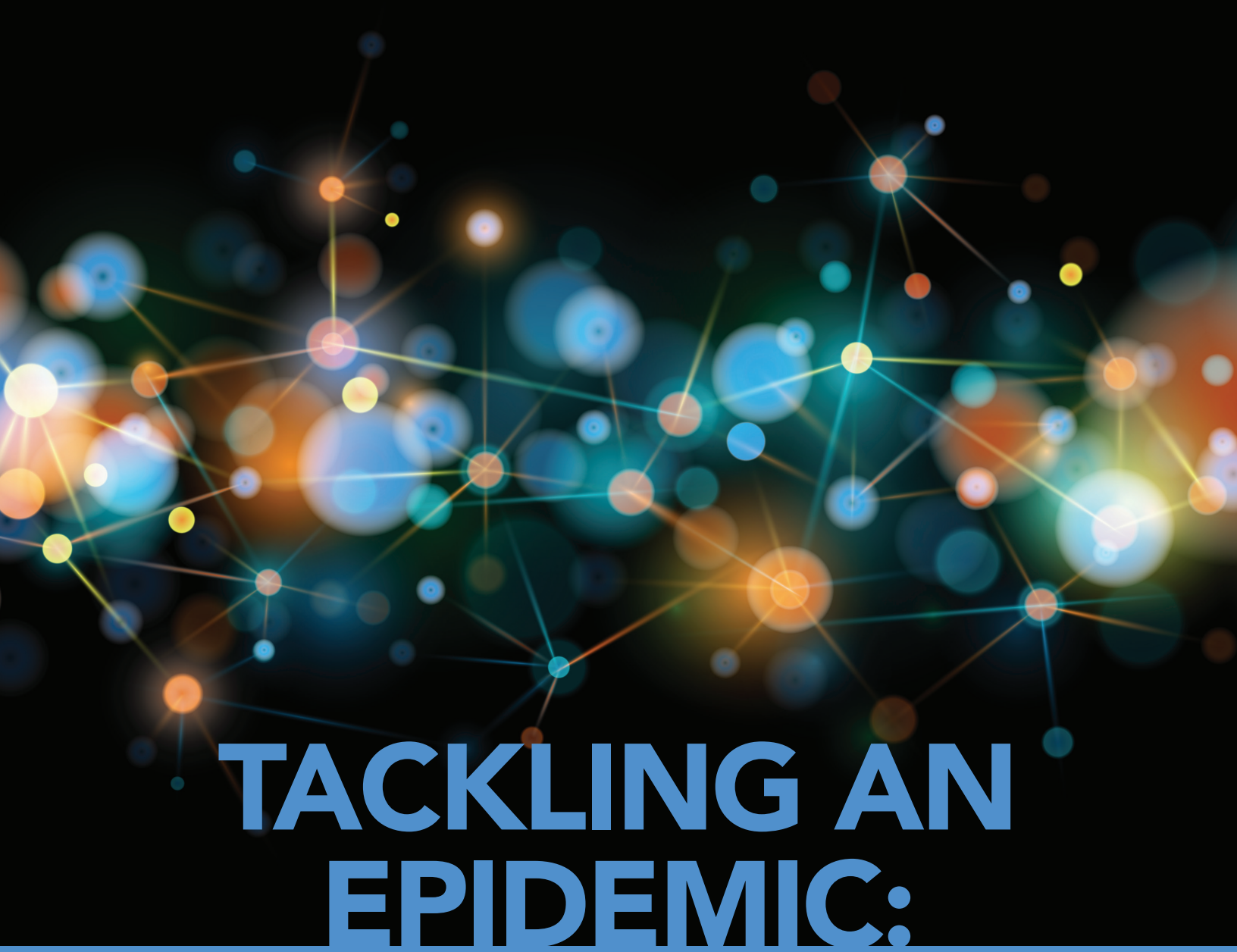

TACKLING AN EPIDEMIC:

An Assessment of the California Opioid Safety Coalitions Network

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About the authors: The Public Health Institute (PHI) is an independent 501(c)(3) dedicated to promoting health, well-being and quality of life for people throughout California, across the nation and around the world. The project team consisted of Amy Max, MPH, Senior Public Health Analyst; Rebecca Garrow, MPH, Program Manager; and Matt Willis, MD, MPH, Marin County Public Health Officer and leader of the RxSafe Marin opioid safety coalition.

Acknowledgements: The authors would like to thank the many people who provided their time and insights for this assessment. Our thanks to local coalition leaders, members of the California Health Care Foundation opioid safety team, state partners, and representatives from parallel efforts outside California. Beyond their contributions to this report, we are deeply grateful for their ongoing dedication to reversing the devastating impact of the opioid crisis.

September 2017

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A. Executive summary

The opioid epidemic is having a devastating impact in communities across the nation, fueling a dramatic increase in premature deaths. In California, there were almost 2,000 opioid overdose deaths in 2016. In late 2015, the California Health Care Foundation (CHCF) launched a statewide network of 16 local coalitions in 23 counties focused on three priority strategies — safe opioid prescribing, use of medication-assisted addiction treatment (MAT), and access to naloxone to reverse drug overdoses.

Coalition counties have built unprecedented partnerships and engagement across sectors. Within just 18 months after launch, more than 90% of coalitions facilitated adoption of safer prescribing guidelines, more than 75% increased access to naloxone to reverse overdoses, and more than 50% expanded use of medication-assisted addiction treatment. Preliminary analyses also indicate that counties with CHCF-supported coalitions increased their buprenorphine prescribing by 20%, nearly double the 11% rate of other counties, and decreased their opioid prescribing rates faster than other counties. While CHCF's intensive efforts focused on 16 coalitions, learning opportunities were open to opioid coalitions across the state. As of April 2017, 36 of California's 58 counties had active coalitions in the statewide network, representing almost 90% of the state population.

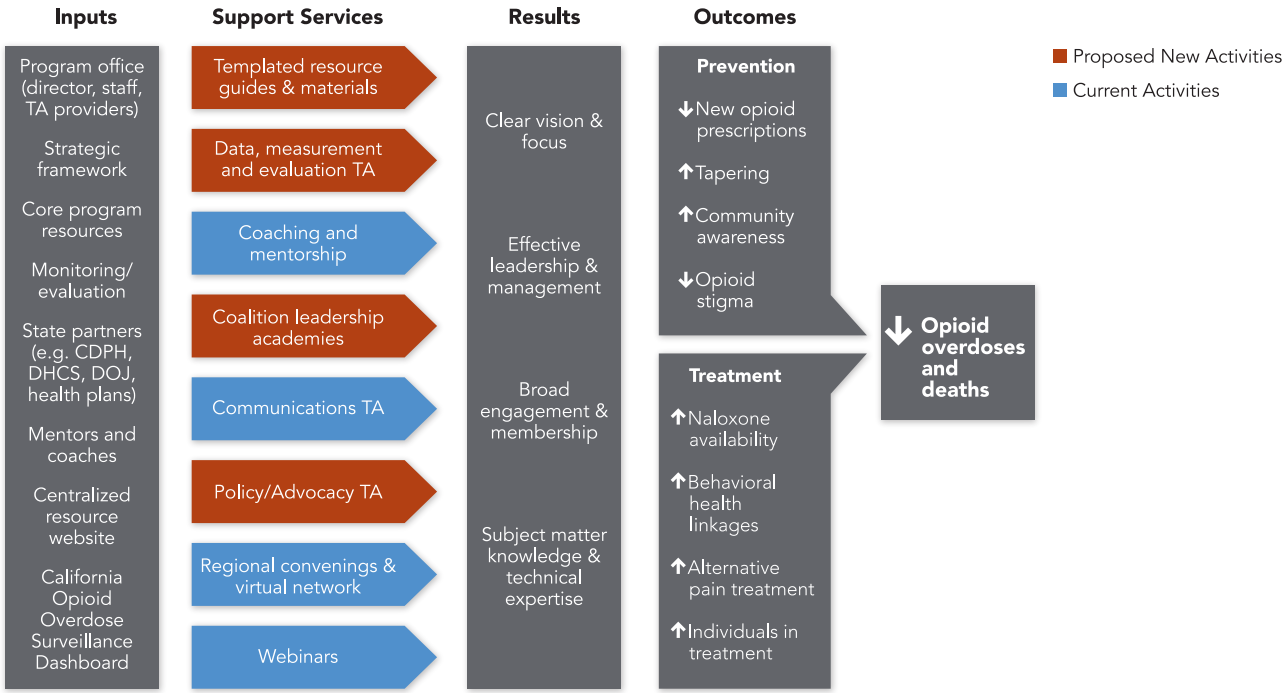
The initiative demonstrates responsiveness to an epidemic that is rooted in medicine, highlighting CHCF as an important driver of sustainable change in health care safety and quality. As an early "incubator" of local coalitions, CHCF has contributed to a timely and critical statewide strategy. However, the natural history of optimal progress among coalitions is measured over years, not months. Continuing to strengthen coalitions and demonstrate their evidence base will maximize CHCF's early investment and vision.

Based on the assessment findings we offer the following recommendations for consideration:

1. **Prioritize investment in high-yield coalitions and maintain wraparound support for the statewide network.** Any direct funding to coalitions should complement a strong, centralized support structure that provides training and technical assistance to the growing network. While all coalitions have made meaningful progress, CHCF should consider deeper investment in high-performing coalitions that can serve as exemplars to other sites. Selection criteria can be based on local opioid-related burden, successful implementation of core strategies, and key infrastructure milestones outlined in the assessment (e.g., established action teams, measurable objectives, broad-based participation). As a demonstration environment, CHCF should also consider sponsoring innovation pilots to test and evaluate novel approaches among local coalitions. CHCF may choose to identify an external organization to operate and manage the overall coalition investment.
2. **Focus support services on the organizational health of coalitions.** Initial technical assistance provided by CHCF has centered on coalition formation and tactical support to advance the three priority strategies. These services were highly valuable to coalitions in their early development, and contributed to their measurable success. In order to maintain these gains and address remaining challenges, CHCF should add support services that strengthen the organizational health and sustainability of coalitions. New forms of technical assistance should build leadership and management capacity, support monitoring and evaluation, advance culturally competent solutions, and promote policy change (see Fig 1). The MassTAPP and OverdoseFreePA models in Massachusetts and Pennsylvania respectively provide technical assistance frameworks that promote the core capabilities of opioid coalitions across statewide networks. Adopting elements of these other models would increase the efficiency and efficacy of coalitions with limited time and resources.

3. **Broaden strategic options and promote integration into the non-healthcare community.** Based on our national review and emerging priorities within California, we recommend a broader menu of strategies beyond MAT, naloxone and safe prescribing. While coalitions should continue their efforts in these areas, strategic planning to expand into complementary interventions would advance adoption of the core strategies and draw in wider local engagement. Emerging strategic priorities identified by coalition leaders include safe medication disposal, behavioral health integration, stigma reduction, prevention strategies, addiction recovery services, and increased youth participation. Achieving goals that support primary prevention of addiction will embed coalitions more wholly in communities and enhance local sustainability.
4. **Demonstrate and disseminate evidence of coalition-based approach.** The coalition network has already made considerable progress. However, local sites have limited capacity to track and measure their outcomes. Support for real-time monitoring and evaluation, both among local coalitions and the statewide network, would facilitate continuous quality improvement, maintain local accountability, and enable identification of scalable best practices. More importantly, it will enable CHCF to expand the national evidence base of using coalition-based strategies to reduce opioid deaths and ensure high-value care. The California Department of Public Health (CDPH) Opioid Overdose Surveillance Dashboard, which offers shared metrics at the state and local level, is a promising new tool to help build a data-informed approach.
5. **Foster an integrated statewide response.** As the opioid epidemic gains scale and complexity, so does the statewide network of stakeholders, resources and strategies. CHCF has established itself as an essential partner and catalyst in this emerging ecosystem. By remaining engaged in its leadership position, CHCF has an important role to play alongside CDPH and other state entities in building a cohesive and integrated statewide response.

Fig 1. Logic Model: CHCF Opioid Safety Coalitions Network



B. Background and methods

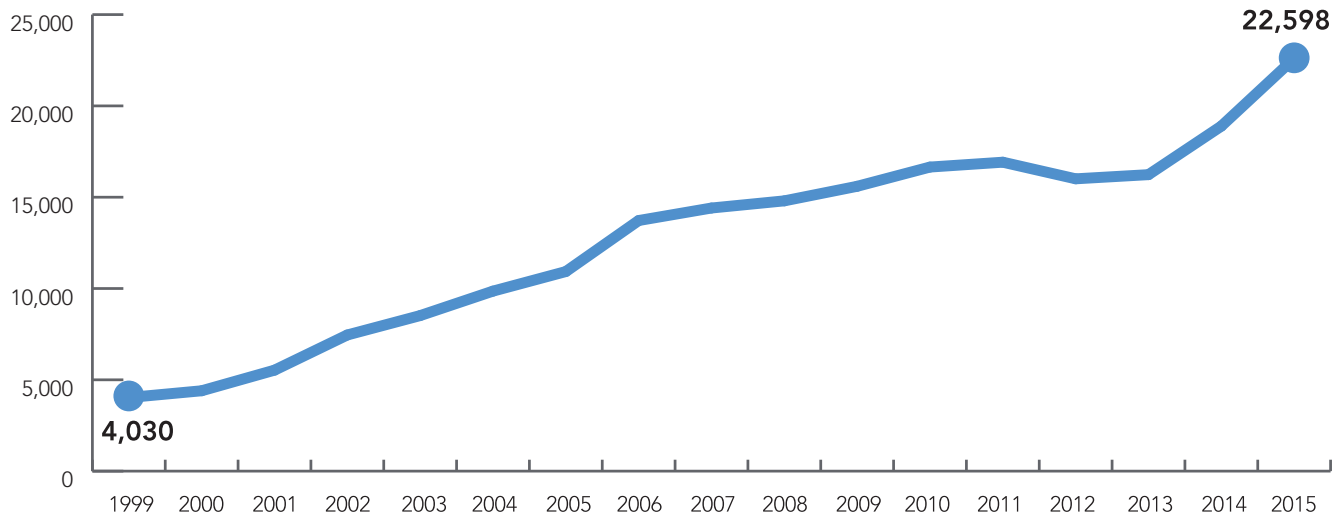
Background

Irrespective of geography or political ideology, few will disagree that our country is experiencing an epidemic of opioid addiction. Drug overdoses kill more people than car crashes, and in California, there were 1,925 opioid-related overdose deaths in 2016. This crisis is gaining complexity as addiction to prescription opioids fuels increased heroin use. While many direct blame towards imprudent providers or profit-driven drug companies, the problem reaches far beyond the doctor's office. A public health epidemic of this complexity requires multifaceted solutions that engage a wide spectrum of stakeholders — including law enforcement, pharmacists, behavioral health specialists, insurers, emergency departments, schools and families.

Opioid safety coalitions are gaining traction as a locally-driven approach to combating the alarming rates of drug overdoses and deaths. In late 2015, the California Health Care Foundation (CHCF) launched a statewide network to support new and emerging coalitions. Offering a range of support services including regular phone-based coaching, access to subject matter experts, and regional convenings, CHCF has accelerated local implementation of evidence-based strategies.

The purpose of this report is to capture the key successes and challenges across the network of CHCF-supported coalitions. Where have coalitions made great strides, and where have they struggled to gain traction? What characteristics define a successful and healthy coalition? Which support services have been most effective, and what are new strategies that might accelerate impact? The report includes a set of considerations as CHCF determines its future approach for advancing opioid safety efforts in California.

Fig 2. Number of Overdose Deaths from Opioid Pain Medications, United States



Source: National Center on Health Statistics, CDC WONDER

Methodology

The Public Health Institute (PHI) conducted this assessment between January and March 2017 using the following combination of data collection and analysis:

Key informant interviews: The project team developed a key informant interview (KII) guide with a mix of qualitative and quantitative measures (see Appendix J). Phone-based interviews were conducted with leaders from the 16 coalitions that received financial and training support from CHCF. During each interview, respondents were asked to validate and build upon their prior responses to a milestone report administered by CHCF. Coalition leads were asked to assess their experience with the resources and technical assistance provided by CHCF, and to describe their future support needs. The interview guide also included an adapted coalition capacity assessment based on evidence-based indicators of success.[1]

Review of CHCF documentation: The project team reviewed CHCF tracking documents, coaching call notes, and quarterly milestone reports. Elements of this documentation were used during key informant interviews and are incorporated into the assessment results.

Site visits: In order to probe specific strengths and challenges with a broader range of coalition members, site visits were held with three coalitions. Sites were selected with input from the CHCF opioid safety team to represent diverse settings. Visits included interviews with coalition members, attendance at coalition meetings, and review of online and printed materials. Participants included physicians, pharmacists, nurses, program coordinators, elected officials, and community members who held a variety of roles within the coalition structure. Interviews included standardized questions and prompts for discussion of successes and challenges using a driver diagram from the Institute for Healthcare Improvement and the "seven deadly sins of coalitions" (see Appendices D and H).

Landscape assessment: Interviews were held with representatives from the CHCF opioid safety team, coalition mentors, and engaged leaders from the California Department of Public Health (CDPH), California Department of Justice (DOJ), Partnership HealthPlan of California (PHC), and state-based technical assistance programs for opioid safety coalitions in Massachusetts and Pennsylvania. A brief survey was also distributed via email to health officers through the California Conference of Local Health Officers (CCLHO).

Comparative analysis: To assess differences in baseline characteristics and preliminary outcomes between California counties with CHCF training and support and counties without this support, a comparative analysis was performed using data generated by CDPH and the California Opioid Overdose Surveillance Dashboard (see page 21). Chi-squared and Student's T-tests (α=0.05) were used to define differences in baseline characteristics. County-level opioid prescribing rates (prescriptions per resident, morphine milligram equivalents per resident, residents on high dose prescriptions) and buprenorphine prescription rates were compared in the fourth quarter of 2015 to the fourth quarter of 2016 for counties with coalitions receiving CHCF support to counties without CHCF coalition support.

1 Raynor, Jared. *What Makes an Effective Coalition? Evidence-Based Indicators of Success.* Funded and prepared for the California Endowment by TCC Group (March 2011).

C. What is the current landscape of opioid safety coalition efforts?

Federal funding and statewide technical assistance models

The scale and severity of opioid addiction is quickly gaining recognition throughout the national consciousness. Almost half of Americans know someone who has been addicted to prescription painkillers,[2] and media outlets continuously publish stories on various facets of the epidemic. At the federal level, then Surgeon General Vivek Murthy sent a letter in 2016 asking every U.S. doctor to pledge their commitment to "turn the tide" on opioid addiction. An unprecedented step, this call to action signaled the true urgency of the epidemic as a national priority.

Bipartisan support has led to expanded funding opportunities for prevention and treatment. Towards the end of his administration, President Obama passed two significant pieces of legislation related to opioids — the 21st Century Cures Act and the Comprehensive Addiction and Recovery Act (CARA). While the first bill directs funding to states for addiction treatment services, CARA authorized $181 million annually for funding the "six pillars" of a coordinated response — prevention, treatment, recovery, law enforcement, criminal justice reform, and overdose reversal. The Trump administration has also expressed a commitment to "end the epidemic," and initiated a federal opioid commission. While promising to some advocates, others see the new commission as redundant, and are concerned that efforts to repeal the Affordable Care Act, cut funding from federal health agencies, and institute a new "war on drugs" will undermine existing strategies.

Through CARA and other federal authorizations, a number of grant opportunities are available for states and local communities. The Substance Abuse and Mental Health Services Administration (SAMHSA) recently began awarding $1 billion to states and territories, including several awards in California, and new funding opportunities have become available from the Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), the Department of Justice (DOJ) and the Drug-Free Communities program. While some local coalitions have been successful in acquiring federal funds, most opportunities are highly specific and preclude core funding for coalition-based efforts.

National experts point to local opioid coalitions as a promising response strategy. In 2016, the Institute for Healthcare Improvement (IHI) published an innovation report to identify new approaches for addressing the prescription opioid crisis.[3] After

"Opioids have become a crippling problem throughout the United States...solving the drug crisis will require cooperation across government and across society."

—President Donald Trump

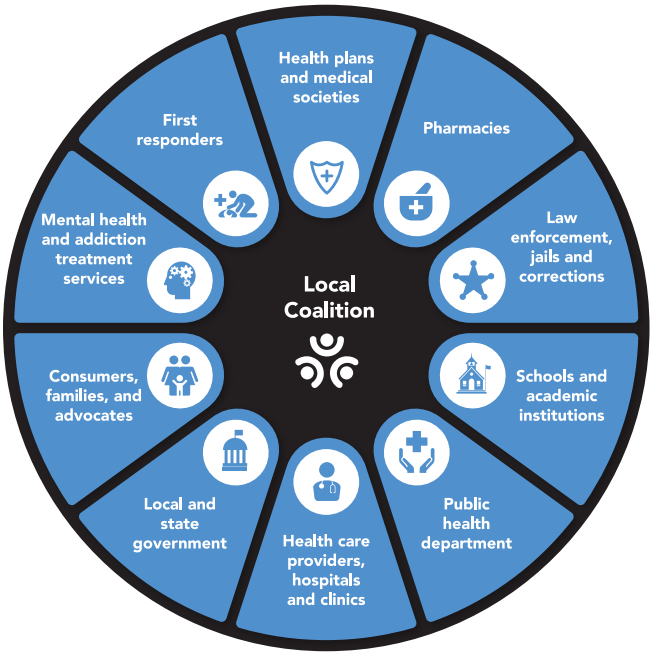
2 Kaiser Family Foundation Health Tracking Poll; April 2016.

scanning existing strategies with millions of dollars in investment, the report concluded that the epidemic will worsen in the absence of a "coordinated and collaborative community-wide approach." IHI's proposed theory of change calls for local efforts that scale promising practices, build public awareness, and engage a broad set of partners beyond public health and health care (see Fig 3 and Appendix D). A key example is the success of Project Lazarus in North Carolina, a multi-stakeholder community-based model that has seen significant reductions in opioid prescribing and deaths.[4] SAMHSA, a leading federal agency in the opioid response, also promotes coalition-based efforts and offers web-based resources and technical assistance.

While new opioid safety coalitions are emerging across the country, few states provide centralized, strategic support to advance local efforts. Two models, in Massachusetts and Pennsylvania, offer important insight as California considers its future statewide strategy:

Massachusetts Opioid Abuse Prevention Collaborative. On behalf of the state's Substance Abuse Prevention and Treatment Block Grant, the Massachusetts Technical Assistance Partnership for Prevention (MassTAPP) supports a network of 19 coalition grantees. The model emphasizes primary prevention, and organizes coalitions into regional "clusters" in which a lead county provides guidance and mentorship to adjacent regions. An assigned MassTAPP TA provider supports each cluster with capacity building and implementation, including an early assessment phase and development of a logic model and strategic plan. TA providers are often former coalition leaders, and bring particular strengths in strategic planning, harm reduction, and measurement strategies. Each cluster receives core funding, which is often used to support a coalition coordinator. Similar to the CHCF opioid safety coalition network, MassTAPP offers expert consultants, online learning events, in-person peer networking, and a centralized website and newsletter.

Fig 3. Multi-Stakeholder Opioid Safety Coalition



TOP 3 INSIGHTS — MassTAPP

3 Martin L, Laderman M, Hyatt J, Krueger J. *Addressing the Opioid Crisis in the United States.* IHI Innovation Report. Cambridge, Massachusetts: Institute for Healthcare Improvement; April 2016.

4 Albert S, Brason FW, Sanford CK, Dasgupta N, et al. *Project Lazarus: Community-Based Overdose Prevention in Rural North Carolina.* Pain Medicine 2011; 12:S77-S85.

1. **Use a standardized framework.** MassTAPP created a detailed guidance document for coalitions based on SAMHSA's Strategic Prevention Framework (see Fig 4). The framework and guidance materials offer a structured process for coalitions and facilitate a cohesive TA delivery model.
2. **Focus on quality and allow time for success.** In following the strategic prevention framework, each coalition conducts an early-stage assessment and develops a focused logic model to guide their implementation efforts. TA providers encourage coalitions to focus on a limited number of strategies that they can execute well. An early adopter of opioid safety coalitions, Massachusetts has had measurable outcomes, including more than 2,000 opioid overdose reversals since 2007. However, a MassTAPP TA provider with more than 30 years of field experience emphasized that, "this work doesn't happen overnight. It's a long process, so allow enough years for change to occur."
3. **Support measurement and evaluation.** MassTAPP uses an evaluation firm to manage quarterly reporting, measure the strength of local collaborations, and conduct discrete evaluations of local pilot strategies. They also evaluate the MassTAPP model by tracking the "dose" of TA provided to each site and collecting feedback on specific support services. Consistent with existing literature, evaluators found that successful TA includes a combination of proactive and reactive support centering on an assigned TA provider with whom coalitions can build a trusting relationship. Investment in evaluation activities enable continuous quality improvement and measurement of local and statewide outcomes.

Fig 4. SAMHSA Strategic Prevention Framework

Source: samhsa.gov

OverdoseFreePA Technical Assistance Center (TAC) — OverdoseFreePA began as an opioid death

"The prevention framework gives us something to follow. When I started, I thought we could just go out and do the work. But I started to realize that having a framework is necessary...it helps us all go through the same process so we're working as a team."

—MassTAPP Technical Assistance Provider

"The biggest TA needs we see center less on the mechanics of implementation strategies, and more on the process of running an effective coalition."

—OverdoseFreePA Technical Assistance Center Project Director

data repository for coroners. Facing the statewide impact of opioid addiction, it has evolved into a collaboration of six partner organizations with a technical assistance center based at the University of Pittsburgh. Launched in 2016, the TAC has quickly scaled from 16 to 36 counties. The TA model consists of a growing team of "coaches" that support a statewide network of coalitions leading overdose prevention and recovery activities. Similar to MassTAPP, the TAC developed a comprehensive implementation manual that incorporates core elements of SAMHSA's Strategic Prevention Framework and includes customizable templates, tools, and assessments. The TAC focuses on the "organizational health" of coalitions, including how to set a strong vision, facilitate an effective meeting, and develop an evaluation plan.

TOP 3 INSIGHTS — OverdoseFreePA

1. **Focus on process and invest in strategic planning.** The TAC adapts its services based on the need of a particular coalition, but also utilizes a structured implementation framework to streamline their statewide support strategy. Coaching is aimed at fostering the "health" of coalitions as a sustainable capacity-building strategy. They also have a strategic planner on staff to work directly with coalitions and help sites create a package of materials that they can re-purpose for grant applications and resource development.
2. **Build a statewide "brand."** OverdoseFreePA emphasizes having a strong communications strategy to maintain external engagement and community support. Similar to the CHCF support model, the TAC helps coalitions draft op-eds, press releases and communications plans. The TAC is also creating a trustworthy brand that sites can adapt and use for meeting agendas, brochures and other collateral. In doing this, the TAC is building statewide recognition and cohesion across their network.
3. **Tailor assistance for urban versus rural communities.** Similar to California, the challenges and TA needs among rural communities do not match those of more urban centers. Differences in geography, culture, infrastructure, and staffing constraints all require the TAC model to be adaptive to the unique characteristics of rural settings. The reliance on a standardized framework that includes cultural competency as a core element, combined with intensive coaching, allows for fidelity in a diversity of settings.

"Rural and urban coalitions need different kinds of support. Shared problem solving across the community is more natural in small towns, but they rarely have the expertise."

—OverdoseFreePA TAC Project Director

California statewide efforts and the Opioid Safety Coalitions Network

In California, a strong collaboration of state partners is working to align system-level efforts related to policy, data systems, consumer engagement and implementation strategies. Convened by the California Department of Public Health (CDPH), the California Prescription Opioid Misuse and Overdose Prevention Workgroup brings together a broad partnership of more than 40 organizations, including the departments of justice, corrections, education, drug enforcement, health care services and others. State efforts focus on broad, cross-sector efforts in place of siloed interventions.

In 2015, CDPH launched the Prescription Drug Overdose Prevention (PDOP) Initiative. Under a 4-year grant from CDC, major efforts include targeted education to physicians, collaborations with health plans to change prescribing patterns, a public education campaign and development of a robust population-level data dashboard. CDPH will release an evaluation across their range of activities in 2020. The California Department of Health Care Services also has federal funding from SAMHSA to expand statewide access to medication-assisted addiction treatment and support prevention activities within high burden rural communities. California counties may also opt in to the new drug Medi-Cal waiver, which provides Medicaid-based funding for substance use treatment at the county level.

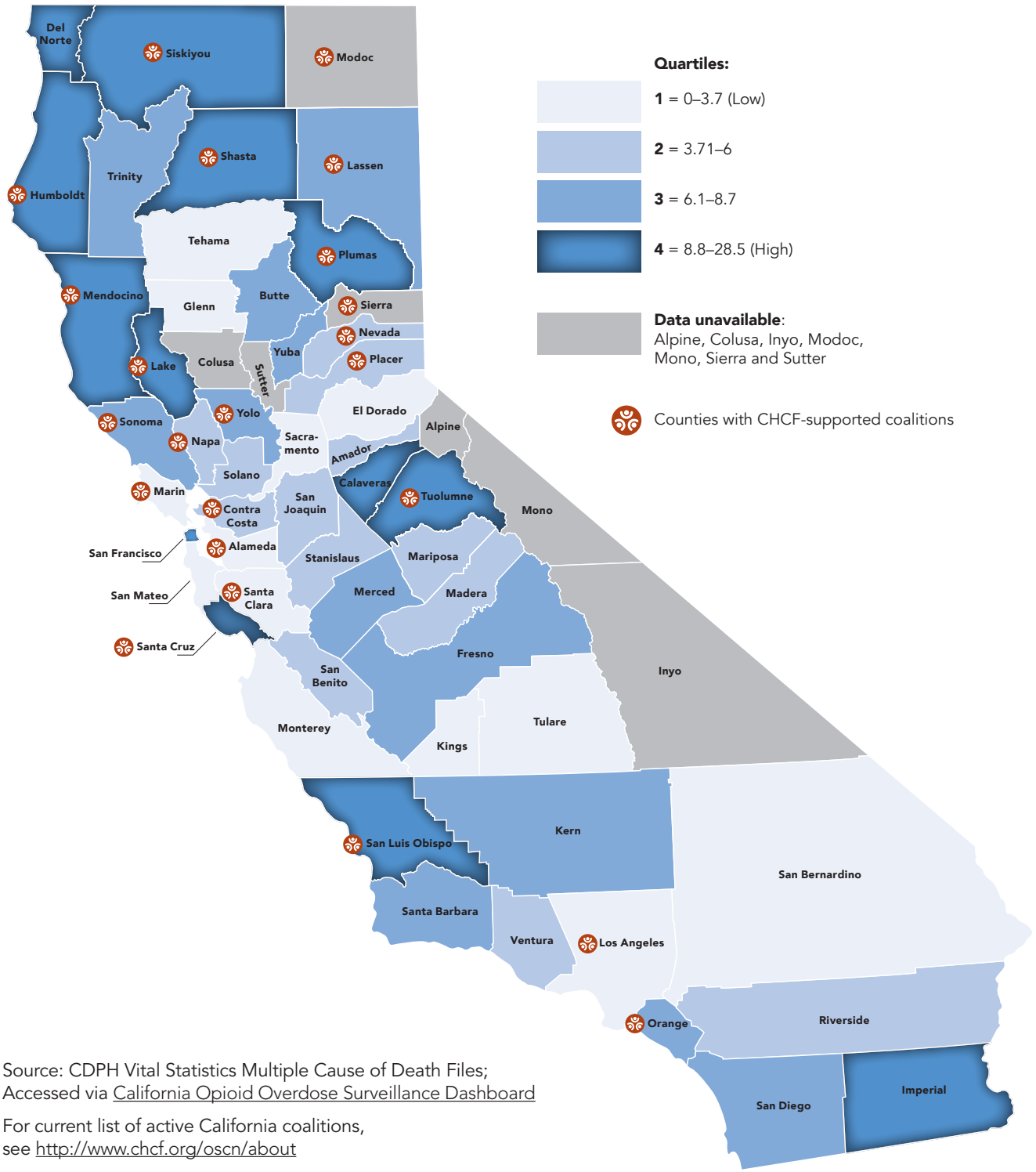
CHCF is an active actor in these statewide activities — as a non-state actor, CHCF has created tremendous gravitational pull as a neutral convener and catalyst. CHCF launched SmartCare California in 2016, a public-private partnership of large California healthcare purchasers, health plans and providers, focusing on opioid overuse as a central priority. With the vision of complementing "top down" state-level strategies with a "bottom up" approach, CHCF began providing technical assistance and training to 16 coalitions across 23 counties in late 2015. This support included webinars, convenings and mentoring. Many coalitions also received modest core support from CHCF, Partnership HealthPlan (the largest Medi-Cal Managed Care Plan in Northern California) and CDPH (see Appendix B). Phase 1 of CHCF coalition support ended May 2017, but the foundation has committed to continuing coalition network training and technical assistance via a partner organization through December 2019. Since CHCF core support ended, CDPH offered this support to 12 coalitions, eight of which are already a part of the CHCF network. Since 2015 the coalition model has spread and as of April 2017, at least 36 of 58 California counties report an active coalition in place and are part of the CHCF network (see Appendix A).

Coalitions in the CHCF cohort represent counties with a range of opioid-overdose burden. Among counties in the top quartile of opioid-related deaths, 75% have a CHCF-supported coalition (see Fig 5). While several coalitions predated the CHCF network, the majority launched their efforts with CHCF funding and support. Participating coalitions also vary widely in the sector of their "backbone" organization. Across the 16 coalitions, seven are led by organizations in the healthcare sector (e.g., hospitals, clinic consortiums, medical associations) while the remainder are led by

"For us, the coalitions are an investment. And the amount of value we're getting out of them is worth the investment."

—Robert Moore, Chief Medical Officer, Partnership HealthPlan of California

Fig 5. Opioid Overdose Death Rate, California, 2015
(Age-Adjusted per 100,000 Residents)



Source: CDPH Vital Statistics Multiple Cause of Death Files;
Accessed via California Opioid Overdose Surveillance Dashboard

For current list of active California coalitions,
see http://www.chcf.org/oscn/about

Fig 6. CHCF Opioid Safety Coalition By Sector of Grantee Organization

CATEGORY	NUMBER OF COALITIONS
Independent Practice or Medical Association	3
Public Health Department	3
Independent Coalition	3
Community Clinic/Clinic Consortium	2
Dept of Behavioral Health/Alcohol and Drug Services	2
University	1
Health Plan	1
Hospital	1

independent entities or local government agencies (e.g., public health and behavioral health departments). The CCLHO survey among local health officers showed a similar distribution for non-CHCF opioid safety coalitions, with one led by a local emergency medical services (EMS) agency.

The combined population of the 23 counties represented in the cohort of CHCF opioid safety coalitions was 20,754,620, or 53% of the total state population (see Table 1 in Appendix G). The CHCF cohort is broadly representative of the state as a whole for diverse geographic and demographic factors relevant to the opioid epidemic. Counties with CHCF-supported coalitions were comparable to all other California counties with regards to median income, median age, and percent of the population living in rural areas, but had a higher proportion of those completing high school, a higher white non-Hispanic population, and lower unemployment rates. While the majority were located in the northern half of the state, the two most populous counties in the cohort were located in Southern California (Orange and Los Angeles.) At baseline, opioid prescribing and opioid overdose death rates were slightly higher across counties with CHCF-funded coalitions, but the differences were not statistically significant.

CHCF implemented a robust model for supporting this diverse network of coalition grantees. Services include a combination of applied technical assistance, knowledge dissemination, and peer-learning. Over the 18-month grant, each coalition received coaching, which included phone-based guidance and support, connections to subject matter experts and mentors, and a combination of webinars, in-person regional convenings and network newsletters to build content knowledge and foster networking. The following section outlines the key successes and challenges across the coalition network, their experience with the CHCF support services, and their future needs for training and technical assistance.

D. What are the key successes, challenges and preliminary outcomes among CHCF opioid safety coalitions?

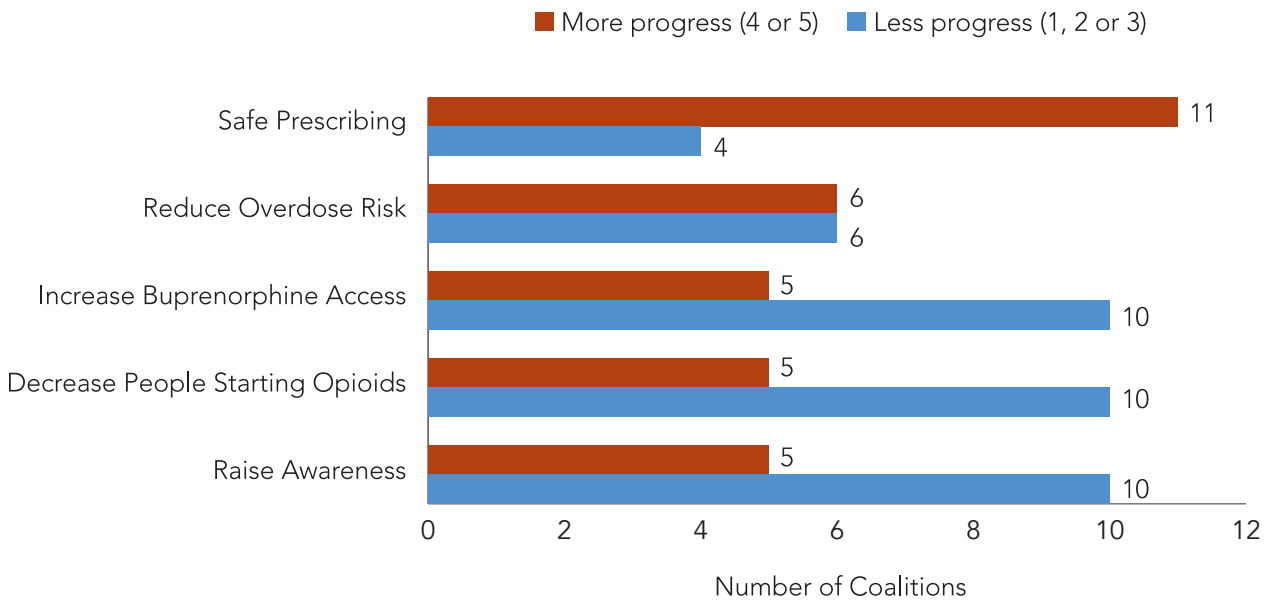
Successes and Challenges — The 3 CHCF Priority Strategies

In alignment with federal priorities, coalitions in the network focus on CHCF's central intervention strategies:

1. **Safe prescribing:** Providing the training, tools, and educational resources that health care professionals need to make more informed prescribing decisions.
2. **Medication assisted treatment (MAT):** Increasing awareness, training, and use of buprenorphine to help lift people out of opioid addiction.
3. **Naloxone:** Increasing availability and access to a drug that can reverse an opioid overdose.

Coalitions demonstrated progress across all three strategy areas, with the greatest success in implementing safer prescribing guidelines. All but one coalition promoted guidelines that were adopted by local health care delivery settings, and 75% of coalitions gave themselves the highest ratings for their self-reported progress in this area (see Fig 7). In contrast, coalitions faced deeper challenges and less self-reported progress in advancing MAT, raising public awareness, and preventing new addictions. This distinction is unsurprising — the majority of coalitions are still in their nascent stages, and adoption of prescriber guidelines represents an easier "early win" in shifting the complex dynamics that contribute to opioid misuse.

Fig 7. CHCF Coalition Self-Reported Progress Rating on Priority Strategies



"We are reaching out to health plans, IPAs, and others who may be positioned to help encourage prescriber adherence to the strategies in our safe-prescribing toolkit."

—Coalition leader, Alameda and Contra Costa Counties

CHCF Strategy 1: Implementing safer prescribing practices	
Key Success	Key Challenge
Local adoption of safer prescribing guidelines: >90% of coalitions developed and/or promoted safe prescribing guidelines that were adopted by primary care and emergency department facilities.	**Reaching prescribers and gaining approval processes:** In taking a community-wide approach, coalitions often face difficulty reaching every local provider and navigating the "multitude of leadership nodal points" to approve guidelines within clinic settings. Guidelines are only the first step, and don't always result in behavior change.

"An important challenge in our community is that we have no residential treatment available for addiction treatment and very little access to outpatient services."

—Coalition leader, Humboldt County

CHCF Strategy 2: Increasing access to MAT for opioid addiction	
Key Success	Key Challenge
Increased awareness and provider capacity for prescribing medication assisted treatment: >50% of coalitions sponsored buprenorphine waiver trainings, conducted outreach to primary care offices to encourage buprenorphine prescribing, or worked with community clinics to integrate addiction treatment into primary care. 80% of coalitions also promoted other addiction medications such as naltrexone.	**Limited availability of interested providers:** Coalitions often find it challenging to identify providers, even among those who are trained and willing to prescribe medication assisted treatment (MAT). Stigma contributes to a reluctance to "attracting" opioid-addicted patients. Other key challenges include lack of staff resources to operationalize MAT programs, lack of outpatient treatment facilities, and lack of sustainable financing.

"We've provided training to the sheriff's department and equipped all patrol vehicles with naloxone kits, making arrangements for replenishment as necessary."

—Coalition leader, Shasta County

Efforts to shift provider attitudes and behaviors related to MAT are highly complex. While clear momentum is underway, this strategy will require additional time and investment among local coalitions. In addition to facilitating MAT adoption among outpatient providers, some coalitions are attempting challenging, yet high-yield strategies in emergency departments, jails and through use of telehealth. Others are pursuing a "hub and spoke" model, wherein a specialty center is dedicated to the initiation and more complex aspects of MAT for a region, and routine maintenance is managed by primary care clinics or other sites. Coalitions within the network have plans in place to continue expansion of these and other strategies throughout 2017. Additional support through an $88M Department of Health Care Services (DHCS) grant will advance hub and spoke models across the state.

CHCF Strategy 3: Increasing access to naloxone to reduce overdose deaths	
Key Success	Key Challenge
Increased naloxone distribution: >75% of coalitions worked with providers to co-prescribe naloxone with opioids and/or supported pharmacies in ensuring naloxone availability. More than two-thirds of coalitions also worked closely with first responders to carry naloxone.	**Engaging pharmacies and scaling local naloxone trainings:** More work is needed to engage pharmacists as partners in naloxone distribution. Many coalitions found a lack of knowledge or interest among local pharmacists in furnishing naloxone despite a law (AB 1535) that allows pharmacists to dispense naloxone without a prescription. Additionally, several coalitions need time to advance approval processes for naloxone trainings and protocol adoption among law enforcement and first responder agencies.

"We have worked to raise public awareness through press releases, radio interviews, creation of our coalition website, data report card, and a drug take-back event."

—Coalition leader, San Luis Obispo County

"I'll tell my story wherever and whenever if it helps people avoid what I went through. I'm a nurse and people need to know this can happen to anyone."

—Plumas County MAT client in recovery

Local efforts to advance naloxone availability are gaining ground, and some coalitions already have compelling stories of life-saving outcomes. In Humboldt County, a local librarian received training on how to administer naloxone and successfully reversed an overdose before the paramedics arrived. The coalition is using this story, and the story of a local sheriff reversing an overdose, to demonstrate the impact of naloxone in the hands of the community and law enforcement.

Across each strategy area, limited capacity to accurately track and measure progress has been a consistent challenge. In taking a systems-level approach, the process for developing tracking mechanisms across siloed agencies can be complex. For example, approximately half of coalitions were not aware of the number of primary care clinics or private practices that adopted safer prescribing guidelines. Going a step further, determining whether future reductions in opioid prescriptions can be attributed to coalition activities requires advanced analyses. The California Opioid Overdose Surveillance Dashboard offers exciting possibilities for tracking county-level outcomes, but coalitions will need support with ongoing measurement and evaluation.

Beyond safe prescribing, MAT, and naloxone, coalitions were asked to list additional strategies that should be prioritized as coalitions evolve. The most commonly cited strategies included those related to stigma reduction, prevention of new addictions, and expansion of non-opioid pain treatment. Each of these areas suggest opportunities for further strategy development and implementation support at the local level.

- **Stigma:** Coalition leaders referenced the need to shift public and professional perception of addiction until it is recognized as a disease rather than a moral failure. Several sites are already looking to lead education efforts that build awareness around the neurobiology of addiction. At the state level, CDPH is working in coordination with CHCF to design a public education campaign to prevent inappropriate opioid use and address stigma.
- **Community based prevention:** While the CHCF strategies focus on clinically-oriented interventions, a number of coalitions are broadening their scope to tackle "upstream" prevention activities. As explained by a pharmacy leader in one coalition, "We need to focus on the public at large and the younger generation. MAT and naloxone focus on those who already have an addiction problem. From a long-term perspective, our most important target are those without a problem yet." A few rural counties recently received SAMHSA funding through the California Department of Health Care Services (DHCS) to implement prevention-based interventions targeting youth.
- **Non-opioid pain treatment:** Another strategy of interest is strengthening provider capacity, referral processes, and payment mechanisms for alternative pain treatments. This includes behavioral therapy, physical reconditioning, and integrative medicine services such as acupuncture and massage therapy. CHCF has served as a thought-leader in this space, sponsoring white papers on complementary therapies. Health plans are also expanding payment structures to cover such modalities. An evolving strategy, coalitions will need further resources and support to optimize local models for alternative pain treatment.

"If not us, then who?"

Case Study: Northern Sierra Opioid Safety Coalition

What makes this coalition unique?
The Northern Sierra Opioid Safety Coalition spans the largest geographic area among the CHCF opioid safety coalitions. The five counties of Lassen, Modoc, Plumas, Sierra, and Siskiyou are rural, lower income Northern California counties with high opioid prescribing and overdose rates. Despite its prevalence, the stigma of opioid addiction remains a barrier to progress regionally.

What are key factors for success?
Coalition members report that by nature of being in a tight knit community with a high opioid burden, stakeholders in all sectors have been affected in their own lives and share a personal drive to address the epidemic. This facilitates broad participation, including county supervisors, MAT clients, and close engagement with law enforcement. Coalition members also note the effectiveness of sharing personal stories publicly to reverse stigma.

In Plumas County, where the lead team is located, the coalition is integrated into an established structure for cross-sector collaboration called "20,000 Lives." The Northern Sierra Opioid Safety Coalition is one of seven workgroups in this local initiative that seeks to collectively achieve positive health outcomes in the region. Coalition action team meetings are supported through an established meeting support structure.

What have been the biggest challenges?
For the Northern Sierra Opioid Safety Coalition, full participation in activities across five large rural counties presents a challenge. Long drives across wilderness areas limits the feasibility of regular in-person gatherings, and most meeting attendees are from Plumas County. Coalition members also report that the stigma of opioid addiction is a cultural barrier to achieving coalition goals, especially with medication assisted treatment.

What lessons can be applied to other coalitions?
Throughout the state, local infrastructure to support coalition activities is limited in rural settings where the opioid burden may be highest. Regional, multi-county coalitions managed through a single hub is a promising approach, assuming sufficient resources and capacity.

The stigma of substance use is a barrier to progress in all areas. Coalitions that engage community members directly and support their voices for sharing personal stories publicly can begin to reduce stigma. This may be especially impactful in small rural communities where social networks are tight, stigma is perceived to be high, and conventional national media lacks a local focus.

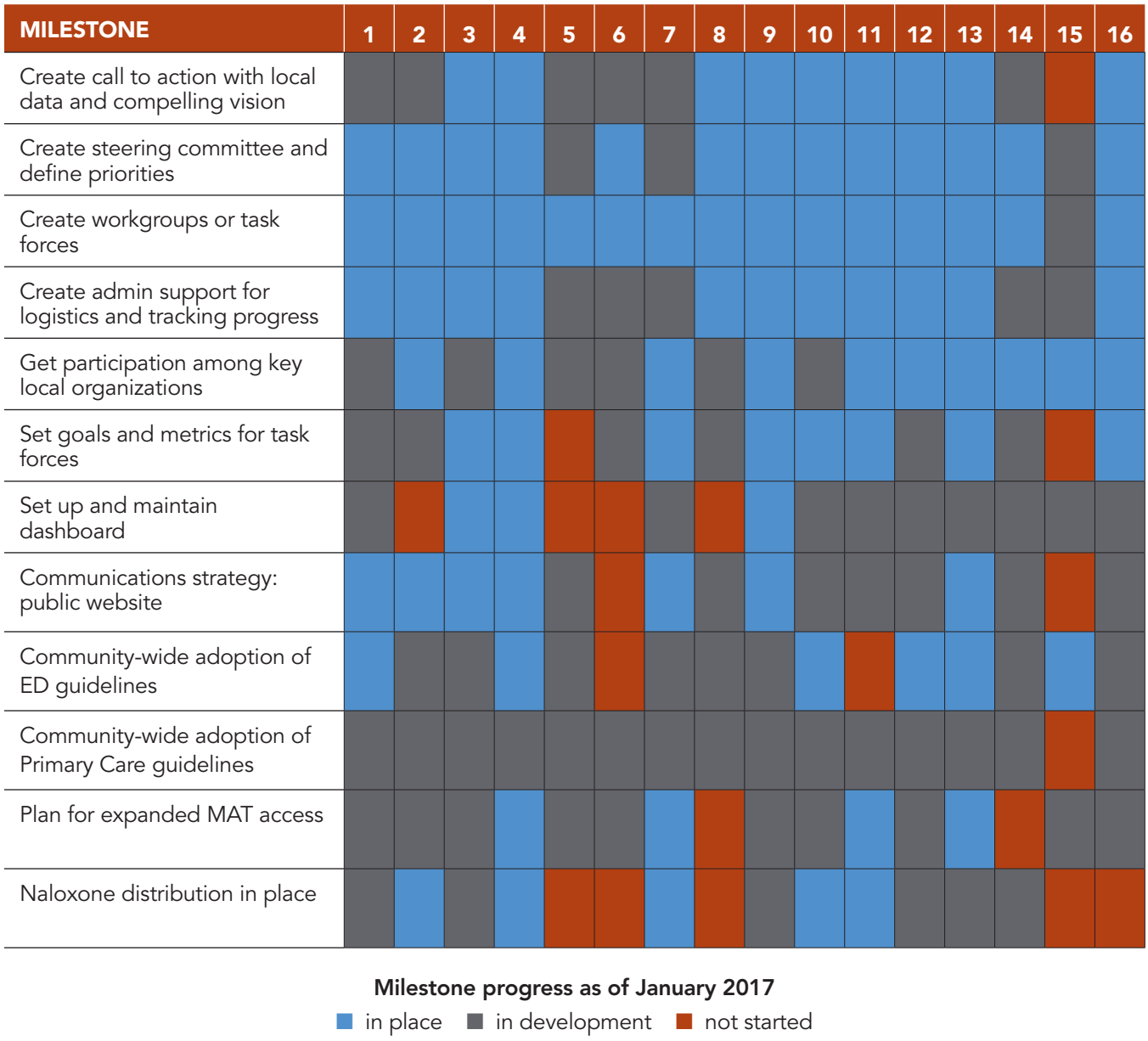
"We can't hide this anymore. I'm in this because my family was caught up in this. As a county supervisor I can tell you most of us have a personal connection to this issue."

—Plumas County Supervisor

Successes and Challenges — The Big Picture

While the coalition network saw accomplishments across the three core strategy areas, they also experienced growth in other key facets of their development. Over the course of the grant, CHCF tracked a series of milestones, with variable progress based on the characteristics, assets, and political contexts within each region. In the aggregate, coalitions were successful in launching core elements of their infrastructure. This included setting up steering committees with diverse representation, creating workgroups, and setting goals. (see Fig 8).

Fig 8. Coalition Milestones



"We were operating in a vacuum. Together we have a multiplied effect."

—Coalition leader, San Luis Obispo County

When asked to report the "single most important success" of their coalition, two key themes emerged:

- **Partnership development across sectors:** Respondents repeatedly emphasized their successful engagement of a diverse set of local partners, which many saw as the most significant outcome of their coalition. Many spoke of the simple value of having multiple agencies together in one room, creating new lines of communication. According to one respondent, "Without the coalition, administrators and providers would never be in the same room to make this happen." In particular, coalition leaders frequently referenced the active participation of law enforcement and local providers as a key success. For many counties, this level of collaboration and buy-in is unprecedented, positioning them to work together across otherwise siloed agencies.
- **Creation and distribution of new tools and resources:** On a pragmatic level, coalitions were enthusiastic about the range of tangible products and services they have already implemented during this early phase of their work. In addition to developing safe-prescribing guidelines, coalitions published press releases to raise local awareness, designed and implemented naloxone and MAT trainings, and distributed opioid alternative resource guides for patients and prescribers. The cross-agency dialogue necessary to generate consensus products in practice guidelines and materials reflects, and reinforces, coalition identity. Coalitions will continue to leverage these resources and generate new products to scale and support their intervention strategies.

Coalition leaders often cited the funding, structure, and support provided by CHCF as a critical factor towards these achievements. Many described how CHCF support enabled them to build their identity as a coalition and hire staff to develop new materials and products. As voiced by one coalition leader, "CHCF should feel very proud for getting so much movement of this area. All the work is a testament to their leadership, and the funds greatly accelerated our efforts."

While sites are generally enthusiastic about their accomplishments, they also face important challenges. When asked about the "single greatest challenge" their coalition has faced, respondents frequently referenced difficulties sustaining staff investment and partner engagement:

- **Limited staff capacity:** The opioid epidemic does not yet have a fully funded and dedicated response infrastructure in the public or private sector. Thus, most coalitions rely on "borrowed" time and in-kind support from willing and voluntary partners to advance their strategies. A shortage of dedicated staff to support coalition activities presents a barrier for most sites. With limited core funds, leaders have difficulty allocating staff to manage operational and administrative functions.
- **Member burnout:** Coalition leaders generally describe their membership as highly engaged and supportive. At the same time, most participants volunteer their time and are often "overcommitted." As shared by one coalition leader, "in our setting, it's the same people doing all the work. Everyone is only spread so thin before folks have to shift to other priorities." It was also noted that a key factor for retaining members was a sense of forward momentum and impact, which requires clear action planning. New strategies will need to be put in play to help coalitions sustain engagement and prevent attrition.

10 Million Lives, One Coalition

Case Study: Safe Med LA Opioid Safety Coalition

What makes this coalition unique?
Covering a population of 10 million, Safe Med LA is the largest of the CHCF coalitions with nine action teams coordinated by program managers, a steering committee, and an executive team. The scale of engagement is unique — the adoption of a safe prescribing toolkit included 78 emergency departments across the county. The coalition is relatively independent in most TA needs, with internal subject matter experts and a strong communication and management infrastructure.

What are key factors for success?
The coalition is embedded in the Substance Abuse Prevention and Control program within the Los Angeles County Department of Public Health. The program has developed a five-year strategic plan that will be carried out through the Safe Med LA coalition. Thus, the coalition is the mechanism for achieving shared departmental and community goals, and resources are dedicated to its success in the context of a strategic plan. These include well-defined and publicly visible goals and a dedicated evaluation.

What have been the biggest challenges?
Community engagement beyond the healthcare sector has been a challenge. Being embedded in a health department with physician leadership has helped open doors, but the coalition seeks to better engage the community as a whole. Safe Med LA members consistently cited the need for stronger ties to law enforcement, young people and schools for coalition growth and sustained impact.

What lessons can be applied to other coalitions?
The development and adherence to a coalition strategic plan was important to Safe Med LA. Harmonizing coalition and departmental strategies in a single plan adds focus, greater managerial support, and access to internal expertise. Technical assistance should also take into account internal coalition resources. Compared to rural settings, urban coalitions may have challenges organizing partners across large and complex systems but greater internal subject matter expertise, communications and operational support.

"The leadership of Safe Med LA has been critical. We have credibility when we reach out to healthcare partners."

—Co-lead, Safe Med LA naloxone team

Preliminary Outcomes

Data for measuring outcomes is limited given the short time frame since the establishment of the coalitions. However, recent progress in the timeliness of data available in the California Opioid Overdose Surveillance Dashboard enables analysis of potential early coalition impact in local prescribing patterns.

Safer opioid prescribing is a goal of the CHCF initiative and was commonly cited among coalitions as an early milestone achievement. Most coalitions were formed in late 2015, and formal technical assistance began in November 2015. This analysis is based on prescribing patterns through December 31, 2016, using a baseline of fourth quarter 2015, offering a limited interval over which to expect any measurable impact.

Opioid prescribing rates declined across the state between fourth quarter 2015 and fourth quarter 2016, and the rate of decline was greater in counties receiving CHCF coalition training and support. This association was present for the number of opioid prescriptions per 1,000 residents (Fig 9) and average annual opioid dose (morphine milligram equivalent, MME) per resident (Fig 10). Data can be found in Table 2 of Appendix G.

Fig 9. Decrease in Number of Opioid Prescriptions per 1,000 Residents

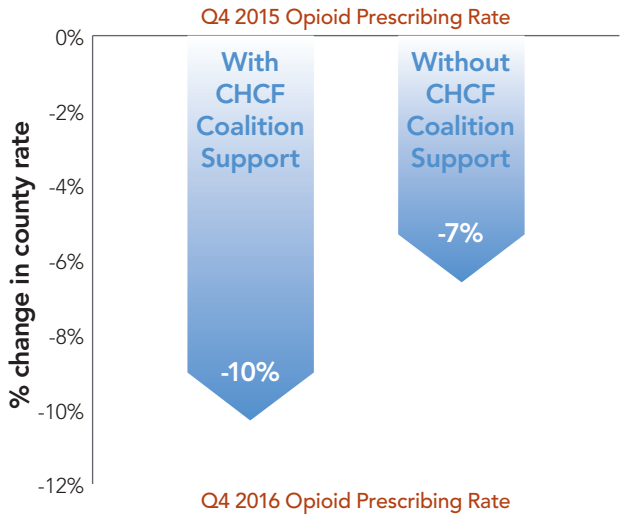


Fig 10. Decrease in Average Annual Opioid Dose (Morphine Milligram Equivalents, MME) per Resident

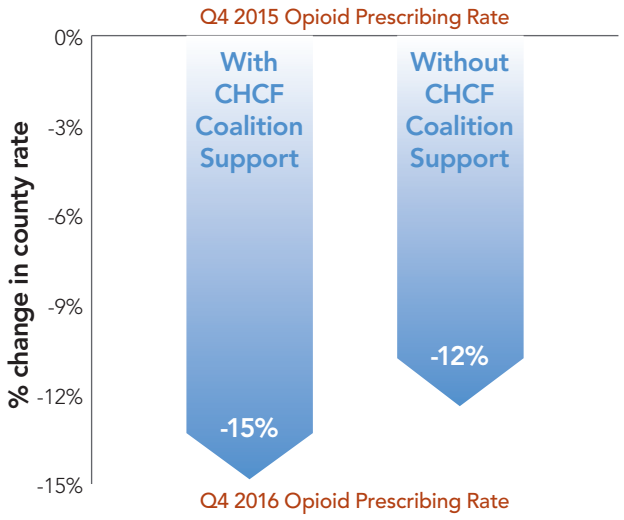
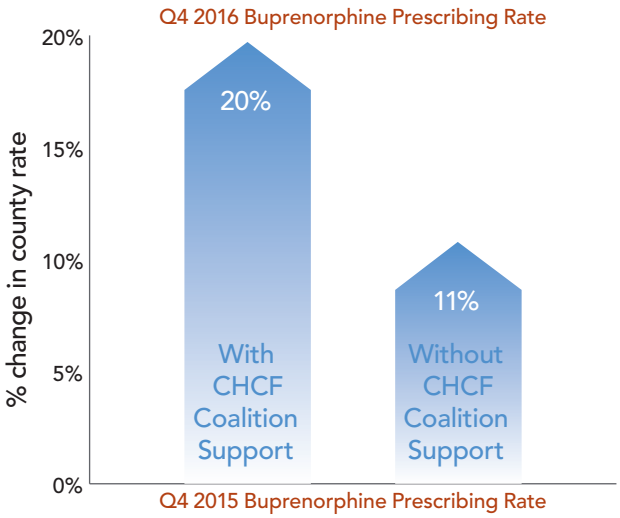


Fig 11. Increase in Number of Buprenorphine Prescriptions per 1,000 Residents



The most dramatic coalition impact can be found in the change in buprenorphine prescribing rates (Fig 11). Counties with coalitions receiving CHCF training and support increased their prescribing rate by 20%, nearly double the 11% increased prescribing rate seen in other counties.

The latest available data in overdose deaths and emergency department visits pre-dates the launch of most coalitions and could not be analyzed. However, the decline in opioid prescription rates and the increase in buprenorphine prescribing rates are promising trends in the overall goal of decreasing opioid overdose deaths.

Building Capacity — Coalition Training and Technical Assistance

The CHCF opioid safety team offered coalitions a wide range of resources, trainings, and technical assistance offerings throughout the grant period (see Fig 15). The most frequently utilized and helpful forms of technical assistance included the following:

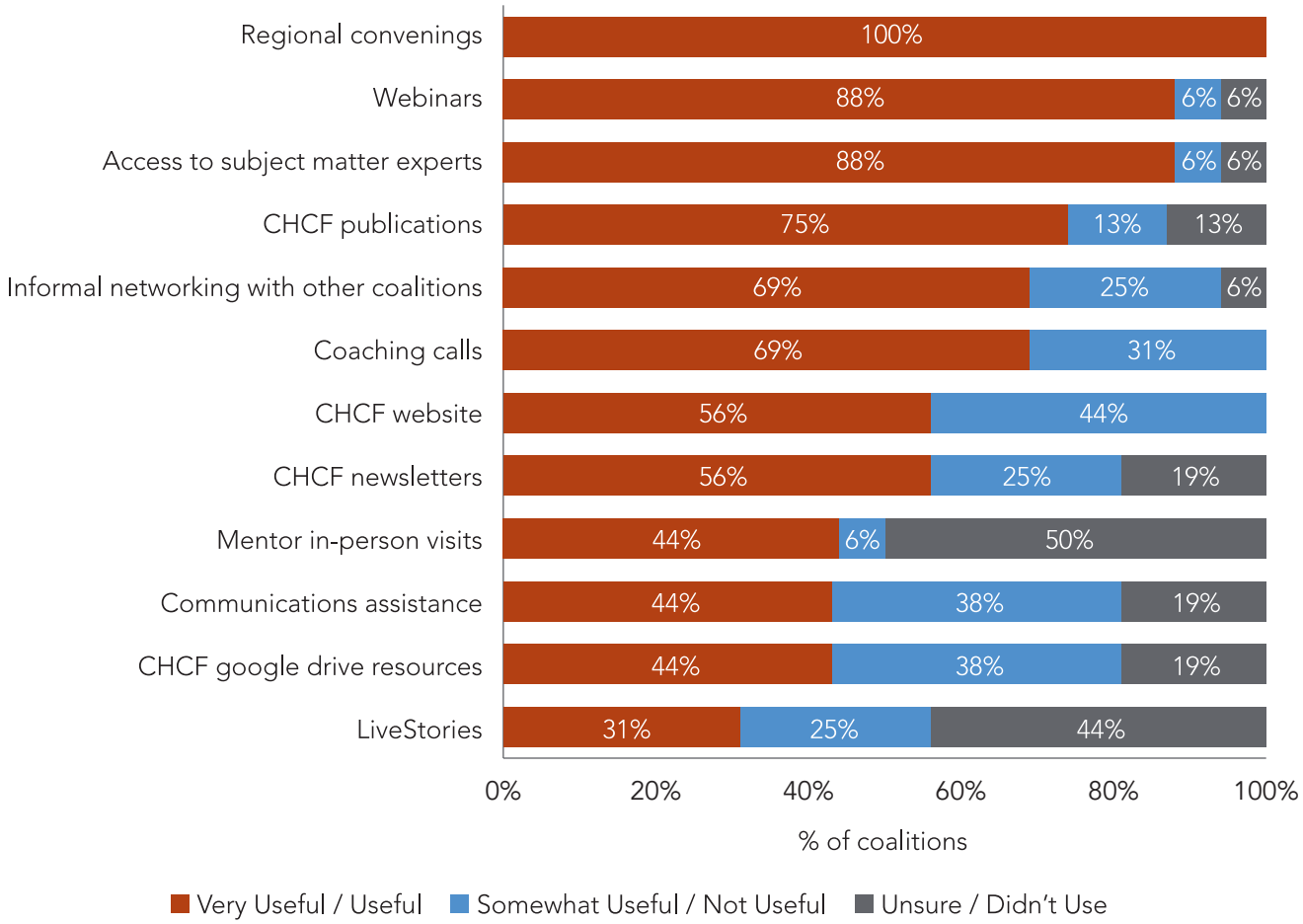
- **Regional convenings and webinars:** Across the board, coalitions found opportunities to build their content knowledge around opioid strategies to be highly valuable. CHCF held regular webinars, provided access to subject matter experts, and hosted regional convenings with leaders in the field. The regional convenings were the most popular CHCF offering, as they allowed coalitions to build their technical knowledge, engage in peer learning, and network with other sites.
- **Coaching calls:** A CHCF "coach" held regular calls with coalitions to provide guidance, track progress, and offer connections to existing tools and resources. Most calls were paired with an assigned physician mentor with experience leading a local opioid safety coalition. These coaching calls were rated as highly valuable, particularly in keeping sites accountable and "on track" with their activities despite competing priorities. Many respondents also cited the strong value in having a centralized point person to connect them with other coalitions across the network to share tools, resources, and strategies.
- **Communications support:** In addition to webinars and online resources, coalitions received up to 10 hours of customized support from a communications strategist. There was a high need for this service across the network — both in building capacity for internal communications (e.g., partner engagement, coalition listservs) and external communications (e.g., press releases, websites, social media strategies). While some sites were able to draw on internal communications expertise, the majority depended on CHCF as an essential starting point to build this core aspect of their infrastructure.

Not all coalitions were able to take advantage of each support offering. For example, almost all coalitions were interested in using the LiveStories platform for data visualization and web content, but many were unable to invest their limited staff capacity to put it into practice. The CHCF team also offered a curated set of documents and resources in an online "Google Drive" folder. However, many coalition leaders found it cumbersome to navigate, suggesting an opportunity to build an improved online resource library.

"CHCF has done a stellar job. I felt really supported. I felt like I could call anyone and they would be open to helping me."

—Local coalition leader

Fig 15. How useful were the following resources and technical assistance provided to your coalition? (n=16)



Training priorities

When asked to list their top three training priorities, coalitions most frequently listed the following:

- Community/stakeholder engagement & partnership development
- Sustainability and funding
- Evidenced-based strategies
- Content-specific trainings (e.g., naloxone, MAT, safer prescribing, etc.)
- Data and evaluation
- Advocacy
- Leadership
- Marketing and public relations

Aside from content-specific trainings, respondents were primarily interested in building capacity to strengthen the structure and sustainability of their coalition. For example, almost every site referenced the need for support with stakeholder engagement and development of future funding strategies. Other topic areas — including evaluation, advocacy, and leadership — represent new opportunities to help enhance their infrastructure and impact.

E. What are the future needs of the California Opioid Safety Coalitions Network?

Despite challenges, all 16 sites planned to continue their efforts after current CHCF grant funding expired in May 2017. When asked what their coalition needed to be successful going forward, respondents referenced the following three themes:

- **Training and technical assistance:** Many coalitions voiced a need for ongoing training and technical support. Most seek general guidance in internal management methods as well as topic-specific support to implement their chosen strategies. In addition to existing support from CHCF, some sites already leverage partnerships with their local public health departments for guidance and technical expertise. For example, the Shasta County coalition utilized communications support from their public health department to generate press releases and materials.
- **Additional time and dedicated staff:** Given the scope of the epidemic and range of activities, almost all sites mentioned the need for additional time to invest in coalition activities. This is an important complement to the observation that distribution of coalition workflow is a challenge for coalition management. In the words of one frustrated coalition leader, "I'm through with people showing up to meetings to make suggestions [for strategies] for awhile. I feel like saying 'no more suggestions unless you're signing up to do the work.'" At current resource levels, most coalition leaders feel unable to dedicate "the time it deserves" to build an efficient and effective coalition structure.
- **Funding:** While not a necessary condition for continuing coalition efforts, many sites admit that they may "limp along" or function at reduced capacity without additional resources. In connection with the theme above, many sites hope to secure additional funding to hire a project coordinator. Several sites have begun the process of seeking new funding, and eight have received new grant support from CDPH. At the same time, several expressed concern that new funding opportunities come with very specific criteria that limit core support for coalition-based efforts or infrastructure.

"We hope we would still have access to the CHCF resources including the website, newsletter, materials, research, mentors, convenings and webinars...we fear if we don't have funding, this immediate support of information would be lost."

—Local coalition leader

"We got this"

Case Study: Safe Rx Mendocino Opioid Safety Coalition

What makes this coalition unique?
The Safe Rx Mendocino opioid safety coalition was not an original member of the CHCF coalition cohort. The local Medi-Cal managed care plan, Partnership HealthPlan (PHC), funded the coalition to join the CHCF network. The coalition includes one of the most robust clinic-based medication assisted treatment (MAT) programs among rural cohort counties.

What are key factors for success?
The success of the coalition is based on a tireless commitment to educating community members and a strong collaboration between clinics, emergency department physicians and other key partners. Additionally, the MAT program at Hillside Clinic in Ukiah is expanding its practice beyond the current 160 buprenorphine clients. The clinic has an institutional commitment to addiction treatment, including an existing buprenorphine program. As a result, the program is able to optimize clinic operations and billing mechanisms in support of MAT. The leadership team from this program are sharing lessons to normalize MAT as a primary care offering. The engagement of the local health plan was also necessary for the coalition to become established and join the statewide cohort.

What have been the biggest challenges?
The Safe Rx Mendocino opioid safety coalition covers two distinct regions divided by a coastal mountain range. Coordinating activities with the coastal community was an early challenge, as most healthcare partners and the coalition backbone team are based in the inland region. To address this challenge, Mendocino developed a regional model in which two coalitions — one inland and one coastal — work in collaboration while also targeting discrete issues. A remaining challenge is identifying ways to reach community members, as many individuals are "off the grid" from traditional media outlets.

What lessons can be applied to other coalitions?
Within the network there are islands of excellence that can demonstrate ways to overcome common barriers. The Safe Rx Mendocino opioid safety coalition includes a successful MAT program in a rural community health center. Coalition technical assistance should be designed to identify and describe the specific elements of success in such exemplary practices, and to integrate this learning into the network as a whole. The active engagement of Partnership HealthPlan among northern California coalitions also exemplifies how health plans can benefit from safe opioid use and see a return on investment in supporting coalitions directly.

"I come to these meetings because I think we can have an impact. I know other docs would want to join...we feel helpless."

—Co-lead, Prescribers Action Team

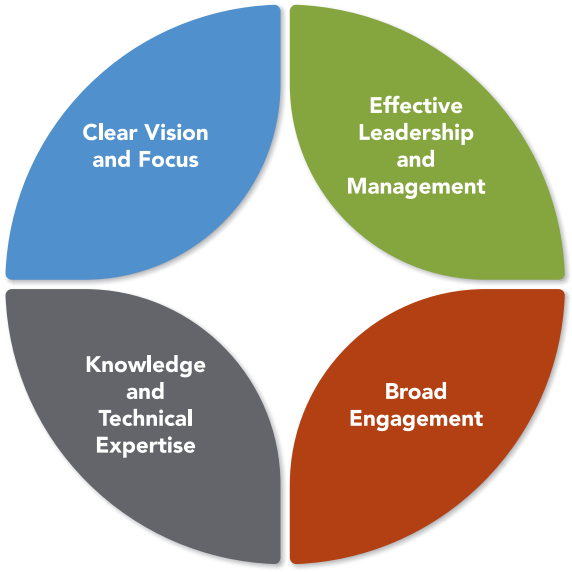
F. What are the characteristics of a "healthy" and successful opioid safety coalition?

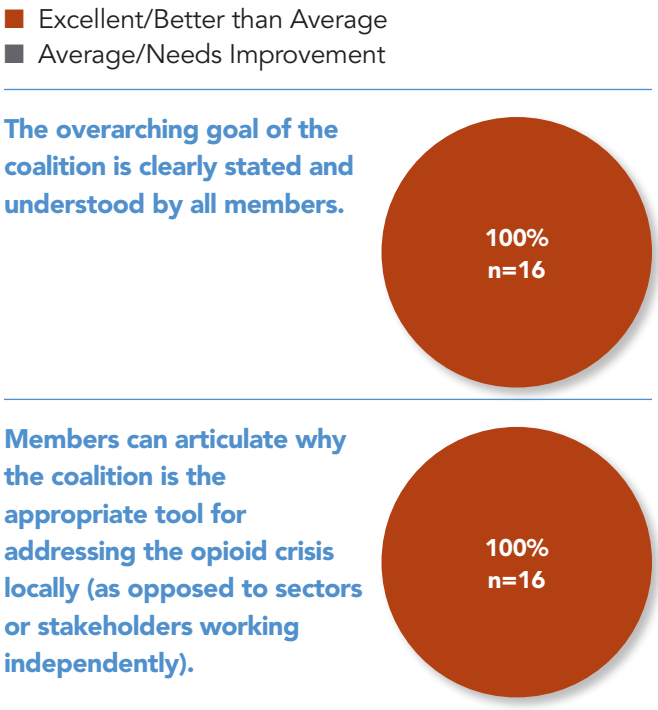
Government agencies and private foundations have long recognized the value of coalitions in tackling substance use and other public health challenges. In California, the growing network of opioid safety coalitions serves as a vehicle for "collective impact," a framework in which entities from different sectors align towards a common agenda and shared measurement strategy. In taking this approach, coalitions face complex dynamics as they build an organizational "backbone" to support new cross-sector relationships and implementation strategies.

As coalitions grow and evolve, it is critical to assess the key determinants of their overall "health." The four-part framework in Figure 16 was developed based on a review of the literature, one author's personal experience leading an effective opioid safety coalition, and interviews with coalition leaders. As part of the assessment, leaders were asked to describe the common characteristics that define a successful, healthy opioid safety coalition based on their own experience and observations of other coalitions within the network. Each interview also included a 19-question assessment of their coalition's performance (see Appendix I), which is incorporated into the analysis below.

Clear vision and focus: As with any organization, a strong coalition must have a clear vision with well-defined goals. Having a shared vision is an essential ingredient for collective impact efforts, providing an aligned sense of purpose and motivation for members to work towards a specified outcome. Given the multi-faceted nature of the opioid epidemic, coalitions are challenged to maintain focus as they engage across sectors. Among the four domains, CHCF-supported coalitions demonstrated the greatest strength in this area.

Fig 16. Characteristics of a healthy opioid safety coalition





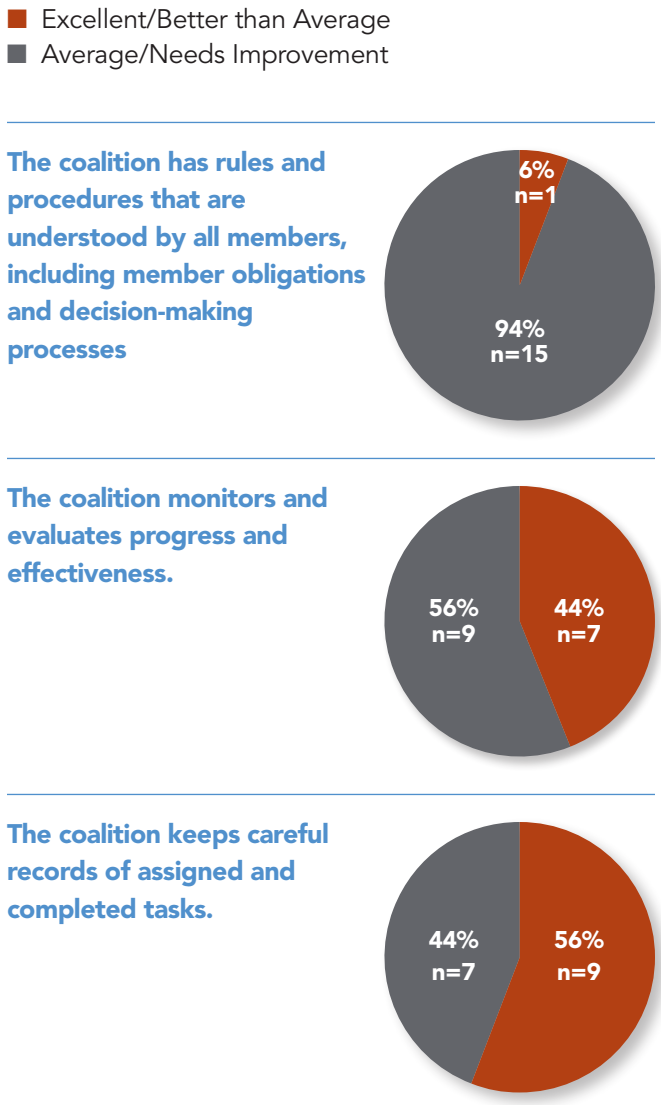
The CHCF team played an important role in helping coalitions set a compelling vision with specific and measureable objectives. This will continue to be a critical need for many sites. In addition to setting goals and metrics, coalitions would benefit from basic strategic planning and logic models that clearly outline their vision, goals, and objectives.

Effective leadership and management: A successful coalition is contingent upon active participation across its membership. However, a centralized leadership structure is also fundamental to operationalize coalition activities. During key informant interviews, respondents consistently emphasized the importance of strong coalition leadership. In particular, many pointed to the success of other sites in which the public health officer or another physician serves as a key champion, bringing attention and credibility to the coalition.

The technical background and expertise of a coalition leader is less important than their ability to galvanize members, bring on new partners, and sustain momentum. In addition to a strong leader, a centralized coordinator also plays a critical role in advancing the operational components of the coalition. While some sites had someone to fill this role and others didn't, almost all respondents referenced the essential function of a coalition coordinator, particularly in minimizing the burden of otherwise busy members.

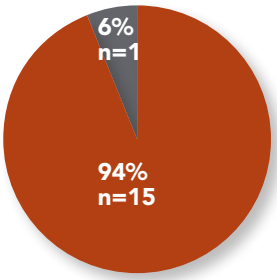
Within the statewide network, respondents demonstrated clear difficulties with core leadership and management functions. The majority of respondents described their coalition as "average" or "needs improvement" for having clear operating processes, systems to monitor progress, and other fundamental elements.

Backbone administrative support is essential, but also time consuming. Coalitions need some level of dedicated staff, but can also find creative ways to draw on existing resources. For example, the Northern Sierra coalition based its operational infrastructure on an existing coalition in the region, utilizing similar processes and documentation. Strong leadership is also something that can be acquired. Many coalitions are currently led by individuals with experience in opioid safety, but could consider engaging others who are already trusted leaders in their community. Leadership skills can also be improved through training and mentorship, a potential future support offering.



Knowledge and technical expertise: To achieve meaningful outcomes, coalitions need to have the knowledge and technical expertise to successfully implement opioid safety interventions. However, technical expertise goes beyond the nuances of safe prescribing, naloxone, and MAT strategies — successful and "healthy" coalitions are also skilled in *how* the work gets done. This includes skills in management, strategic planning, policy, communications, measurement and evaluation, and resource development. Within the network, almost all coalitions had sufficient subject matter expertise, but relied on technical support from CHCF in other areas, such as communications and goal setting. As coalitions grow their efforts, they will need to draw on existing expertise as well as outside capacity building and technical support.

The coalition has sufficient subject matter knowledge to manage chosen strategies.



Broad engagement: The complexity of the opioid problem is unmistakable, and requires a constellation of partners to implement meaningful solutions. The "life" of an opioid pill touches many parts of a community, including prescribers, pharmacists, family members, schools and law enforcement. Diverse membership within a coalition allows members to connect to the issue and put system-level solutions into play. According to coalition leaders, the opportunity to engage a broad set of partners has been one of their greatest successes to date.

A common observation was the value of having the local public health department serve in a convening role. Several coalitions successfully leveraged public health competencies in data collection, oversight of clinical care, and structural relationships with public safety, schools, businesses, and elected officials. As no other single sector spans this range of competencies, California Public Health Officer Karen Smith, MD, has referred to the opioid epidemic as "the perfect public health problem."

Almost all coalitions reported that their members trust one another and feel free to disagree with one another in meetings — two signs of a "healthy" coalition. At the same time, many are challenged with maintaining engagement among members with competing priorities. As evidenced in the figures above, coalition leaders may need additional support in applying methods to sustain engagement and encourage active participation as opposed to relying on core staff to carry out the work (see "deadly sins" #5 and #6 in Appendix H).

G. Conclusion

Innovative solutions are needed to stem the growing opioid crisis. The coalition-based approach is gaining recognition both statewide and nationally. In just 18 months after CHCF launched training and technical assistance to 16 coalitions across 23 California counties, at least a dozen other counties formed local opioid coalitions and participate in the CHCF network to benefit from subject matter experts and peer learning.

As more communities look to coalitions to tackle the epidemic, there is increased need to describe what is being learned to advance statewide progress. After more than a year of observation, the CHCF network offers a unique opportunity to describe coalition function and define the most successful practices. These coalitions have rapidly organized a local response and have met important milestones. During this period, prescribing rates have declined more in counties with CHCF opioid safety coalitions than other California counties. While it's too early to measure health outcomes, the selected strategies have been shown to reduce overdose events over time and contribute to CHCF's goal of decreasing opioid related deaths by 20% by 2020.[5,6,7]

The technical assistance provided by CHCF has allowed coalitions to launch their efforts and implement key strategies. Going forward, coalitions will need further support to strengthen their core infrastructure in leadership, management and organizational health. Examples of intensive technical assistance for statewide opioid coalition networks are well described in Pennsylvania and Massachusetts, and can serve as models to consider. Additional recommendations can be found in the executive summary on page 2.

The opioid epidemic is a complex public health crisis rooted in healthcare, and solutions are not self-evident. Reversing trends will require ongoing commitment and thoughtful agencies dedicated to innovation, working directly with affected communities. In California, CHCF has helped catalyze a statewide response aligning government agencies, health plans, and community coalitions. The Opioid Safety Coalitions Network is now a hub for a statewide learning community — a critical achievement within a short time period. With targeted support, coalitions nurtured in this environment are well prepared to be changemakers in opioid safety and advance promising practices nationally.

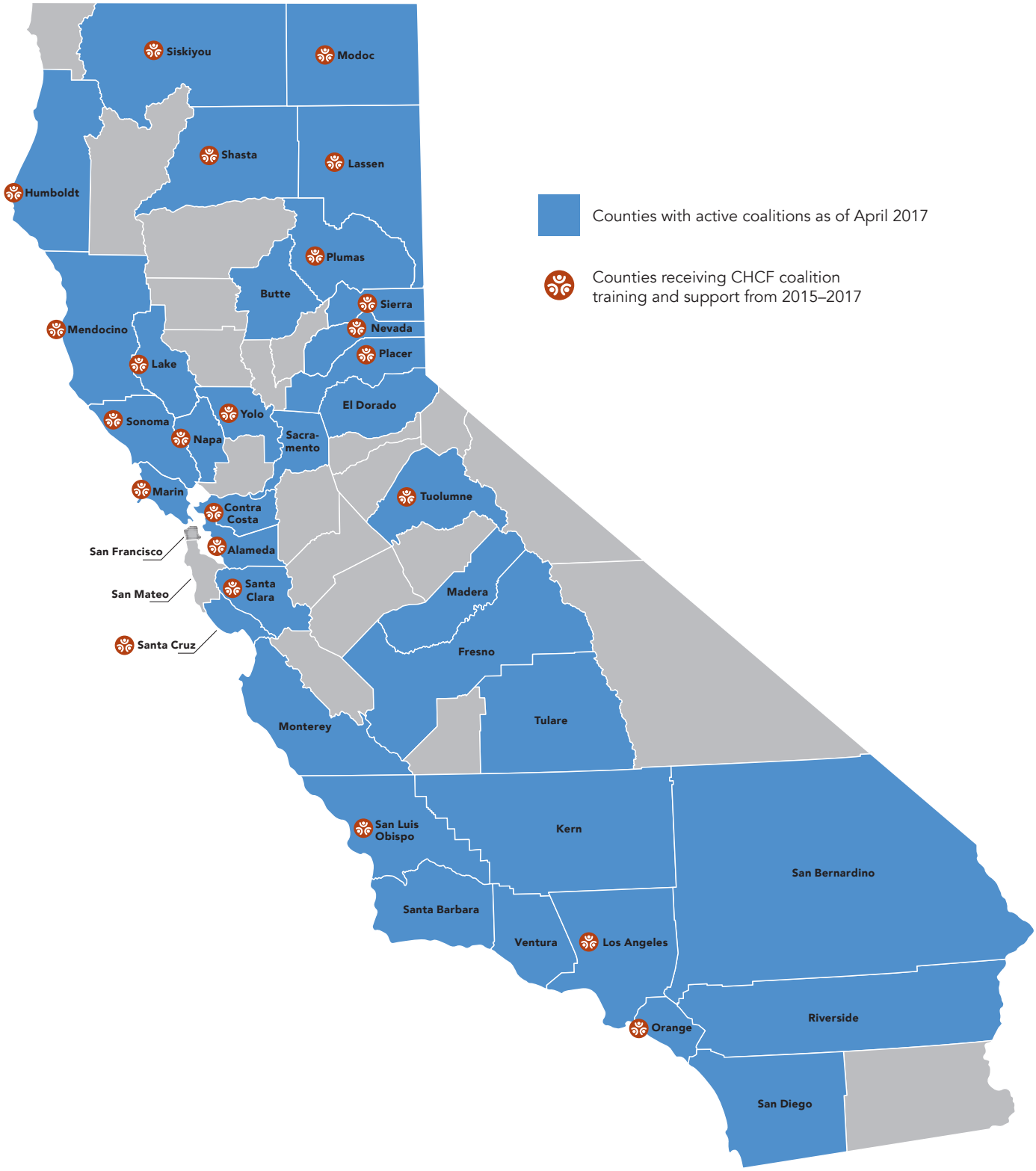
5 Gwira Baumblatt JA, et al. *High-risk Use by Patients Prescribed Opioids for Pain and its Role in Overdose Deaths*. JAMA Intern Med. 2014 May;174(5):796-801.

6 Coffin PO, Behar E, Rowe C, et al. *Nonrandomized Intervention Study of Naloxone Coprescription for Primary Care Patients Receiving Long-Term Opioid Therapy for Pain*. Ann Intern Med. 2016;165(4):245-252.

7 Rudd RA, Seth P, David F, Scholl L. *Increases in Drug and Opioid Overdose Deaths—United States, 2000–2015*. MMWR Morb Mortal Wkly Rep. 2016;65:1445-1452.

Appendices

A. California Opioid Safety Coalitions Network



B. CA Opioid Safety Coalitions Network — Funded

COUNTY/ REGION	COALITION NAME	WEBSITE	CORE SUPPORT	GRANTEE
Alameda & Contra Costa	East Bay Safe Prescribing	www.accma.org/community-health/safe-prescribing	CHCF	Alameda-Contra Costa Medical Association
Humboldt	Rx Safe Humboldt	www.rxsafehumboldt.org	CHCF	Humboldt IPA
Lake	Safe Rx Lake County	www.saferxlakecounty.org	CHCF	St Helena Hospital Clear Lake/ Adventist Health
Los Angeles	Safe Med LA	www.safemedla.org	CHCF	LA Care (Medi-Cal Health Plan)
Marin	Rx Safe Marin	www.rxsafemarin.org	CHCF	Marin County Public Health (through Redwood Community Health Coalition)
Mendocino	SafeRx Mendocino	www.saferxmendocino.com	Partnership HealthPlan	Mendocino County Public Health
Napa	Napa Opiate Safety Coalition		Partnership HealthPlan	OLE Health (Community Health Center)
Orange	Safe Rx OC	www.saferxoc.org	CHCF	University of CA, Irvine
Placer & Nevada	Rx Drug Safety	www.pncms.org/rxdrugsafety	CHCF	Placer-Nevada County Medical Society
Plumas, Lassen, Sierra, Modoc & Siskiyou	Northern Sierra Opioid Safety Coalition	www.countyofplumas.com/index.aspx?nid=2448	CHCF & CDPH	Plumas County Public Health
San Luis Obispo	San Luis Obispo Opioid Safety Coalition	www.opioidsafetyslo.org	CHCF	County of San Luis Obispo Drug and Alcohol Services
Santa Clara	Santa Clara County Opioid Overdose Prevention Project	www.facebook.com/SCCoOOP	Santa Clara County	Santa Clara County Alcohol and Drug Services
Santa Cruz	Safe Rx Santa Cruz County	www.facebook.com/Safe-Rx-Santa-Cruz-County-128209120939899	CHCF	Health Improvement Partnership (independent coalition)
Shasta	NoRxAbuse	www.norxabuse.org	CHCF	NoRxAbuse (independent coalition)
Siskiyou	Siskiyou Against Rx Addiction		Partnership HealthPlan	Siskiyou Against Rx Addiction (independent coalition)
Sonoma		www.rchc.net/ebc-opio-test-draft	CHCF	Redwood Community Health Coalition (clinic consortium)
Tuolumne	Tuolumne County Opioid Safety Coalition		CHCF & CDPH	Tuolumne County Public Health
Yolo			CHCF	Redwood Community Health Coalition (clinic consortium)

C. CA Opioid Safety Coalitions Network Curriculum (November 2015–May 2017)

Opioid Safety Coalition Convenings

1. November 2015 kickoff agenda topics:
   - *Overview and Statewide Plans , Safer Prescribing, Implementation Strategies, MAT and Naloxone, Communications, Patient and Family Perspectives, CURES and EDIE demos, Networking*
2. September 2016 Northern CA (6 sites – live event and remote streaming) and November 2016 Southern CA agenda topics:
   - *DEA visits, CURES 2.0, Naloxone in the ED, MAT and jail transitions, PreManage ED, community and statewide perspective and strategies, Prescribing Buprenorphine, Understanding Treatments For Opioids Use Disorder, Changing Community Hearts and Minds, Integrating Addiction Treatment Across Spectrum of Care, Tapering, Implementing Safer Prescribing Guidelines, Naloxone in the Community, Law Enforcement Approaches, Adoption of MAT- what's needed, Communications change strategies, MAT in Primary Care.* **Additional November Topics:** *Data Impact, Addiction and the Brain, Practitioner role and responsibilities in reducing Opioid Addiction, MAT in ED and Urgent Care, Engaging Public Officials, Systems Approaches to Ending the Epidemic*

Webinars

- *Opioid Safety Coalitions Kick-Off Webinar*
- *Building A Call To Action Using Data*
- *Bringing Clinicians Together Around Common Guidelines*
- *Setting Up Your Coalition For Success*
- *Understanding and Using Prescription and Public Health Data*
- *Expanding Access to Buprenorphine in Primary Care Practices*
- *Familiarizing Yourself with The LiveStories Platform*
- *Storytelling With Data and Beyond*
- *Data Dashboards On Opioid Outcome Data*
- *Is Buprenorphine For Pain A Safer Alternative to High Dose or Long Term Opioid Use?*
- *CURES 2.0: What the Busy Clinician Needs to Know*
- *Addiction Neurobiology and the Impact of Long-Term Opioids on the Brain*
- *Spreading the Word: How to Reach Audiences and Inspire Action*
- *Making Lifesaving Naloxone Accessible*
- *Evolving Your Goals: Coalition Strategy for Impact*
- *Sustainable Funding Strategies For Opioid Safety Coalitions*
- *Connecting Medication Assisted Treatment to Primary Care: the Hub and Spoke Model*
- *Academic Detailing: Changing Prescriber Behavior Through Brief, In-Person Encounters*
- *Treating Maternal Addiction with Buprenorphine*
- *How to Use LiveStories to Engage Your Community*

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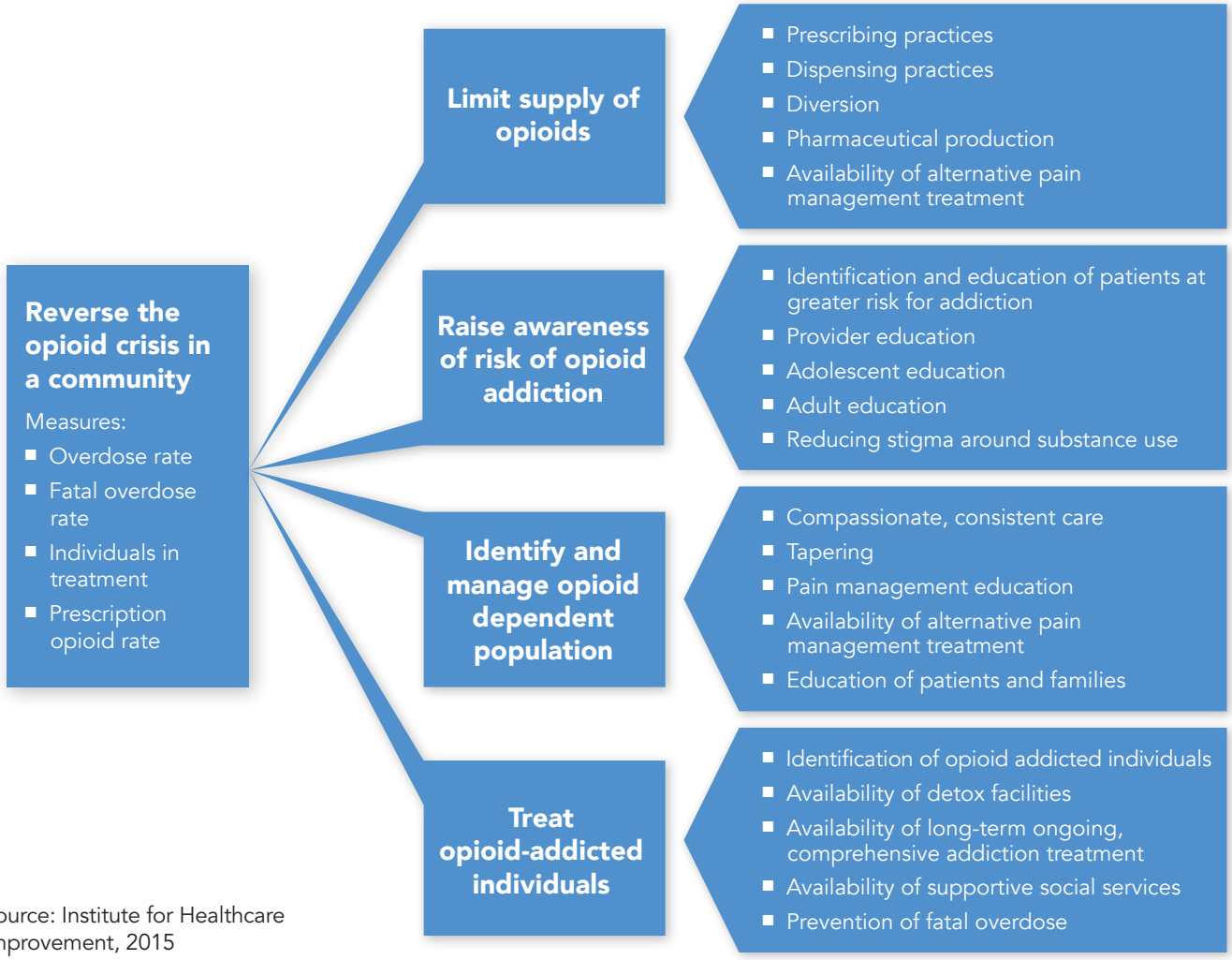
Small Group Call Topics

- *Tips For Engaging Your Community*
- *Northern Rural Coalitions – Sharing Naloxone and MAT Strategies*
- *Large Coalitions – Sharing Naloxone and MAT Strategies*
- *From X to Rx: Activating Waivered Clinicians*
- *Guideline Implementation Pilots*
- *Naloxone Furnishing*
- *Data Dashboard in Action*
- *Consumer Coalition Engagement*
- *Coalition Leadership Round Table: Sustaining Success and Avoiding Burnout*
- *Naloxone Strategies for Law Enforcement and Co-prescribing*

D. Institute for Healthcare Improvement Driver Diagram: Reversing the Opioid Crisis in a Community



Source: Institute for Healthcare Improvement, 2015

E. Coalition strategies to increase access to medication assisted treatment (MAT)

Which strategies, if any, is your coalition using to increase access to buprenorphine and methadone?

STRATEGY	n	%
Conducting outreach to primary care offices to encourage buprenorphine prescribing	11	69%
Sponsoring buprenorphine waiver trainings	8	50%
Working with community clinics to integrate addiction treatment into primary care	8	50%
Measuring or estimating community need and creating an action plan to address those needs	7	44%
Matching prescribers to mentors (e.g., PCCS-MAT, free ECHO program, others)	6	38%
Starting buprenorphine and/or methadone treatment in jails	5	31%
Setting up induction clinics to manage new starts, and then hand off to primary care or other prescribers	4	25%
Exploring telemedicine options	4	25%
Starting buprenorphine treatment in emergency departments	4	25%
Expanding access to specialty opioid treatment programs ("methadone clinics")	3	19%
Working with health plans on incentives or payment options to encourage buprenorphine prescribing	2	13%
Our coalition is not currently working on expanding access to addiction treatment	1	6%
Other strategies	6	38%
Total Respondents	**16**	—

Totals do not add up to 100% because respondents were permitted to select more than one answer.
Source: CHCF Milestone Report, January 2017.

F. Coalition strategies to increase access to naloxone

Where is your coalition working to increase distribution of naloxone?

DISTRIBUTION ARENA	n	%
Primary care providers: co-prescribing naloxone with opioids	12	75%
Pharmacies: working to make sure naloxone is in stock	12	75%
First responders: carrying naloxone	11	69%
Pharmacists: furnishing naloxone without a prescription	10	63%
Law enforcement: carrying naloxone	10	63%
Needle exchange distribution	8	50%
Substance use treatment centers	8	50%
Emergency departments: dispensing or prescribing on discharge	7	44%
Jails: dispensing on release	6	38%
Mental health treatment centers	3	19%
Our coalition does not have any strategies in place right now	1	6%
Total Respondents	**16**	—

Totals do not add up to 100% because respondents were permitted to select more than one answer.
Source: CHCF Milestone Report, January 2017.

G. Coalition Comparative Analysis

Methodology

Chi-squared tests of independence and Student's T-tests (α=0.05) were used to assess significant differences in baseline characteristics between coalition and non-coalition counties for morbidity and mortality indicators, prescribing patterns, and sociodemographic characteristics. Data were obtained from the California Department of Public Health (CDPH) on county-specific opioid prescribing patterns (rate of opioid prescriptions, morphine milligram equivalents per resident, residents on high dose prescriptions, and buprenorphine prescriptions). These standard indicators of safe opioid prescribing are included on the California Opioid Overdose Surveillance Dashboard, which utilizes prescribing data from CURES, the state's prescription drug monitoring program. The data were stratified by coalition status (CHCF-supported coalition county versus non-CHCF coalition county) and generated aggregate outcome metrics by coalition status.

Limitations

Most coalitions were formed in 2015, and formal technical assistance began in November 2015. This analysis is based on prescribing patterns through December 31, 2016, the latest available prescribing data available. This offers a limited interval over which to expect any measurable impact. By aggregating across counties, this analysis does not take into account any variation in time between the institution of strategies toward safe prescribing and the third quarter of 2016 across coalitions. Those few counties with opioid safety coalitions outside of the CHCF cohort are included in the "non-coalition" cohort in this analysis. Aggregated data obscures significant variation between counties in both coalition and non-coalition cohorts. Finally, federally sponsored drug treatment centers are prohibited from reporting buprenorphine prescriptions to CURES, limiting the ability to describe MAT prescribing.

Table 1: Baseline characteristics between California counties with CHCF coalition support and counties without such support — 2015

Characteristic	County with CHCF-Supported Coalition N=23	County without CHCF-Supported Coalition N=35	p-value[1]
Total Population	20,754,620	18,390,196	NA
Population (2015) Median Range	 196,275 2,967–10,170,292	 182,322 1,110–3,299,521	0.79[2]
Median Income ($) Median Range	 56,359 35,578-96,310	 52,093 34,974-93,623	0.42[2]
Percent of individuals living in poverty Average percent (Standard Deviation)	14.9 (4.4)	17.7 (5.5)	0.05
Percent completing high school, % Average Percent (Standard Deviation)	**87.6 (4.3)**	**80.8 (7.7)**	**<0.001[3]**
Percent White, non-Hispanic, % Average Percent (Standard Deviation)	**65 (18)**	**51 (19)**	**0.01**
Median Age, years Median Range	 40.6 30.9-54.5	 35.5 30.3-50.7	0.06[2]
Average Population Density, per sq. mile (Standard Deviation) (2010)	615 (1,003)	693 (2,850)	0.88[3]
Percent of the Population Living in Rural Areas, % (2010) Average Percent (Standard Deviation)	28.5 (28.9)	28.8 (29.3)	0.97
Unemployment Rate, % (Standard Deviation)	**6.2 (1.8)**	**8.4 (3.6)**	**0.003**
Opioid Overdose Deaths Crude Average Rate per 100,000 (Standard Deviation)	908 41 (73) 8 (8)	992 28 (47) 5 (4)	 0.43[3] 0.09[3]
Drug Overdose Deaths Average number (Standard Deviation) Crude Average Rate per 100,000 (Standard Deviation)	1,913 87 (158) 15 (11)	2,498 69 (97) 14 (6)	 0.64[3] 0.50[3]
Opioid-Related Emergency Department Encounters Average number (Standard Deviation) Crude Average Rate per 100,000 (Standard Deviation)	1,698 77 (143) 17 (11)	2,237 62 (83) 15 (10)	 0.66[3] 0.50
Opioids Prescribed per 1,000 residents (Standard Deviation) (Q4, 2015)	227.5 (83.2)	214.2 (78.3)	0.54
MMEs per resident per year (Standard Deviation) (Q4, 2015)	255.5 (129.2)	241.1 (122.7)	0.67
Residents on > 90 MMEs per day for 30 days per 1,000 residents (Standard Deviation) (Q4, 2015)	11.3 (5.1)	10.1 (5.0)	0.39
Buprenorphine Prescriptions per 1,000 residents (Standard Deviation) (Q4, 2015)	5.8 (4.2)	4.0 (3.3)	0.07

Characteristics highlighted in bold were statistically significant.

1 A two-sample T-test was used for all significance testing unless otherwise specified.
2 A non-parametric equality of medians test was used to determine statistical significance. The null hypothesis was that the two samples were drawn from populations with the same median.
3 A two-sample T-test correcting for unequal variances was used given the large difference between the variances of the two populations.

Counties with coalitions receiving CHCF training and support (N=23)*

Alameda	Contra Costa	Humboldt	Lake	Lassen	Los Angeles	Marin
Mendocino	Modoc	Napa	Nevada	Orange	Placer	Plumas
San Luis Obispo	Santa Clara	Santa Cruz	Shasta	Sierra	Siskiyou**	Sonoma
Tuolumne	Yolo					

Counties without coalitions receiving CHCF training and support (N=35)***

Alpine	Amador	Butte	Calaveras	Colusa	Del Norte	El Dorado
Fresno	Glenn	Imperial	Inyo	Kern	Kings	Madera
Mariposa	Merced	Mono	Monterey	Riverside	Sacramento	San Benito
San Bernardino	San Diego	San Francisco	San Joaquin	San Mateo	Santa Barbara	Solano
Stanislaus	Sutter	Tehama	Trinity	Tulare	Ventura	Yuba

*CHCF support included core funding ($60,000 over 18 months), monthly coaching, in-person and virtual access to physicians with coalition leadership experience, customized communications technical assistance, and virtual small group learning. Webinars and in-person convenings were open to all attendees.

**Although Siskiyou received CHCF funding, the coalition did not begin until late 2016 and is therefore considered a non-coalition county in this analysis.

***Several counties, such as Monterey and San Diego, had active coalitions prior to the CHCF network, and some contributed subject matter expertise, but did not receive CHCF training and support.

Table 2. Comparing trends in opioid prescribing among all California counties by CHCF opioid safety coalition status, Q4 2015 to Q4 2016

	Coalition County N=22*				Non-Coalition County N=36*			
	Baseline (Q4 2015)	Post (Q4 2016)	Difference	% Change	Baseline (Q4 2015)	Post (Q4 2016)	Difference	% Change
Opioids Prescribed per 1,000 residents	227.54	204.09	23.45	-10.31	214.19	200.09	14.10	-6.58
MMEs per resident	255.52	217.48	38.04	-14.89	241.11	211.27	29.84	-12.38
Residents on >90 MMEs per day for 30 days per 1,000 residents	11.28	9.78	1.50	-13.30	10.11	8.82	1.29	-12.76
Buprenorphine Prescriptions per 1,000 residents	5.84	6.99	-1.15	19.69	3.98	4.41	-0.43	10.80

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H. 7 Deadly Sins of Coalitions

1. **Debate to Death:** Nitpicking and nuancing every bit of information or potential action resulting in a bias for arguing over action.

2. **Social Orientation:** Commitment to the group as a group rather than the group as a vehicle for action with a clear goal destination and value proposition.

3. **Avoidance of Conflict:** Mask dissent or disagreement in order to create harmony at the expense of thoughtful vetting and buy-in. One of the most valuable roles that a coalition can play in today's policy environment is to uncover sticking points and resolve them within the coalition as opposed to airing grievances publicly.

4. **Lack of Technical Expertise:** Feeling that the coalition is a substitute for specific technical knowledge on things such as policy and advocacy work, fundraising, evaluation, etc. A coalition, in and of itself, is not advocacy, but rather a tool for generating effective advocacy. Coalitions need the skills and ability to conduct advocacy activities, which may be contributed by coalition staff or individual coalition members with specific advocacy skills (e.g., lobbying, grassroots mobilizing, media engagement, judicial intervention, etc.).

5. **Turn it Over to the Staff:** Members play a passive role, leaving the work of the coalition in the hands of staff members (who might be employed by the coalition or dedicated staff from member organizations).

6. **No Ongoing Role for Members:** Members in the coalition don't have specific tasks or assignments over time.

7. **Dividing up Credit:** As the coalition makes gains, members try to take individual credit for success over the coalition ("I did more than you and am therefore more responsible").

Source: Raynor, Jared. *What Makes an Effective Coalition? Evidence-Based Indicators of Success.* Funded and prepared for the California Endowment by TCC Group; March 2011

I. Coalition "Health Assessment"

RESPONSE	%	n
LEADERSHIP		
The overarching goal of the coalition is clearly stated and understood by all members.		
Excellent/Better than Average	100%	16
Average/Needs Improvement	0%	0
Don't know	0%	0
Total	**100%**	**16**
Members can articulate why the coalition is the appropriate tool for addressing the opioid crisis locally (as opposed to sectors or stakeholders working independently).		
Excellent/Better than Average	100%	16
Average/Needs Improvement	0%	0
Don't know	0%	0
Total	**100%**	**16**
The coalition has rules and procedures that are understood by all members, including member obligations and decision-making processes.		
Excellent/Better than Average	6%	1
Average/Needs Improvement	94%	15
Don't know	0%	0
Total	**100%**	**16**
The coalition has a leadership core team tasked with keeping the coalition on track.		
Excellent/Better than Average	69%	11
Average/Needs Improvement	31%	5
Don't know	0%	0
Total	**100%**	**16**
The coalition is action-oriented (i.e., more time is spent doing work than talking about it).		
Excellent/Better than Average	69%	11
Average/Needs Improvement	31%	5
Don't know	0%	0
Total	**100%**	**16**

RESPONSE	%	n
ADAPTIVE		
The coalition organizes its work around clearly defined goals. Action team members can articulate the current goals for their team.		
Excellent/Better than Average	75%	12
Average/Needs Improvement	25%	4
Don't know	0%	0
Total	**100%**	**16**
The coalition is able to pivot its strategy based on evolving needs.		
Excellent/Better than Average	69%	11
Average/Needs Improvement	31%	5
Don't know	0%	0
Total	**100%**	**16**
The coalition monitors and evaluates progress and effectiveness.		
Excellent/Better than Average	44%	7
Average/Needs Improvement	56%	9
Don't know	0%	0
Total	**100%**	**16**
MANAGEMENT		
The coalition has frequent and productive communication with all members.		
Excellent/Better than Average	50%	8
Average/Needs Improvement	50%	8
Don't know	0%	0
Total	**100%**	**16**
Members actively participate in coalition activities.		
Excellent/Better than Average	56%	9
Average/Needs Improvement	44%	7
Don't know	0%	0
Total	**100%**	**16**

Management continued next page

RESPONSE	%	n
Members are given clear tasks and goals.		
Excellent/Better than Average	50%	8
Average/Needs Improvement	44%	7
Don't know	6%	1
Total	**100%**	**16**
The coalition keeps careful records of assigned and completed tasks.		
Excellent/Better than Average	56%	9
Average/Needs Improvement	44%	7
Don't know	0%	0
Total	**100%**	**16**
TECHNICAL		
Staff in the coalition have a greater role in facilitating the work of the coalition than doing the work.		
Excellent/Better than Average	38%	6
Average/Needs Improvement	63%	10
Don't know	0%	0
Total	**100%**	**16**
The coalition has sufficient tangible resources (space, equipment, etc.) to carry out its activities.		
Excellent/Better than Average	75%	12
Average/Needs Improvement	25%	4
Don't know	0%	0
Total	**100%**	**16**
The coalition has sufficient subject matter knowledge to manage chosen strategies.		
Excellent/Better than Average	94%	15
Average/Needs Improvement	6%	1
Don't know	0%	0
Total	**100%**	**16**

RESPONSE	%	n
CULTURE		
Members in the coalition trust each other.		
Excellent/Better than Average	94%	15
Average/Needs Improvement	6%	1
Don't know	0%	0
Total	**100%**	**16**
Members feel free to disagree with one another in coalition meetings.		
Excellent/Better than Average	88%	14
Average/Needs Improvement	12%	2
Don't know	0%	0
Total	**100%**	**16**
Members speak with a united voice when speaking for the coalition, even if they are not in full agreement with all coalition decisions.		
Excellent/Better than Average	63%	10
Average/Needs Improvement	31%	5
Don't know	6%	1
Total	**100%**	**16**
Members in the coalition are engaged in steering committee activities on a consistent basis.		
Excellent/Better than Average	44%	7
Average/Needs Improvement	50%	8
Don't know	6%	1
Total	**100%**	**16**

Assessment tool adapted from the following report: *What Makes an Effective Coalition? Evidence-Based Indicators of Success.* Funded and prepared for the California Endowment by TCC Group (March 2011)

J. Key Informant Interview Guide

California Opioid Safety Coalition Assessment Key Informant Interview Guide

Target Audience: Coalition leads

Goal: Assess the "health" of the coalitions, as well as their strengths, needs, and gaps, to inform CHCF's future strategy.

Interviewer Name: (Drop Down)

Amy

Matt

1. Key Informant Name

   (Name)

2. Coalition

   - ☐ Alameda/ Contra Costa
   - ☐ Humboldt
   - ☐ Lake
   - ☐ LA
   - ☐ Mendocino County
   - ☐ Napa
   - ☐ Northern Sierra
   - ☐ Orange
   - ☐ Placer Nevada
   - ☐ San Luis Obispo
   - ☐ Santa Clara
   - ☐ Santa Cruz
   - ☐ Shasta
   - ☐ Siskiyou
   - ☐ Tuolumne
   - ☐ RCHC (Napa, Marin, Sonoma, Yolo)

3. Key Informant Role

   - ☐ Coalition Lead
   - ☐ Coalition Member
   - ☐ Clinical Champion
   - ☐ Coalition Coordinator
   - ☐ Other

4. Start Date of Coalition Role

   MM/DD/YY

5. When was your coalition kick-off meeting?

   MM/DD/YY

   Don't Know/Not Sure

I want to ask you some questions about your Coalition.

Each coalition has some real successes and some real challenges. We want to hear your insights and what you've learned in helping lead your coalition. This is not an evaluation of you or your coalition, and this interview will not affect your eligibility for future funding. Rather, we're interested in describing the factors associated with success and challenges, for our own learning to best support this work going forward.

6. What do you see as the single most important success of your coalition? What factors contributed to this success?

7. You reported X, X, and X as some challenges your coalition was facing (PULL FROM QUESTION 33 in SurveyMonkey for each interview). Is this still accurate? What do you see as the single greatest challenge your coalition faced? Can you describe what you would need to overcome this challenge? (PROMPT: Personal challenges leading a coalition? Burnout among coalition members?)

8. You reported that you needed _____ to sustain your coalition after CHCF grant funding expires in May 2017 (PULL FROM QUESTION 38 in SurveyMonkey for each interview). Does your coalition plan to continue operation after CHCF grant funding expires in May? What else would your coalition need to sustain, and potentially expand your work after May?

9. You reported X, X, and X as the top three training priorities for your coalition (PULL FROM QUESTION 37 in SurveyMonkey for each interview). Is this still accurate? Why were these your three top training needs? Can you anticipate training priorities for the future?

10. What sorts of technical assistance did your coalition utilize?

How useful were the following types of technical assistance provided to your coalition?

Category		Very Useful	Useful	Somewhat Useful	Not Useful	Unsure/ Didn't Use
1	Coaching calls	☐	☐	☐	☐	☐
2	Access to subject matter experts	☐	☐	☐	☐	☐
3	Mentor calls	☐	☐	☐	☐	☐
4	Mentors In-person visits	☐	☐	☐	☐	☐
5	Webinars	☐	☐	☐	☐	☐
6	LiveStories	☐	☐	☐	☐	☐
7	Informal networking with other coalition leaders	☐	☐	☐	☐	☐
8	Regional convenings	☐	☐	☐	☐	☐
9	CHCF publications	☐	☐	☐	☐	☐
10	CHCF newsletters	☐	☐	☐	☐	☐
11	CHCF website	☐	☐	☐	☐	☐
12	CHCF google drive resources	☐	☐	☐	☐	☐
13	Communications assistance	☐	☐	☐	☐	☐

Comments/Quotes for Technical Assistance

_____

_____

_____

11. Each coalition has the option of 10 hours of communications technical assistance. If you have used this time, was it helpful? If not, why not?

12. What else does your coalition need to be successful?

Now I want to ask you about California Opioid Coalitions in general.

As part of this CHCF coalition group, you've had some opportunities to engage with other coalitions.

13. Have you observed major common characteristics that define a successful, healthy opioid coalition?

14. What would you say are the major common challenges for California opioid coalitions?

15. What do you feel are key considerations for CHCF, or any other organizations, that support California opioid coalitions in the future?

16. As coalitions evolve, aside from safe prescribing, MAT and naloxone, are there other strategies that should be prioritized to address the opioid epidemic?

17. Is there anything else that you think would be useful for us to know about how to best support CA opioid coalitions in the future?

I'd like to ask you a series of general coalition performance questions, and ask you how well you feel your coalition is doing in each area by ranking it as Excellent, Better than Average, Average, or Needs Improvement. You can also let me know if you don't know.

LEADERSHIP

18. The overarching goal of the coalition is clearly stated and understood by all members.

☐ Excellent
☐ Better than Average
☐ Average
☐ Needs Improvement
☐ Don't Know

19. Members can articulate why the coalition is the appropriate tool for addressing the opioid crisis locally (as opposed to sectors or stakeholders working independently).

☐ Excellent
☐ Better than Average
☐ Average
☐ Needs Improvement
☐ Don't Know

20. The coalition has rules and procedures that are understood by all members, including member obligations and decision-making processes.

☐ Excellent
☐ Better than Average
☐ Average
☐ Needs Improvement
☐ Don't Know

21. The coalition has a leadership core team tasked with keeping the coalition on track.

☐ Excellent
☐ Better than Average
☐ Average
☐ Needs Improvement
☐ Don't Know

22. The coalition is action-oriented (i.e., more time is spent doing work than talking about it).

- ☐ Excellent
- ☐ Better than Average
- ☐ Average
- ☐ Needs Improvement
- ☐ Don't Know

ADAPTIVE

23. The coalition organizes its work around clearly defined goals. Action team members can articulate the current goals for their team.

- ☐ Excellent
- ☐ Better than Average
- ☐ Average
- ☐ Needs Improvement
- ☐ Don't Know

24. The coalition monitors and evaluates progress and effectiveness.

- ☐ Excellent
- ☐ Better than Average
- ☐ Average
- ☐ Needs Improvement
- ☐ Don't Know

25. The coalition is able to pivot its strategy based on evolving needs.

- ☐ Excellent
- ☐ Better than Average
- ☐ Average
- ☐ Needs Improvement
- ☐ Don't Know

MANAGEMENT

26. The coalition has frequent and productive communication with all members.

- ☐ Excellent
- ☐ Better than Average
- ☐ Average
- ☐ Needs Improvement
- ☐ Don't Know

27. Members actively participate in coalition activities.

- ☐ Excellent
- ☐ Better than Average
- ☐ Average
- ☐ Needs Improvement
- ☐ Don't Know

28. Members are given clear tasks and goals.

- ☐ Excellent
- ☐ Better than Average
- ☐ Average
- ☐ Needs Improvement
- ☐ Don't Know

29. The coalition keeps careful records of assigned and completed tasks.

- ☐ Excellent
- ☐ Better than Average
- ☐ Average
- ☐ Needs Improvement
- ☐ Don't Know

TECHNICAL

30. Staff in the coalition have a greater role in facilitating the work of the coalition than doing the work.

- ☐ Excellent
- ☐ Better than Average
- ☐ Average
- ☐ Needs Improvement
- ☐ Don't Know

31. The coalition has sufficient tangible resources (space, equipment, etc.) to carry out its activities.

- ☐ Excellent
- ☐ Better than Average
- ☐ Average
- ☐ Needs Improvement
- ☐ Don't Know

32. The coalition has sufficient subject matter knowledge to manage chosen strategies.

- ☐ Excellent
- ☐ Better than Average
- ☐ Average
- ☐ Needs Improvement
- ☐ Don't Know

CULTURE

33. Members in the coalition trust each other.

- ☐ Excellent
- ☐ Better than Average
- ☐ Average
- ☐ Needs Improvement
- ☐ Don't Know

34. Members feel free to disagree with one another in coalition meetings.

- ☐ Excellent
- ☐ Better than Average
- ☐ Average
- ☐ Needs Improvement
- ☐ Don't Know

35. Members speak with a united voice when speaking for the coalition, even if they are not in full agreement with all coalition decisions.

- ☐ Excellent
- ☐ Better than Average
- ☐ Average
- ☐ Needs Improvement
- ☐ Don't Know

36. Members of the coalition are engaged in steering committee activities on a consistent basis.

- ☐ Excellent
- ☐ Better than Average
- ☐ Average
- ☐ Needs Improvement
- ☐ Don't Know

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PUBLIC HEALTH INSTITUTE®

Headquarters 555 12th Street, 10th Floor, Oakland, CA 94607 tel: 510.285.5500
Washington Office 1201 Pennsylvania Avenue, NW Washington, DC 20004
www.phi.org