Needs Assessment and Priority Setting
RCORP Tillamook
Tillamook, Oregon
December 2019

Grantee Organization	Northwest Medical Foundation of Tillamook DBA: Adventist Health Tillamook 1000 Third Street, Tillamook, OR 97141
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Service Area	Tillamook County, Oregon
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Note: This RCORP Tillamook needs assessment is to be a living document updated on an ongoing basis. On December 12, 2019, the Adventist Health Tillamook Governing Board reviewed this version of the RCORP Tillamook Needs Assessment.

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Introduction and Background Information

RCORP Tillamook

The RCORP Tillamook members and stakeholders play a vital role in the community by providing primary health care services, substance abuse screening, emergency and inpatient services, mental health care, and law enforcement and community safety. Each brings an expertise and perspective that is vital to developing a complete and comprehensive action plan to effectively address the addiction treatment and recovery needs in the community. Partners that were added to the workgroup during the work on this document were identified and confirmed by the RCORP Tillamook group.

- **Adventist Health Tillamook** provides acute treatment at the hospital as well as several rural health clinics for primary care and mental health services.

- **CARE** provides emergency services for those experiencing homelessness, and low-income individuals and families such as walk-in case management, temporary rental assistance, permanent housing units, utility bill assistance, and other emergency services.

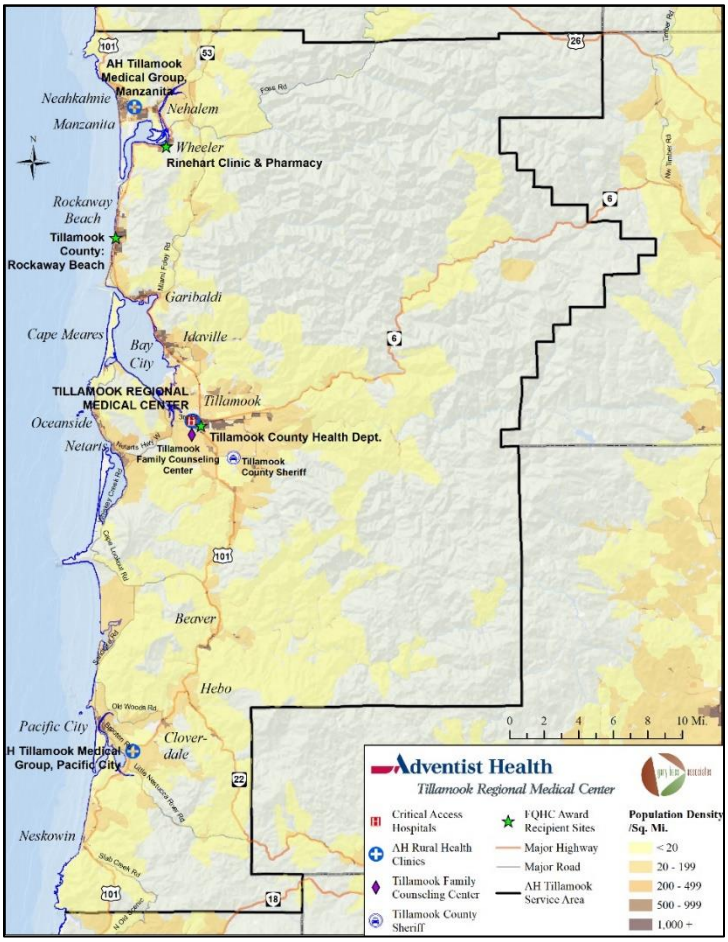
- **Oregon State University Extension Service** engages the community with research-based knowledge and education that strengthen economies, sustain natural resources, and promote healthy families and individuals.

- **Rinehart Clinic** is a Federally Qualified Health Center (FQHC). The primary care clinic offers a team-based, patient-centered approach to preventative, chronic, and acute medical treatment including behavioral health services. Treatment modalities for all ages include allopathic and naturopathic medicine, acupuncture, and individual and group therapy focused on addiction. The clinic also has an on-site pharmacy.

- **Tillamook County Community Health Centers** is another FQHC providing preventative, chronic, and acute medical treatment services.

- **Tillamook County Sheriff's Office** provides law enforcement and emergency response to the unincorporated parts of Tillamook County along with (but not limited to) running and maintaining the jail, Community Corrections (Parole and Probation), Court House Security, Emergency Management, major crime team response, and support of the municipal city police departments.

- **Tillamook Family Counseling Center** offers counseling and behavioral health services for a variety of issues, including substance use.



Geography

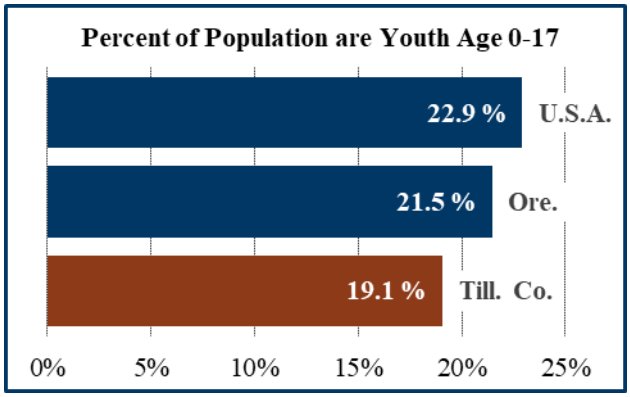
The geographic service area for this needs assessment is Tillamook County, located on the Pacific coast in the northwest corner of the state of Oregon. Known as “the land of cheese, trees and ocean breeze,” Tillamook County was established in 1853 and named after the Tillamook Indians who occupied the areas around the Tillamook and Nehalem Bays. The major physical features of Tillamook County consist of the rocky and irregular coastline that forms the county's western boundary, stretches of coastal lowlands, and heavily timbered interior parts, which comprise the main span and several spurs of the Coast Range. Principal industries are agriculture, lumber, fishing, and recreation. Dairy farms dominate the county's fertile valleys providing milk for the well-known Tillamook cheese.[1]

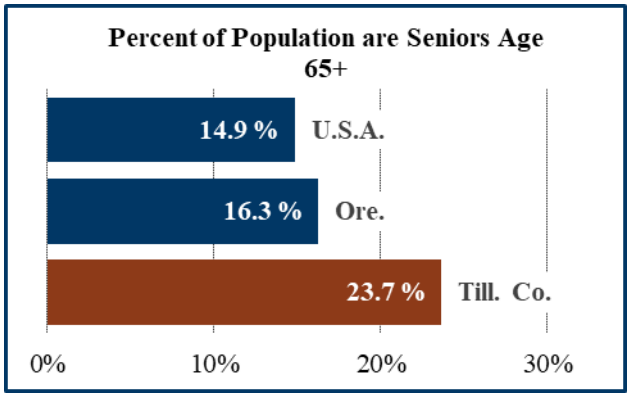
Tillamook County is geographically small, ranking 26 of 36 Oregon counties for size, with just over 1,100 square miles of land. According to the Oregon Secretary of State website, in 2016, Tillamook County ranked 23 of 36 counties for total population, with just under 26,000 residents. Within the County, the total population comprises nearly 11,000 households.[2] According to U.S. Census Bureau statistics from 2010-2014, the County’s population density is 23 people per square mile; significantly less dense than Multnomah County, the most densely populated county in Oregon, at 1,626 people per square mile. Tillamook County is designated by the Health Resources and Services Administration (HRSA) as having rural status, as depicted in the map above.

[1] Oregon Secretary of State Website, Tillamook County History: https://sos.oregon.gov/archives/records/county/Pages/tillamook-history.aspx, accessed October 21, 2019.
[2] Oregon Secretary of State Website, County Populations: https://sos.oregon.gov/blue-book/Pages/local/county-population.aspx, accessed October 21, 2019.

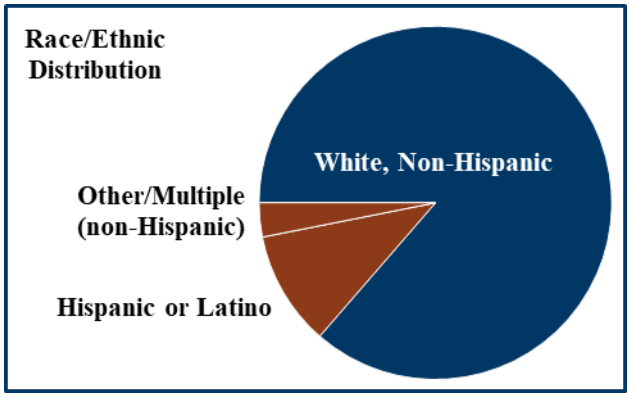
Age, Ethnicity and Language

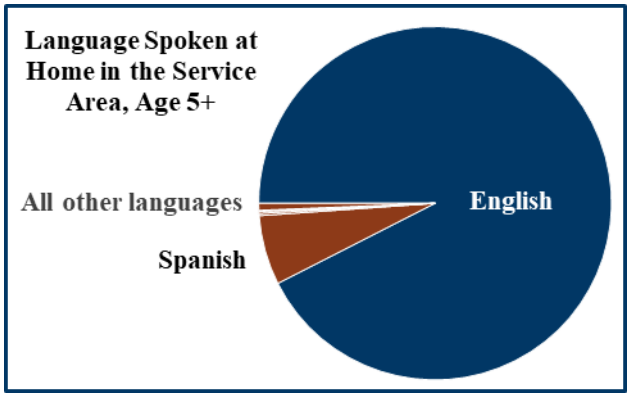
The age of residents within Tillamook County is slightly older than that in the state and nation. As reported by the U.S. Census Bureau, American Community Survey 5-Year Estimates (2013-2017), the percentage of Tillamook County residents ages 0-17 stands at 19.1%, lower than corresponding rates for the state and nation, which are at 21.5% and 22.9% respectively. Additionally, there are significantly more residents age 65 and older in the service area (23.7%), as compared with the state (16.3%) and the nation (14.9%).





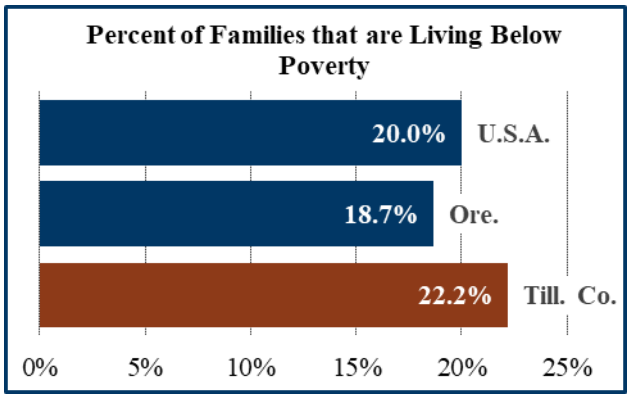
According to the U.S. Census Bureau, American Community Survey 5-Year Estimates (2013-2017), the majority of the service area residents (84.9%) identifies as white, non-Hispanic. There is a higher concentration of white residents within Tillamook County than in the state (77.0%) and the nation (62.0%). One in 10 (10.2%) residents within the service area identify as Hispanic, compared to 12.4% in the state and 17.3% in the nation. These two predominant races/ethnicities total 95.1% of the service area. The other races/ethnicities in the service are each less than one percent of the total population. These races/ethnicities include American Indian/Alaska Native (0.8%); Asian/Asian Indian (0.7%); Black/African American (0.3%); and Native Hawaiian/Pacific Islander (0.4%). Lastly, 2.7% of service area residents identify as other or multiple races. The predominant language spoken in the service area is English, followed by Spanish.

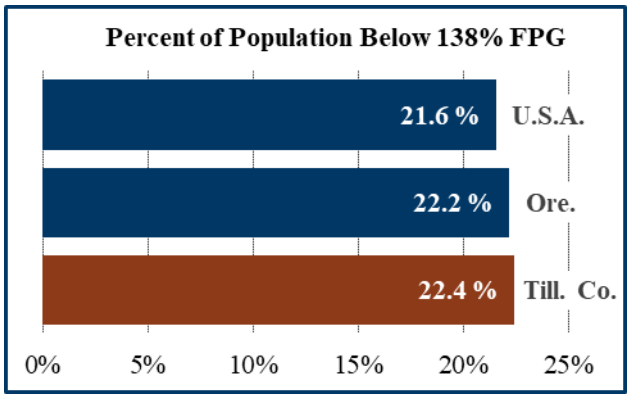




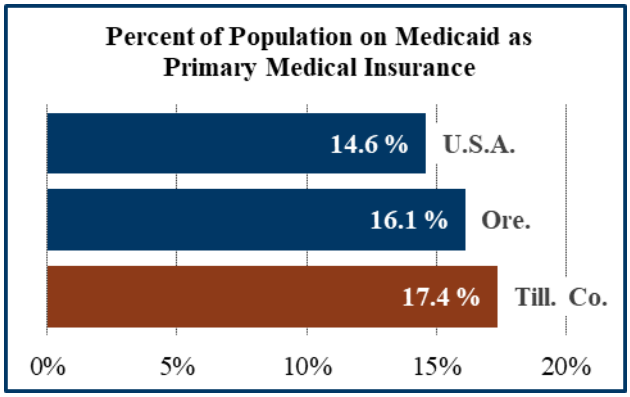
Income and Insurance Coverage

The service area is home to numerous low-income and impoverished individuals and families, more so than throughout Oregon and the United States. According to the U.S. Census Bureau, American Community Survey 5-Year Estimates, on average between 2013 and 2017, more than two in 10 (22.2%) service area residents were classified as impoverished, with income below 100% of the Federal Poverty Guidelines (FPG). This percentage is higher than both the state and national rates (18.7% and 20.0% respectively). Also, more Tillamook County residents (22.4%) have sufficiently low incomes to qualify them for Medicaid (income below 138% of the FPG), as compared with the state (22.2%) and the nation (21.6%). Tillamook County's most recent Community Health Needs Assessment (CHNA), conducted in 2019, illustrates the higher rate of childhood poverty in Tillamook County, at 22.9% compared with 18.7% statewide. Of note, this is substantially better than 27.25% which was measured in Tillamook County just three years ago.





The percentage of service area residents enrolled in Medicaid as their primary medical insurance is 17.4%, higher than the state (16.1%) and U.S. (14.6%) rates.

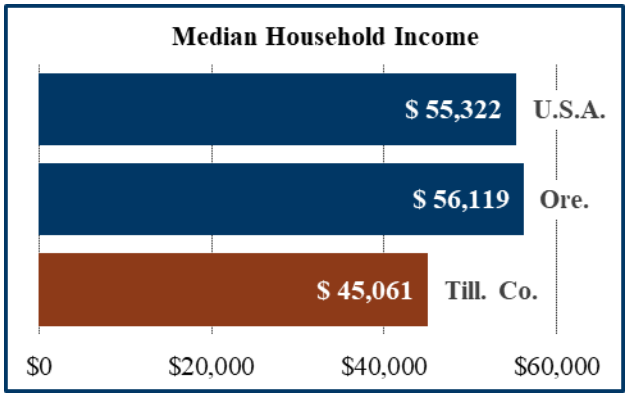


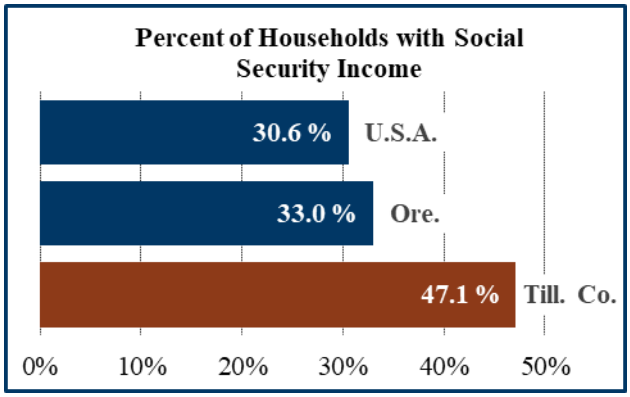
Before the Medicaid expansion in 2014, the percentage of uninsured residents of Tillamook County was as high as 17.0%; after the expansion, the rate dropped to 7.7%. In the years since the expansion, the percentage of uninsured residents increased to 10.9%, according to the U.S. Census Bureau, American Community Survey (ACS) 5-Year Estimates (2013-2017). Many of Tillamook County's uninsured residents are eligible for state or federally sponsored programs but remain medically uninsured for a variety of reasons.

Within the service area, the types of insurance coverage for the remaining residents vary. Significantly more residents of the service area are insured by Medicare (16.7%) when compared with the state (11.1%) and the nation (9.9%). Additionally, twice as many residents in the county receive health insurance via the Veteran's Administration and/or TRICARE[3] (6.2%), when compared to the state (3.5%) and the nation (3.3%). Finally, one-half of residents of Tillamook's service area (50.7%) are covered by private insurance as provided by the workplace. This percentage is less than the state (59.7%) and the nation (60.9%), indicating that residents of Tillamook County rely on the government for medical insurance at a greater rate than the state and nation.

[3] *TRICARE* is a health care program for uniformed service members, retirees, and their families.

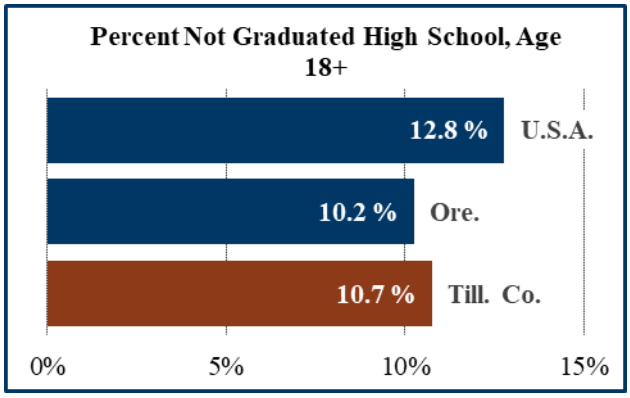
According to the U.S. Census Bureau, American Community Survey 5-Year Estimates, Tillamook County's median household income is $45,061, which is considerably lower than the state ($56,119) and the nation ($55,322). There is also a significantly higher percentage of households in the service area that rely on Social Security Income, at nearly one-half (47.1%) compared with the state (33.0%) and nation (30.6%) as a whole.

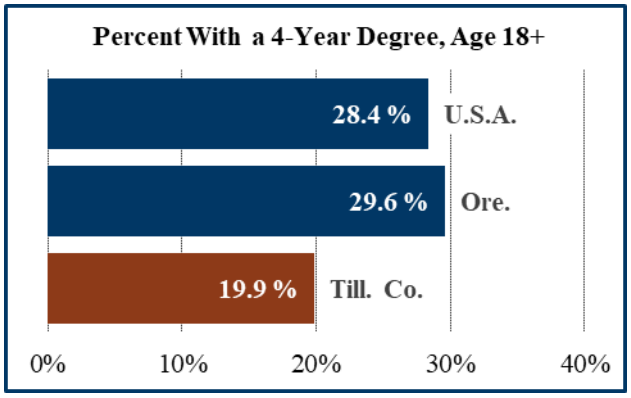




Education and Employment

Tillamook County education and employment status data were obtained from the U.S. Census Bureau, American Community Survey 5-Year Estimates (2013-2017). The percentage of Tillamook County residents ages 18 and older who have not graduated high school (10.7%) is slightly higher than the Oregon statewide rate (10.2%) and the percentage of service area residents ages 18 and older with a four-year degree significantly lags both the Oregon (29.6%) and U.S. (28.4%) rates.

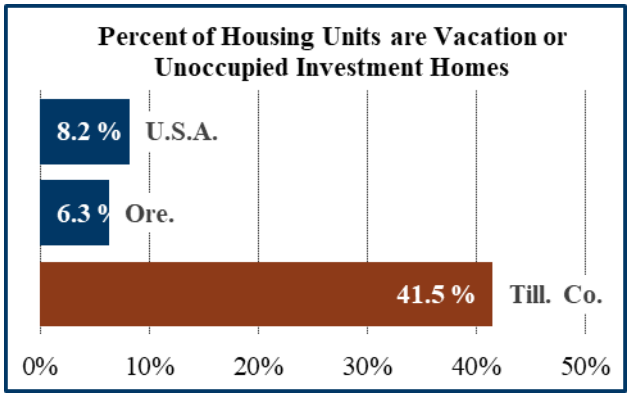


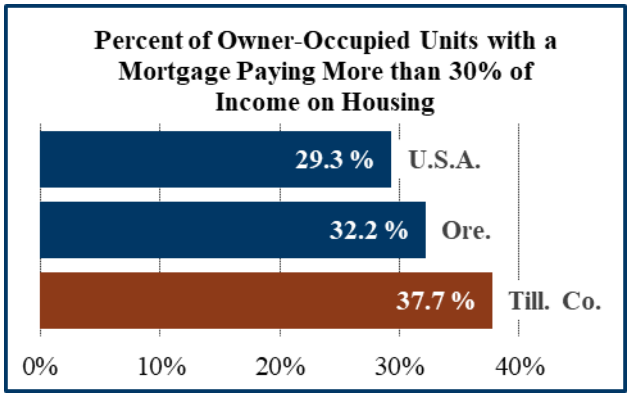


In terms of employment, data reported in the 2019 CHNA indicates that Tillamook County's unemployment rate stands at 3.4%, slightly higher than the state rate of 3.3%. However, Tillamook County's percentage of young people not in school and not working, defined as youth ages 16-19 years (14.4%), is twice as high as the state rate of 7.2%. Unemployment can lead to financial instability and serve as a barrier to health care access and utilization. A lack of employer-sponsored health coverage may prevent individuals from seeking preventive and primary care treatment for injuries or medical conditions that might make them more susceptible to misuse of opioids and other drugs.

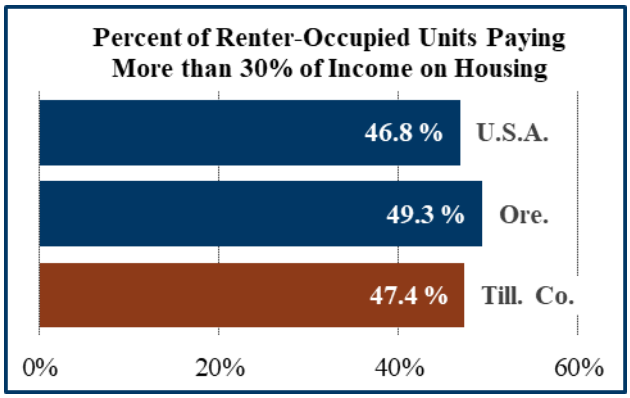
Housing Availability and Affordability

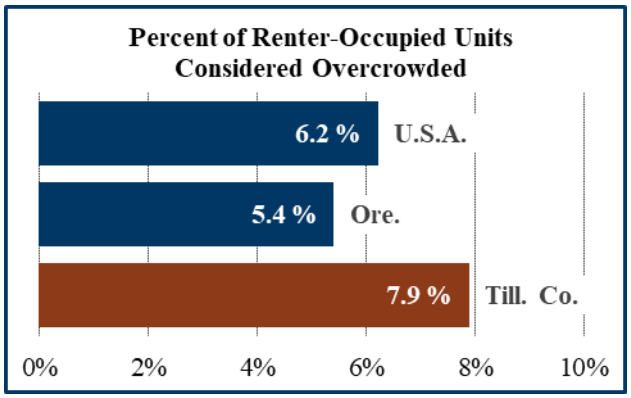
In looking at U.S. Census Bureau, American Community Survey data related to housing availability and affordability, we found that a high percentage of housing units in Tillamook County (41.5%) are vacation homes or unoccupied investment homes, as compared with similar housing throughout the state (6.3%) and nation (8.2%). The heavy concentration of vacation/investment homes correlates serves to limit the availability of affordable primary dwellings for permanent service area residents. Not surprisingly, a significantly larger percentage of Tillamook County residents who live in their own homes and carry a mortgage spend more than 30% of their income on housing (37.7%) than Oregon (32.2%) and U.S. (29.3%) residents as a whole.





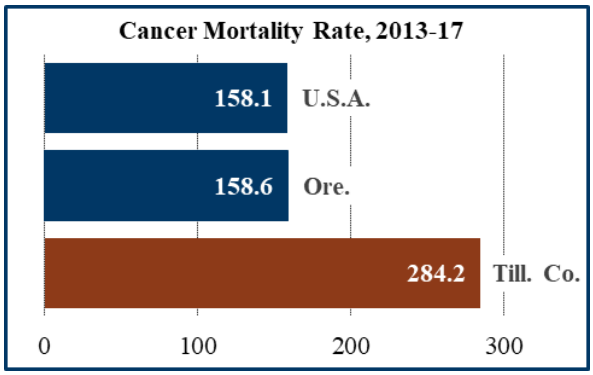
An even higher percentage of service area renters pay more than 30% of their income on housing (47.4%), roughly on par with state and national rates. However, the percentage of renter-occupied units in Tillamook County that are considered overcrowded (7.9%) is notably higher than those throughout Oregon (5.4%) and the U.S. (6.2%), which may contribute to living environments with increased levels of stress and anxiety.

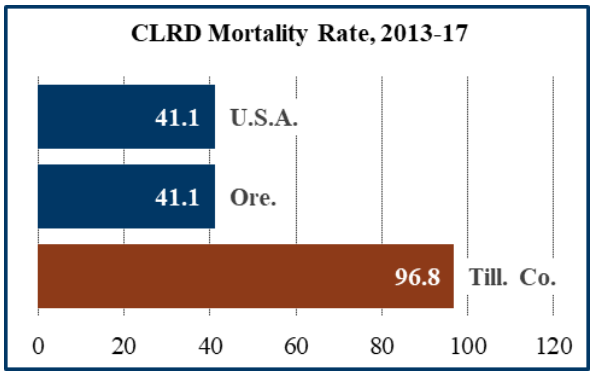


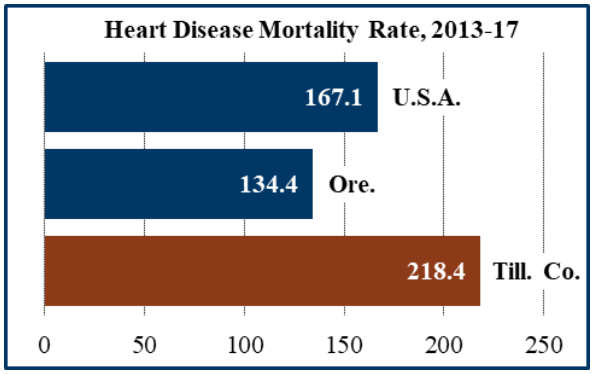


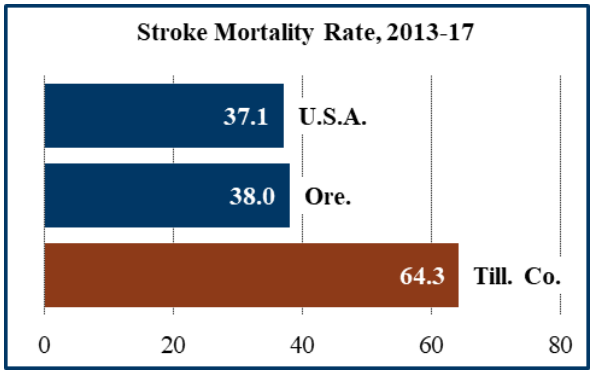
Mortality Rates

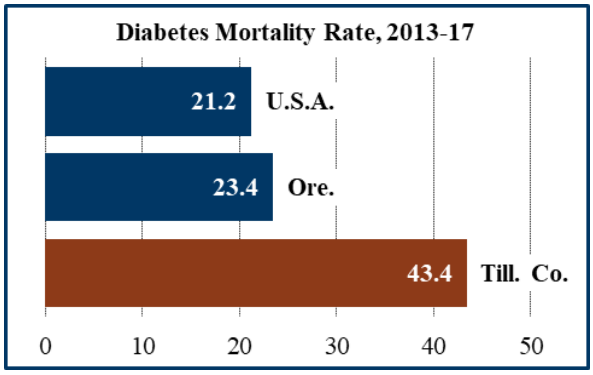
In looking at crude mortality rates, sourced from U.S. Census Bureau, American Community Survey (2013-2017), Tillamook County outpaced Oregon and the U.S. by a large margin in deaths per 100,000 individuals due to acute and chronic diseases, including cancer, chronic lower respiratory disease, heart disease, stroke, diabetes, and liver disease. Furthermore, crude accident and suicide mortality rates for Tillamook County (56.5, 24.8) are also disproportionately high compared with state (43.3, 18.0) and U.S. (44.0, 13.3) rates.

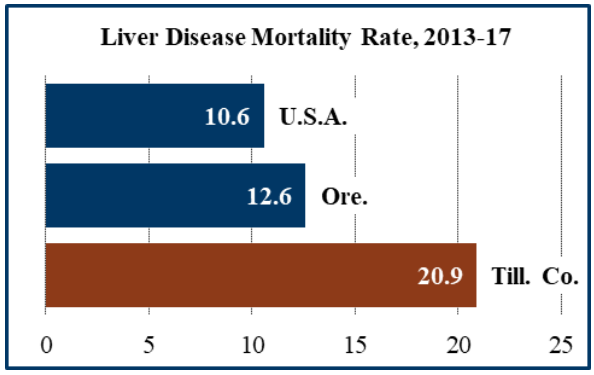


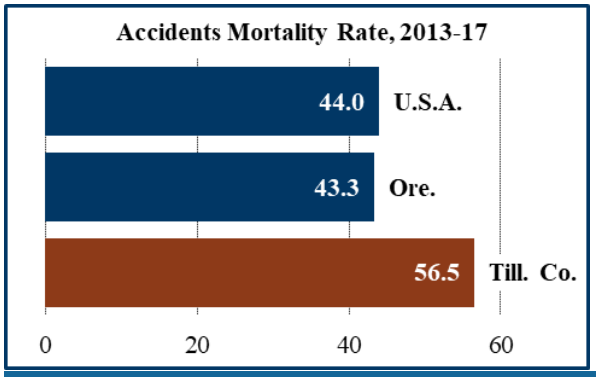


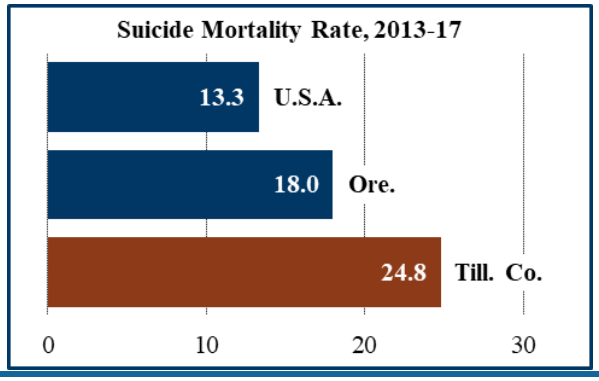












As a whole, the demographic data presented above highlight significant challenges that predispose Tillamook County residents to higher than average rates of substance use disorders (SUD) and opioid use disorders (OUD). A substantial portion of the target population are low-income or living in poverty, uninsured or underinsured, and lagging state and national rates in education, employment, and household income. Combined with a general lack of affordable housing, the prevalence of multiple chronic health conditions, and alarmingly high rates of mortality due to accidents and suicide, it is not surprising that according to a Tillamook Headlight Herald article published on May 2, 2018,[4] Tillamook County is "currently experiencing the fastest increase in the rate of per-capita prescription opioid overdose deaths and has the highest level of high-dose opioid prescribing in the state." Furthermore, according to Oregon Health Authority's Opioid Overdose and Misuse webpage,[5] Oregon has one of the highest rates of misuse of prescription opioids in the nation. The nature and extent of the OUD problem in Tillamook County is outlined here:

- According to the Oregon Health Authority, Opioid Overdose and Misuse data, in 2012-2016, Tillamook County had the highest rate of Drug Overdose Deaths from "All Opioids" than any other county in Oregon (13.4 deaths per 100,000 people). The state measure for this statistic is significantly lower, at 5.98 deaths per 100,000 people.

- Tillamook County had the highest rate of overdose deaths in the state for pharmaceutical opioid overdose deaths (10.6 deaths per 100,000 people). This rate is more than three times the state measure for this statistic, at 3.02 deaths per 100,000 people. The majority of opioid overdose deaths in Tillamook County were from pharmaceutical opioids.

- Tillamook County ranks second of 36 counties in Oregon for drug overdose from "All Drugs" (16.58 deaths per 100,000 people).

- Between 2010 and 2014, Tillamook County had a high rate of hospitalizations for pharmaceutical opioid overdose (12.64 per 100,000 people). The highest rate in the state for hospitalization due to pharmaceutical opioid overdose was in Lincoln County, just south of Tillamook County (18.20 per 100,000 people). The rate for the state of Oregon was much less, at 7.95 per 100,000 residents.

- Oregon Health Authority's opioid overdose and misuse data seems to indicate that in Tillamook County the opioid type causing most concern is pharmaceutical opioids.

These statistics demonstrate the urgency and magnitude of the OUD problem in Tillamook County. Behind each overdose death there is a family in mourning, children without parents, and traumatic impact that can last for years.

[4] Year of Wellness: Highlights from the Northwest Opioid and Substance Use Summit, published in the Tillamook Herald, retrieved on January 5, 2019 from https://www.tillamookheadlightherald.com/community/year-of-wellness-highlights-from-the-northwest-opioid-and-substance/article_aa78a940-4e56-11e8-826e-330e69f781ed.html.

[5] Retrieved from Oregon Health Authority, Opioid Overdose and Misuse webpage on January 5, 2019, at: https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/index.aspx

Vision, Mission and Planning Values

Mission

RCORP Tillamook will improve health and well-being in Tillamook County through collaborative and sustainable solutions that address substance use and opioid use disorders.

Vision

RCORP Tillamook will promote health, wholeness and hope by reducing the impact of substance use and opioid use disorders through treatment, recovery and prevention solutions for all people in Tillamook County.

Values

- Comprehensive approach: seeking whole-person solutions along the continuum of care for substance use and opioid use disorders, including prevention, treatment, and recovery
- Data and best practices: basing decisions on data rather than assumptions, and focusing on best practices
- Collaboration: community partners working together with transparency, inclusion, and non-duplication of effort
- Sustainability: focusing on practical, financially-viable solutions that support long-term sustainability
- Equity: seeking out, listening to and supporting the community, especially those that may be underrepresented or marginalized

Methodologies

Quantitative

Some aspects of this serious public health issue have already been identified and communicated via Tillamook County's 2019 CHNA, the principal research tool for developing short- and long-term strategic plans, a community benefits plan, and other planning documents. The CHNA is based on data from existing public health reports, community health panels, State Office of Rural Health, and a community needs survey that is conducted in partnership with the Oregon Office of Rural Health and compiled every three years. A total of 124 participants from Tillamook County were involved in either online surveys, focus groups or stakeholder interviews. These participants range from public health organization staff to unspecified community members.

In addition to analyzing the most recent national, state, and local data, each RCORP Tillamook member in health care aggregated patient admissions data from electronic health records of their respective organizations to determine utilization rates for mental health and substance use services among their current patient population.

Secondary data is also incorporated from a variety of local, county, and state sources, including community demographics, social and economic factors, health care access, birth characteristics, leading causes of death, chronic disease, mental health, substance use, health behaviors, and preventive practices. These data points are presented in the context of Tillamook County and the State of Oregon, framing the scope of an issue as it relates to the broader community. The RCORP Tillamook members and contracted consulting partners followed a similar approach in collecting and analyzing the most current and relevant data available, which will inform and guide our strategic planning process.

Qualitative

Qualitative data was collected by RCORP Tillamook consulting partners, Lines for Life. In the Fall of 2019, Dwight Holton and Donna Libemday with Lines for Life held eight 45-minute phone interviews with key informants identified by the RCORP Tillamook team along with a few members of the Columbia Pacific CCO team and Adventist Health. Interviewees were identified based on their involvement with RCORP Tillamook, their role in Tillamook County health care, and engagement in substance and opioid use disorder services. Questions during the interviews were open-ended with the intention of creating conversation. These were the questions that were addressed:

- What resources/services do you currently bring/provide to the Tillamook community?
- What challenges or barriers do you face in this community?
- What solutions or what do you wish for when you think about these challenges?

A nine-question survey was also distributed to a number of Tillamook County prescribers, healthcare professionals and leaders in the substance and opioid use treatment and recovery community as identified by RCORP Tillamook. This survey included open-ended questions focused on opioid use prevention, treatment and recovery, successes and challenges. The feedback collected was included in this document and referred to as a resource while creating a plan to address OUD in Tillamook County. Questions and answers from this survey can be found in the appendix.

A survey specific to this needs assessment was not offered to the general public, as this and other methodologies such as focus groups and additional stakeholder interviews were recently conducted in the process of developing the 2019 Tillamook County CHNA, a document that was utilized frequently in formulating this needs assessment.

Results and Findings

Prevalence in Tillamook County

The volume of need for OUD services among residents of Tillamook County is estimated by Gary Bess Associates using data from the National Survey on Drug Use and Health (NSDUH),[6] the Oregon Health Authority (OHA),[7] and the U.S. Census Bureau.[8]

A median estimate of 1,742 Tillamook County residents “misuse opioids” over a 12-month period. This estimate was made using data from 2016, which is the latest published data from NSDUH. At that time, the survey indicated that 37.5% of all people who misuse opioids received the substance through a prescription. The remainder received it through other means such as given/bought/stolen from a friend, relative, or a drug dealer. OHA reports that in 2016, an annual average of 25.28 per 1,000 Tillamook County residents (average of four quarters: 26.77, 25.42, 24.96, and 23.96) received a prescription of opioids that exceeded 90 morphine equivalent doses (MED) over the quarter, which is used as a probability threshold indicating likelihood of opioid misuse. Using the Census Bureau’s county

[6] U.S. Substance Abuse and Mental Health Services Administration. (2017). *Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health*. Washington, DC

[7] Oregon Health Authority. (2019). Oregon Prescribing and Drug Overdose Data Dashboard. Accessed October 24, 2019. https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/data.aspx

[8] U.S. Census Bureau. (2018). 2013-2017 American Community Survey 5-Year Estimates. Accessed January 14, 2019. https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml

population estimate of 25,840, this calculates to 653 residents who had opioid prescriptions receiving greater than 90 MED. If this represents 37.5% of all opioid misusers as indicated by NHDUH, then the total universe of opioid misusers living in the county would be 1,742.

Please note that this is a rough estimate. It is not a survey-based estimate, so a confidence interval cannot be calculated. However, the RCORP Tillamook team can be relatively confident that the actual number of people who misuse opioids is somewhere in the 1,700 to 1,800 range, with 1,742 as a median estimate. This represents 7.7% of the county's population ages 12 and older.

The group estimated to have misused opioids can be broken out into three subgroups:

1) People who are either diagnosed with OUD or likely to be diagnosed if their situation were presented to a provider trained in diagnosing OUD. The likelihood of diagnosis is based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV)[9] and queried in the NSDUH. A respondent was classified as having an opioid use disorder if he or she met DSM-IV criteria for heroin use disorder or pain reliever use disorder.

2) People with opioid dependence, a situation where a diagnosis of OUD is not made or is unlikely, although signs of dependence are present and intervention is required to move the patients from a dependent to a non-dependent state.

3) People without dependence. This includes people who take opioids to get high one or a few times. The DSM-IV criteria for SUDs include separate criteria for dependence and abuse. Individuals who met the criteria for abuse of a given substance (e.g., alcohol) may not always meet the criteria for dependence.

Understanding the distribution of opioid misusers amongst these three groups would be valuable for policy and action items. Unfortunately, the data that could be used to accomplish this is either of poor quality, require an undue number of assumptions, or non-existent. One breakout that can be calculated is the OUD component. The NSDUH estimates prescription pain reliever misuse at the state scale, so there are estimates for Oregon. Further, these estimates are given by age group (12-17, 18-25, and 26+), which allows interpolation of local estimates. Prescription pain reliever abuse in Oregon is significantly higher – about 5.3% of the population ages 12 and older compared with 4.3% nationally. Therefore, the interpolation was run on state data rather than national data to avoid a chance of underestimation. As a result, GBA estimates there is a median estimate of 233 people who have been or would be diagnosed with OUD. As with opioid misuse, this estimate should be seen as somewhere in the 200-300 range.

Age Group	Till. Co. Population (a)	Natl. OUD Rate (NHDUH) (b)	Natl. Prescr. Pain Reliever Misuse (NSDUH) (c)	Ore. Prescr. Pain Reliever Misuse (NSDUH) (d)	Till. Co. OUD Estimate $\frac{((a) \times (d)) \times ((a) \times (c))}{((a) \times (b))}$
Ages 12-17	1,705	0.6 %	3.5 %	3.57 %	10
Ages 18-25	2,008	1.1 %	7.1 %	10.34 %	22
Ages 26+	18,903	0.8 %	3.9 %	4.90 %	151
Total Ages 12+	22,616	0.8 %	4.3 %	5.28 %	233

[9] American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (4th ed.). Washington, DC

The remaining two categories, non-OUD dependence and non-dependence, is the remainder of the 1,742 misusers minus 233 OUD for a total estimate of about 1,509, or somewhere in the neighborhood of 1,500 residents. There is no reliable data available to split these estimated 1,500 residents between non-OUD dependence and non-dependence. However, given the nature of opioids and opioid dependence, GBA recommends assuming that the vast majority of this group belongs in non-OUD dependence, with a small minority in non-dependence.

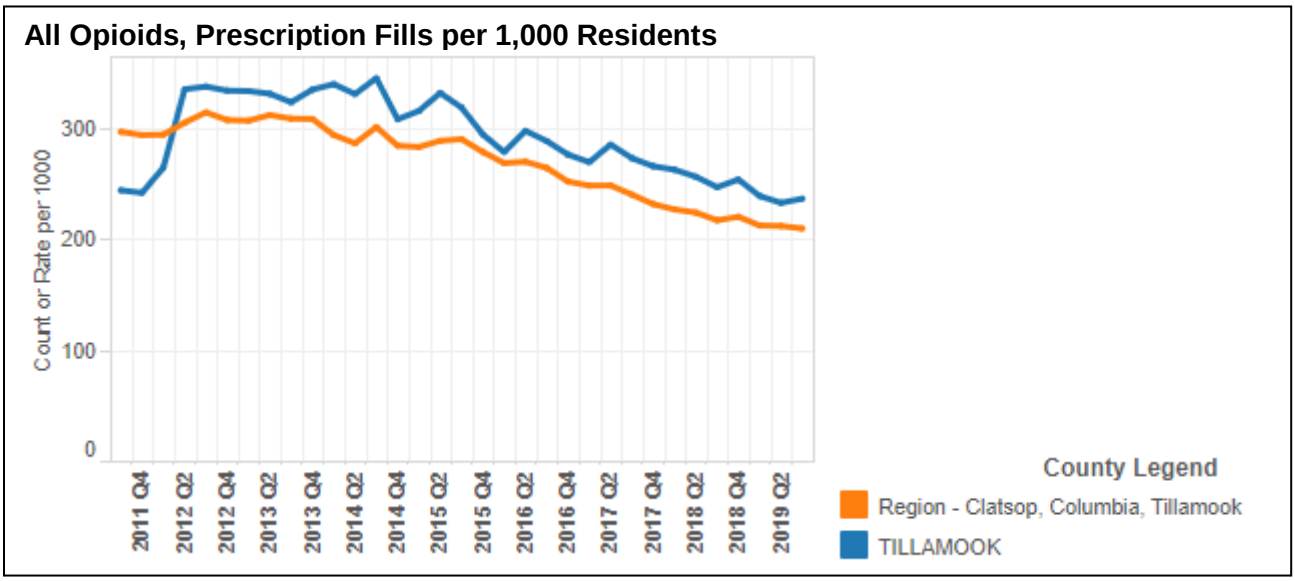
Opioid Data Dashboard

The Oregon Health Authority maintains an Opioid Data Dashboard on its Oregon.gov website. This interactive tool contains state and county-level data on controlled substance prescribing and drug overdose health outcomes (hospitalizations and deaths). Data for this dashboard is from published and unpublished Oregon Health Authority datasets. Prescription data from the Oregon Prescription Drug Monitoring Program (PDMP) which collects all schedule II, III and IV outpatient retail pharmacy fills dispensed in Oregon or to Oregonians.

All Opioids, Prescription Fills per 1,000 Residents

All Opioids identified in the graph below, include full opioid agonist, partial opioid agonist, and combination opioid agonist/antagonist pharmacological classes. This includes buprenorphine/naloxone combinations as well as codeine antitussives. Rate measurements are calculated using county populations as denominators.

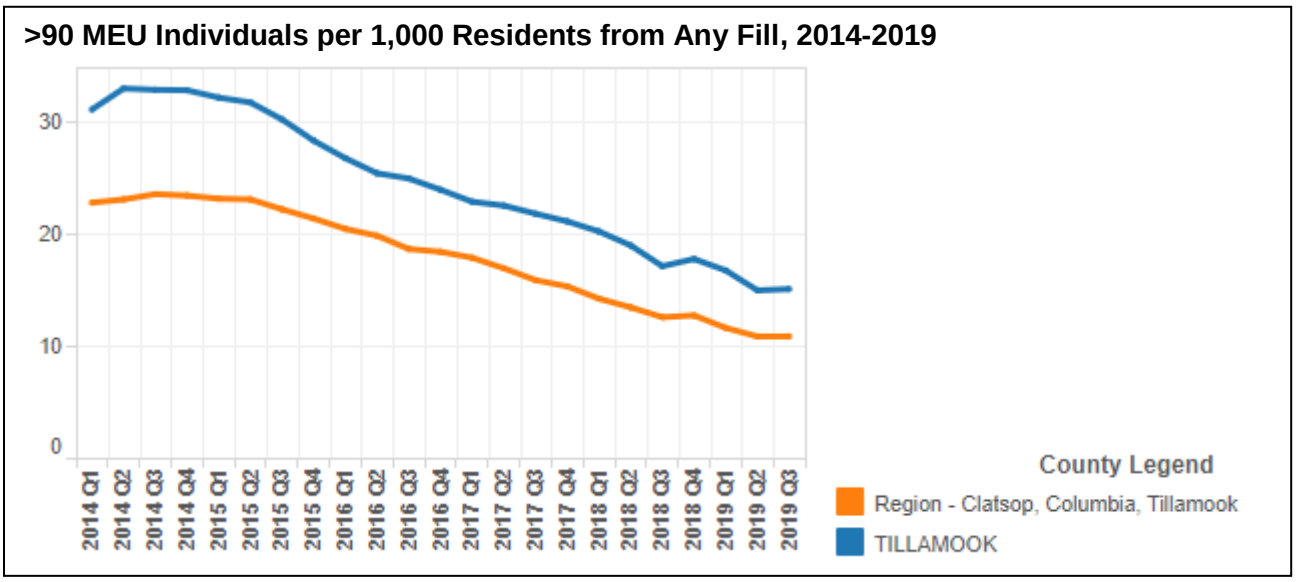
Tillamook County has made significant progress in reducing opioid prescribing, as evidenced in the graph below. That said, Tillamook still prescribed opioids at a higher rate than the region as a whole.



In Q2 of 2015, Tillamook had an estimated high of 365 prescription fills per 1,000 residents compared to the Region (Clatsop, Columbia, Tillamook) with an estimated 317 prescription fills. By the Q3 of 2019, Tillamook dropped to an estimated 268 prescription fills per 1,000. This represents a reduction of almost 100 fills per 1,000 residents. The region dropped to 234 by 2019 or by 83 prescription fills per 1,000.

>90 MEU Individuals per 1,000 Residents from Any Fill, 2014-2019

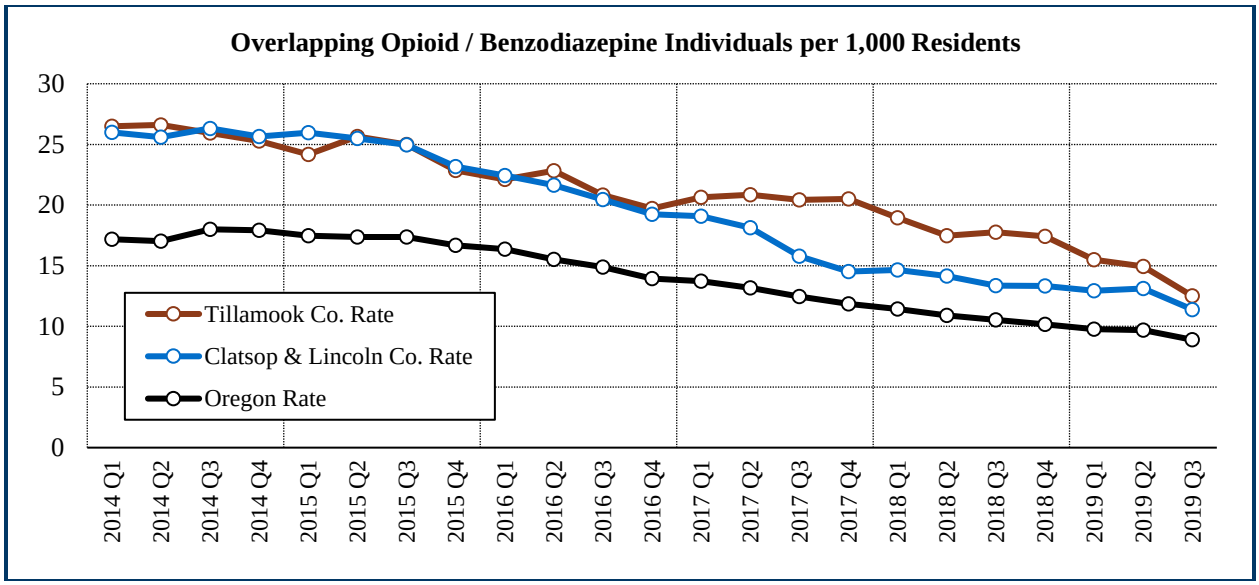
The Oregon PDMP also provides data for high dose prescribing of opioids – including a measure of how many individuals are receiving an opioid prescription for a daily dose of over 90 morphine equivalent units (MEU). The thresholds of 50, 90 and 120 MED are based on CDC opioid prescribing guidelines and an Oregon Medicaid performance improvement project. In the Q2 of 2014, an estimated 33 Tillamook individuals per 1,000 residents received a high dose prescribing of >90 MEU. By 2019 the estimated rate dropped to 15 residents per 1000. In 2014, the region had an estimated 23 individuals per 1,000 residents receiving >90MEU. By 2019, the region dropped to 10.85 per 1,000 residents.



Overlapping Opioid/Benzodiazepine individuals per 1,000 residents.

The combination of opioids and benzodiazepine can be especially dangerous – a significant number of opioid overdose deaths occur when the victim also used benzodiazepines. A combination of benzos and opioids is thus an important measure of risky prescribing, and the Oregon PDMP tracks the rate of combined benzo-opioid prescribing in Oregon Counties.

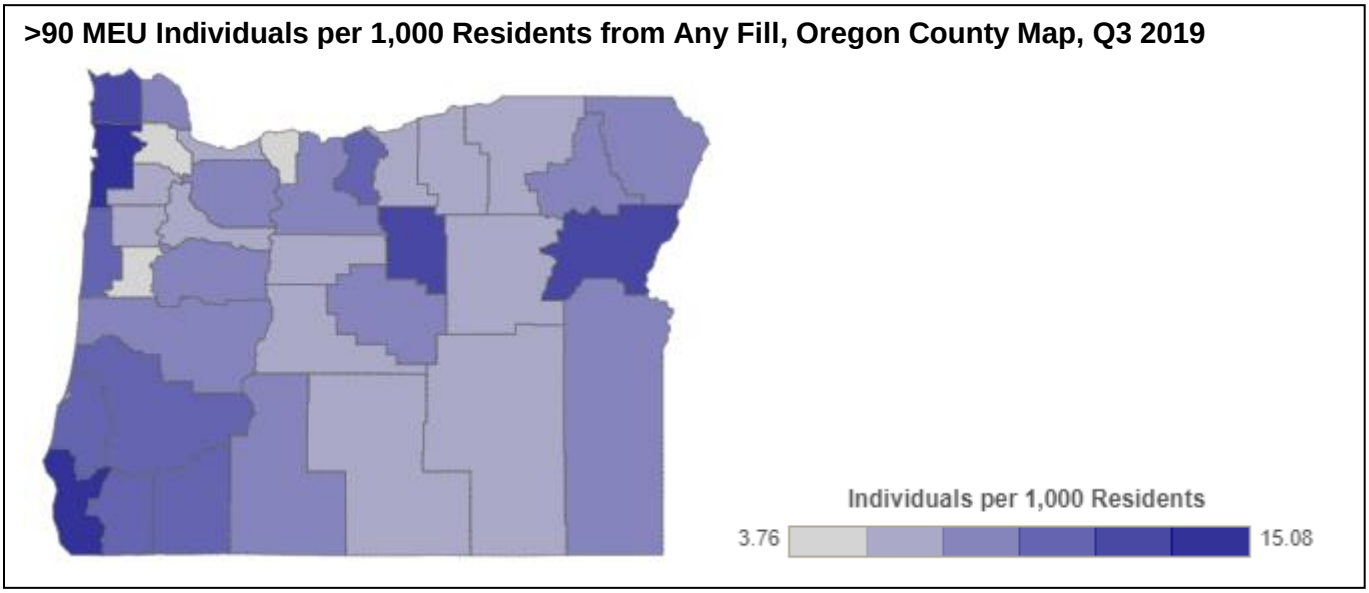
In 2014, Tillamook had an estimated 26 per 1,000 residents who received an overlapping opioid and benzodiazepine prescription. By 2019, the rate dropped to 12.50 per 1,000. If you look at the raw numbers for Tillamook, prescriptions in 2014 went from a high of 685 individuals to 323 individuals in 2019. Tillamook's drop in high risk prescribing rates is similar to neighboring counties but still higher than the state rates.



(Overlapping opioid and benzodiazepine prescriptions are identified if the date dispensed for one drug is within the day's supply of the other. If an individual has one or more overlapping fills in a calendar quarter, that person is included in the numerator.)

>90 MEU Oregon County Map, Q3, 2019.

Since 2016, Tillamook has trended downward in high risk prescribing but when compared with other counties across the state, Tillamook has the highest rate of >90 MEU prescriptions in the state at 15.08 individuals per 1,000 residents.



Unused Prescription Opioids Left in Medicine Cabinets

Disused opioid pills – those pills leftover in our medicine cabinets – pose a significant risk of addiction. Nearly one in five teens reported that they have used prescription medication to get high, and study after study indicates that most teens get these medications from friends or family members. According to the Centers for Disease Control, about two-thirds of all prescriptions remain unused, and when surveyed, over half of patients reported storing leftover medications in their home instead of disposing of them.

Tillamook County pharmacies filled 28,730 prescriptions for all opioids from October 1, 2018 to September 30, 2019. Assuming an average of 30 pills per prescription (a conservative assumption), an estimated 861,900 pills were prescribed in Tillamook county in this one year. If, as CDC data suggest, two-thirds of these pills went unused, we can conclude that over 565,000 disused opioid pills were leftover from prescriptions filled in Tillamook County.

Supply, Utilization, and Gap in SUD/OUD Services

Data on supply and utilization is imprecise, although it is robust enough to conclude that there is a significant gap between the prevalence of opioid dependence and the utilization of treatment services.

According to OHA, there are 10 physicians with a primary address in Tillamook County who have an X-waiver to prescribe buprenorphine to treat opioid dependence. Of these, only a few are “active” in that they wrote more than 30 prescriptions for buprenorphine, the primary drug for medication-assisted treatment (MAT) as of 2019, that were filled in the third quarter of 2019. An additional 72 physicians practice in Tillamook County according to their license information, although their primary address is somewhere else, usually in the Portland area. The vast majority of physicians wrote fills for one or two patients.

Based on the above information, there is a large volume of potential x-waivers to prescribe drugs for MAT of opioids, but very little of that capacity is being utilized. According to OHA, there are a total of 123 residents with at least one prescription fill of buprenorphine during the third quarter of 2019. Inquiries to OHA revealed that 90 of these patients had at least 60 days’ supply of buprenorphine filled at one time. For this needs assessment, the 60-day supply fill will be used as the probability threshold above which it is likely that a patient is receiving MAT for OUD. The remaining 33 patients have providers who are either experimenting with buprenorphine or are actively being weaned from an opioid to the MAT drug. Compared with the estimated OUD prevalence ranging between 200 and 300 Tillamook County Residents (median estimate of 233), that only 40% to 60% of residents with OUD are being treated, and that there are likely to be at least 77 and as many as 177 residents with OUD who are not currently being treated.

At this time, there is not a reliable source of data that is consistent across providers and EHR systems to determine the number of people being treated for opioid dependence. This is largely because treatments vary and ICD code destinations tend to be inconsistent and incomplete. Generally, with non-OUD dependence, a physician will attempt to taper off dosages to wean the patient off opioids, so prescription data would not a reliable measure.

Tillamook Resident's Successes and Barriers

A few RCORP Tillamook partners shared real stories of people living in Tillamook County. The following anecdotal information, is useful to personalize the SUD/OUD crisis in Tillamook County and illustrate how increased capacity to provide SUD/OUD treatment and recovery services would be beneficial for these and many other patients in need:

- **Resident #1** This person's opioid use started to address pain and eventually moved from prescriptions to using other drugs. Following a long history with opioid use, this patient sought counseling. They have since engaged in treatment at an agency, making use of a curriculum that is focused on recovery. This person works primarily with individual sessions and because of their history of trauma and some domestic violence, counseling has helped them to reinforce positive family of origin values and to identify new strategies for their emotional and physical self-care. These two areas have been critical for their recovery.

- **Resident #2** This patient sought counseling after being referred by a community health care provider. To manage pain, they began abusing opioids and alcohol. They are maintaining sobriety using individual and group counseling and has been referred to peer support, but not yet made a connection. However, Narcotics Anonymous has been a positive experience and they are very committed to attending, working the program, and engaging with a sponsor. They have also engaged with a primary care physician to address their pain/health concerns appropriately.

- **Resident #3** This person was referred to counseling for substance abuse and dependence on heroin, tobacco, and methamphetamine by the case management department at the hospital that they are currently staying in. They were admitted due to complications of their substance use and dependence that almost led to death. This client is the parent of 2 young children whose partner has sole custody of since the client gave up rights when going into a detox program for heroin. Some of the barriers to care include struggling with staying sober, underemployment due to losing jobs for substance abuse and dependence and having relapsed a couple of dozen times since beginning use at age 15. This person has been in and out of inpatient rehabilitation programs for years. It is not yet clear what discharge plans have been made for this client by the case management department. It is evident that the client needs inpatient hospitalization. They have been in and out of jail numerous times since age 15 for various misdemeanors and petty crimes all in an effort to obtain drugs and heroin. The person has an interest in being sober from heroin and other drug and plans to continue smoking after discharge.

Stakeholder Interviews

After reviewing the interview notes, Lines for Life identified three key themes that stakeholders continually addressed: 1) Pain management and prescribing practices; 2) Addiction, treatment and recovery; and 3) Harm reduction and education. Each theme along with the encompassing items was discussed by RCORP Tillamook members together. Discussions explored the challenges and opportunities for collaboration, communication and growth. The full list of statements can be found in the appendix of this document.

Key Themes

Because many RCORP Tillamook members were included in the initial interviews, there was support of the three categories based on first-hand knowledge of the community. These themes were formally discussed at RCORP Tillamook meetings to confirm the gaps and need in Tillamook County and determine possible strategies of action.

Each of the listed initiatives is important in the fight against opioid addiction, and each plays a role in combatting this nationwide problem. Because some of the mentioned initiatives and solutions have similar goals, objectives, and activities as RCORP Tillamook, collaboration and sharing of data will be essential. If an overlap in goals or activities is revealed, RCORP Tillamook will work to avoid duplication in efforts through effective communication and establishing relationships to facilitate collaboration and sharing of work. Throughout the process, RCORP Tillamook will be transparent and forthcoming with data, new strategies, and findings.

Theme 1: Pain Management and Prescribing Practices

Assets and Opportunities

Local

- **Adventist Health Tillamook Clinics** have an organization-specific pain management plan. They provide chronic pain patients with pain management contracts and tapering plans to reduce the use of opioids. The monthly Medical Group Operations Council reviews policy changes and quality metrics such as patient and provider experience, national benchmarks and prescribing by providers.

- **Rinehart Clinic - Federally Qualified Health Center (FQHC)** is in its fourth year of active opioid reduction work and has reduced the number of patients on monthly opioids, total dose, quantity, and co-prescribing. Using a team-based care model, the entire team is involved in this work. The Panel Coordinator manages a panel of patients prescribed opioids and prompts the necessary follow-up. RN Care Coordinators track SUD results, PDMP and ensure Narcan access for every patient in this panel. LCSWs assess pain before PCP prescribing, manage updated pain treatment agreements, and provide ongoing behavioral health services. The opioid Oversight Committee reviews progress quarterly and makes ongoing policy and procedure updates per OHA and PMIT recommendations.

- **Tillamook County Community Health Center (FQHC)** has already begun some work on pain management and prescribing. Patients receive a pain management contract as well as education to their options available and why those are their options. All these FQHC's providers are trained and use the prescription drug and monitoring program (PDMP). The review committee also looks at prescribing practices.

Federal and State

- **The American Medical Association (AMA) Opioid Task Force** recognizes the need for increased physician leadership, a greater emphasis on overdose prevention and treatment, and the need to coordinate and amplify the efforts and best practices already occurring across the country.

- **Association of State and Territorial Health Officers** has created a series of opioid best practices for public health agencies and professionals.

- **The Northwest Opioid & Substance Use Summit** is hosted by the Oregon Pain Guidance annually. This event provides training on best prescribing practices, as well as effective treatment options for chronic pain and substance use disorder.

- **Opioid Epidemic Task Force**, a statewide effort to combat opioid abuse and dependency. The Task Force consists of medical experts, drug treatment specialists, and government officials. The objective of this state initiative is to identify and implement strategies to address the growing opioid misuse and abuse across the state. Task Force priorities include reducing the number of opioid pills in circulation, improving access to high-quality treatment, facilitating data sharing, and education outreach.

- **Oregon's Alcohol and Drug Policy Commission** is currently working on developing a strategic plan for reducing drug and alcohol addiction and increasing recovery rates in Oregon. The plan is due to be finalized in 2020.

- **The Oregon Health Authority Opioid Initiative** brings statewide partners and communities together to reduce deaths, non-fatal overdoses, and harm to residents from prescription opioids while expanding the use of non-opioid pain care.

- **State Mental Health and Addictions Services** staff can provide technical assistance and data.

- **Substance Abuse and Mental Health Services Administration (SAMHSA)** offers an opioid prevention toolkit as well as no-cost CME courses.

- **U.S. Health Resources and Services Administration (HRSA)** provides resources and assistance to grant recipients.

- **Western Interstate Commission for Higher Education (WICHE)** provides technical assistance for HRSA grantees.

Challenges, Gaps and Needs

- **Safe Guidelines**. Tillamook County prescribers do not yet have a shared strategy for addressing pain and prescribing. As a key preventive measure, many informants discussed a desire for safe prescribing guidelines to be a priority.

- **Resources.** A lack of SUD resources available to both the community and healthcare providers frequently came up. Tillamook County is a Health Professional Shortage Areas (HPSA) meaning there are not enough providers available to the community and even less who are local since most live in the Portland metro area. The shortage affects patients with chronic pain and seniors who need a provider that understands their relationship with opioids. On the other hand, there may be a handful of X-waivered providers providing medication-assisted treatment (MAT), but there is not a county-wide support system to facilitate services by those providers and to help others cross over into MAT care.

- **Data.** One of the most pressing challenges for prescribing practices is that record systems across Tillamook County healthcare organizations cannot easily communicate information with each other. Even within some organizations, there is not a culture of sharing data with prescribers. There also is a level of data mistrust that needs to be addressed for providers to have confidence when data may not match their practice experience.

Evidence-based Practices and Proposed Solutions

- **County-wide strategy for prescribing.** This includes the sharing of reliable and pertinent data and continuous communication between healthcare partners in Tillamook County. In a best-practice scenario, all prescribers would accept and commit to following county-wide prescribing guidelines.

- **Transitional plan for high use patients.** With a county-wide prescribing strategy, some patients will need a plan to lower their use and special attention will need to be given to senior citizens who have age-specific needs. Providers will need education on transitional plans and resources available such as tapering clinics.

- **Alternatives for pain management.** There are some county programs available to help people with pain management, but they are not widely or well known. The programs may not work together or communicate effectively with each other. Providers and the public will need more readily available options information about their options. Referral plan built into clinic EMRs.

- **Continuity of care from jail.** Both law enforcement and health care providers need to work together to understand their role in a person's recovery and how to support them while in jail. Safe detox for substance use as well as a warm handoff to treatment and recovery options are vital to long-term recovery and will need to be an integrated effort by all community health care organizations.

Theme 2: Addiction, Treatment, Recovery

Assets and Opportunities

Local

Below is a chart listing provider types in Tillamook County related to SUD and OUD and where they can be found.

Providers Currently Available in Tillamook County		
Provider Type	**Number of Providers in Tillamook County**	**Location(s) of Provider(s)**
Mental Health Providers		
Psychiatrist	1.8 FTE	Till. Family Counseling Center
Psychologist	0.1 FTE (4 hr/week)	Till. Co. Community Health Centers
Licensed Clinical Social Worker (LCSW)	15 FTE	Adventist Health Tillamook, Rinehart Clinic, Till. Family Counseling Center, Till. Co. Community Health Centers
Licensed professional counselors (LPC)	6 FTE	Till. Family Counseling Center
Licensed AODS Counselor	8 FTE	Adventist Health Tillamook, Till. Family Counseling Center, Till. Co. Community Health Centers

Peer Support Specialist	3.25 FTE	Till. Family Counseling Center
Providers with Drug Enforcement Administration Waiver to Prescribe Buprenorphine		
Physician	3	Rinehart Clinic, Till. Co. Community Health Centers*
Nurse Practitioner	1	Adventist Health Tillamook
Physician Assistant	1	Till. Co. Community Health Centers*

**Medical providers review the SBIRT, PHQ, etc. with patients at prescribed times/visits each year and make internal and external referrals to Behavioral Health Services.*

- **Adventist Health Tillamook's** RN care coordinators work with patients and providers to ensure team integration. Each clinic has LCSWs embedded to provide care with a CADC III and CADC I also available to provide addictions counseling.
- **Alcoholics Anonymous, Narcotics Anonymous** facilitates support groups and meetings at various locations in Tillamook County.
- **CARE** offers a coordinated entry program. Their risk assessment addresses addiction and primarily refers to Tillamook Family Counseling Center because it opens doors to other services. If detox is needed, CARE can help individuals coordinate access and transportation to services.
- **Celebrate Recovery** hosts recovery meetings.
- **Coastal Bay Counseling** focuses around a variety of issues, including alcohol and drugs.
- **Coastal Health Center** offers preventative, chronic, and acute medical treatment.
- **DeCambra House** is a community-based recovery support facility.
- **Helping Hands** provides open meetings for Dual Diagnosis Anonymous, resources, recovery, and a re-entry program with one re-entry facility serving men, women, and children.
- **House of Grace** is a faith-based sober living option for women.
- **Ivy Avenue Wellness Center** offers a 10-week program for pain management. It is a program of the Tillamook Family Counseling Center.
- **Lines for Life** is a state-wide drug and alcohol health line and suicide crisis line.
- **Nehalem Bay Counseling** focuses on a variety of issues, including alcohol and drugs.
- **Peace Work** offers counseling for a variety of issues, including alcohol and drugs.
- **Rinehart Clinic (FQHC)** has provided a Medication-Assisted Treatment (MAT) program for the last two years, using a team-based care model. The MAT team consists of an X-Waivered MD, RN Care Coordinator, LCSWs, Acupuncturist, Quality Director, and Panel Coordinator. The team meets regularly to review patients included in this treatment program and new potential

patients. Individual counseling with LCSWs is provided for those with SUD. Weekly SMART Recovery meetings are held at the Rinehart Clinic for patients and non-patients.

- **Tillamook County Community Health Center (FQHC)** has two X-waivered physicians currently seeing patients for MAT. Providers use OCHIN dashboards and utilize a harm reduction model rather than abstinence. Maintenance after the induction phase is easier and working well. Staff is learning to be more efficient and more successful in engagement with clients.

- **Tillamook County Health Department** offers HIV/AIDS medical treatment, prevention education, drug purchasing assistance, Ryan White services, HIV test counseling, safe sex education.

- **Tillamook County Library** hosts an open meeting for Dual Diagnosis Anonymous.

- **Tillamook Family Counseling Center,** in the city of Tillamook also has clinics in two other county locations. Their behavioral health services providers offer screening, assessment, mobile crisis services, counseling, peer support, recovery mentors and SUD assessment, treatment and prevention.

- **Tillamook Serenity Club** is a community-based support group for individuals recovering from addiction. They provide a clean, sober environment for family or social functions.

Federal, National and State

- **American Academy of Addiction Medicine** provides professional training on additions.

- **American Association of Nurse Practitioners** offers CME waiver training.

- **Mental Health and Addiction Counselor Certification Board (MHACBO)** is the state certification board for mental health, addictions and peer support specialists. It offers regular training on evidence-based practices, which are open to anyone.

- **National Association of Alcohol and Drug Abuse Counselors (NAADAC)** offers a variety of CEU training options, including independent study sources and webinars.

- **Northwest Addiction Technology Transfer Center (NWATTC)** provides services to develop and strengthen community-based implementation of evidence-based practices (EBPs) for substance use disorder treatment and recovery the treatment and recovery workforce in Alaska, Idaho, Oregon, and Washington.

- **The Northwest Opioid & Substance Use Summit** is hosted by the Oregon Pain Guidance annually. This event provides training on best prescribing practices, as well as effective treatment options for chronic pain and substance use disorder.

- **Opioid Epidemic Task Force**, a statewide effort to combat opioid abuse and dependency. The Task Force consists of medical experts, drug treatment specialists, and government officials. The objective of this state initiative is to identify and implement strategies to address the growing opioid misuse and abuse across the state. Task Force priorities include reducing the number of opioid pills in circulation, improving access to high-quality treatment, facilitating data sharing, and education outreach.

- **Opioid Workforce Expansion Program for Professionals (OWEP)** enhances community-based experiential training focused on OUD and other substance use disorders for students preparing to become behavioral health professionals. The OWEP for Paraprofessionals NOFO funds this same training for peer support specialists and other types of behavioral health-related Paraprofessionals.

- **Oregon's Alcohol and Drug Policy Commission** is currently working on developing a strategic plan for reducing drug and alcohol addiction and increasing recovery rates in Oregon. The plan is due to be finalized in 2020.

- **Oregon Coalition for the Responsible Use of Meds (OrCRM)** collaborates with health systems, behavioral health, law enforcement, addiction treatment, and other stakeholders to advocate for policies that reduce the harms of opioid misuse.

- **Oregon Conference on Opioids + Other Drugs, Pain + Addiction Treatment (OPAT)** is an annual multi-day event where stakeholders, providers, leaders, and advocates come together to battle opioid abuse. This event was most recently held in Bend, Oregon on May 29-31, 2019.

- **Oregon Health Authority (OHA)** offers technical assistance and access to training for the addiction treatment workforce.

- **Oregon Recovers** is a coalition advocating for better addiction treatment and prevention across the state of Oregon.

- **Oregon State University** received a two-year grant from the USDA National Institute of Food and Agriculture. Beginning September 1, 2019, they will pilot a new outreach effort in mental health and substance misuse prevention in Tillamook, Lincoln, Baker and Union Counties.

- **Project ECHO (Extension for Community Healthcare Outcomes)** enhances the ability of primary care providers to treat chronic and complex illnesses in their hometown clinic and increases patient access to care. This program connects primary care providers with OHSU specialists for live, weekly video teleconferences to review complex cases.

- **State Mental Health and Addictions Services** staff can provide technical assistance and data.

- **U.S. Health Resources and Services Administration (HRSA)** provides resources and assistance to grant recipients.

- **Western Interstate Commission for Higher Education (WICHE)** provides technical assistance for HRSA grantees.

Challenges, Gaps and Needs

- **Diagnosing substance use disorder.** Substance use disorder (SUD) often presents itself under the mask of seemingly unrelated issues. Because the patient and provider are focused on solving the presenting problem, they may miss the root cause. Some providers also defer diagnosing a patient with SUD since there isn't help readily available to refer them to.

- **Workforce**. Tillamook County is designated as a Medically Underserved Area (MUA) and a Health Professional Shortage Areas (HPSA). These classifications, provided by the federal government, indicate the area has a shortage of health professionals for primary care, dental care and mental health care. Tillamook County is documented with a ratio of 490 residents per

mental health provider, compared with Oregon's ratio of 270 residents per provider. Despite the county's efforts to attract, recruit, and retain providers, there is still a demand for providers of mental health, substance abuse and primary care. Based on the need and recruitment efforts of Tillamook County's four main health care organizations, these are the most urgent workforce shortages in substance use and behavioral health care:

  - Certified Alcohol and Drug Counselors (CADC)
  - X-waivered prescribers (MD or NP) to expand access
  - PMHNP, or psychiatrist
  - Jail Clinician/Coordinator (LCSW/LPC)
  - Behavioral Health Clinician (LCSW/LPC)
  - Peer Support Specialists (Peer Recovery Mentors)
  - Behavior Health Manager

- **Barriers to treatment and recovery.** Crisis services are utilized at a very vulnerable moment in people's lives. Many barriers can prevent someone from benefitting from these services. Limited peer support, extensive paperwork, and lack of readily available post-treatment/follow-up recovery options all push people away.

- **Facilities and resources.** Two facilities in Tillamook County currently provide basic levels of detox support for withdrawal: the hospital emergency department and the County Jail. Neither of these facilities is an appropriate environment for managing withdrawal symptoms. Neither of these facilities have resources for individuals wanting to pursue ongoing treatment. Wait times to access an inpatient treatment program after withdrawal, all located outside of Tillamook County, can range from two weeks to a month. This is well outside of the typical window that someone is open and willing to take action in addressing their addiction.

  An additional barrier to accessing treatment is lack of insurance coverage options for treatment options closer to home. All too often, individuals are sent to programs in Eastern Oregon, far from their local social support, because that is the program or facility their insurance covers.

  Once individuals return to Tillamook County from treatment, they frequently rely on local recovery clubs for ongoing support. These local clubs, though established and reputable, are now experiencing barriers to sustainable funding because grant funding trends are focused on MAT and providing that level of support that is not attainable for some groups.

- **Stigma.** Tillamook County residents, like many others, approach addiction, poverty and homelessness with their own oversimplified understanding. There is a generalization that addiction is a moral failing rather than a disorder and that those seeking housing have long-standing addiction issues. Even in the recovery community those with opioid use disorder are frequently misunderstood or rejected because of stigma around medication-assisted treatment (MAT). Tillamook County has some community-based recovery groups focused on drugs and alcohol that don't share the same philosophical view of MAT versus complete substance abstinence. It is a topic that is highly sensitive and frequently debated.

Evidence-based Practices and Proposed Solutions

- **Easier access to treatment.** Treatment should be a welcoming process. As soon as someone decides to seek treatment, they need to be met with as few barriers as possible. Having a focus on streamlining will make sure that individuals aren't buried with paperwork, but instead

surrounded by support. Ideally, each person accessing treatment would be offered a peer to talk them through the process and provide responsive support.

- **Addiction and treatment referrals.** The hospital emergency department and county jail need a referral process. Neither place should be used as a detox facility, however, that is what is currently happening. Once someone expresses interest in treatment both facilities want to know where to refer them. Healthcare partners need to share information, so everyone knows what is available to the community at that time. After treatment referral, there will need to be an outpatient strategy for ongoing recovery which includes peer support, appointments and group counseling involving families.

- **Medication-Assisted Treatment (MAT) and support.** The most basic need is for more MAT options and making this service more accessible to county residents. However, RCORP Tillamook recognizes that infrastructure is key to ensuring effective MAT is offered to patients. That means providers are part of a support team with knowledgeable internal and external partners. For patients, it looks like receiving coordinated treatment from that team. This could be receiving complementary counseling and MAT while finding a local recovery support group.

- **Training and resources.** This solution would focus on training certain hospital and clinic staff about opioid use disorder and how to provide behavioral health support. This can help support the work of MAT providers. Other basic resources needed include having SUD consulting contacts for providers in criminal justice and the emergency department. Leaders in both law enforcement and emergency health services expressed the need for on-call advice and behavioral health support.

- **Education.** Erasing stigma is a lofty and long-term goal, but it needs to start now to have time to grow. Through community messaging and partnering with other local campaigns some broader, community-wide education can begin. This messaging could use local faces and success stories about living with substance use disorder and their recovery. Another education point is focused on people in treatment and recovery. RCORP Tillamook would like to see more peer recovery mentorship. It is important to have a connection with someone who has gone through treatment and can help alleviate some of the pressure of public stigma.

Theme 3: Harm Reduction and Education

Assets and Opportunities

Local

- **CARE** provides emergency services for those experiencing homelessness, and low-income individuals and families such as walk-in case management, temporary rental assistance, permanent housing units, utility bill assistance, and other emergency services.

- **Clatsop and Columbia Counties** are starting up a needle exchange program as a regional initiative.

- **Rinehart Clinic (FQHC)** offers a team-based approach to treatment, including a Medication-Assisted Treatment (MAT) program, hosting SMART Recovery meetings, and helping connect patients to resources that help address barriers to treatment.

Sources: Compilations of Community Resources in Tillamook County, as provided by:
http://tillamookbaycc.edu/wpcontent/uploads/2017/03/Tillamook_County_Human_Services_Resource_Directory.pdf

- **Tillamook County Community Health Center (FQHC)** currently co-prescribes naloxone and provides those patients with training on naloxone use.

- **Tillamook County Treatment Court** is a new initiative to Tillamook County which is not yet fully functioning but has support from the county, law enforcement, and community leaders.

- **Tillamook Family Counseling Center** is located in Tillamook with two other clinics in the county. Their specialties include women, DUII, gambling and intellectually developmentally disabled. Their behavioral health services providers offer screening, assessment, mobile crisis services, counseling, peer support, recovery mentors and SUD assessment, treatment and prevention.

Federal, National and State

- **Association of State and Territorial Health Officers** has created a series of opioid best practices for public health agencies and professionals.

- **Harm Reduction Coalition** offers online harm reduction training and multimedia resources.

- **Mental Health and Addiction Counselor Certification Board (MHACBO)** is the state certification board for mental health, addictions and peer support specialists. It offers regular training on evidence-based practices, which are open to anyone.

- **Northwest Addiction Technology Transfer Center (NWATTC)** provides services to develop and strengthen community-based implementation of evidence-based practices (EBPs) for substance use disorder treatment and recovery the treatment and recovery workforce in Alaska, Idaho, Oregon, and Washington.

- **Opioid Workforce Expansion Program for Professionals (OWEP)** enhances community-based experiential training focused on OUD and other substance use disorders for students preparing to become behavioral health professionals. The OWEP for Paraprofessionals NOFO funds this same training for peer support specialists and other types of behavioral health-related Paraprofessionals.

- **Oregon's Alcohol and Drug Policy Commission** is currently working on developing a strategic plan for reducing drug and alcohol addiction and increasing recovery rates in Oregon. The plan is due to be finalized in 2020.

- **Oregon Coalition for the Responsible Use of Meds (OrCRM)** collaborates with health systems, behavioral health, law enforcement, addiction treatment and other stakeholders to advocate for policies that reduce the harms of opioid misuse.

- **Oregon Conference on Opioids + Other Drugs, Pain + Addiction Treatment (OPAT)** is an annual multi-day event where stakeholders, providers, leaders, and advocates come together to battle opioid abuse. This event was most recently held in Bend, Oregon on May 29-31, 2019.

- **Substance Abuse and Mental Health Services Administration (SAMHSA)** offers an opioid prevention toolkit as well as no-cost CME courses.

- **U.S. Health Resources and Services Administration (HRSA)** provides resources and assistance to grant recipients.

- **Western Interstate Commission for Higher Education (WICHE)** provides technical assistance for HRSA grantees.

Challenges, Gaps and Needs

- **No needle exchange programs.** There used to be a needle exchange for many years but was discontinued 10 years ago. Now needles are often found in public places like park bathrooms. In Tillamook County, there are only three locations that people can dispose of medications and needles, and these locations often have limited availability.

- **Moral objection to harm reduction.** Harm reduction techniques face general opposition from the public. This is especially true for safe use sites because it is perceived as taking a stance on condoning use. Those who are not familiar with substance use disorder and some who are, feel that harm reduction allows or promotes continued substance use.

- **Misperceptions from courts and bar.** Legal practitioners may not understand that they have a role in preventing and responding to opioid use disorder. The courts have the unique ability to influence harm reduction by mandating strategies as a part of offender sentencing.

Evidence-based Practices and Proposed Solutions

- **Develop understanding and support with local courts and law enforcement.** Local attorneys and judges need to be educated on the treatment services available and what can be mandated, like medication-assisted treatment, etc. They also have a role in supporting consistent access to naloxone for law enforcement, those with opioid prescriptions, and other at-risk individuals. They should also be advocates to encourage support from the public for these practices.

- **Safe disposal and exchanges.** RCORP Tillamook wants to remove barriers to safe disposal of medications and needles. A focus on providing needle receptacles in public places like park bathrooms could be a natural starting point to eventually reintroduce a needle exchange program.

- **Work closely with Columbia Pacific CCO.** The overdose crisis response strategy task force could provide expertise and funding.

Conclusion

Tillamook County leaders and citizens recognize the pressing need for a collaborative effort to address the substantial opioid and substance use disorder challenge our community faces. Stakeholders and citizens in this rural coastal region have a strong history of coming together in times of natural disaster and community crisis to pool resources and identify a way forward together. The RCORP Tillamook consortium, larger workgroup, as well as other community partners and leaders recognize that this challenge is complex, will require a long-term approach, and must be addressed through an integrated and sustainable strategic plan. The process of compiling this needs assessment document has provided a significant starting point on Tillamook County's long-term journey to create a future of community well-being that meets a critical identified health need for addictions prevention, treatment, and support.

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Appendix:

NOTE: Some comments were edited to maintain anonymity and/or clarity.

RCORP Tillamook Key Informant Interviews

Process Summary

Qualitative data was collected by RCORP Tillamook consulting partners, Lines for Life. In the Fall of 2019, Dwight Holton and Donna Libemday with Lines for Life held eight 45-minute phone interviews with key informants identified by the RCORP Tillamook team along with a few members of the Columbia Pacific CCO team and Adventist Health. Interviewees were identified based on their involvement with RCORP Tillamook and their role in Tillamook County health care, and specifically substance and opioid use disorder services.

Questions during the interviews were open-ended with the intention of creating conversation. These were the questions that were addressed:

- What resources/services do you currently bring/provide to the Tillamook community?
- What challenges or barriers do you face in this community?
- What solutions or what do you wish for when you think about these challenges?

Topics discussed during the interview naturally separated by themes: 1) Pain management and prescribing practices; 2) Addiction, treatment and recovery; 3) Harm reduction and education.
Following those three themes, Lines for Life summarized, and bulleted key information, starting with the first interview. If a similar comment was shared by another informant, the number of times the idea was restated is noted at the end of the bulleted comment.

Pain Management & Prescribing Practices

Resources

- Till. Co. Community Health Center – Federally Qualified Health Center (FQHC)
    - Developed a plan on tapering down
    - Pain management contracts
    - Have own review committee looking at prescribing practices
    - All FQHC providers/behavioral health and dentists are trained and use Prescription Drug Monitoring Program (PDMP)
    - Educating patients on why and available options
- Adventist Health Emergency Department (ED)
    - Hired new midlevel physician's assistant
    - Surge capacity – nurses come in
    - Critical care/overdose flown out of county
- Adventist Health Clinics (2)
    - Chronic pain patients – contracts and work to reduce load of opioids
    - Practice Operations Council – monthly meetings, quality metrics, policy changes
        - Metrics: patient experience, provider experience, national benchmarks; prescribing by providers;
    - Grand Rounds: provider meetings, clinic site visits; townhalls
    - No MAT waivered doctors; but new Nurse Practitioner who is waivered.

Challenges /Barriers

- Prescribing
    - Not all in the county are on same page on prescribing guidelines

    - We have guidelines and policies but without resources, committing to shared prescribing practices is not a priority
    - Not screening for domestic violence
- Data
    - Data is not currently being pulled and shared with prescribers (2)
    - Quality improvement through data, is what we want but can't get to it.
    - Data issues on overdoses – Don't see many overdoses, because once diagnosed they leave. 3 ICU beds – rare to admit critical care/ overdose
    - Some data reports not beneficial: 23-27% of patient population; not detailed; doesn't exclude oncology
    - Record systems don't talk to each other (3)
- Resources
    - Short on Primary Care Physicians due to retirement; All providers live in Portland area; One pain specialist, one cardiologist.
    - Must depend on Emergency Dept and Primary Care (2)
    - No MAT waivered doctors at some facilities
    - Lack of resources. What do we do with chronic pain patients? How do we get patient satisfaction?
        - ED great for emergency care but chronic patients are a challenge. How much pain is SUD driven? Hard to identify SUD patient. (2)
        - Patients can't always be pain free
        - New patients coming into community on high loads of opioids
        - At the clinic level, supposed to be opioid free, where do the patients go? Balance is what we are looking for. You can't just turn high use patients down. Is there a transitional plan?
- Seniors
    - Assisted Living: elderly with pain issues have opioids taken away when they need them, not tapered down. Impact of opioid on elderly population and impact of decreasing them … moving to other drugs
    - Geriatric medicine needs to handle patients differently. Can't be in assisted living without a physician but can't get a physician to see them when still on high level of opioids

Proposed Solutions

- Partners of consortium prioritize and commit to addressing prescribing practices
    - Consensus to work together, continuous communication so all on the same page (2)
    - Data on prescribing practices is shared…share guidelines
    - data provide more detail, exclude oncology, differentiate acute, ongoing, chronic
    - Everyone in county use same prescribing guidelines (3)
    - Everyone in county use the PDMP
    - Get dentists engagement
    - No kids prescribed opioids
    - Building Block Assessment of clinic and prescribing
- Transitional plan for high use patients
    - Tapering clinic to serve as resource for providers (2)
    - Need different guidelines for seniors using opioids where others are administering medication, less risk
- Continuity of care from the jail (3)
- Alternatives for pain management (2)
- Screening for domestic violence during health care appointments and general services

Addiction, Treatment, Recovery

Resources

- Outpatient Therapy Services – divert from ED
- Till. Co. Community Health Center - FQHC
    - 2 MAT waivered doctors; Behavioral health manager to be hired soon
    - More of a harm reduction model then abstinence
    - Maintenance after induction phase is easier and working; learning to be more efficient and more successful in engagement
    - Providers use dashboards. OCHIN
- Adventist Health Tillamook
    - LCSW's embedded in each clinic, (not behavioral health integration team)
    - RN Care Coordinators – work with patients, handle team integration
    - CADC III and CADC I provide counseling
- CARE
    - Coordinated entry program: risk assessment asks about addiction; Tillamook Family Counseling Center primary referral because it opens door to other services; if detox, we help;
- Tillamook Family Counseling Center
    - Behavioral Health Services Provider: screening; assessment; mobile crisis services; counseling; peer support; recovery mentors; SUD assessment, treatment and prevention
    - Specialties: DUII, Gambling, intellectually developmentally disabled
    - Main office Tillamook, clinics – Pacific City, Rockaway Beach
- Serenity Club
    - 2 meeting rooms noon till evening
    - Provides fellowship, clean and sober functions for families to attend, BBQ social supports; safe place to rebuild families who lost custody; Safe spaces for supervision when visiting; safe place for kids…movie nights, etc.
    - Funded by sponsorships and grants – not faith-based

Challenges/Barriers

- Education on diagnosing SUD
    - without resources to refer to, providers won't spend time diagnosing
    - Presenting problem is not SUD, so treat presenting problem but not address the SUD disorder.
- Till. Co. Community Health Center MAT – seeing 25 patients. 1/3 internal; 1/3 referral; 1/3 people show up
    - Initially agreed to see 10 per provider but now above that #
    - Intensive up-front induction
- Stigma; ambivalent about poverty; addiction is a moral failing
    - Legal system may not understand how MAT/recovery works (2)
    - Philosophical difference between abstinence and MAT in community (2)
    - Not everyone seeking housing is in recovery, have long standing addiction issues
- Rural: resources and capacity. limited (2)
    - Primary care follow-up after ED, is 6 weeks out.
    - No beds available when someone is open and ready to address addiction. 2 weeks to a month out, they are no longer ready. (3)
        - ER is a revolving door; no place to refer for treatment; can't get placement
        - Lack of treatment facilities, Jail and hospital ED are only options right now
    - No short-term inpatient treatment. (3)
        - No residential treatment in your community is a big disconnect. No strong connections to a recovery community, no social supports.
        - Community emphasizes need for inpatient, but only one of many tools
        - Not having detox in our county… not able to help survivors needing detox

- If a patient is being held in ED TFCC placement, hospital ends up housing without reimbursement until placed
  - Record systems don't talk to each other
  - Can't get past bureaucracy and barriers for preserving reimbursement; need to get paid for services provided.
- Funding is limited and funding now coming through MAT. Puts our communities at odds. MAT kicked is in and now we have to do MAT to access funds. Recovery clubs need help financially…but should not all be required to include MAT

Proposed Solutions

- Rural: Addiction/ TX Referral
  - An infrastructure for where to send people to. Sharing of info between partners so know what is currently available.
  - ED advice (line/mentor) for rural communities; information/referral
  - Behavioral health resources for the ED
  - Behavioral health support – on call 24 hours a day – find inpatient bed, connect to services.
  - Tapering clinic to serve as resource for providers
  - Capacity building grant for getting integrated behavioral health capacity
- ED could be a portal to addiction treatment;
  - Buprenorphine induction possible if we have an infrastructure to support ongoing treatment
  - Outpatient Therapy Services could be a vehicle for helping with addiction since it is staffed by nurses.
- Strengthen relationship/Collaboration with Tillamook Family Counseling Center
  - Additional access points for treatment
  - Enough funding to support integrated support
  - Clinics handle medical portions of treatment and get reimbursed for buprenorphine. Need to be able to keep the patient and work with Tillamook Family Counseling Center to provide counseling portion of care

- MAT
  - Support staff to monitor MAT is what providers need
  - Be a part of a team. Prescriber wants to be a part of their portion of the care. Involved even if hand off for ongoing maintenance
  - Focus group (learning collaborative) on what the barriers are to using MAT – include MAT providers, behavioral health and support staff. (2)
  - Local buprenorphine prescribers and a local infrastructure to support.
  - Clinics do MAT and counseling in house, using LCSW or approval of CADC to provide counseling
  - MAT more accessible; more options
  - Think about how MAT is rolled out in Tillamook. MAT is the new thing that will work and so we put all our money into it, but maybe focus some money on things that have been and are still working
  - Respect all the hard work that has been done in this community for years…. Helping hands, ensure people and their work is honored and respected.

- Training
  - ECHO MAT practice training by CPCCO (too technical, need process not explanation.) (2)
  - Education plan including MAT for the steering committee
  - Education on diagnosing SUD
  - Could train ED nurses or nurse supervisors to provide behavioral health support (2)
  - Prev/educ when someone is prescribed is clear and thorough and opioids are last choice (2)
  - Computerized modules, online training

- Treatment Resources
  - Open inpatient treatment beds. When they say they are ready, we need to get them in (2)

- Increase resources for Criminal Justice addiction treatment and inpatient resources (2)
  - Continuity of care from jail back to clinics
- Outpatient transition: supports, peer recovery; connections, have appointment; families in group counseling; Salem Bridgeway model
- Detox; transition housing (2)
  - More comprehensive array of services…detox to outpatient

Harm Reduction & Education

Resources

- Till. Co. Community Health Center - FQHC
  - Train and Co-prescribe patients on use of naloxone
  - Needle exchange program starting up (regional initiative – Clatsop and Columbia)
  - Helping Hands reentry – 20-25 clean and sober
- CARE Current
  - Emergency services, Rapid housing; units for mental health; services for vets; homeless warming; one-time assistance, healthy families
  - Sometimes we have treatment personnel come to our office to help those who need it which can be very helpful, but a lot of paperwork which pushes the client away. We need someone that is responsive and can talk the client through the process, like a peer which can make a difference, however they only have one peer.
- Tillamook Family Counseling Center
  - Behavioral Health Services Provider: screening; assessment; mobile crisis services; counseling; peer support; recovery mentors; SUD assessment, treatment and prevention
  - Specialties: DUII, Gambling, intellectually developmentally disabled
  - Main office Tillamook, clinics – Pacific City, Rockaway Beach

Challenges/Barriers

- Had needle exchange for many years but went away 10 years ago.
- Resistance from Law Enforcement/ judicial to new framework
- Misperception (MAT and Naloxone) with courts and local bar – can't mandate
- All detox beds are in Portland (2)
- Moral objection to harm reduction, safer substance use sites.
- Park bathrooms have needles
- Enter CARE services at a very vulnerable moment, extensive paperwork pushes people away. Only one peer at Tillamook Family Counseling Center
- No post treatment/follow up recovery services. (2)
- Stigma: moral failure; ambivalence about poverty

Solutions

- Proposed
  - Develop understanding/support with sheriff and newly minted mental health court (2)
  - More education with local attorneys and judge
  - Remove barriers to access, naloxone, needle exchange
  - Clear Lake Model: shelter program for those active in addiction
  - A system that welcomes you into the treatment process, doesn't bury you in paperwork, with as few barriers and then wraps around you to support your recovery including housing. (3)
  - Funding for use of more peer supporters (2)
  - Needle receptacles in park bathrooms.
  - RX disposal

- Messaging/ campaign with local faces: success dealing with addiction; partner with other local campaigns; connect to broader community
- Overdose Crisis Response Strategy Task Force
- Recovery Supports: CCO is currently looking at opportunities here

Opioid Use Disorder in Tillamook County Survey

1. **What services do you currently provide to Tillamook County?**
   - Outpatient behavioral health services for mental health and substance abuse
   - Community mental health instructor.
   - Certified nurse's assistant
   - CADC/LPC with adult population, often mandated by corrections and child welfare.
   - Mental health peer support
   - Primary care provider
   - I work in a primary care clinic where we have integrated behavioral health and provide MAT services
   - Clinician with a specialization of addictions treatment for adults and teens referred by probation, child welfare, and voluntarily.
   - Dental treatment
   - A biblical-based, 12-step recovery program for community members, inmate population.
   - Mental health and substance abuse training
   - Mental health and substance abuse comprehensive assessment, treatment planning, outpatient cognitive behavioral therapy, case management and crisis response.
   - non-profit organization which provides a variety of 12 step meetings as well as the opportunity for fellowship and the safety of a supportive community
   - Family Navigator working with families on Temporary Assistance for Needy Families and involved with Child Welfare.
   - Mental health services (individual psychotherapy to children, adolescents and adults; couples and family psychotherapy), case management, psychiatric crisis intervention

2. **What are the most common problems you see related to opioid misuse, including heroin and fentanyl, in Tillamook County?**
   - Lack of access to MAT, lack of reliable transportation to treatment, inconsistent MAT programs throughout the county (each provider does it differently), no funding for outreach and engagement for people who are not enrolled in services already.
   - Health complications, limited access to services (transportation, hours, detox), loss of housing, unsafe/at-risk behaviors for adults/teens. Significant health difficulties when individuals try to stop. Another concern is the resistance of providers to address education around use/misuse as well as thorough assessments.
   - That the individual with OUD has no outside resources, such as housing, cognitive interventions and job resources.
   - Apathy; financial (even though there are job listings, criminal history interferes with hiring); homelessness; crime (not in any specific order); domestic violence
   - Little to no resources for harm reduction such as needle exchanges, access to Narcan, a safe, no-judgement drop in center to get a meal, a shower, mail, laundry.
   - The most common problem is a large percentage of clients seeking treatment also seek drugs due to, until recently, a lack of availability of MAT services in this county. Now, clients receiving MAT at the health department or Rhinehart Clinic have higher success rates.
   - Lack of resources for rehabilitation

- Homelessness, broken family units, negative impact on children, and criminal activities to support addiction.
- Jails, institutions, and death
- Relapse, needle sharing, hepatitis, infectious disease
- Depression with anxiety, PTSD, grief and loss
- It appears to be easy to obtain prescription and illegal drugs, lack of knowledge about real dangers of overdose, and lack of available inpatient treatment.
- Chronic use due to being started on pain medications, prescribed for long periods of time, then suddenly taken off them and people switch to street opioids. Heroin is a big one in this area, I am hearing about fentanyl, and opioid pain meds being sold
- The lack of long-term substance abuse treatment that is accessible and affordable

3. **Are there any prevention strategies that you think are working well to keep people from misusing opioids in Tillamook County?**
   - Education (2)
   - I don't know about any extant prevention strategies in Tillamook County (2)
   - Peer support through TFCC, 12 step programs, Celebrate Recovery.
   - The concepts around harm reduction and education of providers about prescribing or approaches to help address misuse.
   - No, not really. A lot of patients who come in are being kept as holds to be seen by Tillamook family health or they're being brought to the hospital under police observation which means that people are brought to the hospital to detox because we have no other place to take them.
   - New to the community: 2 more medical facilities have begun Suboxone/buprenorphine therapy and are making recommendation for active AOD treatment involvement.
   - Mental health education starting from a young age. A living wage so self-care can even be considered. Domestic violence and abuse education and prevention along with an importance placed on emotional intelligence.
   - None that I know of. I would like to see more information presented, or at least available, for the citizens of Tillamook County covering a wider audience than the population with prior or current difficulties. Doctors and MAT providers in the Portland area following best practices, and a concerted effort to educate adults, older adults, and anyone prescribed opioid medications that one can get physically addicted by following a provider’s prescription recommendations.
   - Building better law enforcement strategies.
   - Strictly limiting prescriptions
   - 12 step meetings, fellowship, and working with others with SUD/OUD
   - Suboxone, Naltrexone, etc.
   - Physician and patient education as well as intervention beyond a certain point.

4. **What is working well in Tillamook County for those seeking treatment and recovery?**
   - MAT programs (2)
   - 12-step programs and community (5)
   - Strong supports throughout the community, peer support

- When people will engage in groups and/individual sessions as well as community resources. Peer services are another component to help provide support with recovery. Another component that is helpful is parent training (PCIT, family therapy, Collaborative Problem Solving) that helps address family dynamics and changes in the family while working with young children about substance/addiction prevention.
- Recovery is a personal choice if you want, you work hard to make sure you can a achieve it. I just don't think Tillamook as a county has resources to offer the support for the family and person with addiction.
- When the client is expected to participate in treatment, it is very helpful. Provider communication with treatment providers.
- Our community loves, we collectively do our best to take care of each other. As far as our recovery and drug abuse prevention infrastructure nothing is working adequately, we have a handful of people working so hard with what we have but there just isn't enough resources.
- This agency has recently been working very well coordinating services with Tillamook County Health Department and The Rhinehart Clinic for MAT and our services. Recovery mentors have done a good job of assisting clients to set up a recovery lifestyle.
- Don’t know what programs exist.
- The collaboration between Tillamook Serenity Club and the jail
- It has to be a concerted approach from NA, AA, CR, and Tillamook Family Counseling Center and the legal system
- Referrals from PCP that is screening for substance abuse effectively
- Not much. Tillamook and Lincoln County need access to detox and inpatient substance abuse treatment for continuity of care.
- Peer support through TFCC, 12 step programs, Celebrate Recovery, Counselors
- Unsure as most patients seem to have to leave the area for treatment

5. What barriers do you see that keep individuals from seeking or receiving treatment?

- no detox in our area, no residential options in our area. (2)
- Lack of information, denial of their addiction, shame, negative peers who support their continued use of drugs, loss of hope, homelessness, lack of consistent phone
- Cost, access, prohibitively long wait lists for residential treatment
- Severely limited knowledge of services in the county as well as limited resources for detox when a person is willing.
- Lack of referrals to 12 step meetings.
- Housing financial stability and in-house treatment that is longer and more intense. It needs to identify the cause of why a person uses. what are the core issues? we need patients who seek outside counseling along with in house help.
- High drug using affiliation interferes with motivation for utilizing treatment and recovery resources effectively.
- Diversion of Suboxone as means of financial support; and/or avoiding withdrawal from heroin/opioid.
- Access to Resources. If someone gets to the point they are ready to go to treatment, there is nothing nearby. There is a critical window in which we must get someone to a facility. Finding one with an open bed let alone one compatible with insurance is even more difficult, if they have insurance at all. I have had colleagues drive people 7 hours to treatment over 500 miles!
- Clean and sober housing is hard to find. Alcohol and drug free housing is hard to find. There are often levels of drug induced psychosis associated with opioid addiction that is rarely identified or disclosed.

- Finances
- Accessibility
- Mental illness, codependency, long term suboxone illegal use
- Pain, both physical and emotional, stigma, and providers generalizing the substance abusing population and homelessness.
- Unrealistic or inappropriate timelines for assessment and appointments
- Only one addiction service provider
- Transportation, childcare, inadequate health insurance/no insurance, long wait times for detox/residential treatment, very few quality mental health services, poverty, absence of a drug court, codependent/toxic relationships, stigma, lack of support from their employer

6. **What changes have you seen related to overdoses in the last three years?**
   - Limited exposure to this information other than parents or families reporting concerns for family members.
   - I see patients come in because they don't have the ability or foresight to see a different way of life. Choosing to end it all seems to be an easier way to handle problems at hand.
   - Increase of heroin (since less prescribing of opioid by provider), and reports that the 'drug is not the same' giving cause for concern of other substances being mixed, as Heroin and Methamphetamine
   - Overdoses has increased exponentially.
   - We continue to see a rise in overdoses- some have been saved through the use of Narcan and some through other interventions.
   - I am aware of families of heroin addicts who have Narcan, with some who have used it to revive their adult children more than once
   - Not many changes
   - increased Narcan availability but we need more.
   - Hospitalizations for infectious disease
   - Officers carrying Narcan, PCPs referring patients to LCSWs with their CADCs for continuity of care.

7. **Have you ever used naloxone/Narcan? How often?**
   - No (11)
   - I have carried it with me at all times for the last year. Thankfully I have not yet had the need for it. Naloxone that I have brought home from trainings in Portland and given to users have saved lives at least twice.
   - Clients? yes
   - I have prescribed only as needed use
   - In tandem with PCP
   - I have not, but we regularly prescribe it
   - Some of our members would be interested in certification.

8. **What are three things that you believe would have the most impact on addressing opioid misuse in Tillamook County?**
   - Increased supports for services of harm reduction, recovery and peer support services with group treatment. (3)

- Naloxone distribution/needle exchanges (2)
- Quality mental health services for all ages (i.e., long-term and intensive psychotherapy offered by skilled clinicians) (2)
- Funding for more outreach that did not require a person to be enrolled in outpatient services, more MAT/consistency among MAT providers and programs
- Education for prescribers/providers
- Detox centers and rehab facility
- Counseling that meets the needs of individuals
- Housing and jobs that can work with the individual. the hospital needs to stop being a facility that detoxes
- Increased invested interest of law enforcement and legal system for reducing the problem, rather than just arresting. IE: drug court
- Increased invested interest of law enforcement for requiring in custody utilization of treatment.
- Financial support for agencies that offer 12 step meetings as well as treatment centers
- Increased Federal/State funding to provide these services.
- Having agencies work together with more interaction and communication and add resources for housing, support network, case management, recreation, and reaching out to family to include them more whenever possible.
- Proper diagnosing and setting correct patient expectations for pain management.
- Reaching families and children before they start using nicotine, alcohol or pot.
- Affordable housing that's safe, adequate, clean, etc
- Prayer, building healthy family structure, stronger law enforcement halfway housing
- Drug court, decriminalization of non-violent crime, treatment facility, CADC education at community college
- Education, counseling, access to detox and housing
- Short-term rather than long-term use of medically assisted treatment
- Referrals to 12 step meetings
- Doctors aware of overprescribing and having alternatives to chronic pain management.
- Keep the resources in the public eye for those who want and need help to get out of their addictive cycle.
- Free long-term residential treatment (> 6 months)

9. If there is anything else that has not been mentioned in the above questions that you would like to share, please include it here.

- Addressing opioid use is not just about the opioids but the system and cycle; providing education to providers/families/community partners/clients about trauma-informed approaches is vital to allowing for disclosure of use as well as engagement in reduction or elimination of at-risk behaviors. Recognizing that there are several services being provided in the county yet not being referred to by community partners is also a barrier for those contemplating change.
- Hospital-based providers can't treat the reason why someone uses, they can treat the aftermath because someone uses, however empathy is lost after a while. The core ability to want to see a person succeed when continuing to come through the doors with the same issue that may have brought them here two days earlier.

- Self-referrals without any mandates have significant lack of support to get sober, due to other substance users in the home IE: alcohol/THC. The perceived criticism from their other family members interferes with motivation to pursue treatment. Social norms may play a bigger part in the challenge than the community is willing to acknowledge, as every fund-raising event is promoted by advertising available alcoholic beverages. Another concern is the lack of emotional/debriefing support for the population that provide services to children and adults, from school teachers to EMS, including law enforcement.
- I hope meth can also be addressed, since many of the adults and teens I have worked with use meth and heroin.
- Housing is a major factor that must be addressed. it's hard to stay sober when you have nowhere to stay.
- In any effort like this there are two things that must happen to be successful ; 1) Look to other communities with similar size and demographics to see what works, and 2) To think outside the box - all too often people with good intentions look for what is available or easily initiated because they feel better when their efforts pay-off and ignore what could be possible if others are consulted and given credit for their effort including, and perhaps especially, the clients that we serve.
- Treatment programs need to be long term – one+ years to allow physical healing of the brain
- We would like to see more collaboration between agencies and groups offering help to end addiction and support suffering addicts in pursuing recovery
- Prescribers educating themselves about the benefits of alternative medicines such as marijuana to treat pain and anxiety.