



**CHAMPS Substance Use Disorder Best Practices Podcast Series**  
**Episode 4: Interview with Dr. Lesley Brooks**  
**From Sunrise Community Health**  
**Interview Date: March 29, 2019**

**Rachel Steinberg:** Welcome to the fourth episode of the Substance Use Disorder Best Practices Podcast Series, produced by [Community Health Association of Mountain/Plains States](#), or CHAMPS. I'm your host, Rachel Steinberg, the CHAMPS Substance Use Disorder Program Specialist. In this series we're highlighting some of the interesting and innovative ways that health centers in Region VIII are addressing substance use disorders. We think the best way to share these ideas is to speak directly with the health center staff who are providing these services and running these programs.

In our last episode, we focused on the importance of local collaborations to address substance use disorders. Today we'll continue to explore how collaboration can positively impact substance use disorder efforts, particularly when it comes to addressing community-wide treatment gaps in areas like criminal justice. I'm thrilled to welcome Lesley Brooks of [Sunrise Community Health](#) to our program. Thank you so much for being with us today, Lesley.

**Lesley Brooks:** Thank you so much for having me Rachel, it's great to be here.

**Rachel Steinberg:** So Lesley, you work at Sunrise Community Health, but you and Sunrise are part of this larger collaborative group that you call the Alliance. Can you tell me a little about you and your role at Sunrise, and then also what the Alliance is and how it formed?

**Lesley Brooks:** Absolutely, absolutely. I'm thrilled to talk about this, and as I mentioned to you before I could talk about this all day long. It is one of the things that I truly enjoy about my job. So by way of introduction, my name is Lesley Brooks, and as you said Rachel I serve as the Chief Medical Officer for Sunrise Community Health. And as with so many of us I wear multiple hats, and I have too many jobs probably. I also serve as the Assistant Medical Director for something called the [North Colorado Health Alliance](#), and the Health Alliance really is one of the ways in which the work that we are doing has really taken shape and really galvanized and coalesced a lot of our community partners in this. So I serve as the Assistant Medical Director for the North Colorado Health Alliance. I also serve, importantly for this conversation, as the Co-Chair for the [Provider Education Workgroup](#) for the [Colorado Consortium for Prescription Drug Abuse Prevention](#) – it's a long, big mouthful of a title, but it's essentially the state's response to the opioid crisis. It is a largely volunteer organization that really has devoted itself to, how does Colorado respond to the opioid crisis? And I co-chair the Provider Education Workgroup, where I have been running around the state for the last three or four years – really since I started work at Sunrise and the Alliance – educating my fellow providers on safe opioid prescribing, on laws and regulations, and on opioid use disorder and medication assisted treatment. And that's really, really evolved over time, and that's been a partnership of the Alliance and the Consortium as well. So that's who I am.

So partnership I really believe is one of the things that we in northern Colorado do exceptionally well, and it's one of the things that I believe Sunrise does exceptionally well. We really appreciate the fact that we can't be all things to all people, and so where we don't have the expertise we really try to hard to partner as robustly as possible. And the Alliance – the North Colorado Health Alliance – is an incredible example of how northern Colorado partners. The Alliance partnership started back in 2002 – so almost 20 years ago – and it started as a partnership between the public health department and the Community Health Center all deciding that wellness

was a community issue, and that there needed to be a place in both space and time where stakeholders committed to wellness in the community could gather. And that included some uncommon partners, right? So school districts, and the health and human services – which is a very common partner – and the Community Health Centers, as well as our local hospitals. And so this partnership really sort of started as a kernel of thought between our public health partners and our community health partners saying, how do we get a robust community response to wellness? It is a public and private venture that really seeks to treat community health as a single complex phenomenon, and our work around advocating for and recognizing substance use as the complex community health issue that it is really begins with the North Colorado Health Alliance.

Through our work with running around the state and providing education, we then, probably about two years ago in May of 2017, we started something called the Northern Colorado Opioid Prevention Work Group, and that too was yet another partnership. That was, in my work as the Assistant Medical Director for the Alliance, as the Chief Medical Officer for Sunrise, and as partners with [SummitStone Health Partners](#), we sort of said – boy, one, we need to start a medication assisted treatment clinic, and we did, in a partnership between SummitStone and Sunrise. Sunrise and [North Range \[Behavioral Health\]](#) also have a similar partnership, this is just where this conversation began. And as we were starting that clinical work, that person and I – the SummitStone Chief Operations Officer at the time – said, boy this is a great effort and we are doing yeoman’s effort to bring our two entities together – because there are a whole slew of reasons why a [Community Health Center](#) and a [Community Mental Health Center](#) can’t work together, right? And we just worked around all of those things.

But beyond that, we kind of took this 50,000-foot view and said, this is not just a Sunrise and SummitStone issue, this is a community-wide issue, and began the work group. And through that work group we brought together all those same stakeholders – so health departments in both counties, Community Mental Health Centers in both Weld and Larimer County, which is in northern Colorado, advocacy organizations. Our OTPs – our [Opioid Treatment Programs](#) – also came to the table in that process, and they rolled up their sleeves and said, yeah, absolutely this is a community-wide issue, and how do we partner with you all to get people with opioid use disorder to the right level of treatment? So our methadone clinics came to the table – methadone clinics, for those of you who may be new to this world, is synonymous with an Opioid Treatment Program. Methadone clinic is the old name, OTP or Opioid Treatment Program is the new name. So OTPs came to the table.

Our law enforcement came to the table. We were really carving – just as the Alliance had done almost 20 years ago – we were really carving uncommon partnerships once again. So we invited law enforcement to the table, understanding that there are pockets in our community where we are housing folks, and really detoxing them from their opioids, from their alcohol, etcetera, etcetera, and those people as they leave those areas really need a transition plan. They need a place to land. And our law enforcement partners were really looking for a partnership to go, we recognize that this is an issue, we also realize that we are not doctors, we are not behavioral health specialists, and that this is not our bailiwick, and so we need partners to make sure that these folks get to the right place and figure out how to stop that revolving door. So too with our emergency departments and our hospitals – they too came to the table and said, we also want to help. So this work that we are doing really around substance use and hub-and-spoke model, which I know we’re going to talk about, really came out of that Northern Colorado Opioid Prevention Work Group, which started with a partnership that is the North Colorado Health Alliance.

**Rachel Steinberg:** That’s fantastic, that’s so many partnerships, so that’s so much to take in. But it really – I mean, to some extent yes, it started in 2002 – but is also started when you identified this 3,300-person gap in

substance use disorder treatment in Larimer and Weld Counties. So can you tell me a little bit about the ways that the Alliance and these partners and all of these organizations are addressing this gap now?

**Lesley Brooks:** Absolutely, and that is – it has been in some respects a long journey and a quick journey. It has happened in a really truncated period of time. As I mentioned, that Northern Colorado Opioid Prevention Work Group started meeting in May of 2017, and we brought together all of those partners and we identified three – through a strategic planning process that one of our partners, yet another partnership, the [Health District of Northern Larimer County](#), which is another agency devoted to partnerships and to wellness in northern Larimer County – they too came to the table as a member of this organization, and really walked us through this strategic planning process, which they do so well, and none of the rest of us had that expertise. And they really said, we really think we need a strategic planning process to guide our efforts. And through that strategic planning process we identified three main areas to really focus our work. The first was harm reduction, the second was prevention, and the third was identification and treatment.

We met our harm reduction strategic planning goal with a naloxone work group that had already been started, and many of our partners were part of that naloxone work group, looking at our community and identifying places where naloxone delivery and naloxone training were really high-value. The second is prevention. And we met that strategic planning goal through applying for a [CDPHE \[Colorado Department of Public Health and Environment\]](#) grant to get funds to do provider education. And we spent the summer and fall of last year running around our two counties and doing a lot of provider education work – a lot of the work that we had started in the Alliance and through the work of the Consortium years before. So it was really easy to bring that resource here to northern Colorado.

And finally, the identification and treatment strategic planning goal we met – really initially said that that bucket, we really wanted to enhance our criminal justice partnerships. We didn't have – we had some at the beginning, but we didn't have a great deal of them. And so the first goal was sort of to go out and create – go out and meet people, right? Go out and create those partnerships. And really what we did was, throughout Larimer and Weld, we – between the health district, SummitStone, Sunrise, and the Alliance – we really went around and did these educational efforts to probation, to community corrections, to our treatment court judges, to our criminal justice advisory council, to parole. I have met so many law enforcement partners and through educating them around what is a substance use disorder, what is medication assisted treatment and why does it work, we really laid the groundwork for what we're going to talk about, which is our [SAMHSA \[Substance Abuse and Mental Health Services Administration\]](#) grant.

So we then, as we sort of laid this groundwork, in about February or March or so of 2018, we of course on the work group had heard about Vermont and their work in establishing a hub-and-spoke model, right? And they, [Denver Health](#), hosted them in a sort of community-wide education event, and we took a road trip. We took a road trip to Denver to see Vermont. And there were three or four of us who went together – again, you know, our partnership – and spent the day listening to [Dr. John Brooklyn](#) and Tony Poland from Vermont really talk about how they established a [hub-and-spoke model](#). And there were some really interesting things about what they did – they really kind of had a blank slate. And they had a galvanizing event – on the cover of [Rolling Stone](#) I think was an image of Vermont as a place you could get heroin. That was really jarring for them, and it really galvanized their base and created some coalition work that wasn't happening before. So – and talked about the elements that they needed to put this together. They talked about, you know, community-based care coordination, they talked about primary care partnering with Opioid Treatment Programs and with Community Mental Health Centers. And as we drove back from that event, you know, February, March of 2018, one of our

partners said, boy, do you think we in the work group would be interested in thinking about a hub-and-spoke model?

And we were like, hmm, I think so. Do we have all the things that we might need to create a hub-and-spoke model? Do we have community-based care coordination? Absolutely. Do we have providers offering medication assisted treatment? We actually are really lucky in northern Colorado to have a number of providers doing MAT already. And that was really very different than the Vermont model, where they really didn't have very many. So second box checked. Do we have OTPs who are willing to partner with us? Check, we have those. Do we have hospitals who are willing to partner? Check, we have those. And do we have law enforcement who was at our table? Yes, we have those. And suddenly we were like, oh my gosh – we don't have any money, but we have all the elements of a hub-and-spoke model. And initially we had a stakeholder meeting with all of those folks – law enforcement, hospital, jail, community mental health, our Medicaid – state Medicaid and the [Regional Accountable Entity](#) – were all present at an initial meeting to kind of go, hey, what might this look like?

And then the SAMHSA grant came up. It was a \$1.5 million grant over the course of three years that we applied for as a collaborative between Weld and Larimer counties in northern Colorado. And we had a writing team, we had about a – I don't know, like a five or six-week window to put this together. We had a writing team of seven or eight of us, and it really was an incredible collaboration of sort of saying, yep, we've got all the elements – how could we put this together? And so as part of that initial group where we got the hospitals and jails together to say, you know, we don't have any money but we want to put together a hub-and-spoke model, we put together that treatment gap analysis that told us that we had about 3,300 patients that we weren't serving with MAT who had an opioid use disorder who weren't getting treatment. It's a rough estimate. And we all really – the crux of this is that we all agreed that we want to serve that population, but none of us had capacity for 3,000 patients, and quite frankly not one of our treatment programs is appropriate for every single one of those individuals. So we all recognized that we had something different to offer and really needed a network to address those needs.

We proposed a phased approach to a hub-and-spoke model using this network, which we called COSLAW – so COSLAW stands for [Colorado Opioid Synergy Larimer and Weld](#). COSLAW. So what we wrote in the grant was to establish the network and take a phased approach to a hub-and-spoke model. So the first phase was to get all of those partners connected – talking to one another, signing a care compact that we would agree to these big principles of how we would treat substance use disorder, signing BAAs [Business Associates Agreements] so that we can share information, and really being connected electronically. We partnered, once again, with a company called Rx Assurance. Rx Assurance has developed an electronic health record called [OpiSafe](#). It is a mini electronic health record that helps you to manage patients on a controlled substance. And our hope inside the network of eight of us is to be connected electronically through OpiSafe so that we can share information. And really our eyes on the prize is that if Lesley, as a patient, has done reasonably well at Sunrise but, you know, for whatever reason there's a bump in that road and she sort of disappears for a while and turns up across the highway at [Salud \[Family Health Centers\]](#), that OpiSafe would be a way for Salud to then go, oh, Lesley was part of the network, if she's consented and agrees, and so that then Salud can begin to treat Lesley and not fly blind, and understand some of the treatment that was delivered to her before.

So again, three phases – phase one was connectivity. Phase two is transitions of care. So again, from the ED, from our jails, from our hospitals, getting those individuals to initiate buprenorphine therapy or initiate MAT in those settings, and doing warm handoffs to one of our COSLAW treatment providers. And then finally, phase three is development of a hub-and-spoke model. And we just – we have tremendous respect for the work that

the Vermont folks have done, and it really laid the groundwork for us to think about how we do this. But really what we wanted in northern Colorado was to have a hub that was more than just a place where you could get opioid use disorder treated. Because we firmly believe that our opioid crisis at some point is going to plateau, right? But waiting for us is the next substance use disorder crisis, right? Opioid use disorder is not our only substance use disorder issue in this country. Alcohol use disorder is a tremendous issue. Tobacco use disorder is a tremendous issue. And of course, folks with a methamphetamine use disorder are – in northern Colorado, it is a huge, huge problem. And we want to make sure that whatever hub that we develop is not only right-sized to treat opioid use disorder, but is prepared for whatever substance use disorder crisis may be awaiting us.

**Rachel Steinberg:** So with that many partners, I have to imagine there have been some hiccups, there have been some barriers as you've implemented this model. So can you talk a little bit about – especially from the perspective of Sunrise, from a Community Health Center perspective – what are the challenges of this kind of complex partnership?

**Lesley Brooks:** Absolutely, absolutely. And I think one of the – first of all, one of the things that we as members of complex and rich partnerships really understand is that there are bumps on this road, six days a week and twice on Sunday there are bumps in this road. And we all agree that we're going to make it to the other side of those bumps. By definition, those bumps are going to happen because our funding streams are different, the way we get paid is different, the codes that we use to see and treat patients are different. And so bringing those things together is necessarily maybe points of friction. But we all agreed that we are going to make a puzzle. We're going to play puzzle, not poker. Nobody's going to take the corner piece and hide it just so that they can finish the puzzle, you know, after everybody else is confused and looking for it, right? We all agreed that we are going to problem solve.

So with that in mind – yes, there have been bumps in this road. I told you about that strategic planning process, right? So that coalition of folks, we had a whole bunch of partners at the table who have different strengths, right? And most of us are doers – we are like, we want to get to work and, you know, start developing programs and treating people and blah blah blah. And our partners at the health district really said, you need a strategic planning process – otherwise you will be wayward. And so we probably took a good four to six weeks to develop a strategic planning process map. And so that was – it took some coming together of minds to go, this process is really worth doing, and balance that out with the need to get to it, to really start doing that work.

As a Community Health Center, there are by definition bumps in the road in partnering with our Community Mental Health Centers. We are both doing incredible work, but our funding streams are different, the codes that we use to treat people are different, our EHRs are different. There's about a million reasons why those partnerships shouldn't work. And the ways in which we solved for those things are many. You know, sometimes we double-document – I know that's a pain point for many. We also have come to some agreements. So getting sort of into the weeds. You know in our MAT clinic, which is a partnership between SummitStone and Sunrise – again, we have the same partnership with Front Range – in that model we function in clinic together. So we both have processes for doing urinalyses [UAs] on patients with a substance use disorder. But we were seeing patients in clinic together, so we really had to figure out, who's going to do the UA, you know, and are we going to make people do it twice? No, we're not going to do that. So we really had to problem solve. Yeah, we'll use your UA. It just so happens that SummitStone's urinalysis is a more robust urinalysis than we do as a point of care test. So we said that anybody who's coming in that needs a UA that you already have one on, we're going to use yours and we're going to scan it into our system.

Other, by definition, points of challenge between Community Health Centers and Community Mental Health Centers is that our Community Health Centers don't have a CCAR [Colorado Client Assessment Record] and a DACOD [Drug and Alcohol Coordinated Data System]. And for our Community Mental Health Centers those terms may be familiar to you. At least in Colorado, those are state-mandated intake forms that need to be completed for a patient in order to continue being seen at the Community Mental Health Center. And if that person isn't seen frequently enough, those CCARs and DACODs need to be closed, and that patient really needs to be closed to Community Mental Health Center services. And for our Community Mental Health partners who may be listening to this podcast, please forgive me if I didn't get all the details in that process. But I think I got the broad strokes right. And that is very different from the Community Health Center world, where really, once a patient of the Community Health Center, always a patient of the Community Health Center. You go away for three years and come back, someone is going to ask you for an updated address, they're going to want to do some financial screening, but there is a very limited amount of steps between you returning three years later and making an appointment for services. And that sort of open and closing process on the part of our Community Mental Health Centers could potentially be an area of strain as you try and partner together.

And once again, we sort of said, look, we're going to continue to serve this patient. And what we really said on the Community Health Center side was, we believe in the behavioral health treatment of patients with a substance use disorder. We believe that it gets better. Medication and therapy is the gold standard for treatment of a substance use disorder. But we're not going to not serve people just because they may not be ready to address the "ick," right? The trauma, the neglect, the abuse, the mood disorder, etcetera etcetera. We are going to continue to serve them and continue to ask them as they travel this journey toward recovery, are you ready for treatment? Are you ready for the mental health treatment that really is going to take you to the next level? So we start with medication assisted treatment and behavioral health, the medication and the mental health therapy together. We make an assumption that that's going to go hand-in-hand. But if it doesn't, it doesn't stop us from delivering care.

Our partnership with criminal justice, I mentioned before – those were uncommon relationships. It's not frequently that primary care has a relationship with our county jail. It's not uncommon for our Community Mental Health Centers, but it was really uncommon for us in the primary care world. So those were relationships that we had to go about and build, and again we did so by really laying the groundwork and being the deliverers of training on, what is a substance use disorder? Let's really talk about that. And, you know, we really talk about the [Partnership for a Drug-Free America Campaign](#) in 1987 that showed you an egg, cracked that egg in a skillet, and said, you know, this is your brain and this is your brain on drugs, right? And how that's not a great explanation for substance use disorder, and really begin to talk about brain science and what are the criteria for a substance use disorder, and really bring that down to the level that people can begin to understand and begin to give up some of the trappings that they have around what they think a substance use disorder is. So that was really one of the ways in which we broke down those barriers.

And I think lastly, one of the ongoing, I think, challenges – it's not a barrier – but a challenge is, our folks in our recovery community often have a different perspective on the role of medication in achieving recovery. And I just – we inside the opioid prevention workgroup and we inside medication assisted treatment clinics, really have put forth a voice of, there is room for everything on the road to improved access to treatment of patients with substance use disorder. A good many people come to their recovery through abstinence-only programming, and we don't want to take that away from people. And what we want is to say, we want you to get primary care, we want you to get substance use care, and we want you to get mental health care. And if what that looks like for you as you come to treatment is abstinence-only, we want to make that happen for you.

But if you feel like medication can assist your recovery, we want to make that happen for you as well. But I think that, you know, is an ongoing challenge, of how we come together to provide evidence-based treatment for substance use disorders.

**Rachel Steinberg:** So you mentioned a little bit there your goal of expanding medication assisted treatment to patients in the criminal justice system, and my understanding is that that recently started or is just getting off the ground or is close to getting off the ground – can you tell me what that’s looking like right now?

**Lesley Brooks:** Absolutely. I think that’s – this whole thing is super exciting, you know. So I mentioned that really that work was supposed to happen in phase two. We were supposed to start those transitions of care from our emergency departments and hospitals and jails in phase two, which technically wouldn’t begin until September of 2019. But that work is happening now, surprisingly. And again, through all of that education that we have been doing, we’ve really just sort of teed up the ability to get started with this work. So on the criminal justice side, again, we had done all of that education to, you know, community corrections, probations, parole, our treatment court judges, our criminal justice advisory council, and anybody else who would listen to us. We hosted opioid overdose awareness day and gave these messages to our community. And through that work we began to really have dialogue with our criminal justice partners about, boy, what would it look like if we were able to offer medication assisted treatment upon discharge? And began to have dialogue around that question.

On the SummitStone side, on one of our partner’s side, they had some grant dollars that they needed to spend, and they had a robust pot of money that they could spend toward initiation of MAT in the jail. So we formed a coalition – because we had met people, we formed a small work group that included our Larimer County Jail leadership, that included leadership and management team members from the health service that provides healthcare in the jail – the county does not do that themselves, they contract with an entity, in this case Armor, to provide those healthcare services – and the Northern Colorado Opioid Prevention Work Group. A small group of us came together with those folks and said, boy, what do you think this might look like?

The jail was open to it. We were initially talking about kind of a small program. And through lots and lots of good conversation sort of came to an agreement around, well maybe this doesn’t have to be so small. Maybe we really can offer this to all of the inmates coming through. And we then began to talk about, well, boy, if we’re going to offer this to everyone, how quickly in the process of getting to jail can we offer this – and not just discharge, but could we offer it upon admission, or upon booking? An evaluation for this upon booking? Once again, our health district partners led us through a strategic planning process to work out the workflows for, what if someone comes in and they have an opioid use disorder? What if someone comes in and they have an alcohol use disorder? And what are the ways in which we deliver medication assisted treatment to those individuals? And how do we use our existing JBBS services – [Jail-Based Behavioral Health Services programs](#), that are programs, established programs inside our jails – how do we take those services and expand them so that we’re not only getting medication for a substance use disorder, but also offering the mental health treatment that those individuals need? And so it is really exciting – we have planned for a comprehensive program of medication assisted treatment delivery inside the Larimer County Jail to both initiate people on buprenorphine and naltrexone, and to continue folks on buprenorphine, naltrexone, and methadone if they come to the jail on those things. So we’ll have initiation for two forms of MAT and continuation for all three forms of medication assisted treatment – it’s a little tricky to do initiation of methadone outside of an Opioid Treatment Program, so that wasn’t, you know, a real possibility for us.

But that's how that happened, and we are doing similar work with our emergency departments. Educating those providers on how you initiate someone – how you recognize opioid use disorder when it shows up in the emergency department, how you deploy buprenorphine for those patients who are in withdrawal, and then a warm handoff to the COSLAW network. The COSLAW network has an 800 number that those ED providers can use to say, I treated Lesley this afternoon at 2 o'clock, started her on 8 milligrams of buprenorphine, and I gave her your number, she's coming to you, will you please get in touch with her? And that's one of those barriers that answers the question you asked me before – one of the barriers that our emergency department providers identified early on is that, look, it is really hard for us to do something if we don't have some semblance of assurance that they're going to get where they need to go. So for us, prescribing buprenorphine requires that we ensure that they get referred and that, to the extent that we can, that that referral gets closed. So we said okay, we can meet you there. With the SAMHSA grant we have care coordinators. We'll have an 800 number. You get them started, you call us, and our care coordinators will deploy to go in and engage with that person and get them into treatment.

**Rachel Steinberg:** So what impact are you seeing as a result of these strong partnerships? What is this looking like on the ground for patients and also for the partners?

**Lesley Brooks:** Oh my gosh, Rachel, people are getting treated! People are getting the treatment that they need and deserve, and our care managers are in the community identifying people and shepherding them into treatment. I mean, it's working – again, with the bumps in the road that we mentioned before – it is working as we had planned, and we are really looking forward to how this evolves and being able to really see a lot of transition, a lot of treatment happening in those transition sites. We are working on the electronic health record – the mini electronic health record I told you about – and getting that stood up as the glue that sort of holds us together. And so those pieces are yet to come. But so yeah, it's working.

**Rachel Steinberg:** Sort of to wrap it all up, what advice do you have for other health centers that are dealing with substance use disorders in their communities, especially those that want to partner with other organizations but might not be sure how to start?

**Lesley Brooks:** Yeah, great question for the folks on the call who are like, oh my god, you mentioned in the course of 20 minutes, you know, 35 partnerships – there's no way I can do that, I'm out. So don't hang up just yet. All of those partnerships predate me, all of them. And what I will say is, it's not as hard as you think. Partnering with our Community Mental Health Centers has really been one of the highlights of the work that we do because there are ways in which we can come together to deliver better care to our patients. Even if it's not, you know, embedded in your Community Health Center and available through the walkie talkies that you use in clinic – even if it's not all of that, just developing those partnerships and developing those name-recognition, face-recognition, and a recognition of the areas where your work overlaps will by definition lead naturally to areas where you can partner and work together. I can tell you that, again, working with our law enforcement partners, I think they have been thrilled to have the community at the table. We have brought dollars through grant work to support patients leaving the jail and getting to treatment, and the opportunity to stop the revolving door of criminality and arrest and detention and release and re-arrest, and to stop that cycle is tremendous I think for them. And they've been, I think, happy – I don't want to speak for them, but happy to have us at the table.

And so how do you do that? I think there are some natural places where partnership really helps us. Our community-based policing really reached out to the Alliance a few years ago and said, hey, we encounter Lesley

on a park bench all the time, and we have two choices when we do that – we can either take her to jail, or we can take her to the hospital. And we know she doesn't need to go either place, so help us figure out how we have a differential response to her. And they were really interested in having us come along. We have something called an inter-agency work group where law enforcement and healthcare have come together to talk through some of those high-risk, high-utilizing patients, and that was one place where we have developed relationships with our law enforcement partners. So I think that might be an area that folks could explore. But I guess at the end of the day I think our partners are not as far away from us as we think and you are likely working with them already in ways that you haven't recognized, and you can reach out to them.

**Rachel Steinberg:** Well thank you, Lesley, for sharing that advice with our Region VIII health centers. And thank you for joining us today for our fourth episode of this Substance Use Disorder Best Practices Podcast Series.

**Lesley Brooks:** This was super fun, Rachel. Thanks for having me.

**Rachel Steinberg:** This and other episodes in our series are available for free download at [www.champsonline.org](http://www.champsonline.org) on our Events & Trainings webpage in the CHAMPS Clinical Podcasts section. Typed transcriptions of each episode are also available. If you're interested in recording an interview for our series, please let us know by sending an email to [rachel@champsonline.org](mailto:rachel@champsonline.org). Thank you for listening!