common barriers and strategies for addressing those barriers.
- Identify at least two potential benefits of implementing mobile OTP approaches.

[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This first section will provide an overview of evolution of opioid treatment program (OTP) services and Mobile OTP.

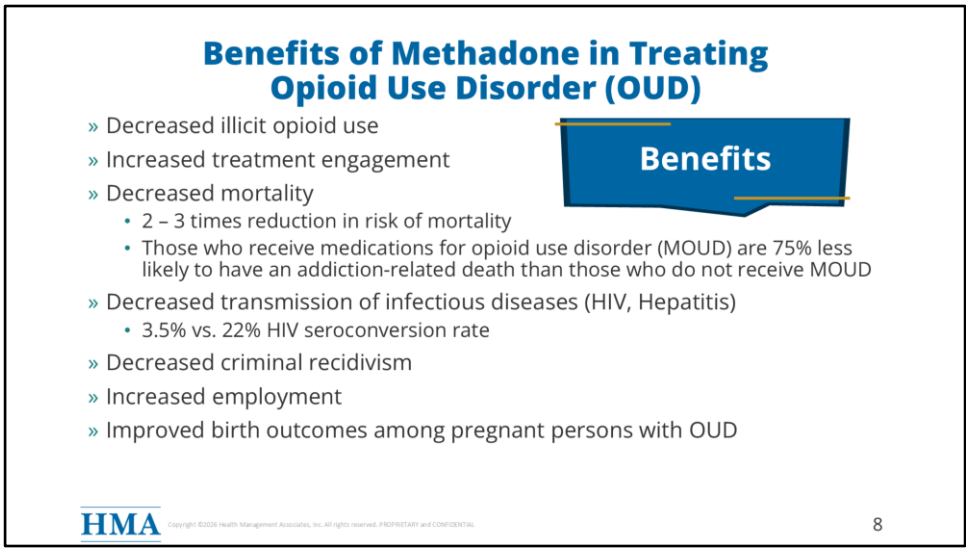


[Slide Image Description: This slide shows a graphic for the history of methadone with colorful boxes on a timeline.]

We'll first provide a history of Methadone. Consider the following timeline:

- 1937: Synthesized by German scientists looking for an analgesic less addictive than morphine.
    - During World War II, another team of German scientists began synthesizing methadone as a result of short supplies of morphine and other analgesics.
    - By the end of the war, the United States had obtained the rights to the drug from war requisitions and later coined the name methadone.
- Soon after in 1947, methadone was introduced into the United States to be used as a pain reliever for a variety of conditions, but eventually uncovered its usefulness in treating addiction to opioids.
- 1965: "A medical treatment for diacetylmorphine (heroin) addiction: a clinical trial with methadone hydrochloride"
    - First trial of methadone maintenance, published in JAMA.
    - Vincent Dole and Marie Nyswander published the first trial of methadone as a treatment for heroin addiction.
    - The trial included 22 men ages 19 – 37 who were injecting heroin.
- Early 1970s: Methadone maintenance restricted to licensed opioid treatment programs (OTPs).
- Strictly governed by Federal (and State) regulations.
- Done as a result of continued concern about diversion and related sequelae.

SOURCE(S): Colorado Behavioral Health Administration, n.d.; National Academies of Sciences, Engineering, and Medicine, 2022; Payte, J. T.,1991.



[Slide Image Description: This slide lists the benefits of methadone in treating opioid use disorder (OUD).]

While methadone is effective at keeping people engaged in treatment longer and reducing opioid use, the benefits of methadone extend beyond treatment attendance and reduction in opioid use.

Methadone is associated with decreased infectious disease transmission, specifically HIV and Hepatitis C, decreased recidivism of criminal activity, and improved birth outcomes in pregnant people with opioid use disorder.

Most importantly, methadone saves lives. Both methadone (and buprenorphine) are associated with a 2 – 3 times reduction in overdose death for people with OUD who are treated with either of these medications as opposed to people with OUD who are not.

[Slide Image Description: This slide lists how methadone is highly regulated.]

Methadone is a highly regulated medication when used for the treatment of opioid use disorder. This slide is an overview of the key points of the regulatory environment.

As noted, methadone is highly regulated. The regulation of methadone for the treatment of opioid dependence is quite specific and detailed. It occurs at the federal and state levels, and can also occur at the local level.

Methadone can only be dispensed for treatment of OUD in a federally certified opioid treatment program. California and the DEA refer to OTPs as narcotic treatment programs (NTPs).

OTPs are certified through a SAMHSA approved accrediting body:

- CARF
- Joint Commission
- Council on Accreditation
- National Commission on Correctional Health

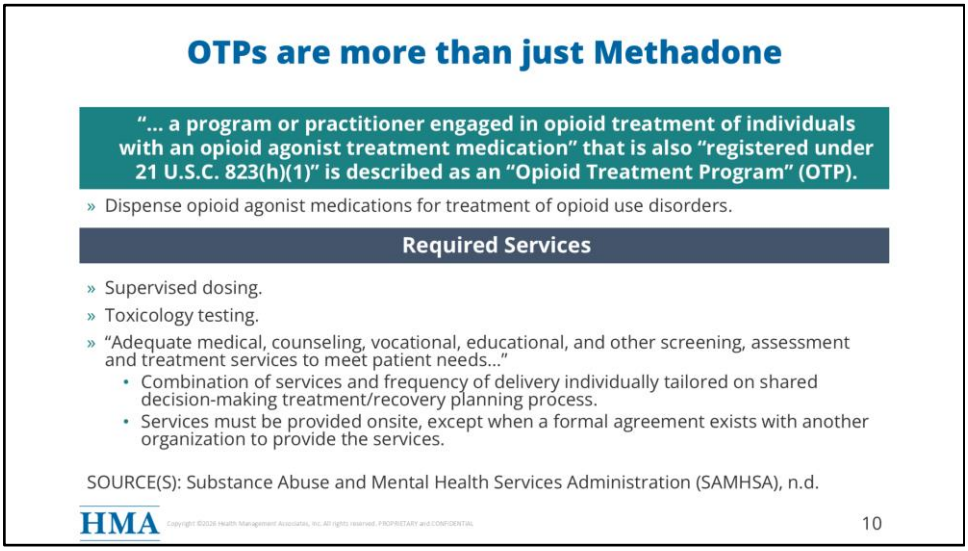
The federal regulations are embedded in the accreditation standards and SAMHSA receives a copy of the report and this prompts certification/recertification (or potential for decertification if they do not perform well).

Each state has a state opioid treatment authority (SOTA) who is responsible for implementing the federal regulations within the state. All OTPs must be licensed in the state.

All OTPs must be registered with the Drug Enforcement Administration (DEA).

For the treatment of pain, methadone can be prescribed just as any other schedule II opioid.

SOURCE(S): Colorado Behavioral Health Administration, n.d.; National Academies of Sciences, Engineering, and Medicine, 2022; Payte, J. T.,1991.



[Slide Image Description: This slide lists how OTPs are more than just methadone with colorful boxes.]

Opioid Treatment Programs or OTPS were the original modality for treating opioid use disorder (OUD) in the United States. Traditionally, opioid treatment programs were often thought of or referred to as methadone maintenance programs. However, OTPs do much more than dispense methadone.

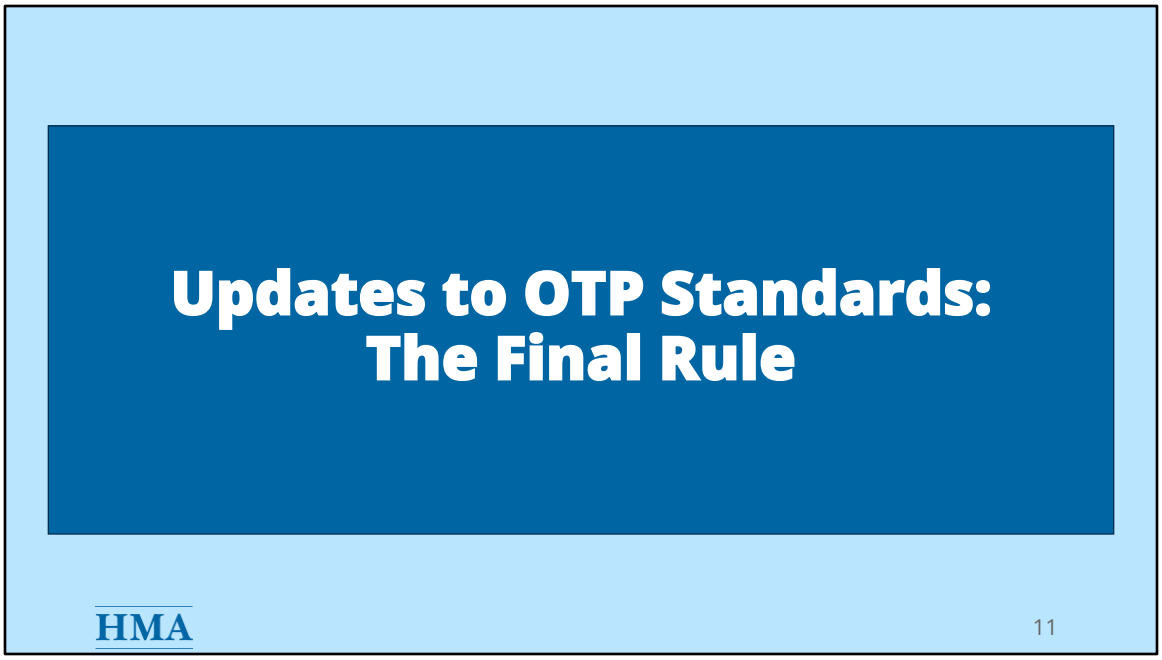
The Code of Federal Regulations defines an OTP as: "... a program or practitioner engaged in opioid treatment of individuals with an opioid agonist treatment medication" that is also "registered under 21 U.S.C. 823(h)(1)."

When initially approved in the 1970s, opioid agonist referred to methadone, as it was the only FDA-approved medication for treatment of OUD. However, now opioid agonist includes both the full agonist, methadone, and the partial agonist, buprenorphine.

In addition to dispensing medication and supervising the dosing of that medication, OTPs are required to provide a variety of other services, including: medical, counseling, vocational, educational, and other screening, assessment, and treatment services to meet patient needs.

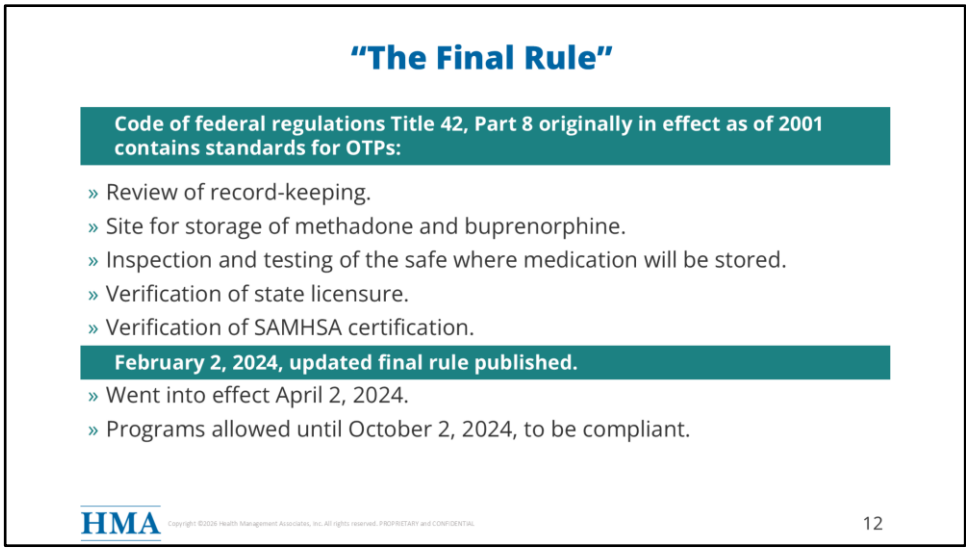
If not provided directly, OTPs must have a formal agreement with other organization(s) to provide those services. All services should be individualized based on each individual's unique treatment and recovery support needs.

SOURCE(S): Substance Abuse and Mental Health Services Administration (SAMHSA), n.d.



[Slide Image Description: This is a sub-section slide with blue boxes.]

This subsection will review updates to OTP standards.



[Slide Image Description: This slide lists "The Final Rule" with colorful boxes.]

Prior to implementation of Part 8, OTPs were regulated under the FDA, with very little focus on outcomes. In the 1990s, they shifted oversight to SAMHSA and adopted an accreditation model. They studied the benefits of accreditation and saw improvements in individualized dosing, treatment planning, and services.

Title 42, Part 8 of the Code of Federal Regulations defines the federal standards for opioid treatment programs and is often referred to as the Final Rule.

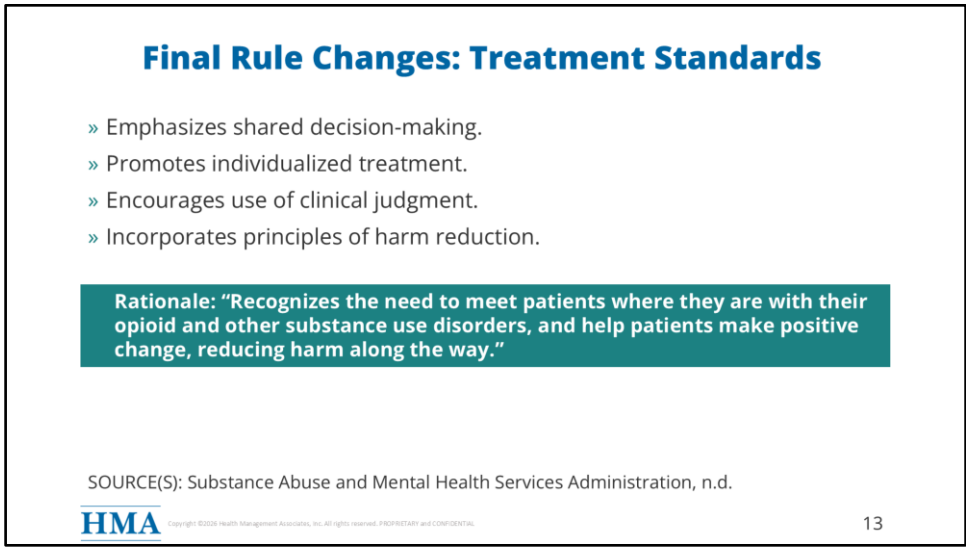
The Final Rule includes standards for OTP:

Certification, accreditation, and treatment standards inclusive of but not limited to:

- OTP admission criteria
- Record-keeping
- Medication storage and dispensing
- Required services
- Personnel, specifically leadership, qualifications

In February of 2024, SAMHSA published the updated "Final Rule." The Final Rule went into effect two months later and programs were given a 6-month grace period to come into compliance.

This 2024 update contained substantial changes to how treatment is to be delivered in the OTP treatment setting.

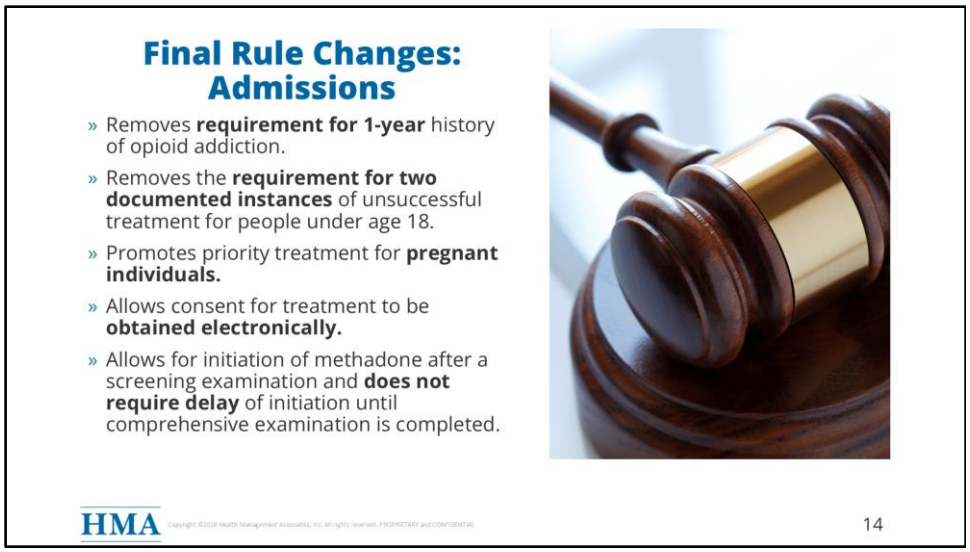


[Slide Image Description: This slide lists final rule changes: treatment standards with colorful boxes.]

We are going to briefly highlight some of the most significant changes to the Final Rule, starting with changes to Treatment Standards.

In contrast to the previous version, the revised Final Rule promotes increased flexibility for the delivery of individualized treatment based on identification of patient's goals and shared decision-making processes, encourages OTP clinicians and medical practitioners to use their clinical judgement, and supports integration of harm reduction principles.

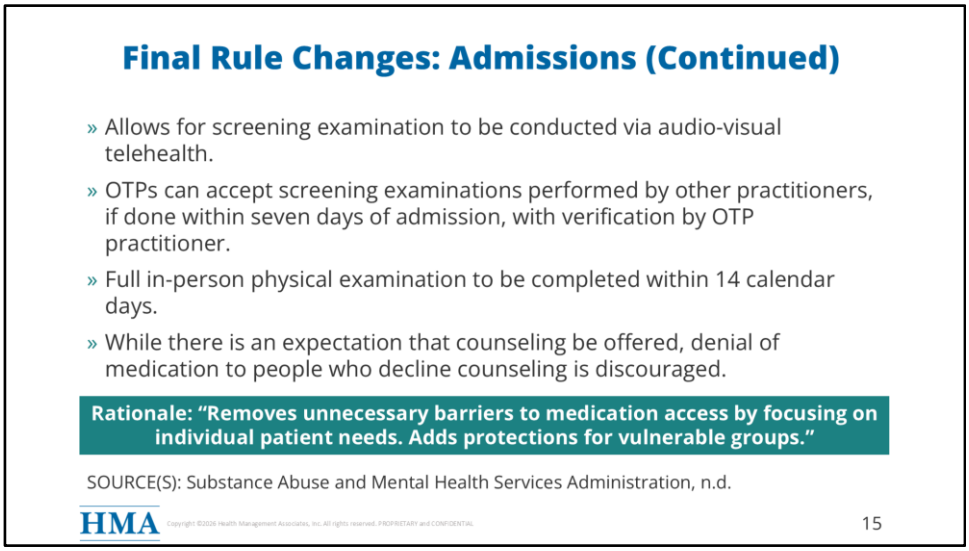
SOURCE(S): Substance Abuse and Mental Health Services Administration, n.d.



[Slide Image Description: This slide lists final rule changes: admissions.]

Changes in the Final Rule pertaining to OTP admission criteria and processes include:

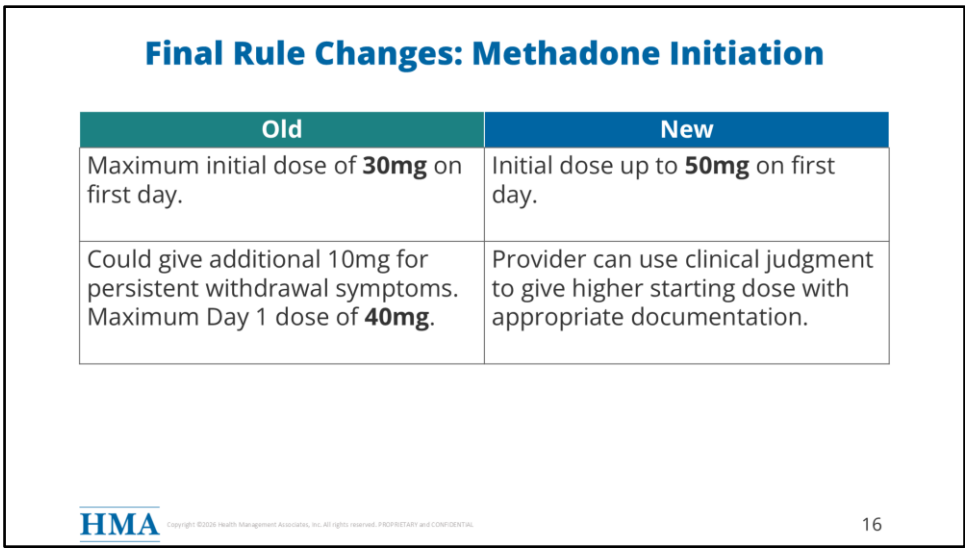
- Removal of the requirement that a person have an OUD diagnosis for at least a year before they can be treated with methadone.
- Removal of the requirement that adolescents under 18 years old must have 2 unsuccessful treatment episodes before being eligible for treatment with methadone.
- Promotes priority enrollment for pregnant people.
- Allowance for electronic consent to treatment.
- Assuming no contraindications, a patient may commence treatment with MOUD after a screening examination has been completed.



[Slide Image Description: This slide lists final rule changes: admissions (Continued) with colorful boxes.]

Assuming no contraindications, a patient may commence treatment with MOUD after the screening examination has been completed.
If it was completed within seven days of admission to the OTP, OTPs practitioners can review, verify and accept a screening exam performed by licensed non-OTP providers (e.g. hospital provider, primary care provider).
When the examination is performed outside of the OTP, the written results and narrative of the examination, as well as available lab testing results, must be transmitted, consistent with applicable privacy laws, to the OTP, and verified by an OTP practitioner.
A full in-person physical examination, including the results of serology and other tests that are considered to be clinically appropriate, must be completed within 14 calendar days following a patient's admission to the OTP.
Both the screening examination and full examination must be completed by an appropriately licensed practitioner.
While counseling should be offered and encouraged, medication should not be denied to individuals who decline counseling.

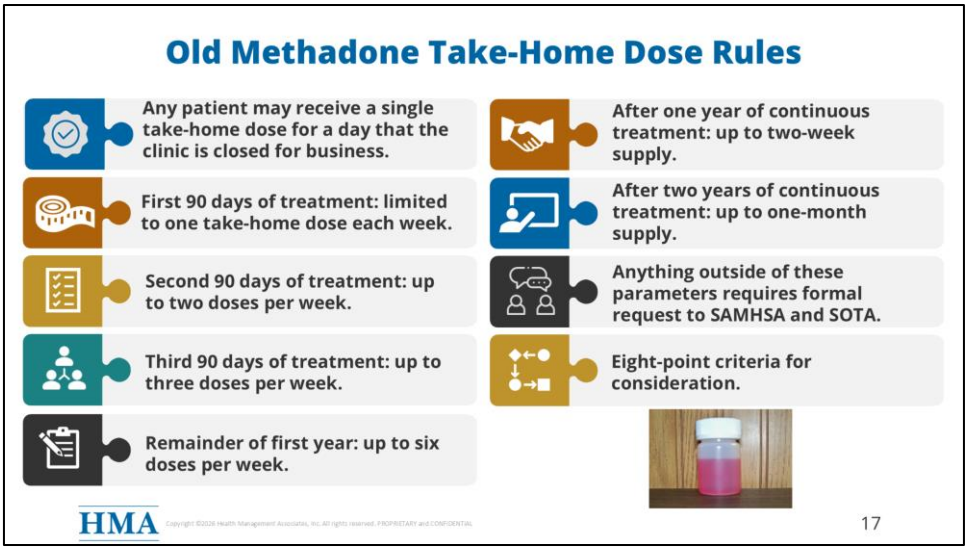
SOURCE(S): Substance Abuse and Mental Health Services Administration, n.d.



[Slide Image Description: This slide lists final rule changes for methadone initiation in a table.]

The maximum amount or upper limit for the initial dose of methadone was increased from 30mg to 50mg.

Providers were also given the ability to give additional methadone on the initiation day, based upon their clinical judgment.

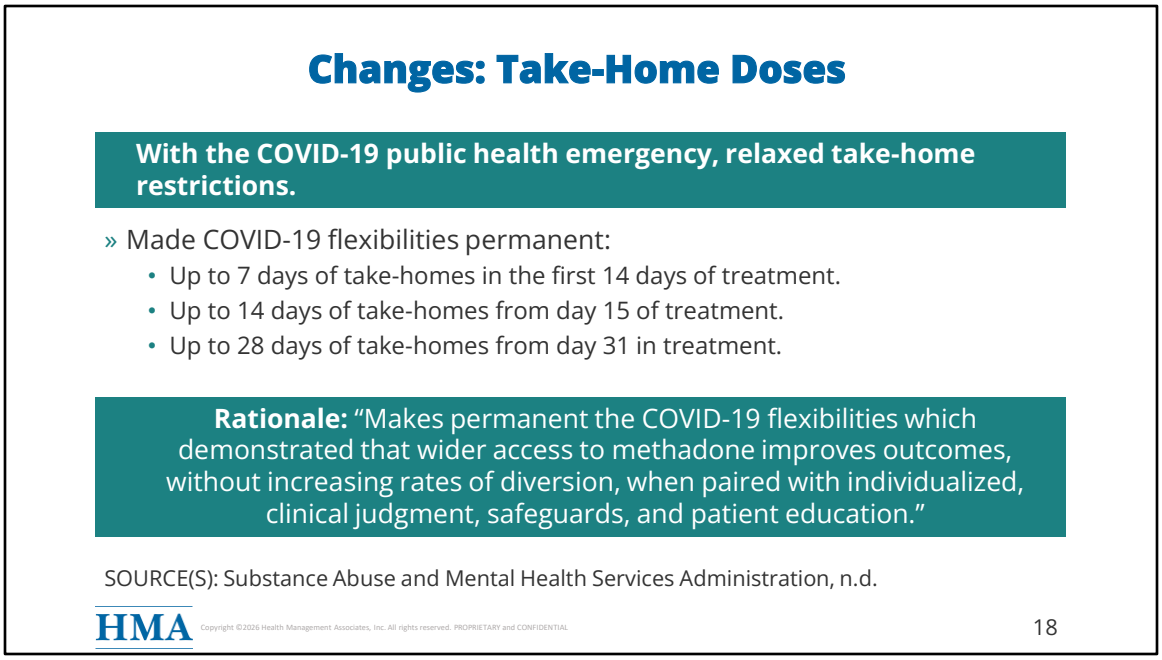


[Slide Image Description: This slide lists old methadone take-home dose rules, with various icons.]

Prior to the COVID-19 global pandemic, the rules governing the allowance for take-home doses of methadone were such that patients had to come to the clinic every day or almost every day, during their initial treatment. For some people, this resulted in a barrier that limited access to this important medication option for treating opioid use disorder.

1. Absence of recent abuse of drugs (opioid or nonnarcotic), including alcohol; Eight-point criteria for take-homes.
2. Regularity of clinic attendance.
3. Absence of serious behavioral problems at the clinic.
4. Absence of known recent criminal activity, e.g., drug dealing.
5. Stability of the patient's home environment and social relationships.
6. Length of time in comprehensive maintenance treatment.
7. Assurance that take-home medication can be safely stored within the patient's home.
8. Whether the rehabilitative benefit the patient derived from decreasing the frequency of clinic attendance outweighs the potential risks of diversion.

Could be in addition to take-home for clinic closure day.



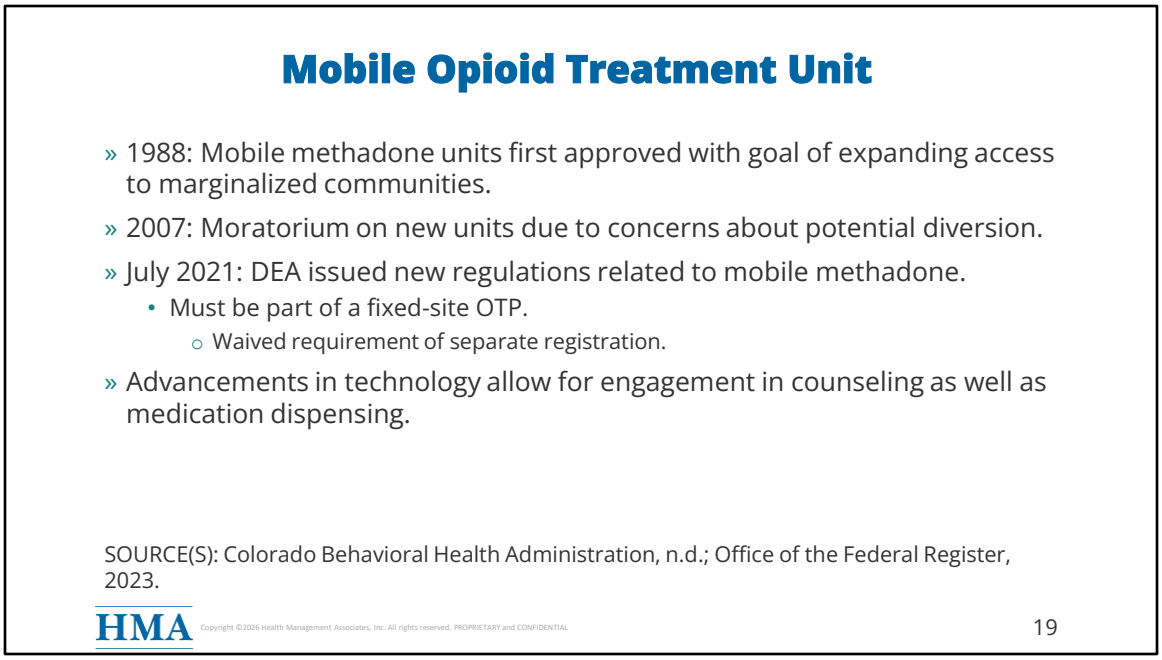
[Slide Image Description: This slide lists changes to take-home doses with colorful boxes.]

In the wake of the COVID-19 pandemic, take home dose flexibilities were issued in response to public health and safety concerns. This relaxation of the take home rules expanded access to life-saving treatment for OUD and was not associated with increases in methadone-related overdose deaths nor increased rates of methadone diversion.

With the publication of the updated Final Rule, the COVID-19 take home dose flexibilities were made permanent.
This includes removal from sole consideration the length of time an individual has been in treatment and requirements for rigid reliance on toxicology testing results that demonstrate complete and sustained abstinence from all substances.

- Up to 7 days of take-homes in the first 14 days of treatment
- Up to 14 days of take-homes from day 15 of treatment
- Up to 28 days of take-homes from day 31 in treatment

SOURCE(S): Substance Abuse and Mental Health Services Administration, n.d.



[Slide Image Description: This slide lists mobile opioid treatment unit.]

Mobile methadone units were first approved in 1988, with the goal of expanding treatment access to marginalized communities (i.e., rural areas and urban areas without a brick-and-mortar OTP, unhoused, under-resourced).

In 2007, the DEA put a moratorium on new mobile units as a result of concerns for potential diversion. Effective on July 28, 2021, after considerable pressure from numerous organizations, the DEA issued new regulations related to registration requirements for NTPs with mobile components (21 CFR (Code of Federal Regulations) Parts 1300, 1301, and 1304).

The mobile OTP unit must be part of a registered, fixed-site OTP, and the mobile unit can only operate in the state where the fixed-site treatment program is registered. The mileage limits for the mobile unit are not specified, but it must return to a fixed site at the end of each day, where it must unload and store all controlled substances, and the vehicle must be

parked in a secured, fenced location. Controlled substances placed in schedules II-V can be dispensed by a mobile narcotic treatment program (MNTP) for maintenance or detoxification and do not require separate registration for the mobile component.

SOURCE(S): Colorado Behavioral Health Administration, n.d.; Office of the Federal Register, 2023.

[Slide Image Description: This is a sub-section slide with blue boxes.]

This subsection will describe models for mobile OTP operation.

Facilities with Higher OUD Prevalence

» One model for operating a mobile OTP unit is to identify and partner with facilities that may have a higher prevalence of individuals with opioid use disorder such as:
  - Correctional facilities
  - Skilled nursing facilities/Long-term care facilities
  - Residential addiction treatment facilities

SOURCE(S): Office of the Assistant Secretary for Planning and Evaluation, n.d.

HMA

[Slide Image Description: This slide lists facilities with higher OUD prevalence with a colorful graphic of a building.]

One model for operating a mobile OTP unit is to identify and partner with facilities that may have a higher prevalence of individuals with opioid use disorder such as:

- Correctional facilities
- Skilled nursing facilities/Long-term care facilities
- Residential addiction treatment facilities

SOURCE(S): Office of the Assistant Secretary for Planning and Evaluation, n.d.

Partners Already Serving Those with OUD

- Another approach is to partner with organizations that are already actively serving people who use drugs, such as:
  - Harm-reduction organizations (e.g., syringe services programs)
  - Recovery organizations

SOURCE(S): Office of the Assistant Secretary for Planning and Evaluation, n.d.

[Slide Image Description: This slide lists partners already serving those with OUD with a colorful graphic of a handshake.]

Another approach is to partner with organizations that are already actively serving people who use drugs such as:

- Harm-reduction organizations (e.g., syringe services programs)
- Recovery organizations

SOURCE(S): Office of the Assistant Secretary for Planning and Evaluation, n.d.

Targeting Populations with High Need

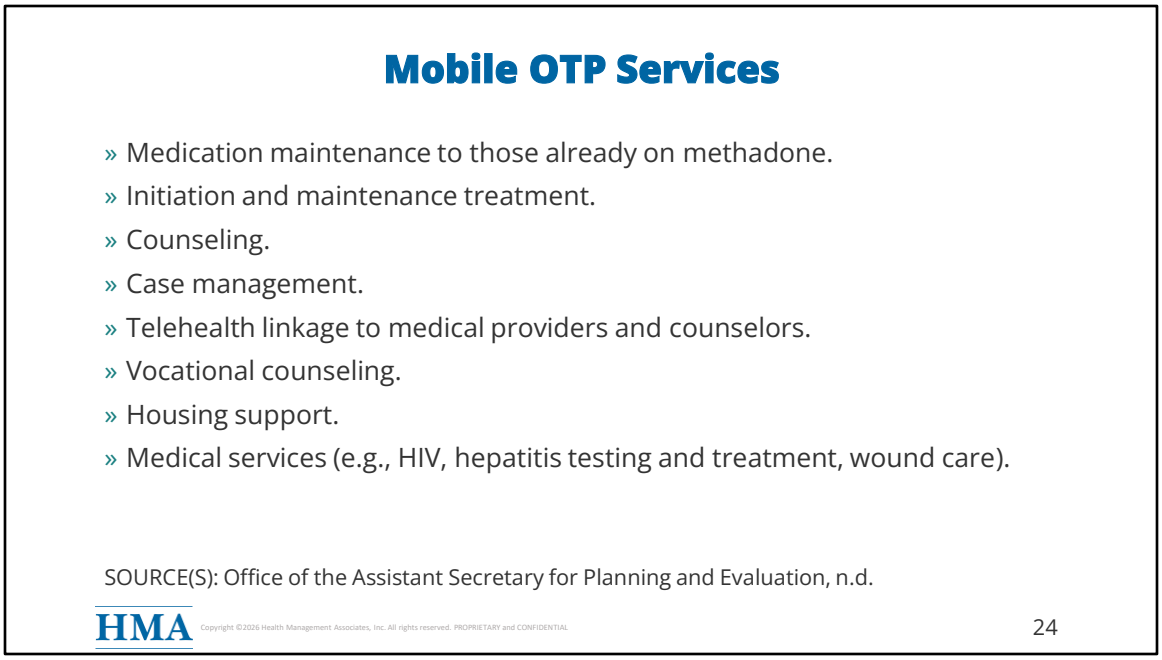
» Lastly, some models include intentional targeting of populations and communities with some of the highest need:
- Rural residents
- Urban residents with limited transportation access
- Tribal communities
- People experiencing homelessness (e.g., shelters, encampments)

SOURCE(S): Office of the Assistant Secretary for Planning and Evaluation, n.d.

[Slide Image Description: This slide lists targeting populations with high need with a colorful graphic of a hand and question marks.]

Lastly, some models include intentional targeting of populations and communities with some of the highest need:
- Rural residents
- Urban residents with limited transportation access
- Tribal communities
- People experiencing homelessness (e.g. shelters, encampments)

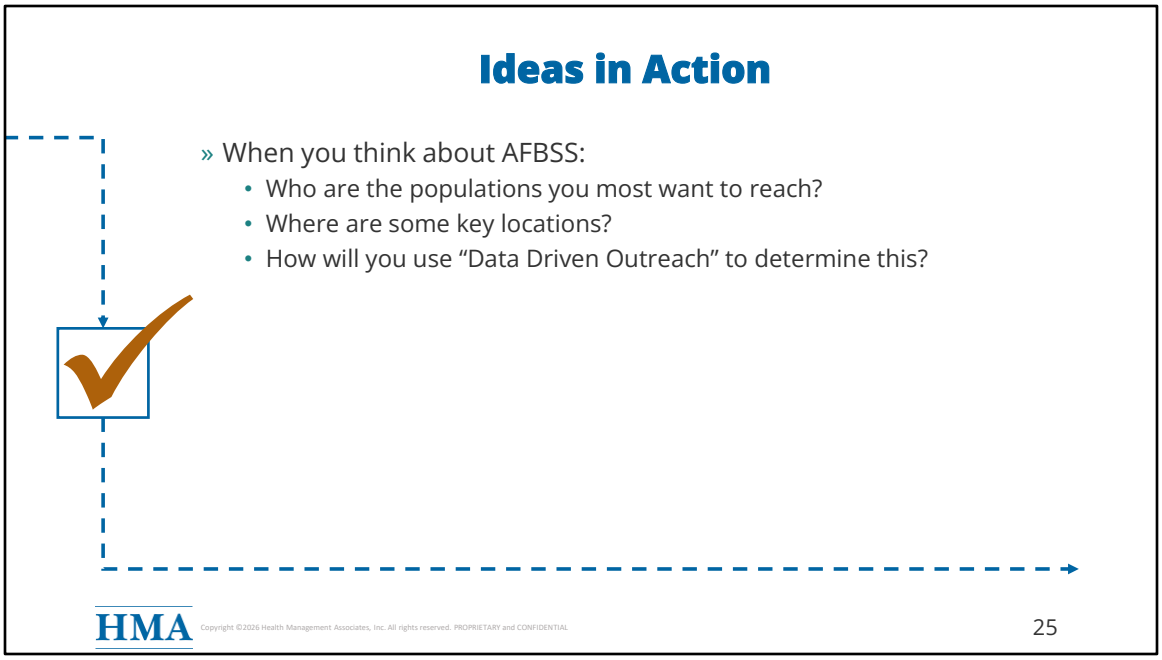
SOURCE(S): Office of the Assistant Secretary for Planning and Evaluation, n.d.



[Slide Image Description: This slide lists mobile OTP services.]

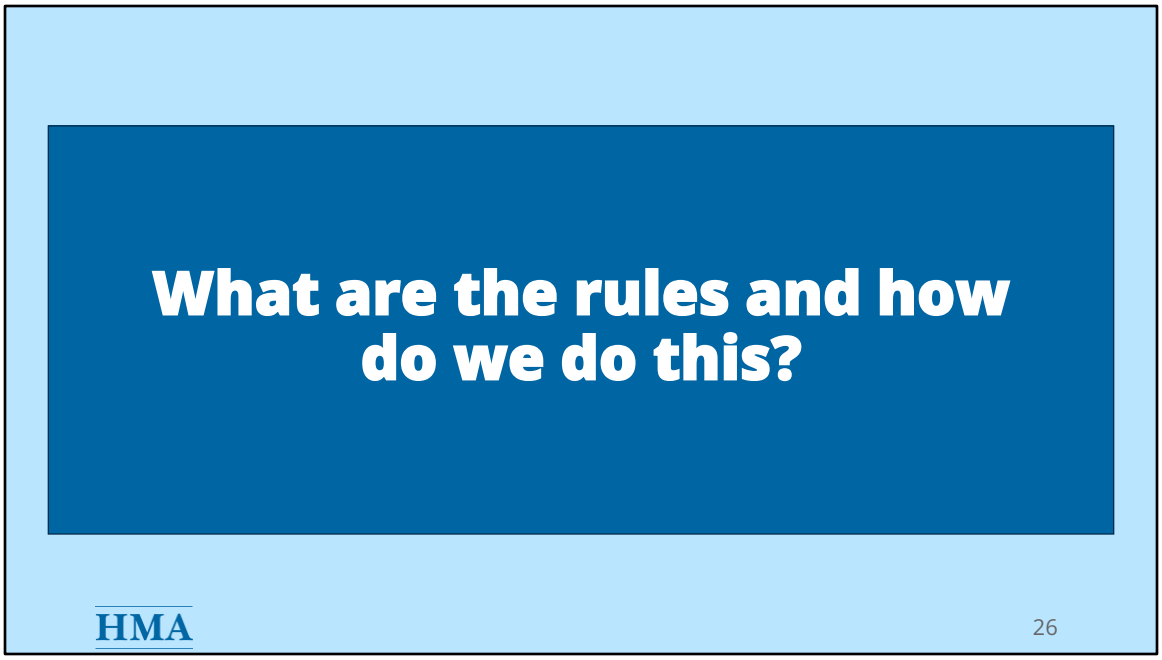
Mobile OTP Services:
- Medication maintenance to those already on methadone
- Initiation and maintenance treatment
- Counseling
- Case management
- Telehealth linkage to medical providers and counselors
- Vocational counseling
- Housing support
- Medical services (e.g., HIV, hepatitis testing and treatment, wound care)

SOURCE(S): Office of the Assistant Secretary for Planning and Evaluation, n.d.



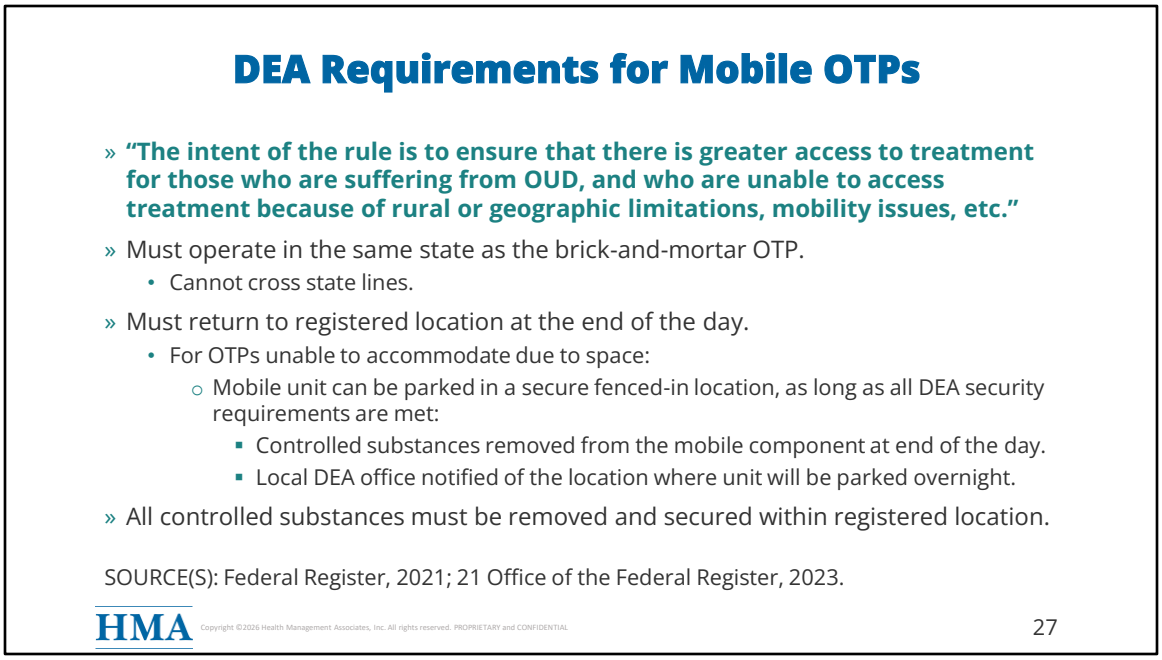
[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

When you think about AFBSS:
- Who are the populations you most want to reach?
- Where are some key locations?
- How will you use “Data Driven Outreach” to determine this?



[Slide Image Description: This is a sub-section slide with blue boxes.]

This subsection will outline rules.



[Slide Image Description: This slide lists DEA Requirements for Mobile OTPs.]

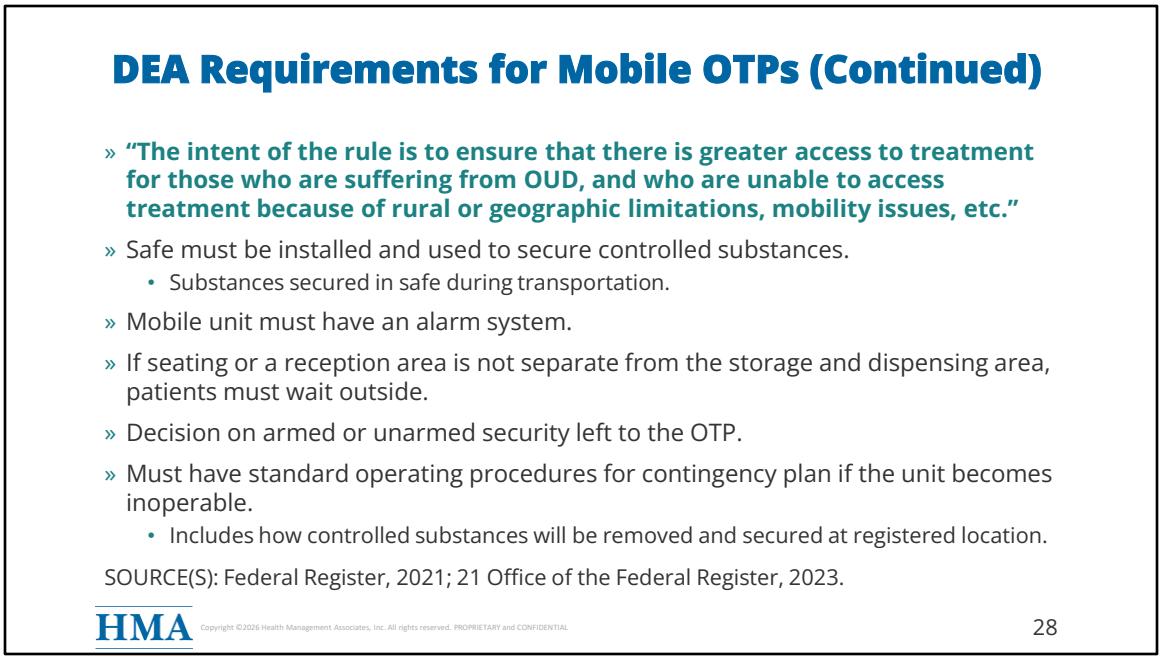
The DEA has strict requirements for operation of a mobile OTP unit. "The intent of the rule is to ensure that there is greater access to treatment for those who are suffering from OUD, and who are unable to access treatment because of rural or geographic limitations, mobility issues, etc."

- The mobile OTP must operate in the same state as the brick-and-mortar OTP to which it is registered, and cannot cross state lines.
- At the end of the day, the mobile unit must return to its registered location.
- For OTPs unable to accommodate this, the mobile unit can be parked in a secured, fenced-in location, with DEA approval.
- All controlled substances must be removed from the unit and secured in the registered location at the end of every day.

A Mobile OTP may apply for an exception to this requirement as provided in this paragraph. The application for such an exception must be submitted in accordance with § 1307.03 of this chapter and must include

the proposed alternate return period, enhanced security measures, and any other factors the applicant wishes the Administrator to consider. The Administrator may grant such an exception in his discretion and will evaluate each application on a case-by-case basis in determining whether the applicant has demonstrated exceptional circumstances that warrant the exception. In making this determination, the Administrator will consider the applicant's security and recordkeeping as well as any other factors he deems relevant to determining whether effective controls against diversion will be maintained.

SOURCE(S): Federal Register, 2021; 21 Office of the Federal Register, 2023.



[Slide Image Description: This slide lists DEA Requirements for Mobile OTPs (Continued).]

Continued DEA requirements:

- Safe must be installed and used to secure controlled substances.
    - Substances secured in safe during transportation.
- Mobile unit must have an alarm system.
- If seating or a reception area is not separate from the storage and dispensing area, patients must wait outside.
- Decision on armed or unarmed security left to the OTP.
- Must have standard operating procedures for contingency plan if the unit becomes inoperable.
    - Includes how controlled substances will be removed and secured at registered location.

SOURCE(S): Federal Register, 2021; 21 Office of the Federal Register, 2023.

Mobile Narcotic Treatment and Medication Units RFA Program Goal

Department of Health Care Services (DHCS)

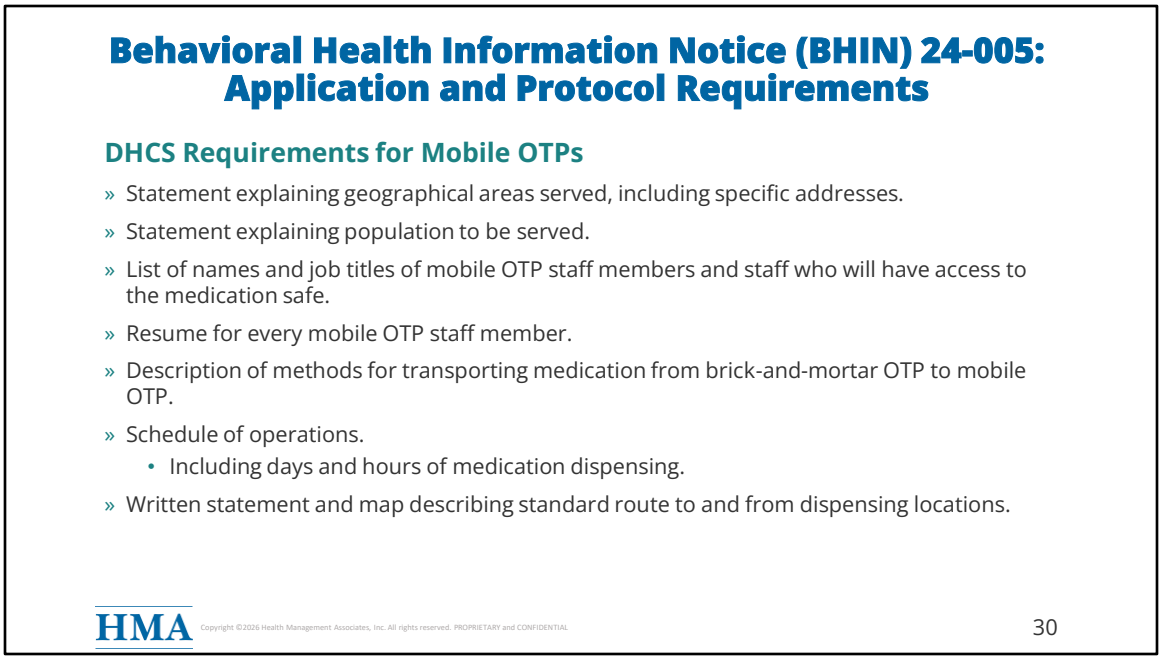
» DHCS' primary objective for this funding opportunity is to expand the availability of medication units (MUs) and mobile narcotic treatment programs (MNTPs), to increase MOUD access for rural areas, justice-involved populations, Indigenous and Native communities, patients without transportation, and areas that do not have a Narcotic Treatment Program (NTP) within close proximity to patients in need of NTP services.

HMA

[Slide Image Description: This slide lists Mobile Narcotic Treatment and Medication Units RFA Program Goal with a graphic of a person and a star.]

In January of 2024, California DHCS released guidance on mobile NTP applications, implementation and operations.
There was an RFP released for expansion of OTP medication units and mobile NTP units with the goal of increasing access with target populations including:

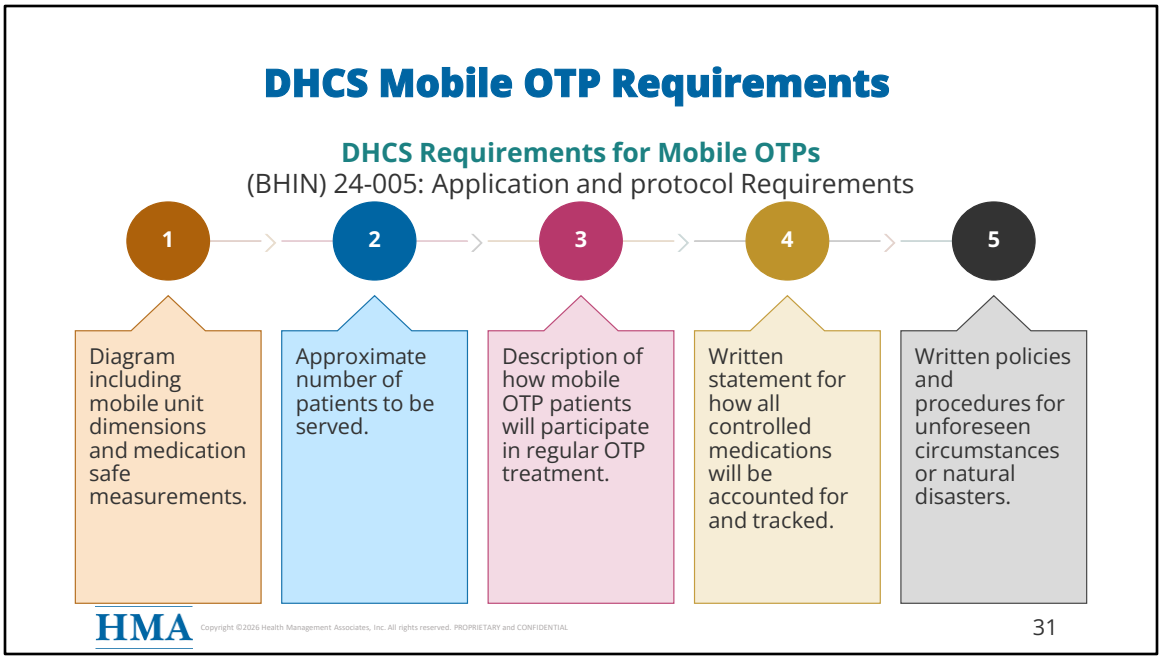
- Rural areas
- Justice-involved populations
- Indigenous and Native communities
- Patients without transportation
- Areas that do not have a Narcotic Treatment Program (NTP) within close proximity



[Slide Image Description: This slide lists Behavioral Health Information Notice (BHIN) 24-005: Application and Protocol Requirements.]

BHIN 24-005 outlines the application and protocol requirements for mobile OTPs:

- Statement explaining the population and geographic areas to be served, including specific addresses.
- List of names and job titles of mobile OTP staff members and staff who will have access to the medication safe.
- Resume for each mobile OTP staff member.
- Description of methods for transporting medication from brick-and-mortar OTP to mobile OTP.
- Schedule of operations.
    - Including days and hours of medication dispensing.
- Written statement and map describing standard route to and from dispensing locations.

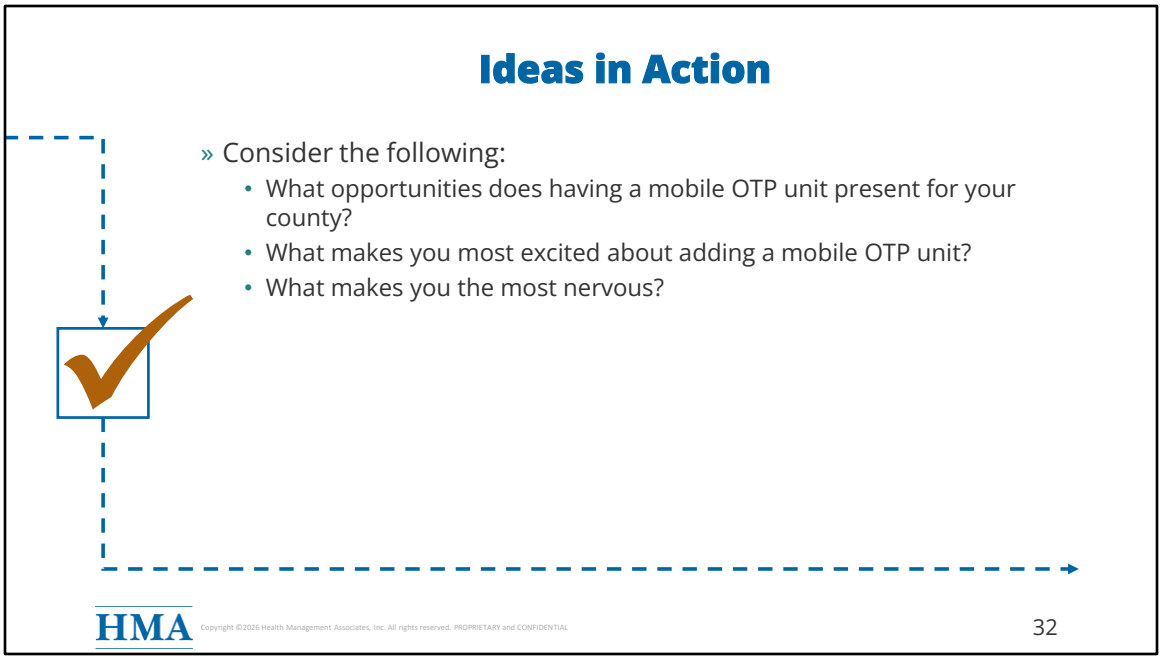


[Slide Image Description: This slide lists DHCS Mobile OTP Requirements with colorful boxes.]

DHCS Mobile OTP Requirements per BHIN 24-005:

- A diagram including mobile unit dimensions, including medication safe measurements. Include narrative describing:
    - Patient flow
    - Waiting areas
    - Parking location when not in operation
- Approximate number of patients to be served.
- Description of how mobile OTP patients will participate in regular OTP treatment.
- Written statement for how all controlled medications will be accounted for and tracked.
- Written policies and procedures for unforeseen circumstances or natural disasters.
    - Including how medication will be removed from unit and secured at registered location.

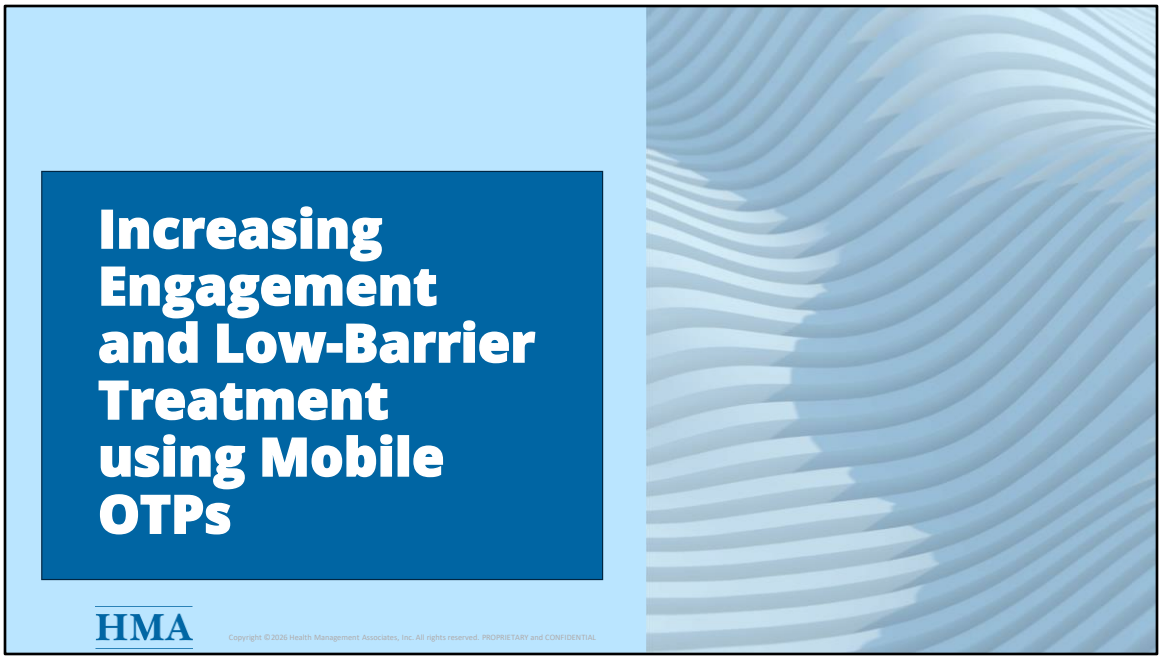
(10) A copy of the vehicle registration of the mobile NTP;
(11) Proof of auto insurance for the mobile NTP;
(12) A written statement describing the mobile NTP safe's alarm system and its direct connection to a central protection company or a local or State police agency.



[Slide Image Description: This slide lists Ideas in Action.]

Consider the following:

- What opportunities does having a mobile OTP unit present for your county?
- What makes you most excited about adding a mobile OTP unit?
- What makes you the most nervous?



[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This second section will highlight increasing engagement and low-barrier treatment using mobile OTPs.

SAMHSA's Previous Definition of Harm Reduction

SAMHSA Definition of HARM Reduction

» "a practical and transformative approach that incorporates **community-driven public health strategies**—including prevention, risk reduction, and health promotion—**to empower people who use drugs (PWUD) and their families with the choice to live healthier, self-directed, and purpose-filled lives.** Harm reduction centers the lived and living experience of PWUD, especially those in underserved communities, in these strategies and the practices that flow from them."

SOURCE(S): Substance Abuse and Mental Health Services Administration, 2023.

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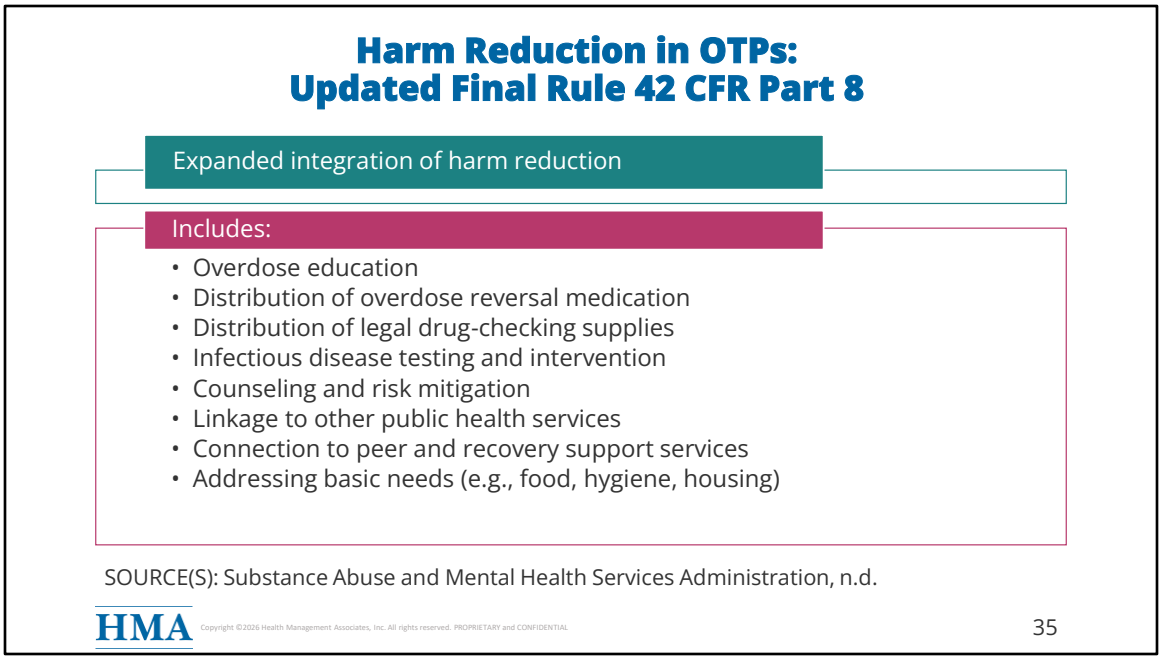
[Slide Image Description: This slide lists SAMHSA's Previous Definition of Harm Reduction.]

And here is how SAMHSA defines Harm Reduction:

"a practical and transformative approach that incorporates community-driven public health strategies—including prevention, risk reduction, and health promotion—to empower people who use drugs (PWUD) and their families with the choice to live healthier, self-directed, and purpose-filled lives. Harm reduction centers the lived and living experience of PWUD, especially those in underserved communities, in these strategies and the practices that flow from them."

SOURCE(S): Substance Abuse and Mental Health Services Administration, 2023.



[Slide Image Description: This slide lists Harm Reduction in OTPs: Updated Final Rule 42 CFR Part 8 with colorful boxes.]

In the most recent update to the Part 8 regulations, SAMHSA expanded the integration of harm reduction in OTPs and named the services they are meant to provide. These include:

- Overdose education
- Distribution of overdose reversal medication
- Distribution of legal drug-checking supplies
- Infectious disease testing and intervention
- Counseling and risk mitigation
- Linkage to other public health services
- Connection to peer and recovery support services
- Addressing basic needs (e.g., food, hygiene, housing)

SOURCE(S): Substance Abuse and Mental Health Services Administration, n.d.

Harm Reduction in OTPs: Updated Final Rule 42 CFR Part 8 (Continued)

- Goes beyond overdose and risk reduction services
- Includes:
  - Cultivation of relationships
  - Engagement and listening
  - Treating individuals with dignity and respect
  - Meeting people where they are

SOURCE(S): Substance Abuse and Mental Health Services Administration, n.d.

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[Slide Image Description: This slide lists Harm Reduction in OTPs: Updated Final Rule 42 CFR Part 8 (Continued).]

And this expansion goes beyond simply the provision of education and safe use supplies. It also includes

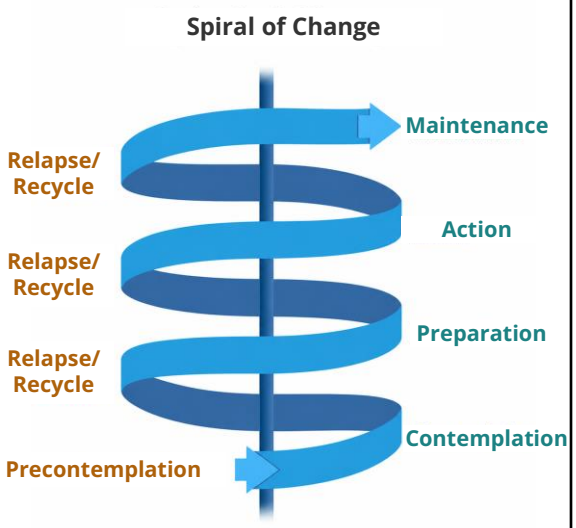
- How you develop relationships
- How you engage and listen to someone
- Treating individuals with dignity and respect
- Meeting people where they are

[Slide Image Description: This is a sub-section slide with blue boxes.]

How we engage persons served is key to everything we do. Here is a framework to consider.

Stages of Change/ Transtheoretical Model

- Change is **gradual.**
- Change is **cyclical and constant.**
- Change is **progressive and sequential** through stages.
- Recurrence is likely and still progress.
- Meet people at their stage, not yours.



SOURCE(S): Prochaska, DiClemente, & Norcross,1992.

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[Slide Image Description: This slide lists Stages of Change/ Transtheoretical Model with a graphic of a Spiral of Change.]

Meeting People Where They Are – includes meeting them at the Stage of Change that they are in

The Transtheoretical Model

- Change is gradual: It's important to keep in mind that while change is possible/inevitable, it will take time. It's important to keep in mind that addiction is surface level and that many of the underlying factors (e.g., trauma, lack of access, poverty, stigma, etc.) will need adequate time and resources to address effectively.
- Change is cyclical and constant: Change is a process/event that happens throughout our lives. For people who use drugs it is important to keep in mind that many have the will power but lack the resources (e.g., employment, treatment, healthcare, etc.) that are needed to create and sustain change.
- Change is progressive and sequential: There are steps/stages within the change process that move individuals forward on their path to recovery.

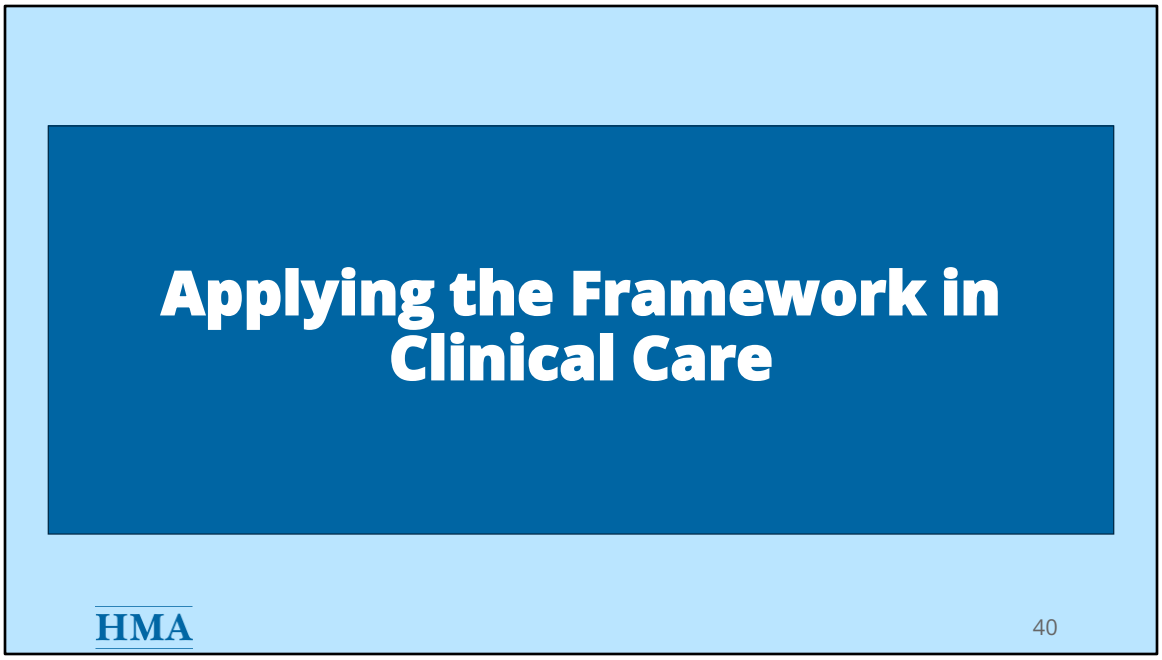
- Recurrence is likely and still progress: This model also challenges a prevailing notion concerning relapse and its role in the process of change. Often, recurrence is discussed in a way that further shames individuals impacted by addiction and could lead them to return to chaotic drug use. However, under the Transtheoretical Model, recurrence is seen as an event/behavior that is likely, but one that won't prevent growth.
- Important to meet people at their stage, not yours: Not only helps us understand the different stages of change, but it also reminds us that interventions must be tailored in ways that meet people at their stage of change. For example, interventions such as medication assisted treatment are effective at meeting individuals with an opioid use disorder where they are in their stage of recovery/change.

SOURCE(S): Prochaska, DiClemente, & Norcross,1992.

[Slide Image Description: This slide lists Core Principles of Engagement with colorful boxes.]

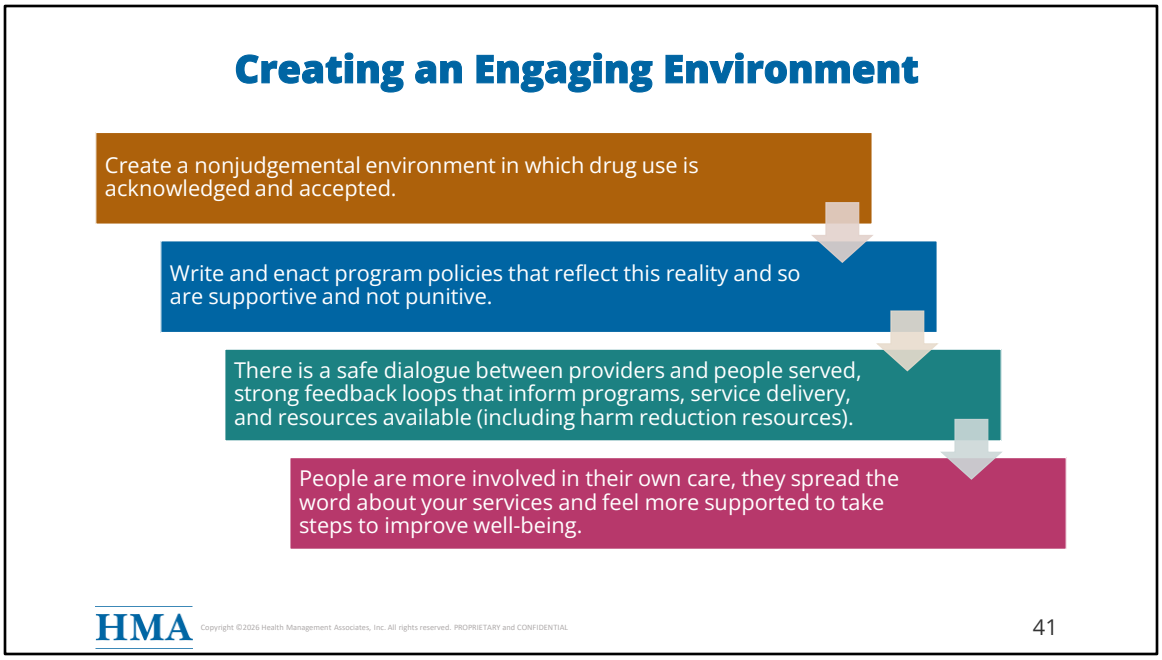
When we think of the core principles, the most important thing is that the safety of the person-served comes first.

- We give respect and dignity for all persons (and that includes persons who may not be ready to receive your services).
- We ensure they understand and can consent to services and include them in all decision-making.
- There is no one right pathway to recovery. Each is individualized.
- Engagement should be supportive and not punitive.
- We collaborate with community resources.



[Slide Image Description: This is a sub-section slide with blue boxes.]

This can be different than what we think of in clinical care. How do we apply the framework – because it actually is in alignment.



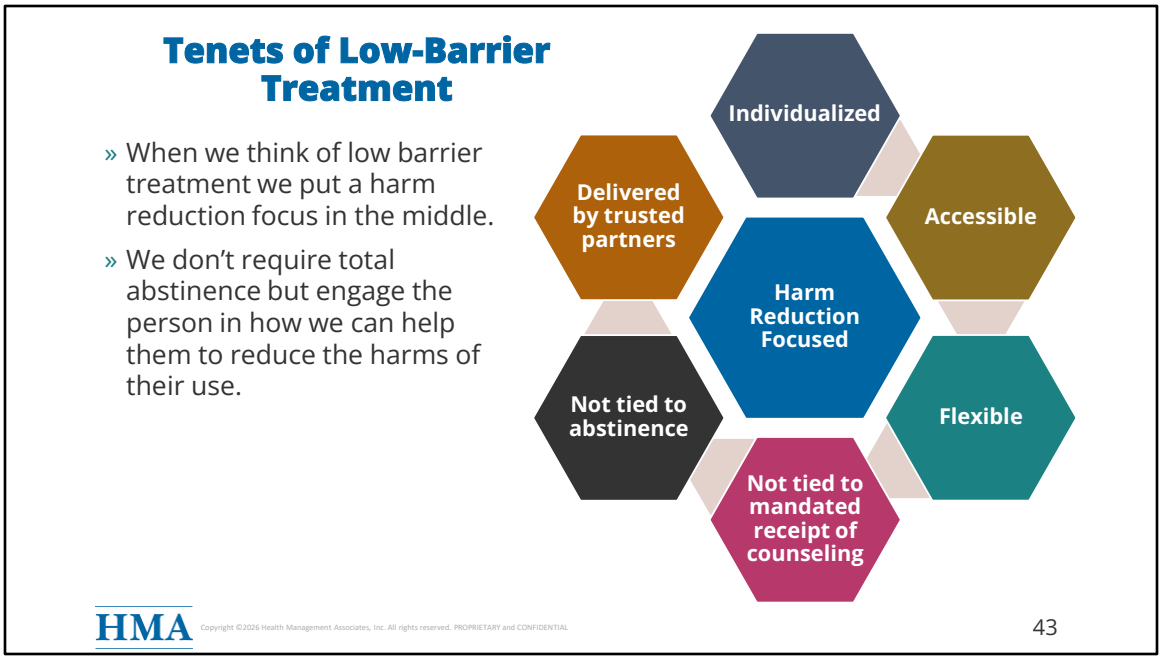
[Slide Image Description: This slide lists creating an engaging environment with colorful boxes.]

"Accepted" does not mean "agreement with." I can firmly disagree with a patient's use of substances, but still engage with them and here are some key principles of how we can do that:

- Create a nonjudgemental environment in which drug use is acknowledged and accepted.
- Write and enact program policies that reflect this reality and so are supportive and not punitive.
- There is a safe dialogue between providers and people served, strong feedback loops that inform programs, service delivery, and resources available (including harm reduction resources).
- People are more involved in their own care, they spread the word about your services and feel more supported to take steps to improve well-being.

[Slide Image Description: This is a sub-section slide with blue boxes.]

And now are going to talk about how we create true low barrier care.

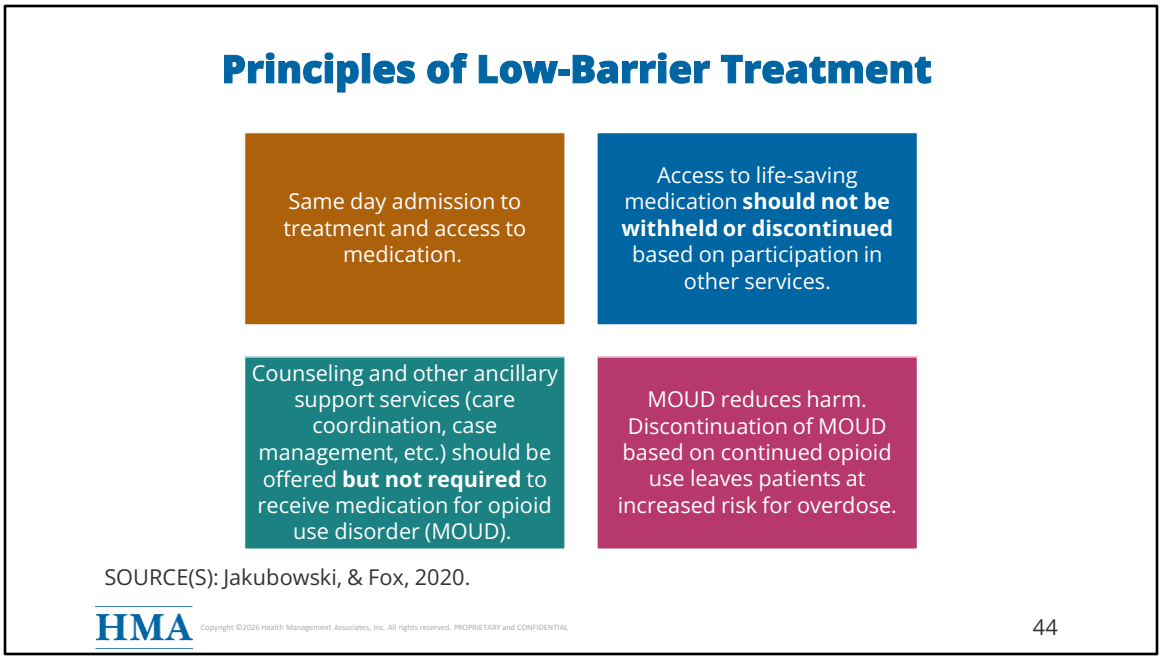


[Slide Image Description: This slide lists tenets of low-barrier treatment with colorful boxes.]

When we think of low barrier treatment we put a harm reduction focus in the middle. We don't require total abstinence but engage the person in how we can help them to reduce the harms of their use.

And then we have all of these other principles around it:

- Accessible
- Individualized
- Delivered by trusted partners
- Flexible
- Not tied to abstinence
- Not tied to mandated receipt of counseling



[Slide Image Description: This slide lists principles of low-barrier treatment with colorful boxes.]

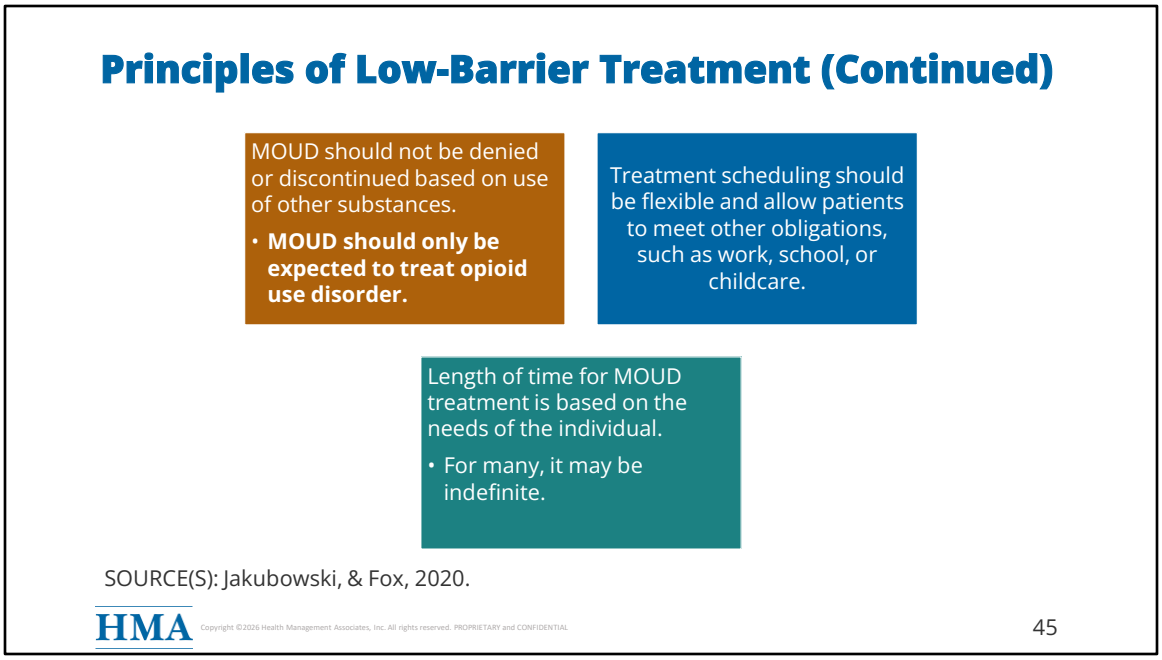
MOUD is safe, effective, and saves lives. Yet only a small percentage of the people who need MOUD receive it.

Traditional models of treatment, where we stand up a building and expect people to find us and walk through the door, don't work for everybody, particularly when we think about serving vulnerable communities.

Low-threshold treatment, which removes barriers to medication, should be the goal for all SUD treatment programs. This includes:

- Same day admission to treatment and access to medication.
- Access to life-saving medication should not be withheld or discontinued based on participation in other services.
- Counseling and other ancillary support services (care coordination, case management, etc.) should be offered but not required to receive MOUD.
- MOUD reduces harm. Discontinuation of MOUD based on continued opioid use leaves patients at increased risk for overdose.

SOURCE(S): Jakubowski, & Fox, 2020.



[Slide Image Description: This slide lists principles of low-barrier treatment (Continued) with colorful boxes.]

Some additional principles of low-barrier treatment include:

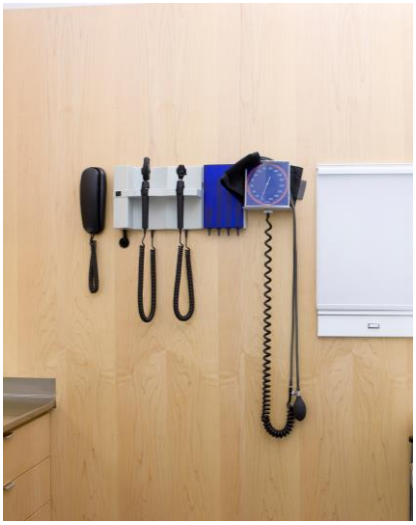
- MOUD should not be denied or discontinued based on use of other substances.
    - MOUD should only be expected to treat opioid use disorder.
- Treatment scheduling should be flexible and allow patients to meet other obligations, such as work, school, or childcare.
- Length of time for MOUD treatment is based on the needs of the individual.
    - For many, it may be indefinite.

SOURCE(S): Jakubowski, & Fox, 2020.

Services Beyond Medication and Counseling

» Excellent Opportunities for:

- Engagement in HIV and Hep C testing and connection to care.
- Initiation of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP).
- Direct observation therapy (DOT) for medications for chronic conditions.
- Connection to primary care and ongoing behavioral health care.
- Long-Acting Injectable (LAI) for psychiatric medications, etc.
- Vaccinations (e.g. Hepatitis, influenza).



[Slide Image Description: This slide lists services beyond medication and counseling with an image of a clinic.]

OTPS were the original modality for treating opioid use disorder (OUD) in the United States. Traditionally, opioid treatment programs were often thought of or referred to as methadone maintenance programs. However, OTPs do much more than dispense methadone, including:

- Engagement in HIV and Hep C testing and connection to care.
- Initiation of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP).
- Direct observation therapy (DOT) for medications for chronic conditions.
- Connection to primary care and ongoing behavioral health care.
- Long-Acting Injectable (LAI) for psychiatric medications, etc.
- Vaccinations (e.g. Hepatitis, influenza).

Ideas in Action

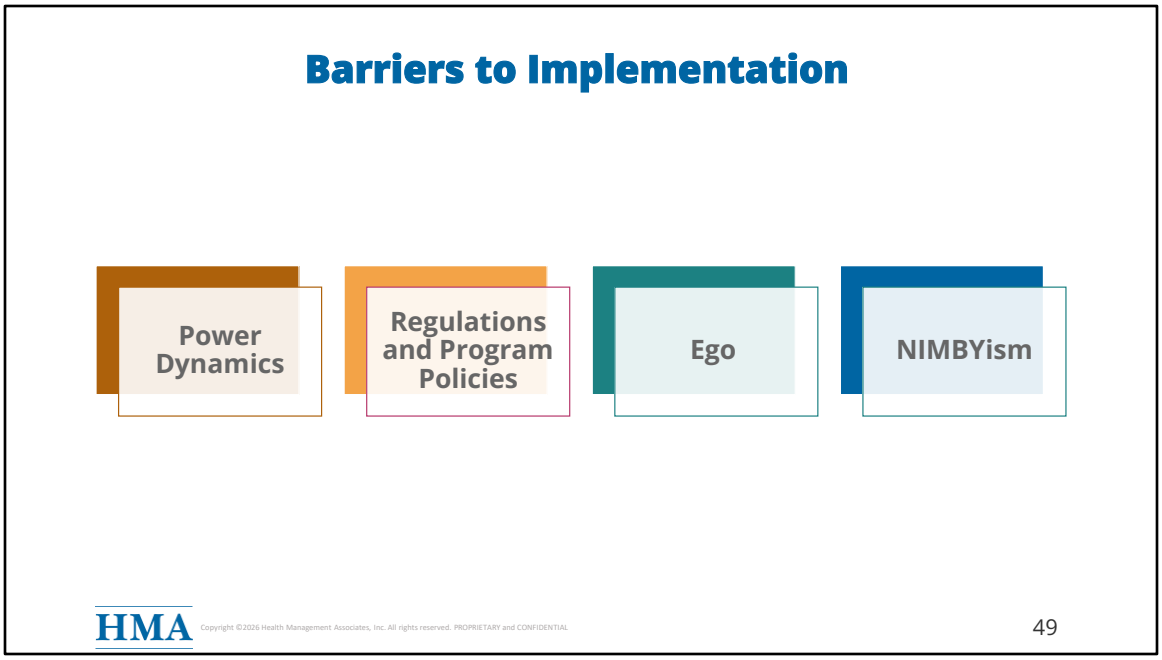
» What services would you want to see provided by a mobile OTP unit operating in your community?

[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

What services would you want to see provided by a mobile OTP unit operating in your community?

[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This third section overviews barriers to and benefits of implementation of mobile OTPs.



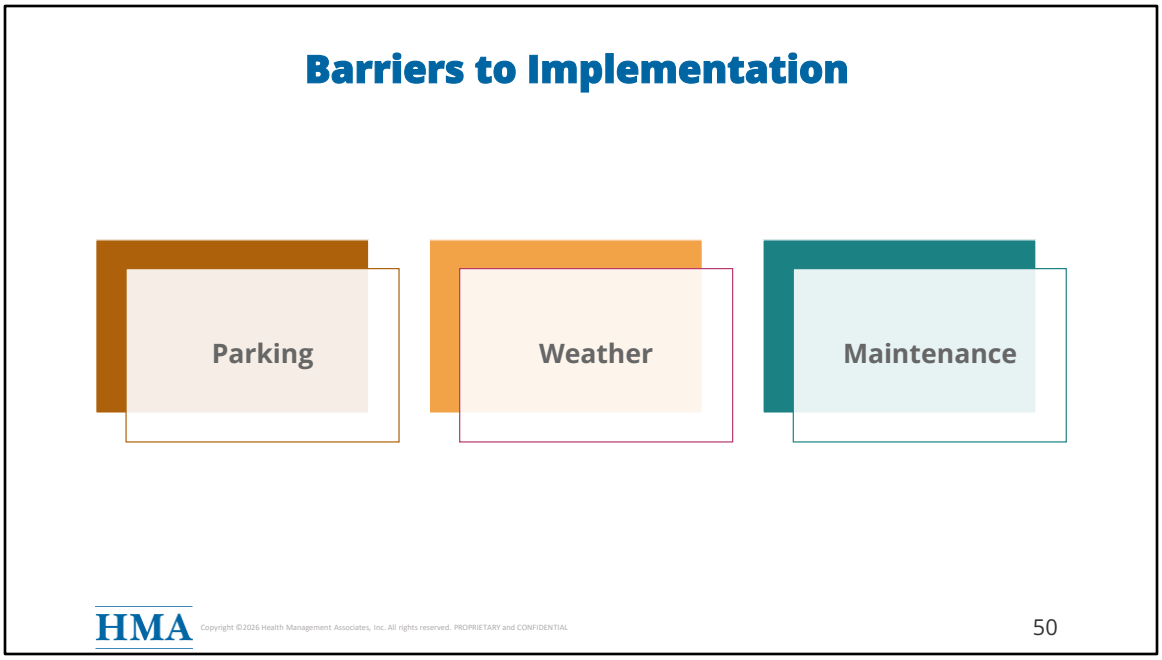
[Slide Image Description: This slide lists barriers to implementation with colorful boxes.]

Consider the following barriers to implementation:

- Power dynamics in which PWUD are subject to the decisions of others, all of their rights are taken away.
- Risk of consequences of violence, retaliation, etc.
- State, local and federal policies can impact and create barriers to implementation, even program policies can (such as requiring counseling to access medication).
- Sometimes the ego of the individuals running systems or programs enter into relationships creating further barriers.
- Not In My Backyard (NIMBY): Often communities do not want programs in their communities (NIMBYism).

Based on experience at all levels of the field:

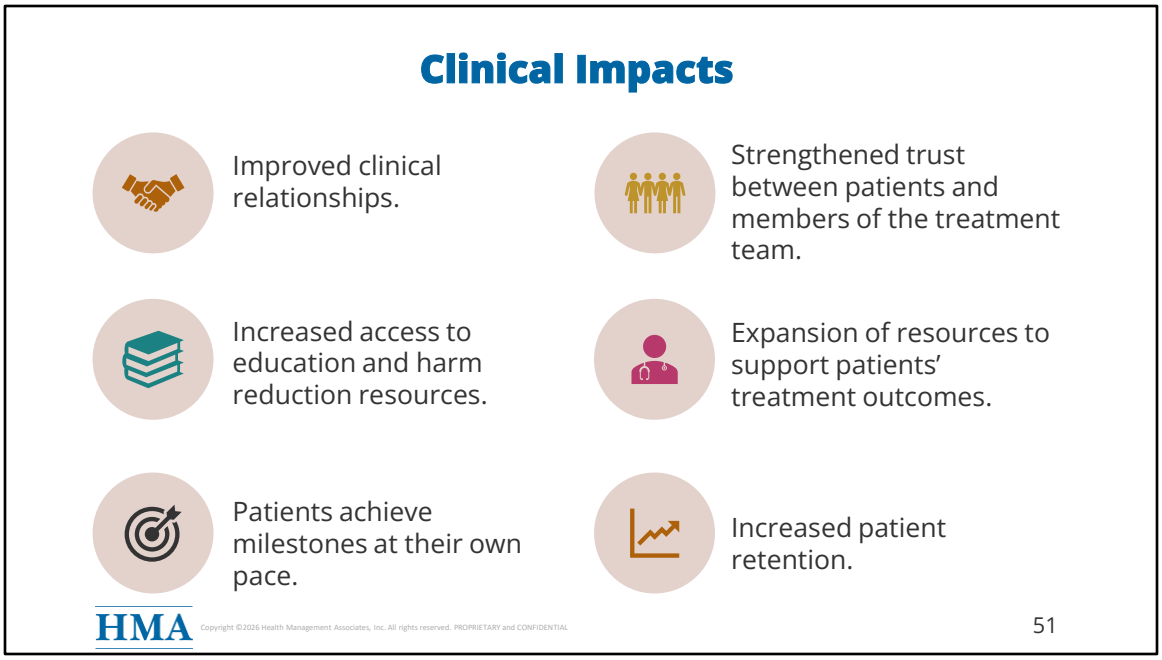
- Criminalization cultivates stigma and exacerbates the risk environment for people who use drugs.
- The federal government controls access to life saving treatment for opioid use disorder (42CFR § 8.12).
- State governments determine overdose prevention resource allocation.



[Slide Image Description: This slide lists barriers to implementation with colorful boxes.]

Other barriers to implementing mobile units include:

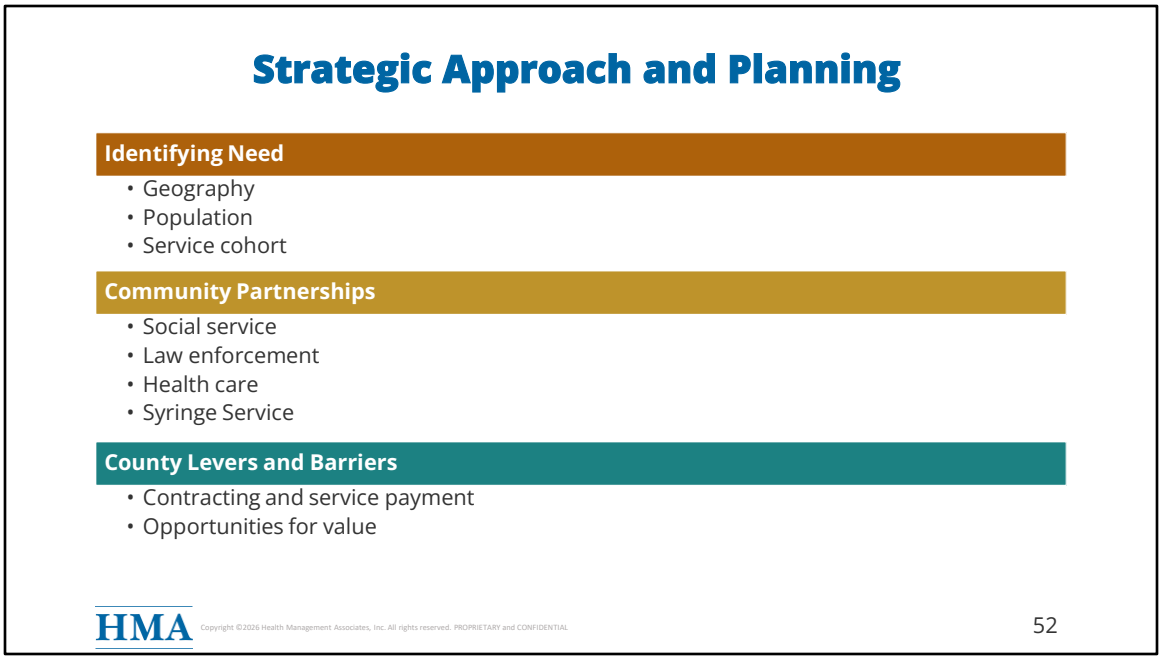
- Determining where to park the mobile unit.
- Managing the mobile unit in inclement weather.
- Ongoing maintenance can be expensive, and back up plans are needed if the unit is under repair.



[Slide Image Description: This slide lists clinical impacts with various icons.]

There are many clinical impacts to persons receiving services in mobile units and low barrier care. They include:

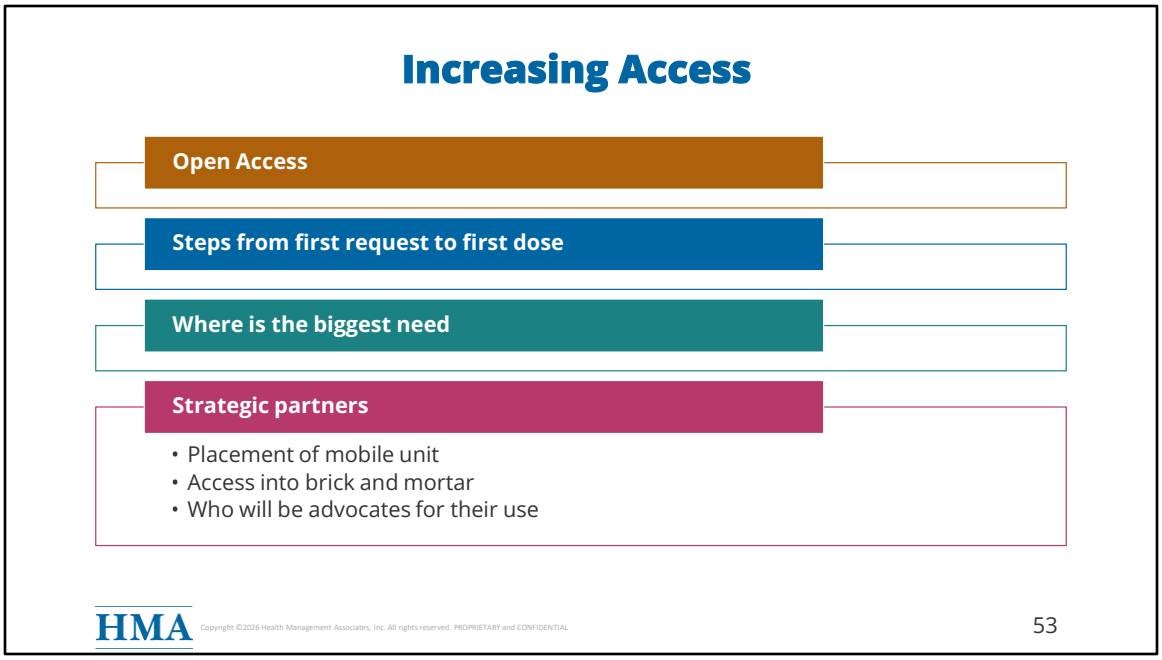
- Improved clinical relationships.
- Strengthened trust between the person served and members of their treatment team.
- Increased access to education and harm reduction resources.
- More resources to support outcomes for the person served.
- Patients achieving milestones at their own pace.
- Increased retention (not just a clinical impact but a business impact).



[Slide Image Description: This slide lists strategic approach and planning with colorful boxes.]

Some of the things to consider in approach and planning (inclusive of the data requirement):

- How do you identify need? This should include:
    - Geography, population, and the service cohort
- Who are your best partners? Consider:
    - Social services, health care, syringe services, law enforcement
    - How do you engage them in a meaningful way that does not result in inhibiting access?
- What are the county levers and barriers? For example:
    - How do you contract for service and payment in a way that ensures compliance with AFBSS and reaching the 98%.
    - Opportunities for value.



[Slide Image Description: This slide lists ways to increasing access with colorful boxes.]

Considerations for implementation planning:

- How do you create an open access model?
- What are the steps from when the individual first requests services to their first dose?
- Where in your county or region is the biggest need?
- Who are the best partners in implementing the model? For example, consider placement of the mobile unit, access into brick and mortar, advocates for their use.

Ideas in Action

» What is your vision for increasing access to hard-to-reach populations in your county?

[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

What is your vision for increasing access to hard-to-reach populations in your county?

[Slide Image Description: This slide shows the AFBSS email address.]

We are here to support you and provide you with those opportunities to connect and hear about implementing AFBSS. Our email address is **info@afbsstraining.org**.

References (1 of 4)

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