CHASE: FAQ for County Commissioners

What is the status of the project proposal and if awarded when might this study begin?

- Part of a major federal initiative to impact the opioid crisis through collaborations with community and academic partners.
- National Institute on Drug Abuse (NIDA) will announce the awards on April 1st.
- 3-4 projects (out of 11 proposals submitted) will be funded nationally (only one per state).
- Site visits between February 15th and March 25th (date for CHASE to be determined).
- This 4-year project is scheduled to start in May 2019.

Understanding the CHASE Model

What does CHASE stand for?

- CHASE ="County-system Hub And Spoke Empowerment" model

What is the CHASE Model?

- CHASE will work with county government units to deliver a comprehensive intervention package that will prevent use of opioids, treat addiction and promote recovery.
- To achieve this, CHASE will establish and support primary care and drug treatment settings (Hubs) in each county.
- Hubs will work in tandem with a wide range of other community organizations (Spokes) to adapt including behavioral health, emergency departments, law enforcement, jail, schools, etc.
- Planning and implementation of the Hub and Spoke network and adaptation of interventions will be guided by county-level CHASE Community Advisory Boards with leadership by the County Health or Mental Health Commissioner.

What outcomes is the CHASE model expected to achieve?

Primary Outcome:

- A 40% reduction in opioid-related overdose deaths in each selected county

Secondary Outcomes:

- Enhanced numbers of providers treating opioid use disorder with medication assisted treatment (MAT) including buprenorphine, methadone and naltrexone
- Increased number of people and community based organization trained to administer naloxone and provide overdose education
- Reduced number of non-fatal overdoses
- Increased numbers of people accessing MAT and other drug treatment
- Increased identification of people with opioid use disorder
- Reduction in number of people progressing to opioid use disorder

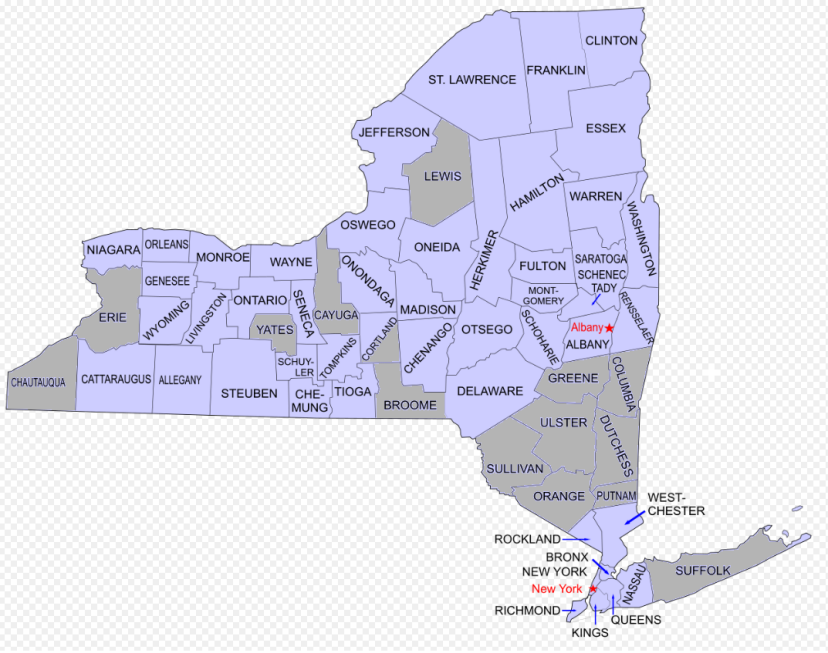
What is so different about CHASE from other initiatives to reduce opioid use?

The CHASE Model:

- Encompasses and links a broad range of evidence-based interventions to prevent and treat opioid misuse at multiple levels, including patients, providers and health systems.
- Builds upon and collaborates with the existing county-level relationships across the delivery system, allowing for maximum local control and adaptation
- Continuously assess the implementation of the intervention activities and outcomes across all CHASE components to support real-time data-driven problem solving and local adaptation of strategies.

Why was our county selected to participate in CHASE?

- To be eligible for CHASE, the annual county death rate for opioid use had to exceed 25/100,000.
- Using state data, we identified 15 New York State counties in the top quartile of opioid use deaths. Across these counties, the death rates was 27.0/100,000 in 2016 and 28.2/100,000 in 2017.
- We plan to include the following highlighted counties:



Can you provide an overview of how this will work?

- CHASE will provide funding to designated health, mental health or similar County Office responsible for addressing opioid use to conduct study activities.
- CHASE will offer a package of evidence-based prevention and treatment strategies to reduce opioid-related deaths (see Appendix 2 below).
- The local Community Advisory Board, including representatives from all Hub and Spoke organizations as well as other key stakeholders will work with the County Office to identify priorities and plan local strategies.
- Funds to address priorities will be awarded to Hubs and Spokes by the County Office.

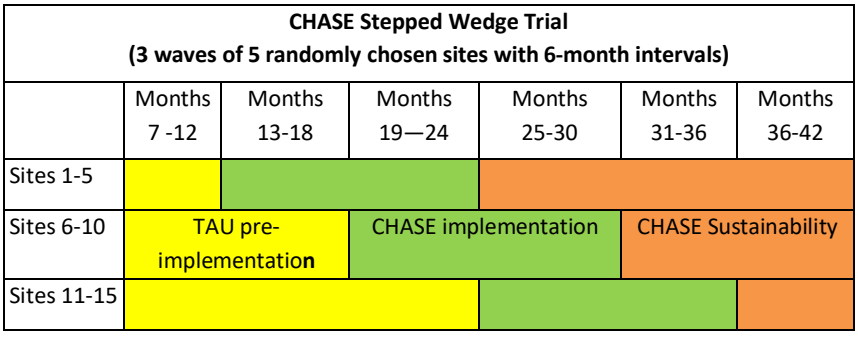
- Grant funds will be used to hire staff in the County Office to provide directly or access technical assistance and support to Hubs and Spokes.

How will the research team work with CHASE to gather data for planning and monitoring outcomes?

- Work with County Offices and Community Advisory Boards to tailor CHASE to each county's unique population, health systems, and sector needs.
- Create interactive, county-specific public health dashboards that will house real time data on fatal and non-fatal overdoses in the county as well as prevention and treatment outcome data to guide implementation of strategies and allocation of resources in order to target each point in the opioid use cascade.
- Monitor whether interventions and strategies are implemented properly and working as intended.
- Survey and interview staff at the County Office and in Hubs and Spokes to capture their perspectives on CHASE.
- Provide on-going feedback on factors that may be facilitating or impeding the reach, impact and sustainability of interventions.
- Monitor the incremental costs of CHASE vs. treatment-as-usual (TAU) in each county.

What is the study design and how will the counties be randomized?

- All 15 counties will participate in CHASE.
- Start-up activities such as hiring, baseline data collection, and organizing the Community Advisory Board will begin prior to initiation of CHASE in each county.
- Treatment as Usual (TAU) Pre-implementation (data collection and capacity building) will begin in all sites in month 7.
- We will roll out the CHASE package of evidence based interventions (EBIs) in three waves, five counties at a time. This is called a stepped wedge study design. Waves will occur at six month intervals, starting in Months 13, 19 and 25. Each county will be assigned at random to one of the three waves. All counties will implement CHASE for at least18 months or longer. The last 6 months of the study (months 42 to 48 will be reserved for data analysis, preparing publications and disseminating study findings. The following graph explains the stepped wedge:



What resources are available through the project period?

- The grant will fund each county to implement and monitor a package of evidence based

prevention and treatment interventions (see below) for opioid misuse to be carried out by hubs and spokes.

- Total funding will vary based on the size of each county and the wave to which each county is randomized, with an average of $2 million over 4 years of project implementation.
- The grant will provide funding for a project director, whose responsibilities are to coordinate all project implementation activities and a data manager/epidemiologist to facilitate data collection and management with all organizations in the CHASE hubs and spokes and with data sources for the dashboard.
- During CHASE implementation, the grant will provide funding for a community engagement coordinator, a clinical coordinator, a training and technical assistance coordinator, a nurse care coordinator and peer navigators.
- Technical assistance and training will also be provided both by the research team and providers engaged from federal, state and local resources, e.g. NIDA, OASAS, DOH and Medicaid, etc.
- Funds will flow to County Offices prior to hiring staff or awarding funds to Hubs and Spokes.

What are the roles, responsibilities and requirements of the County Health or Mental Health Commissioner?

- CHASE places the County Health or Mental Health Commissioner at the head of the implementation effort.
- The Commissioner will oversee the CHASE budget, the County Community Advisory Board and other community engagement efforts.
- With ongoing input from the County Community Advisory Board, the Commissioner's Office will select the package of evidence based interventions and disburse funds to support CHASE.
- Staff roles in the Commissioner's Office supported by the CHASE grant will include:
- The CHASE Director in the County Office will organize daily operations and will be responsible for organizing and leading the Advisory Board with the County Commissioner.
- A CHASE Data Manager and epidemiologist will assist in the data collection design and collection.

What other technical assistance and support will be available from the research team?

- The research team will provide support for all other project activities, including organization of the Community Advisory Board, data collection, protocol development for MAT, engagement of prevention providers, etc.
- For example, the research team will provide expertise and training on Buprenorphine, protocol development for jails and emergency rooms, and stages of Community Advisory Board development.

How much discretion do County Offices have in use of funds directed to this county?

- Some funding will be directed to carrying out specific types of interventions. Other funds will be discretionary and can be used for locally identified priorities with input from the research leadership and the Community Advisory Board.

- There will be room to adapt all interventions to fit the current situation in each county.

How do you envision setting up, initiating and operating this program in my county?

- The study will follow a timeline described above with particular activities that will be guided by the research team.
- The main phases include: Start Up, Pre-implementation, Implementation
- The chart below includes sample activities that will need to occur during each phase.

Project Phase	Task	Responsible
Start-up	• Contracting with counties • Hiring of project staff or effort assignment • Development of Community Advisory Boards (CABs) • Selection of Hubs and Spokes and contracting • Data collection to inform dashboard design	Commissioners
	• Assessment of county readiness for CHASE and training and technical assistance needs • Collaborating on data sourcing and dashboard development • Development of a computer assisted SBIRT tool	Research Team
Pre-implementation	• Assessment of current state of OD prevention and fit with CHASE • Development of protocols as needed in Hubs and Spokes • Participation in training and technical assistance activities	Commissioners CABs External resources
	• Conduct assessment and data collection of current state of opioid response by county • Prepare sites for CHASE intervention implementation • Implement Data Dashboard	Research Team
Implementation	• Model implementation • Supporting the Hubs and Spokes collaboration	Commissioners CAB
	• Data collection including data to capture the "process" of implementation and barriers and facilitators of the chosen evidence-based interventions.	Research Team

How can and should CHASE be integrated with our other on-going and planned SU programs and initiatives?

- CHASE is meant to complement and to build on existing efforts in each county, as well as to streamline data collection among all of these efforts.
- Integrating CHASE into existing SU programs may mean making slight modifications in those program activities.
- We will also ask that existing programs incorporate some data collection with CHASE requirements to augment their current system.

Managing Hubs and Spokes

What are the different roles of Hubs and Spokes?

- Hubs will be FQHCs, substance abuse treatment providers or other medical organizations, which have the resources to coordinate and provide treatment for OUD.
- In the Hubs, care coordination of opioid use disorder patients will be implemented by nurse coordinators and peer navigators along with recovery and treatment providers (e.g. Waivered MAT providers, recovery coach, CASAC)
- Hubs will link patients to Spokes that provide recovery, harm reduction, mental health and social services.
- Hubs will also receive referrals from Spokes such as jails and emergency rooms.

Who is responsible for identifying and mobilizing hubs and spokes?

- Commissioners will select hubs and spokes to participate in the CHASE model with input from the Community Advisory Board and research leadership.

How will selection occur? Will there be bidding? Who decides?

- The investigative team will provide criteria for hubs and spokes to ensure consistency across the research design. However, the final selection of hubs and spokes will be a collaborative process between the county leadership, the Community Advisory Board, and the researchers.
- Depending on procurement rules in each county, counties may choose certain staff be paid directly by the research institution and others by the county health or mental health commissioner with county approvals.

Who will be providing technical assistance and training to these organizations?

- Technical assistance will come from the investigative team, as well as existing technical assistance resources.

Are we able to expand or modify the model during the project?

- Yes, we expect that the model will be adjusted and optimized for each county using a data-driven approach. These changes will be documented to ensure research integrity.

How are organizations expected to report on their activities and outcomes?

- The investigators will provide standardized forms, instruments, and relevant training. All data collection will consider existing personal data protections as required, and designed to reduce intrusion as much as possible, e.g. using on-line collection.

How do we handle a partner that is not performing?

- The investigator team and Community Advisory Board will advise on specific situations that arise such as this. In general, a non-performing partner should be understood from a real world perspective and barriers and facilitators addressed. Our goal is to learn together about the model's implementation.

Data and Reporting Requirements

How will performance at the county level be monitored?

- We will compare outcomes in participants exposed to CHASE and those not exposed using aggregate county-level surveillance data on outcomes by gender and race/ethnicity.
- We will also conduct systems-level data tracking of quantity of services and interventions delivered in the county at the spokes (e.g. jails, EDs), working through the County Office's Epidemiologist.

What types and sources of surveillance do you require?

- County Commissioners in NYS are charged with collecting and monitoring all surveillance data related to opioid epidemic in county townships and, thus, are ideally structured to serve as "back bone" organizations to Hub and Spoke systems.
- NYS has a coordinated surveillance database for the opioid epidemic (www.health.ny.gov/statistics/ opioid) and will provide our main source of primary outcome data. State sources listed here provide nearly all of the outcome measures required by the RFA.
- Deaths and cause of death are tracked by the NYS Vital Statistics Service (NYSVS), and we will use deaths involving any opioid as our primary outcome measure – opioid overdose deaths across 15 NYS counties.
- Source of data for secondary outcomes include NYS Statewide Planning and Research Cooperative System (SPARCS), OD Mapping, NEXIS 3, Syndromic Data and OASAS treatment data.

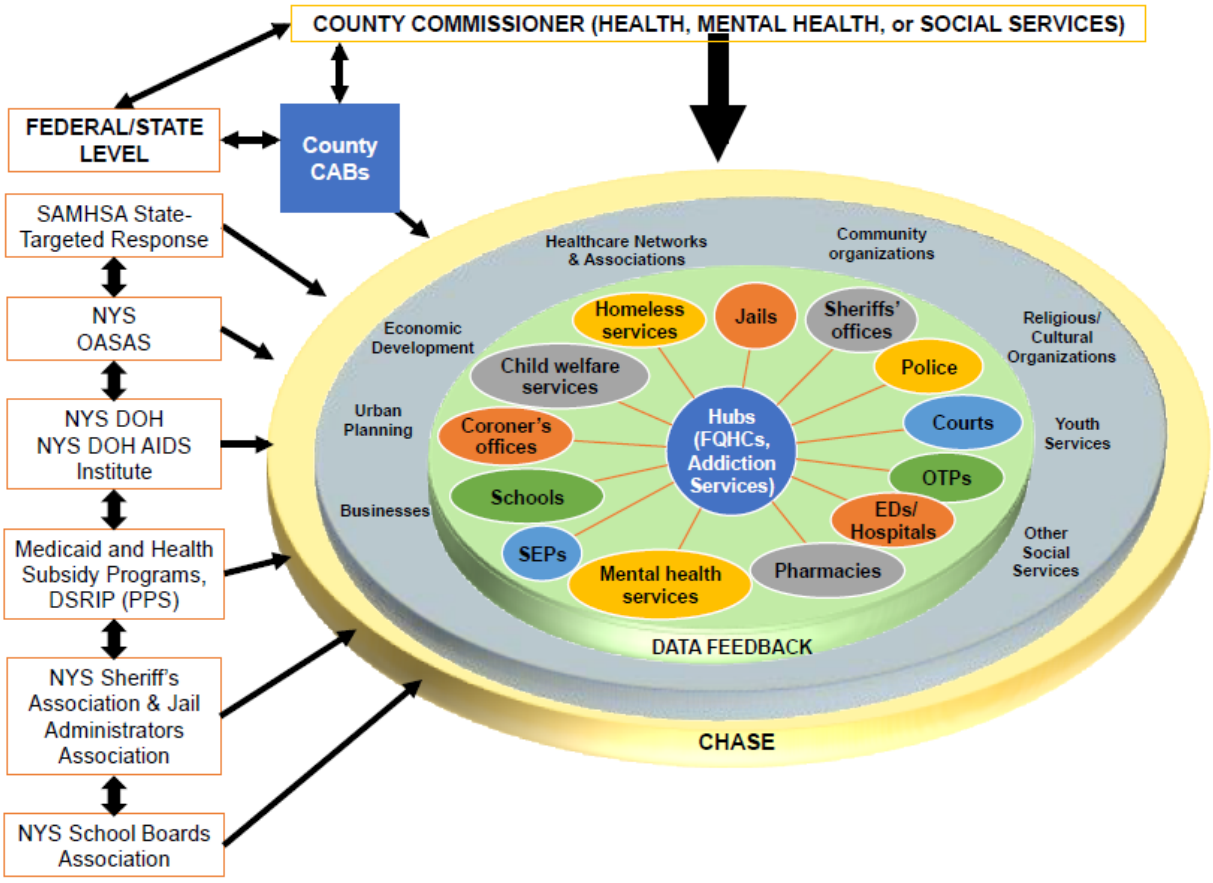
How and how frequently are we expected to report on project activities?

- Most program level reporting will be monthly while research implementation data will be primarily reported in six month periods. The research team will work closely with the county health or mental health commissioner to makes sure instruments are well understood and reporting plan well integrated.

Appendix 1: CHASE Model

The following chart provides a closer look at the entities involved in the hub and spoke model on a county level:

Figure A.1 CHASE Model



Appendix 2: The CHASE Intervention

CHASE consists of a package of evidence-based interventions. These interventions focus on both prevention and treatment of OUD, and are intended to be implemented across a wide range of partners in each county. Some of the CHASE interventions are marked as mandatory and others are optional. The county leadership, in conjunction with the county community advisory board and research leadership, will select the most appropriate strategies for their particular county's readiness and needs.

The following is a list of the mandatory evidence based interventions included in CHASE. All counties will implement these interventions:

Modified Hub & Spoke Community Collaborative to increase access and capacity for Medication for Opioid Use Disorder (MOUD) delivery

County-level intervention (providing an umbrella to support the implementation of other EBIs); identify 1-2 key community organizations with Medication for Opioid Use Disorder expertise and/or capacity (e.g., FQHC, other primary care providers, specialty addiction program) to act as centralized treatment provider; spokes are less experienced organizations (e.g., office-based opioid treatment [OBOT]), primarily linkage organizations (e.g., ED, inpatient) or provide adjunct services (e.g., behavioral health, harm reduction, housing, employment). In addition, hubs will be linked to schools, jails and other justice settings to support as needed. All hubs and spokes will be provided technical assistance to support implementation, including collaborative care addiction teams (e.g., nurse care manager model) that will provide Medication for Opioid Use Disorder with the continuum of HIV/HCV prevention, testing and treatment services. The collaborative care model will also identify high-risk Medication for Opioid Use Disorder patients who will be linked to behavioral therapies, harm reduction, mental health and social services using peer navigation as needed. Specific focus will be on developing capacity within FQHC or other primary care networks to increase capacity to deliver Medication for Opioid Use Disorder so that every county has sufficient coverage for all the county residents with OUD. This model is supported by Vermont's Hub and Spoke[1,2] and other versions of organizational collaboration[3].

Justice setting: screening and Medication for Opioid Use Disorder

Build capacity within justice settings to deliver best practices: using a computerized screening, brief intervention, referral to treatment tool (SBIRT) for OUD and other substance use disorders (SUDs) that may be administered by individuals or by providers/peer navigators, initiating Medication for Opioid Use Disorder, including all three FDA-approved medications, continue Medication for Opioid Use Disorder for individuals entering jail, delivering Medication for Opioid Use Disorder pre-release as well as conducting routine HIV/HCV testing and treatment, linking individuals to peer navigators and strengthening linkages to treatment at re-entry. This package of best practices is supported by numerous research trials including: Kinlock et al., 2007; 2008[4,5] (methadone initiated prior to release results in better outcomes); Magura et al., 2009[6] (Buprenorphine-initiated prisoners more likely to report to post-release treatment compared to methadone); Springer et al., 2012 [7] (Buprenorphine at re-entry improved viral suppression

outcomes); Gordon et al., 2014[8] (prison-initiated Buprenorphine associated with post-release treatment entry); Rich et al., 2015[9] (Methadone continuation in prison associated with greater treatment engagement post-release); Springer et al., 2015; 2018 [10,11] (XR-naltrexone for justice-involved PLWH improved viral suppression); Lee et al., 2016[12] (XR-naltrexone associated with lower opioid relapse among justice-involved); Friedmann et al., 2018 [13] (pre-release XR-naltrexone increased retention in treatment and abstinence); and Green et al., 2018 [14] (reductions in fatal OD in RI after statewide Medication for Opioid Use Disorder implementation in justice settings).

ED screening, Medication for Opioid Use Disorder, peer navigation

Build capacity within emergency departments to implement computerized assisted or self-paced SBIRT tool for OUD and other SUDs, Medication for Opioid Use Disorder induction (initiating buprenorphine), warm hand-offs or strong linkage to community treatment at discharge (e.g., within 72-hours), utilizing rapid response peer navigation to support linkage to treatment with Overdose Education and Naloxone Distribution (OEND), and outreach to social networks[15]; "bridge" clinics within the hospital system to manage patients waiting for community referrals and linkages will also be explored[16].

Community-based Overdose Education and Naloxone Distribution (OEND)

All hub and spoke sites in the 15 NYS counties will be trained and certified to provide OEND with free naloxone kits to their clients and family members by the NYS DOH Opioid Overdose Prevention Program (NYSOOPP). The Overdose Education and Naloxone Distribution strategy for CHASE will be data-driven based on real time data on GIS location of fatal and non-fatal opioid overdose and feedback from community. This strategy will target social services, networks of people with Opioid Use Disorder, friends and family, harm reduction settings, EDs and justice settings and utilize rapid response navigators to provide Overdose Education and Naloxone Distribution to social networks who have overdosed (e.g., referrals by medical examiner, first responders, EDs) and overdose hotspots along with providing computerized assisted or self-paced SBIRT for Opioid Use Disorder and other Substance Use Disorders. Focus on increasing training and distribution capacity, increasing accessibility and managing cost. Scale up of community-based Overdose Education and Naloxone Distribution is associated with significantly reduced rates of opioid overdose deaths[17]. Overdose Education and Naloxone Distribution is feasible among justice populations[18] and associated with reductions in prisoner overdose deaths[19]. Social media (e.g., SubReddit) to outreach to people with Opioid Use Disorder.

Peer Navigators and Recovery Coaches

Expand capacity for employing NYS certified peer navigators (i.e., trained individuals with a history of addiction and recovery) to support prevention, treatment, and recovery efforts, including within community-based treatment settings (e.g., to support retention, abstinence, and psychosocial services), in EDs, inpatient settings, justice settings, and harm reduction settings. Peer navigators will be trained to administer Overdose Education and Naloxone Distribution, computerized Opioid Use Disorder and Substance Use Disorder SBIRT tool with linkage to hubs for Medication for Opioid Use Disorder and other services in spokes. Emerging research demonstrates promise that peer recovery coaches may enhance engagement in care, relationships with providers, and promote abstinence, including among justice-involved populations[20–22].

Communities That Care (CTC)[23]
The Collective Impact (CI) framework was used to guide the design of Communities that Care; it was found to be effective in reducing substance use and increase abstinence among youth in a randomized trial[24]. Consistent with Collective Impact and Communities that Care, counties will be able to select evidence-based prevention EBIs utilizing local data to identify risk and protective factors. The 5 phases of the Communities that Care intervention map well onto theoretical and conceptual frameworks used to implement CHASE and include readiness, organization, assessment, action planning, and implementation planning and evaluation[25]. Evidence-based prevention interventions which may be selected by communities include Life Skills Training[26,27] and Strengthening Families Program, a SAMHSA model program (e.g., Spoth et al., 2008[28]).

Prescription opioid dosing guidelines are intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose[29].

Prescription take-back programs will provide a safe, convenient, and responsible means of disposing of prescription drugs in each township in the county, while also educating the general public about the potential for abuse of medications

Stigma reduction
Comprehensive Package for Reducing Stigma and Discrimination in Health Facilities (HIV specific adapted to OUD)[30–32]; specified for health systems and other organizations.

The following are recommended evidence-based interventions that can be implemented at the discretion of each county:

Pre-incarceration diversion
Support best practice alternatives to incarceration within drug treatment courts (e.g., 141 in operation throughout NYS) and enhance availability of opioid-specific courts (e.g., Buffalo Opioid Intervention Court)[33].

Pediatric primary care
Support SBIRT and Medication for Opioid Use Disorder delivery for adolescents and young adults. Recent research and professional organization guidelines support the timely receipt of Medication for Opioid Use Disorder among youth, including in primary care and developmentally appropriate addiction treatment settings[34,35].

Medical inpatient screening and Medication for Opioid Use Disorder
Build capacity for computerized assisted or self-paced SBIRT tool for Opioid Use Disorder and other Substance Use Disorders, Medication for Opioid Use Disorder induction (development and

utilization of addiction consult service), and warm hand-offs/linkage to care (or utilize a bridge clinic model; e.g., Massachusetts General Hospital pilot) during inpatient stay (e.g., infectious disease, psychiatry, orthopedics). Research indicates induction onto buprenorphine is superior to detox for treatment linkage[36] and using addiction consult services are feasible for diagnosis, Medication for Opioid Use Disorder initiation, and linkage to care[37]. Englander et al., 2017[38] found a multi-component hospital intervention successfully reframed provider attitudes towards Medication for Opioid Use Disorder delivery.

First responders: identification of OUD and OD/linkage to care

Explore and develop the capacity for utilizing post overdose outreach and follow up procedures. These may include multidisciplinary team visits to individuals who have experienced overdose (e.g. post overdose response teams in OH), police-initiated post-overdose visits with the goal of liking individuals to treatment, clinician outreach, location-based outreach[39], and rapid response peer navigators[15].

Use Police Assisted Addiction and Recovery Initiative (PAARI), as implemented in Gloucester, MA[40] also known as "Angel Program"). Police-led treatment referral program found to be feasible, acceptable, and effective in initial treatment linkage (although this was primarily detox).

Explore and utilize, as needed, "safe stations" (e.g., Manchester, NH) whereby walk-ins to fire houses are linked directly to treatment.

Recovery-oriented systems of care

Promote recovery-oriented systems of care by offering comprehensive treatment and recovery services within treatment organizations.

OUD Awareness

Prevention and treatment messaging for patients (primary care, schools, harm reduction settings) and community members to raise awareness of Opioid Use Disorder, misuse prevention, and treatment availability, risks of overdose, importance of OEND, and access to CHASE. Pre-existing effective social media and marketing campaigns will be available for modification (e.g., SAMHSA-compiled media campaigns on prescription drug and opioid misuse

Additional Resources:

The following is a partial list of topic areas that can be addressed with additional resources provided in conjunction with NIDA, ASAM, SAMHSA, OASAS, CDC and NYS to implement the CHASE model:

Overdose Training Resource, Pain Management, Prescribing Guidelines and Training, Social Marketing, Anti-Stigma, Policy, Housing, Prevention Training For Schools and Adolescents, HIV Related, OUD Treatment, Buprenorphine, Naltrexone, Building Motivation, Retention, Certified Training Recovery, Navigation, Screening and Assessment, and Treatment For Special Populations, Pregnancy

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