Addiction Treatment Starts Here: Primary Care

September 4, 2019

Kick-Off Webinar

CCI
CENTER FOR CARE INNOVATIONS

Webinar Reminders

1. Everyone is muted.
   - Press *7 to **unmute and** *6 to re-**mute** yourself.
2. Remember to chat in questions!
3. Webinar is being recorded and will be sent out via email and posted to the program page!

Agenda

1. Welcome & Introductions
2. ATSH: PC Overview and Expectations
3. Program Measures
4. Pre-Work
5. Wave 1 Report
6. Calendar + Resource Center
7. Questions + Answers
8. Appendices

Welcome + Introductions

Addiction Treatment Starts Here: Program Team

Primary Care Collaborative

Tammy Fisher
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Sandy Newman
Principal, LSN Health Strategy
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Brian Hurley, MD
Addiction Physician and
General Psychiatrist, L.A.
County Dept. of Mental Health

Briana Harris-Mills
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Meaghan Copeland
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Community Partnerships

Jennifer Wright
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Diana Nguyen
Program Coordinator
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ATSH Project Partners

- Addiction Treatment Starts Here Coaches
  - Katie Bell
  - Brian Hurley (coach and ATSH Clinical Director)
- Mark McGovern, Stanford University School of Medicine (evaluation)
- Bridget Cole and Chris Hunt, Institute for High Quality Care (quality improvement methods)

About The Center for Care Innovations (CCI)

Addiction Treatment Starts Here

We're joining California efforts to combat the state's opioid crisis

We Are

CCI
CENTER FOR CARE INNOVATIONS

We Help You

- Boost your energy and confidence to work differently
- Embrace solutions that work through virtual and in-person learning
- Collaborate with your peers, experts, and coaches
- Accelerate the pace of change
- Build community

CLINICAL TRANSFORMATION

PRIMARY CARE
Primary Care Health Centers

BEHAVIORAL HEALTH
Specialty Mental Health and Substance Use Disorder Treatment Providers

MULTI-SECTOR COLLABORATION

COMMUNITY PARTNERSHIPS
Community Opioid Coalitions

Goal

Increase access to **medications for addiction treatment (MAT)** — the use of FDA-approved medications in combination with counseling and behavioral therapies — for opioid use disorder.

www.careinnovations.org/addiction-treatment-starts-here

ATSH:PC Overview + Expectations

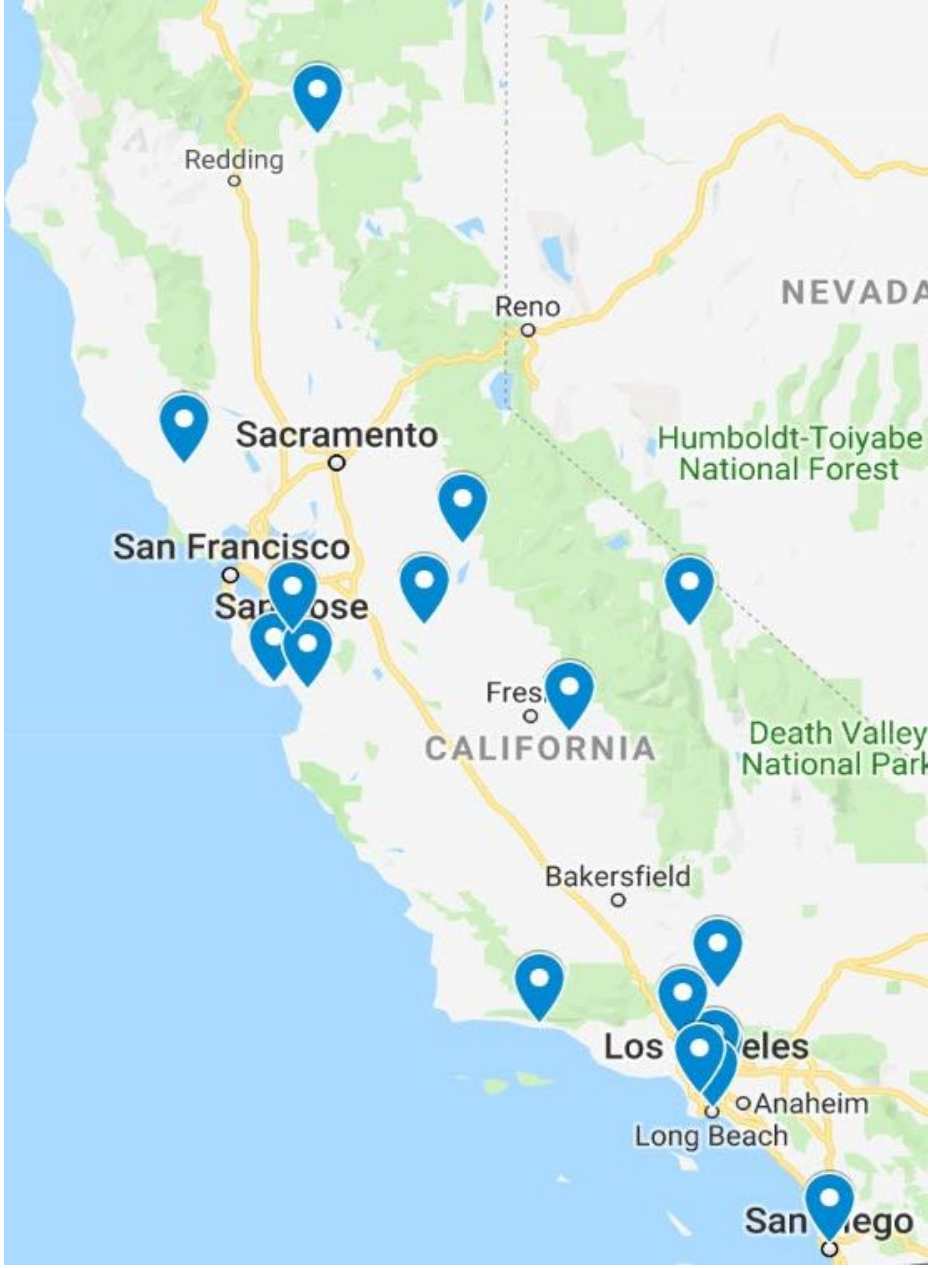
ATSH:PC Cohort At a Glance

Program Cohort

- 19 teams
- 16 organizations represented
- 8 teams in Track 1
- 11 teams in Track 2

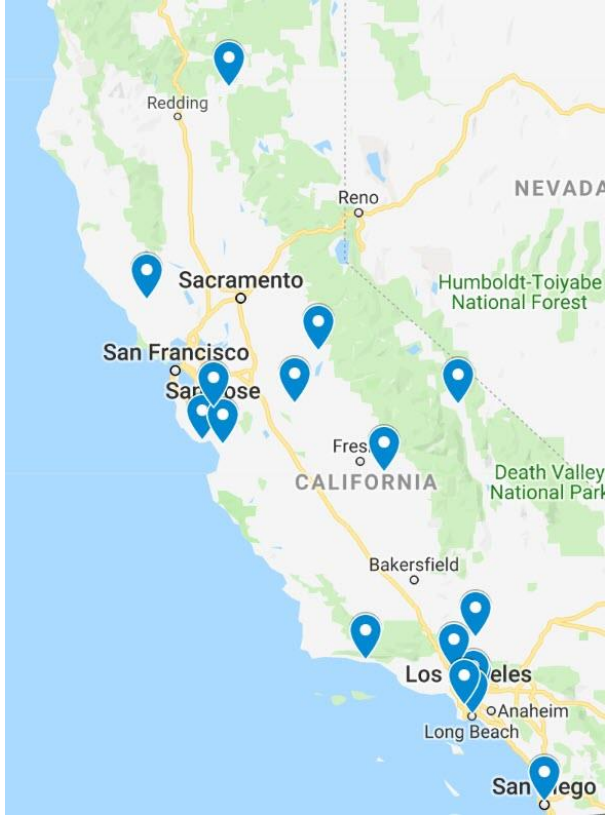
Organization Characteristics

- 11 counties
- 6 teams serving <10,000 patients
- 4 teams serving 10,000 – 15,000 patients
- 8 teams serving 18,000 – 100,000 patients
- 1 teams serving >100,000 patients



ATSH:PC Cohort At a Glance*

- Adventist Health - Reedley
- Adventist Health - Sonora
- Alliance Medical Center
- Bartz-Altadonna Community Health Center
- BHS Health Center Network
- Family Health Care Centers of Greater Los Angeles
- JWCH Institute
- Livingston Community Health
- Livingston Health Campus
- Northern Inyo Healthcare District
- UCLA Medical Center – Olive View
- Pit River Health Service
- Salud Para La Gente
- Santa Barbara Neighborhood Clinics
- Santa Cruz Health Services Agency – Watsonville Health Center
- School Health Clinics of Santa Clara County
- St. Vincent de Paul Village, Inc. (dba Father Joe's Villages)
- The Children's Clinic Family Health Center at Century Villages Cabrillo
- The Children's Clinic Family Health Center at Multi-Service Center for the Homeless



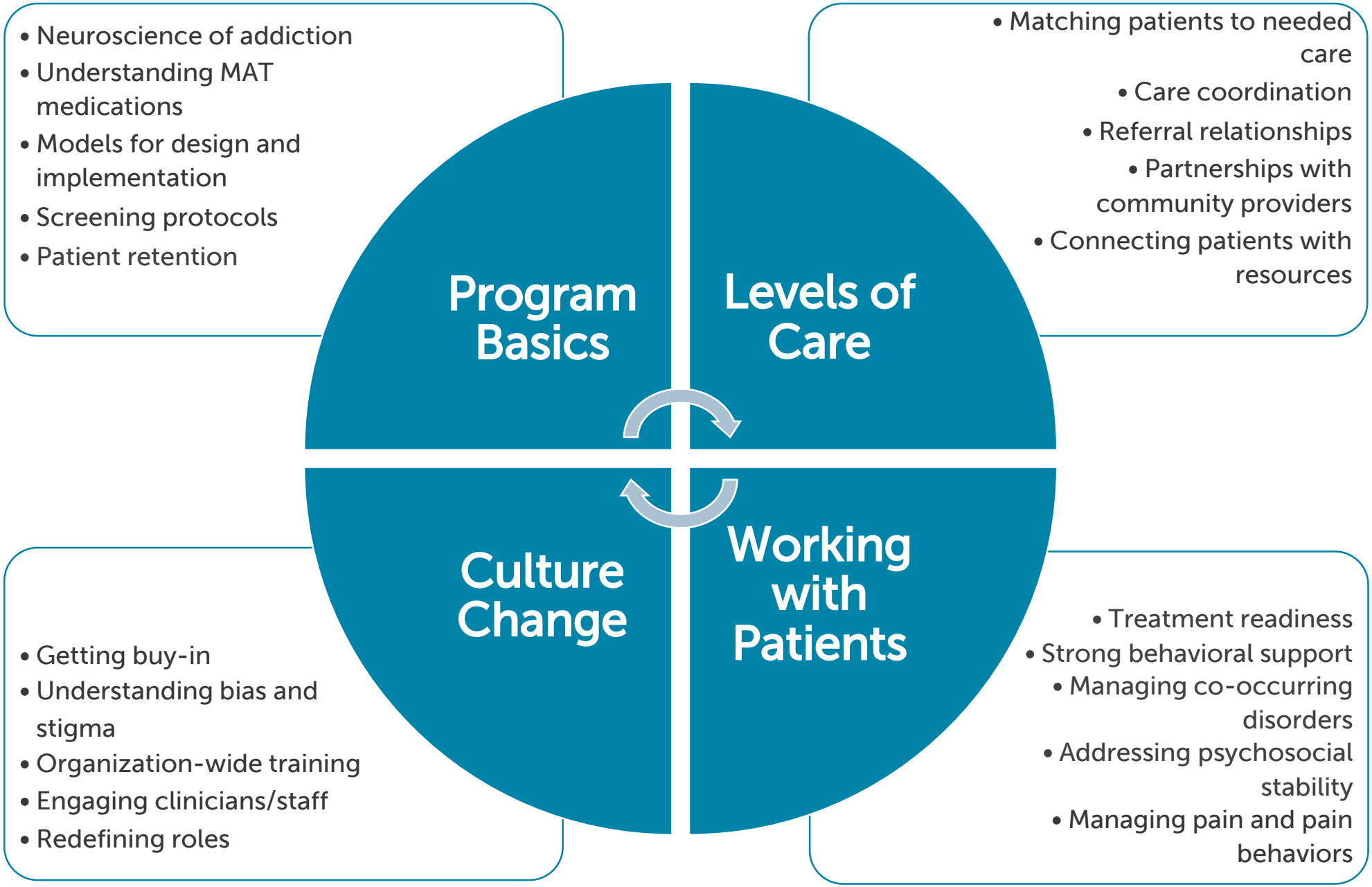
*This list is based on CCI's recommendation. The grant award is not final until approved by the Tides Center CEO and Board of Directors.

Program Goal

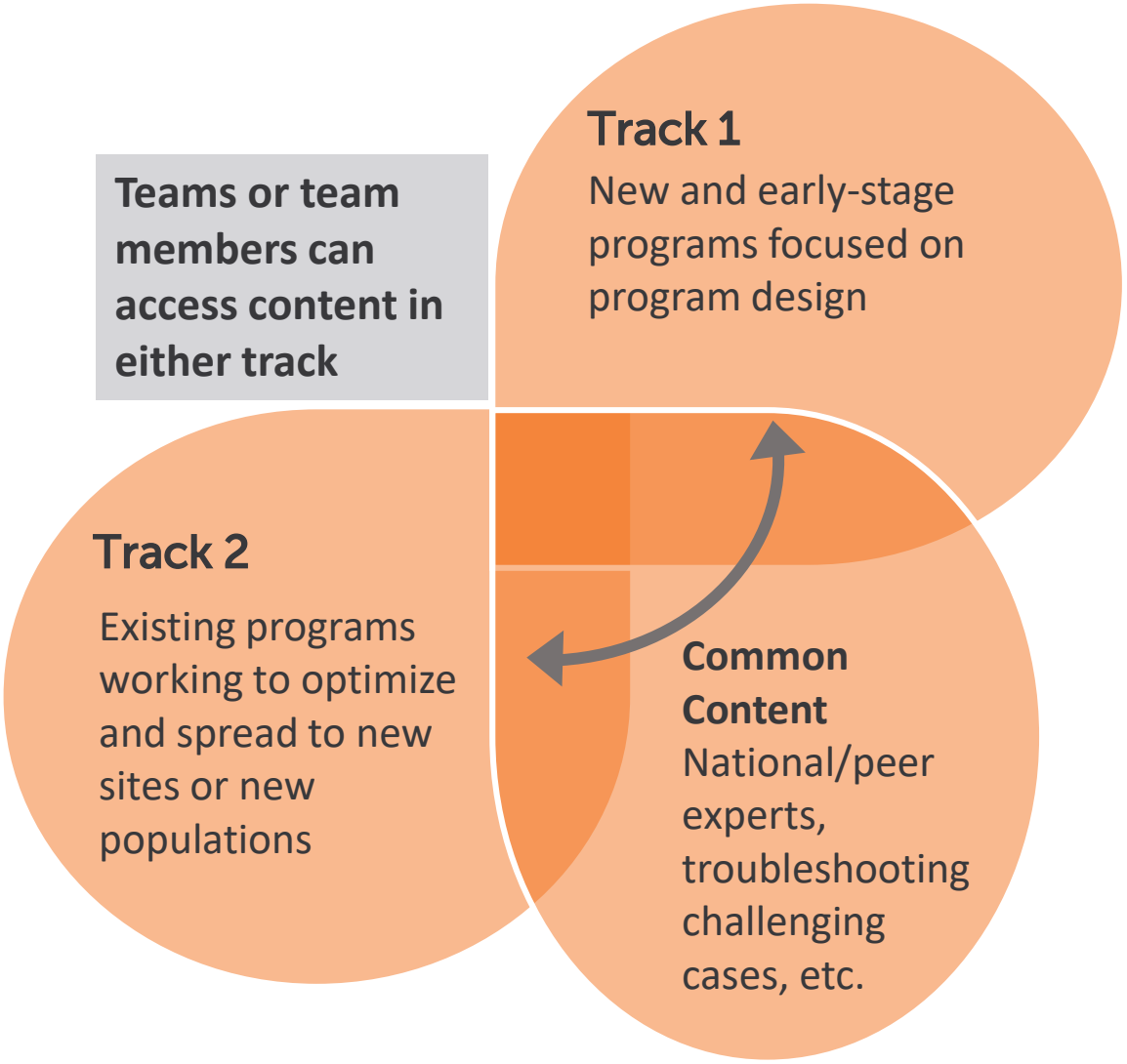
Increase access to **MAT in primary care by working with up to 60 community health center sites** to advance the learning and sharing of best practices in integrating MAT into primary care services through 12 and 18-month learning collaboratives.

Wave 1: 39 sites participating – launched February 2019
Wave 2: 19 sites participating – launched today!

ATSH:PC Program Components


• Neuroscience of addiction
• Understanding MAT medications
• Models for design and implementation
• Screening protocols
• Patient retention
Program Basics
• Matching patients to needed care
• Care coordination
• Referral relationships
• Partnerships with community providers
• Connecting patients with resources
Levels of Care
Culture Change
• Getting buy-in
• Understanding bias and stigma
• Organization-wide training
• Engaging clinicians/staff
• Redefining roles
Working with Patients
• Treatment readiness
• Strong behavioral support
• Managing co-occurring disorders
• Addressing psychosocial stability
• Managing pain and pain behaviors

ATSH Tracks


Teams or team members can access content in either track
Track 1
New and early-stage programs focused on program design
Track 2
Existing programs working to optimize and spread to new sites or new populations
Common Content
National/peer experts, troubleshooting challenging cases, etc.

Participation Requirements

The Give & The Get

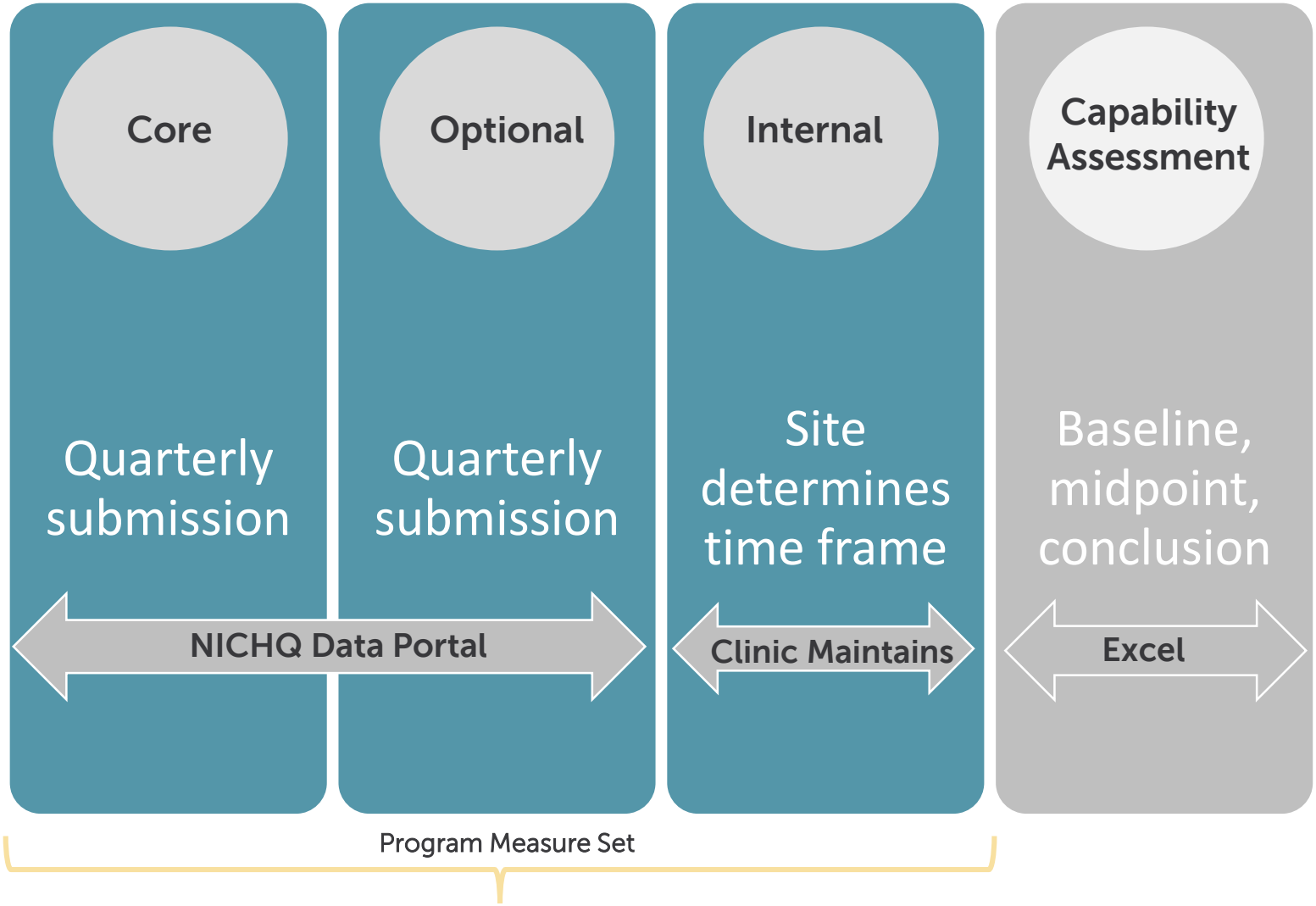
Give	Get
▪ Identify a team of 4 – 6 individuals ▪ Participate in the three in-person learning sessions (participation by your core team is a condition of the grant!) ▪ Share your experiences and tools with others ▪ Submit data on small measure set (quarterly) ▪ Commitment to start, improve and/or expand MAT in your clinic site	▪ Access to technical assistance and experts to help you design, standardize or spread your program ▪ Coaching ▪ Site visits to learn from peers ▪ $50,000 per site to offset travel expenses to in-person sessions ▪ Participate in a learning community that optimizes peer sharing ▪ Online resource center

Elements of an Effective Coaching/Clinic Partnership

- Establishing a warm, listening, collaborative relationship with the MAT team and to have a point of contact is essential!
- An effective coach fully understands how primary care systems operate.
- The initial site discussion will allow the coach to get to know the team, hear the concerns, make a complete needs assessments and develop a working plan.
- Availability of the MAT coach for ad hoc questions or a quick case review keeps things moving and builds confidence. A coach must be a good problem solver for systems challenges and for the challenges in patient care.
- Clinics which are in MAT launch phase (Track 1 in ATSH) usually want help with development of program with Treatment Agreements, Phases of Care, billing, clinic culture and policies and procedures.
- Clinics with programs that are operational (Track 2 in ATSH) frequently struggle with challenging patient flow issues, patient care issues and barriers.

Program Measures

Measurement Strategy: How and When



Measure Set: Summary

Core Required Measures

- **Adoption:** Four sub measures, tracking waivered prescribers
- **Reach:** Three sub measures, tracking patients receiving medications for addiction treatment
- **Retention:** Two sub measures, addressing adherence and continuation in care

Optional Measures

- **Screening:** Patients screened for OUD
- **Initiation:** Patients with follow-up visits after a medication start
- **Engagement:** Patients with follow-up visits after initial prescription
- **Toxicology:** Urine toxicology tests (2 sub measures)

Internal Measures

- **Process and Outcome Measures:** To support your planning and implementation efforts. Measures could address training and education, patient outreach and identification, or other data that will inform your improvement activities.

Measure Set: Collecting & Submitting Data April (due Oct 31)

Who is responsible? Determine who will be responsible for pulling quarterly data reports. We suggest your team lead or a data team member have responsibility for entering data to the portal each quarter.

Will you report on optional measures? Determine if you will report on the optional measures and let CCI know. For internal measures, determine as a team what internal measures will be useful for you to collect and review. How often will your team review data together to use for improvement?

Timeframe of data. Data should be rolled up on a quarterly basis (starting with reporting period: July 1, 2019 – September 30, 2019).

How to submit. Data is usually due 15 days after each quarter ends, except for your first reporting period where we've extended it by 15 days. Log into the NICHQ data portal and enter data for each measure set for that quarter. For more information visit: www.careinnovations.org/atshprimarycarewave2-teams/data-reporting/#measures

Measure Set: Using the NICHQ Data Portal

Attend training webinar. Register for the October 2nd webinar.

Who should attend? The person(s) responsible for entering data on a quarterly basis (we recommend either the team lead or data person on team). Any other team members are welcome to join.

What will be covered? The webinar will show how to log into your account and enter data on a quarterly basis. It will also show what types of reports will be generated and how to download these reports. You will also be able to ask questions about the specific measures and definitions.

Wave 1 Report

Alameda Health System

David Tian, MD

Medical Director, AHS Buprenorphine Induction Clinic

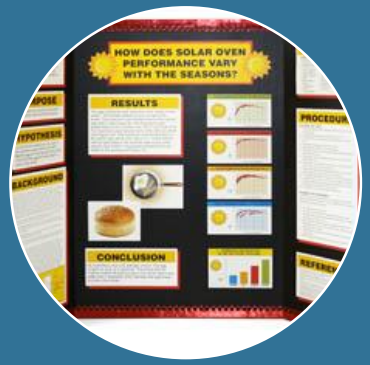
Alameda Health System, Highland Wellness Center

ATSH:PC Wave 1 Participant

- Eastmont Wellness Center and Highland Wellness Center are participants (go PCATS!)
- Aim: By July 2020, Highland Wellness's Primary Care Addiction Treatment Team will:
  - Conduct at least one training each for the following groups on an addiction-related topic: (a) providers, (b) trainees, and (c) clinic staff;
  - Create and enroll patients in a contingency management program;
  - Provide long-acting inject able treatment options for opioid use disorder to at multiple patients; and,
  - Increase the number patients initiated and maintained with MAT by non-PCAT members.

Pre-Work

1. Capability Assessment

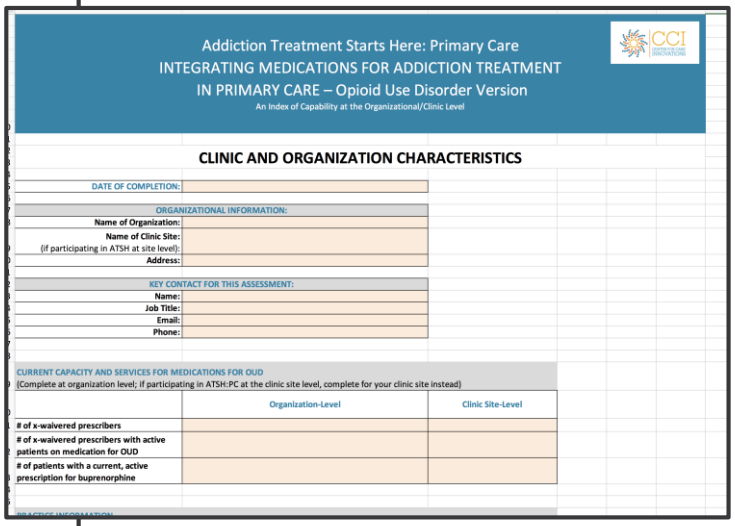


2. Storyboards

3. Learning from Your Team and Your Patients

Capability Assessment: Your MAT Infrastructure

- Medications for Addiction Treatment in Primary Care (IMAT-PC) will support teams to better understand their current state, identify areas to make better, and evaluate change over time
  - The goal is to better understand MAT processes, approaches and environment – evaluating from multiple perspectives across multiple dimensions
- Development led by Mark McGovern, leveraging evidence-based processes, with support from Brian Hurley the CCI team
- Teams will complete the capability assessment three times:
  - Baseline, midpoint, ATSH conclusion



Addiction Treatment Starts Here: Primary Care
INTEGRATING MEDICATIONS FOR ADDICTION TREATMENT
IN PRIMARY CARE – Opioid Use Disorder Version
An Index of Capability at the Organizational/Clinic Level

CLINIC AND ORGANIZATION CHARACTERISTICS

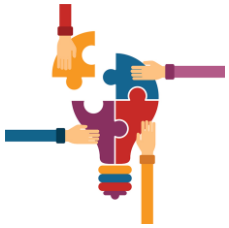
DATE OF COMPLETION:	
ORGANIZATIONAL INFORMATION:	
Name of Organization:	
Name of Clinic Site: (if participating in ATSH at site level):	
Address:	
KEY CONTACT FOR THIS ASSESSMENT:	
Name:	
Job Title:	
Email:	
Phone:	

CURRENT CAPACITY AND SERVICES FOR MEDICATIONS FOR OUD
(Complete at organization level; if participating in ATSH:PC at the clinic site level, complete for your clinic site instead)

	Organization-Level	Clinic Site-Level
# of x-waivered prescribers		
# of x-waivered prescribers with active patients on medication for OUD		
# of patients with a current, active prescription for buprenorphine		

Capability Assessment: Completing the Assessment

Schedule time! We suggest that you set aside **75 minutes** to complete it.



Work with your team! This is an opportunity for you to learn more about your colleague's perspectives.

Rate conservatively! Select the lower of the two ratings when you're in between.

This isn't a test! Be candid and use the tool to support transformation.

Beta Tester Feedback

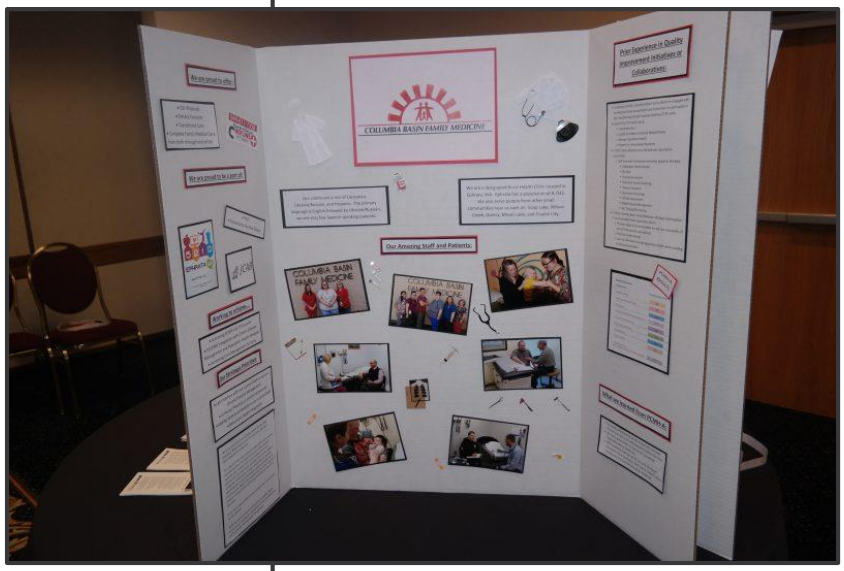
"It would be good to have a behavioral health team member, administrative team member and primary care team member participate, as well as the Champion. **This is a good starting point for core teams to look at their programs and it's a good guide for programs that have already rolled out MAT** to think about how to further integrate at both the Clinic and Organizational level."

"It was very thorough and definitely **gave us ideas for how we can develop and/or augment our current MAT treatment**. We don't routinely check CURES bimonthly; not sure if this is the new best practices guideline, but we usually just check CURES each time we prescribe."

"We printed out the survey for each member of the team and went through each question together. One team member recorded notes we wanted to have for ourselves, as **we saw this as a great tool to find the gaps in our program and begin to tackle the gaps**. It took us about an hour to answer the questions, but we were rushed at the end. The questions spurred great discussion amongst the team."

Storyboards

- Also part of pre-work – completing a storyboard
- Start sharing in a visual way!
- Storyboard gallery at LS 1 to support learning from each other
- We want to hear what you learned through your pre-work, where you have best practices to share and what support you need
- See the template in the Appendix (we will also send the template to you)



Learning From Your Team and Your Patients

- Leverage all the resources you have, including people!
- Understand your processes better: Get closer to the ground by observing and talking to people

"...as front-line workers, supervisors, clinicians, our observations of our patients as they interact with us, in the context of the systems and workflows that we created, offers a wealth of data about the quality of the work we do."

"We have a sense of when our patients are struggling with something we ask of them; we hear them speak about their lives and we learn about barriers they face to taking steps in favor of their own health."

Learning From Your Team

- Define your stakeholders:
  - Who do you want to learn from?
  - What do you want to learn?
- Methods
  - Small group discussions as part of existing meetings
  - 1:1 discussions out of the office, walks, over coffee
  - Observation – because you are curious and working to make things better!
  - Surveys
- You'll get started when completing your baseline capability assessment!

Learning From Your Team and Your Staff: Sample Inquiries

- What is working well at your site and what could be better?
  - Patient identification and treatment initiation
  - MAT patient flow
  - Staff engagement
  - Clearly defined staff roles
  - Inter-department cooperation
- Do staff/clinicians outside of your MAT program know how to refer patients?
- What are the attitudes about MAT and about patients with opioid use disorder?

Learning From Your Patients

- What do you want to learn from your patients?
- Get started, feedback from 5 patients provides a lot of insight!
- Leveraging existing structure – part of MAT intake process?
- Methods:
  - Observations
  - Humble Inquiry to do "intercepts" or after-visit discussions
  - Journey and Empathy Mapping (combined with observation and/or humble inquiry) – ask us for more information!

Learning From Your Patients: Sample Questions

- Have you ever received care at a program that specialized in addiction—such as a residential rehab, detox, or outpatient program?
    - If so: What is different about getting care for addiction here in primary care? What things are better? Not better?
- How do the people who work here make you feel about being here?
- What worked well about today's visit?
- What did you like least about today's visit?
    - Follow-up question: What could have made your visit even better? Or,
    - For the things that didn't go well, what could have made them go better?
- What are some words or things you remember about today's visit?
- What surprised you about today's visit?

Calendar, Program Page, Resource Hub

Pre-Work + Onboarding Checklist

Action Item	Date
Finalize team composition and send list with contact information to Briana Harris Mills	ASAP!
Data portal webinar (program measure set)	October 2
Schedule first coaching call	October 4
Team registration deadline for LS 1	October 16
Complete baseline capability assessment	October 18
Prepare storyboard for LS 1	October 18
First quarterly program measure set report due	October 31

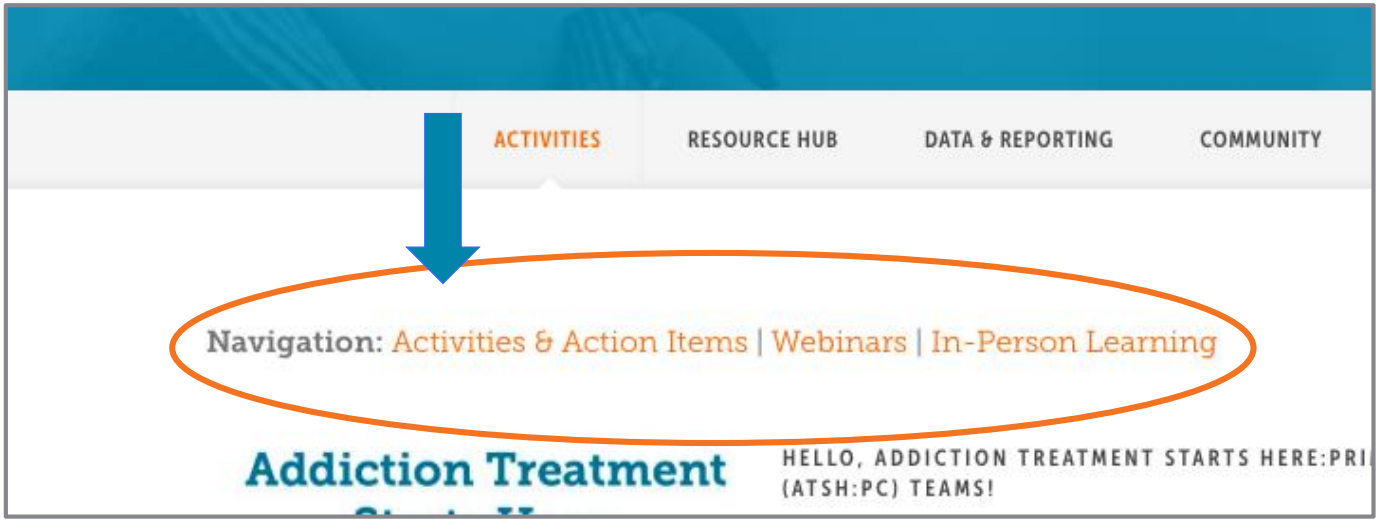
Project Calendar

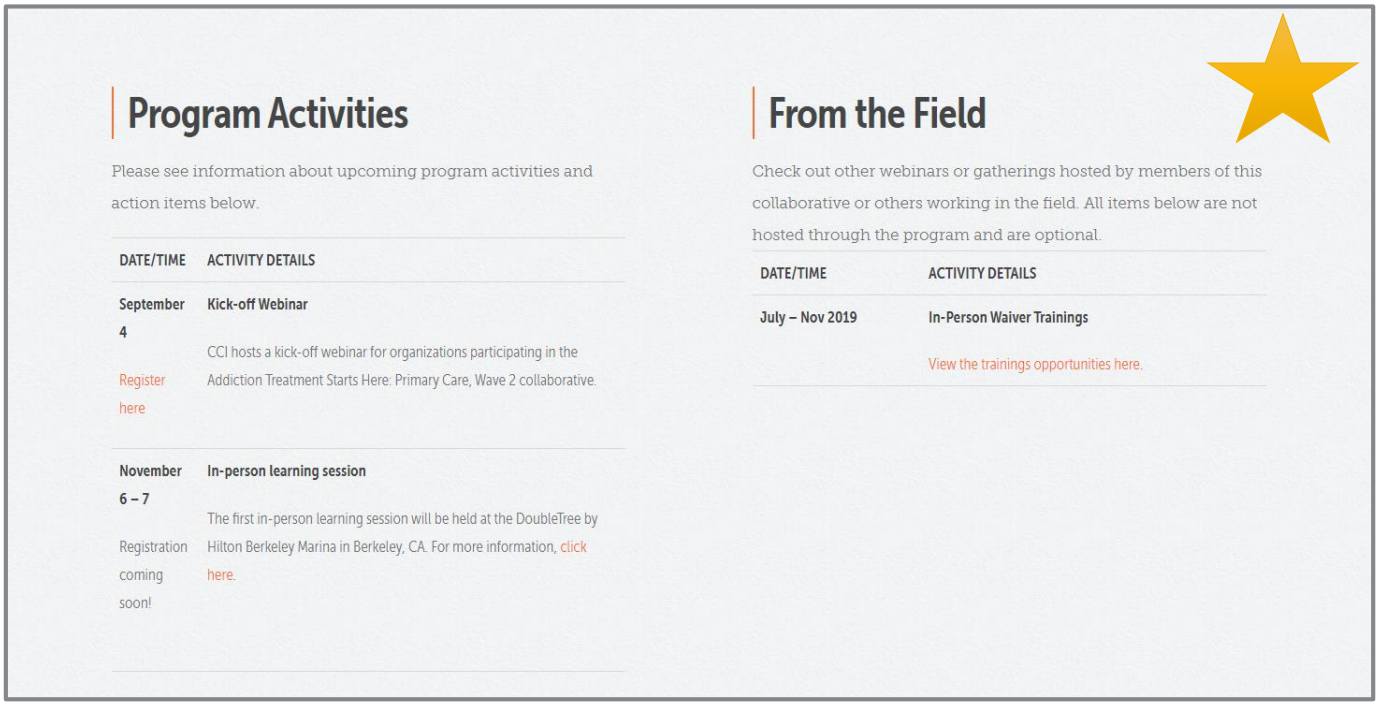
September – December 2019		January 2020 – September 2020	
August 23	1st Grant Installment Release	Quarterly Data Submission Due Progress Report 1 Due	January 15
September 4	Kick-Off Webinar (today!)	Quarterly Data Submission Due Progress Report 2 Due	April 15
tbd – Sept/ October	Pre-Work Office Hours (optional)	Learning Session 2 (L.A. Area)	April 15 – April 16
October 2	NICHQ Data Portal Training	3rd Grant Installment Release	July 1
October 16	Learning Session 1 Reg Deadline	Quarterly Data Submission Due	July 15
October 31	Quarterly Data Submission Due	Learning Session 3 (tbd)	August 8
November 6 – November 7	Learning Session 1 (Bay Area)	Final Report Due	August 31
November 29	2nd Grant Installment Release	4th Grant Installment Released	September 15

ATSH Program Page

Visit: https://www.careinnovations.org/atshprimarycarewave2-teams/

ATSH Program Page





Check **Activities & Action Items** for updates about upcoming webinars, events, and more. This is where we'll include registration links, pre-work assignments and other "to-dos."

Visit: https://www.careinnovations.org/atshprimarycarewave2-teams/

Questions + Answers

Thank you!

For questions contact:

Tammy Fisher
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Center for Care Innovations
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Sandy Newman
Principal
LSN Health Strategy
sandy@lsnhealthstrategy.com

https://www.careinnovations.org/atshprimarycarewave2-teams/

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Appendix 1: Measures & Definitions

CORE (Required) Program Measure Definitions

	MEASURE	DEFINITION
A.	**Adoption**	
A1	# of x-waivered prescribers	Total number of physicians, certified nurse practitioners or physician assistants, onsite and with whom the health center has contracts, who have obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications approved by the U.S. Food and Drug Administration (FDA) for this indication. This number must be current up to the reporting date. Planned, in process or pending waivers do not count.
A2	# of x-waivered prescribers actively prescribing	Total number of prescribers who have prescribed buprenorphine for opioid use disorder (OUD) to at least 1 patient over the three months prior to or on the reporting date.
A3	% of x-waivered prescribers of all eligible prescribers in practice	The numerator is calculated by the # in A1. The denominator is calculated by the total # of physicians, certified nurse practitioners and physician assistants who work onsite and who are under contract at the ATSH participating health center location. This denominator does not include providers at other locations of the participating health center.
A4	Ratio of x-waivered prescribers actively prescribing to the clinic's total patient panel size	The numerator is calculated by the # in A2. The denominator is calculated by an estimate of the total number of patients at, or active panel size of, the ATSH participating health center location. "Active panel size" is defined as the estimated total number of unduplicated patients visiting the health center location in the last 18-24 months (or however your clinic usually determines this).

CORE (Required) Program Measure Definitions: cont.

	MEASURE	DEFINITION
B.	**Reach**	
B1	# of patients prescribed buprenorphine	The total number of unique patients in the ATSH participating health center location with a current, active prescription for buprenorphine. Treat each reporting period separately, meaning that the same patient with an active prescription in the previous reporting period can be counted again in the current reporting period as long as they still have an active prescription. The buprenorphine medication should be FDA approved for the indication of OUD. Included patients may be newly prescribed or established. "Active" is defined as a prescription covering any of the past 30 days of the reporting month. This number must be current up to the reporting date.
B2	# of patients prescribed naltrexone long-acting injection	The total number of patients in the ATSH participating health center location with a current, active prescription for naltrexone long-acting injection. Included patients may be newly prescribed or established. "Active" is defined as a prescription covering any of the past 30 days of the reporting month. This number must be current up to the reporting date. If your clinic does not prescribe naltrexone long-acting injection, write "0" and make a note in the annotation field. If you don't know whether this is being prescribed or don't have a way to pull data, mark "No data" and make a note in the annotation field.
B3	% of patients prescribed buprenorphine or naltrexone long-acting injection of all patients with OUD	The numerator is calculated by adding the total number of patients in B1 + B2. The denominator is calculated by counting the number of patients in the ATSH participating health center location with a current ICD10 or DSM5 diagnosis of OUD (i.e. valid within the past 30 days). This percentage is to be calculated quarterly during the ATSH project. Please annotate this measure with information about whether or not you are able to accurately pull data on this measure. If you do not have data for this, mark "No data" and make a note in the annotation field.

CORE (Required) Program Measure Definitions: cont.

	MEASURE	DEFINITION
C.	**Retention**	
C1	# of patients prescribed buprenorphine or naltrexone long-acting injection 6 months prior who have adhered to this medication continuously for 6 consecutive months	Total number of patients started on either buprenorphine or naltrexone long-acting injection at 6 months prior to the reporting date, and who have remained in care continuously and without interruption. This includes new patients who have started on medication and continued with refills, and who have attended clinic visits. This also includes established patients who may have discontinued treatment for at least 2 months and have been “restarted”.
C2	% of patients prescribed buprenorphine or naltrexone long-acting injection 6 months ago who have continued in treatment for 6 consecutive months of all patients prescribed buprenorphine or naltrexone long-acting injection 6 month prior	The numerator is calculated in C1. The denominator is calculated by including a count of the total of all patients started on either buprenorphine or naltrexone long-acting injection at 6 months prior to the reporting date. This percentage is to be calculated only on the data panel of eligible patients (i.e., those who started or restarted at 6 months prior to the reporting date) at every quarter of the ATSH project.

OPTIONAL Program Measure Definitions

	MEASURE	DEFINITION
D.	**Screening**	
D1	% of patients screened for opioid use disorder of all patients seen during the last quarter	The numerator is calculated by counting the number of patients screened over the past 3 months. A standardized measure for OUD risk must be used to count in the numerator. Options for standardized measures include: NIDA Quick Screen, Drug Abuse Screening Test (DAST), DSM5 Checklist, the Tobacco, Alcohol, Prescription Medication and Other Substance Use (TAPS1 or TAPS 2), PRIME 1.1.1 or other validated screening tools. The denominator is calculated by counting the number of all patients seen during the last 3 months. The goal is at least 1 screening for OUD risk per year for all patients. This percentage is to be calculated quarterly during the ATSH project, and only for those patients not included in the previous quarter period data calculation.
E.	**Initiation**	
E1	% of patients with 1 follow-up visit within 14 days of starting buprenorphine or naltrexone long-acting injection	The numerator is calculated by counting the number of patients started on either buprenorphine or naltrexone long-acting injection and making at least 1 follow-up visit to the clinic within 14 days (2 weeks) of their initial prescription. Either individual or group visits count in the numerator. The denominator is calculated by counting the total number of patients prescribed either buprenorphine or naltrexone long-acting injection. This percentage is to be calculated quarterly during the ATSH project, and only for those patients not included in the previous quarter period data calculation.
F.	**Engagement**	
F1	% of patients with 2 follow-up visits within 30 days of the date of the initial prescription for buprenorphine or naltrexone long-acting injection	The numerator is calculated by counting the number of patients prescribed either buprenorphine or naltrexone long-acting injection and making at least 2 follow-up visits (either individual or group) to the clinic within 30 days of their initial prescription. The denominator is calculated by counting the total number of patients prescribed either buprenorphine or naltrexone long-acting injection. This percentage is to be calculated quarterly during the ATSH project, and only for those patients not included in the previous quarter period data calculation.

OPTIONAL Program Measure Definitions

	MEASURE	DEFINITION
G.	**Toxicology Monitoring**	
G1	% of patients prescribed buprenorphine or naltrexone long-acting injection who received a urine toxicology test within 3 days of starting of all patients starting their medication	The numerator is calculated by counting the number of patients prescribed either buprenorphine or naltrexone long-acting injection with documentation of one or more urine toxicology test results within 3 days of starting either medication. If saliva toxicology or other validated toxicology test is performed and documented, this counts towards the numerator. The denominator is calculated by counting the total number of patients prescribed either buprenorphine or naltrexone long-acting injection. This percentage is to be calculated quarterly during the ATSH project, and only for those patients not included in the previous quarter period data calculation.
G2	% of patients taking buprenorphine or naltrexone long-acting injection receiving a urine toxicology test at least once per month in the six months prior to the reporting period, of all patients taking buprenorphine or naltrexone long-acting injection six months prior to the reporting period	The numerator is calculated by pulling toxicology documentation on patients in C2 denominator and counting the number who have at least monthly urine toxicology tests for each month receiving treatment in the six months prior to the reporting period. The denominator is all patients in C2. You should count patients who have the same number of toxicology tests as the number of months they received treatment (i.e., 3 months of treatment = 3 toxicology tests). You may also count patients who missed one month of toxicology testing but subsequently received two toxicology tests in the next month, so that the total number of toxicology tests equals the number of months in treatment.

Appendix 2: Storyboard Template

Instructions

- This template outlines the information we would like you to include for your storyboard. Feel free to change font size, color, add slides, but please provide as much information as possible that is requested in this template. **Delete this slide from the presentation once you're done!**
- At Learning Session 1 (LS 1), we will have a storyboard gallery for each team to present their storyboard and to engage in discussion with other teams.
- Teams will have about 10 minutes to share their storyboard; best to limit your storyboard to 10 slides.
- Display boards will be available at LS 1. Bring a printed color copy of your slides. You can attach them to the poster board the morning of November 6 (day 1 of the learning session).
- **Display Tips**
  - Fewer words: more pictures and graphics
  - Real people pictures… at least of your teams
  - Font size as big as possible
  - Color to highlight key messages
  - Reach out to us if you have questions!

Organization/Site Name

Photo/Graphic (if possible)

Our ATSH Team

- Our Core MAT Team:
  - Name, title, areas of responsibility
  - Name, title, areas of responsibility
  - Name, title, areas of responsibility
  - Name, title, areas of responsibility
- Our Site's MAT Team by Function and FTE:
  - MAT Prescribers:
  - Nursing:
  - Social Work:
  - Behavioral Health:

Current State [site level]

- **Our community:** Short description of the community that your site is in (e.g., urban/rural, large OUD population, relationships with emergency departments and other organizations in the behavioral health ecosystem)
- **Current state:**
  - **Short description of our MAT program:** describe your MAT program model, whether you do home inductions, etc.
  - **Capacity:** # of waivered providers
  - **Patient population:** # of patients receiving MAT in the previous 6 months
- **Goals for ATSH participation:**

Capability Assessment: What We Learned

- In completing the assessment, we were surprised by:
- Our team's areas of strength:
- Areas for development:

Current State Assessment

- We used the following methods to learn more about our current state:
- We spoke to:
  - Staff:
  - Patients:
  - Anyone else?
- From providers and staff we learned:
- From patients we learned:
- Other insights we gathered from current state activities:
- We received the following feedback on the appropriateness and acceptability of using MAT in our clinic:

Our Team Has Been Wondering . . .

- Our questions to other teams:
- Our questions for faculty:
- We need support to accomplish:

Advice/Guidance/Tools For Other Teams

- Do you have policies, protocols, tools to share with others?
- Are there specific content areas or specific sub populations where your team has developed deep expertise and you may serve as faculty or do more formal sharing?