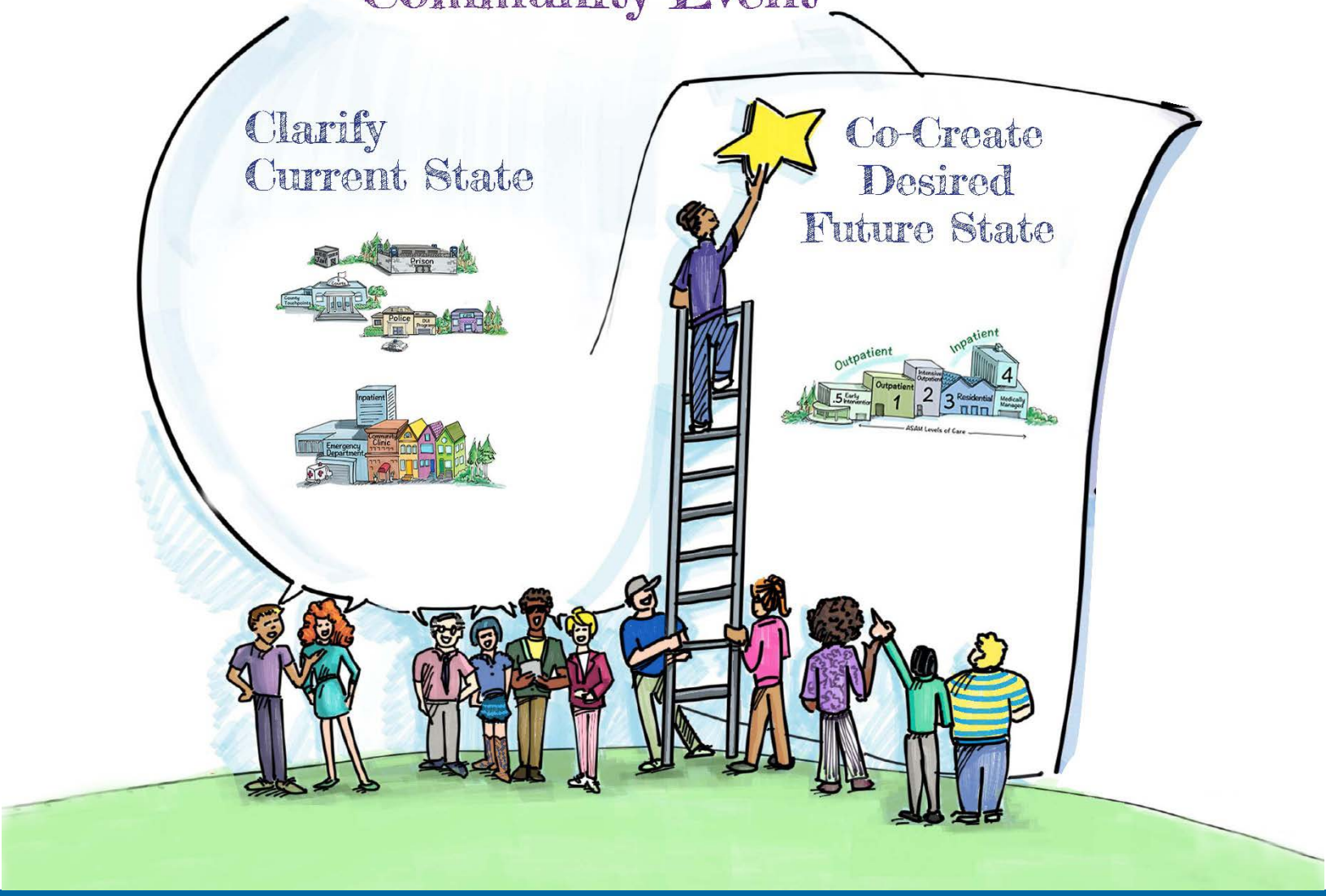
Collaborative Provider Community Event



BUILDING SUSTAINABLE TRANSITIONS OF CARE FOR PEOPLE WITH ADDICTIONS

Kern County Community Process Improvement Event

June 3-4, 2019

HEALTH MANAGEMENT ASSOCIATES

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Executive Summary

Overdose is the leading cause of accident-related death in the United States. The vast majority of these overdoses come from a combination of prescribed opioids and heroin. As we have watched the opioid crisis worsen over the last 10 years, we have reached a point where the treatment system, in its current state, can no longer handle the volume of patients needing care. Opioid use and overdose have been increasing in California, though the rates of use and overdose are lower than in many states.

Understanding this reality, the federal government has allocated billions of dollars to states to build appropriate systems of care for patients with opioid use disorder (OUD) and other addictions; including the State Treatment Response (STR) and State Opioid Response (SOR) grants. The California Department of Health Care Services (DHCS) received STR and SOR grants which are being used for the California Medication Assisted Treatment (MAT) Expansion Project. This initiative aims to serve an estimated 290,000 individuals with Opioid Use Disorders (OUD), prevent drug overdoses, and treat OUD as a chronic disease. Health Management Associates (HMA) received SOR funding from DHCS to focus on developing predictable and consistent transitions of care to sustain addiction treatment as individual transition from locations such as emergency departments, jails, primary care clinics, the community at large and/or inpatient hospital settings. Ten counties across California were selected to participate in the Transitions of Care project based on need and capacity within the county. The Transitions of Care project: 1) engages stakeholders in each selected county in a two-day countywide process improvement event and; 2) subsequently provides 12 months of ongoing technical assistance to support the county in achieving their ideal future state for addiction treatment. Kern County, one of the 10 counties selected, participated in a large-scale process improvement event on June 3 - 4, 2019 that included members from different aspects of government, healthcare, addiction treatment, and those who pay for that treatment. During the event, attendees participated in intense work sessions with a focus on identifying current treatment processes, barriers and gaps in these processes and a future state treatment system to support transitions of care for Kern County residents in need of addiction treatment and support services.

Kern County Behavioral Health partnered with HMA to convene stakeholders, examine the disease of addiction and evidence-based treatments, and to conduct an evaluation of the entire addiction treatment system in and around Kern County, CA.

The two-day event concluded with a group discussion about the ideal elements of a future state, including stronger coordination, a “no wrong door” approach to service delivery, effective communication about the services available in Kern County and reduced stigma around substance use disorders. In addition to these elements of a future state, HMA recommends a ubiquitously used release of information form, a universal standardized screening based on the NIDA 4, and a narrow set of severity tools as well as the American Society of Addiction Medicine’s (ASAM) criteria for level of care placement.

The rich discussions held over the two days coupled with the didactic training of all parties involved will yield one of the most comprehensive and easy-to-use addiction treatment ecosystems in the country. To implement the future state as envisioned by this group, there will need to be ongoing collaborative interaction and a bevy of systems developed to receive and track patients as they flow through the system. However, given the collective buy-in by the County, we should be able to achieve this over the next year without significant difficulty.

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Section 1: Introduction and Background

A. Level Setting

Overdose is the number one cause of death for people under 50 years old. For the first time in the history of the United States, drug overdose kills more people annually than car accidents or gun violence. The vast majority of these overdoses are due to opioids, including prescription pain medication, heroin and synthetic opioids. Opioid use has been increasing in California, though the rates of use and overdose are lower than in many states. The number of heroin-related emergency department visits in California more than tripled between 2006 and 2017. Non-heroin opioid-related ED visits nearly doubled during the same time. In 2017, 1,335 of the 1,882 deaths from opioid overdose in California involved prescription opioids. Death rates from heroin overdose have remained flat since 2014, after annual increases from 2011 to 2014. Deaths resulting from fentanyl overdose increased by more than 50% between 2016 and 2017.

In response to this, DHCS applied for and received over $140 million dollars in support from the federal government to build appropriate systems of care for patients with opioid use disorder and other addictions, such as methamphetamine or alcohol use disorders. California is utilizing State Treatment Response (STR) and State Opioid Response (SOR) dollars to fund the California Medication Assisted Treatment (MAT) Expansion Project which aims to serve an estimated 290,000 individuals with Opioid Use Disorders (OUD), prevent drug overdoses, and treat OUD as a chronic disease. The first phase of the project, California MAT Expansion Project 1.0, is funded by STR and focuses on populations with limited MAT access (including rural areas, American Indian and Alaskan Native tribal communities) and increasing statewide access to buprenorphine. The California MAT Expansion Project 2.0 project is funded by SOR and builds upon the existing STR funded work. California MAT Expansion Project 2.0 runs for two years beginning in September 2018.

HMA received SOR funding from DHCS to focus on developing predictable and consistent transitions of care to sustain addiction treatment as individual transition from locations such as emergency departments, jails, primary care clinics, the community at large and/or inpatient hospital settings. Through rigorous assessment of all 58 counties in California, HMA identified Kern County as being an optimal location to build and stabilize such transitions of care to decrease the risk of overdose and death amongst citizens with opioid use disorder. In addition to Kern County, nine other counties were identified as key locations on which to focus these efforts.

The Transitions of Care project engages stakeholders in each selected county in a two-day countywide process improvement event, followed by 12 months of ongoing

technical assistance so the community-defined "ideal future state value stream map" can be fully realized. Those who are directly involved with the development of the transitions plan for the County will be eligible to receive ongoing individualized technical assistance from a team of national experts covering all aspects of knowledge required to build and sustain an evidence-based addiction treatment ecosystem.

HMA worked closely with Kern Behavioral Health and Recovery Services (KBHRS), specifically Ana Olvera and staff, to launch the process improvement event and subsequent ongoing technical assistance program. KBHRS identified key stakeholders to engage, conducted outreach, and distributed invitations. KBHRS took an active role in ensuring the event included stakeholders from all areas of the addiction treatment ecosystem, and their leadership set a strong tone of collaboration for the event.

B. County Leadership/ Key Change Agents

Kern Behavioral Health and Recovery Services

- Ana Olvera, SUD Administrator
- Bill Walker, Department Director
- Alison Burrowes, Deputy Director
- Ann Sherwood, Prevention Team Supervisor

C. Who Was Involved

- KBHRS
- Bakersfield Recovery Services
- CCS
- Cigna Healthcare
- CSV Ebony
- Kern County Department of Human Services
- Heather Berry Counseling
- Kern County Behavioral Health Board
- KCHC Outpatient Recovery Services
- Kern County Police Department
- Keepers of the Cross
- Kern County Environmental Health Services
- Kern County Probation
- Kern County Public Health
- Kern County EMS
- Kern County Sheriff's Office
- Kern Health Systems
- Kern School Districts
- Kern Medical Hospital
- Kern Public Defender
- Kern Valley Healthcare
- KUSD KRV Family Resource Center
- Legacy Village, LLC
- Oildale Community Action Team
- AEGIS Treatment Centers
- Omni Family Health
- One Door Recovery
- Owens Valley Career Development

- Positive Visions
- U.S. Attorney's Office

- STEPS
- Your Drug Store
- Synergy Recovery Services
- Clinica Sierra Vista
- Cottage of Hope and Gratitude
- College Community Services

D. Structure of the Intervention

In advance of the event, HMA worked with the county to electronically gather high-level information on addiction treatment capacity in Kern in preparation for two days of intensive on-site value stream mapping, presentation, and discussion.

Most healthcare professionals are familiar with LEAN processing and the need to improve efficiency of an existing system. Some are familiar with the technique of agile innovation (or SCRUM) and the role it can play in developing and managing an entirely new process. However, the field of addiction medicine is neither fully built nor just being born. Given this, HMA facilitated a hybrid process to obtain the current state structure and wrap around the proposed new pathways and future state.

This event included a variety of stakeholders who represent different aspects of the addiction space in Kern County: SUD treatment, hospitals, corrections, law enforcement, education, behavioral health, public health, emergency medicine, elected officials, people with lived experience, and many others. HMA used the morning of day one to develop the scope of the project as a group and help develop the problem statement that would drive the entire process. We also identified desired outcomes from any intervention/future state plan.

In the afternoon, attendees were split into two cohorts. Cohort 1 included attendees from SUD treatment and medical provider organizations, while Cohort 2 included stakeholders from justice, education, and other community-based organizations. Cohort 1 completed their current state mapping exercise on the afternoon of day one, while Cohort 2 did current state mapping on the morning of day two. While one cohort did value stream mapping, the other participated in a facilitated discussion on gaps, barriers and potential solutions in the addiction treatment system.

The cohorts divided themselves into smaller groups by organization/addiction treatment program area to develop a current state value stream map that depicted exactly how a community member moves through their system. Participants were tasked with including all interventions and decision points, who performs them, and how long they take. Stakeholders were also instructed to discuss both intervention-specific and global barriers and gaps.

While the work product had some variation in depth, scope, and structure, we were able to get a good sense of the current state of addiction screening, placement and treatment in Kern County. In a standard process improvement event any one of the providers would take a full week to develop the same amount of work produced in only a few hours during this event. After each provider group developed a current state map, groups presented their maps to the rest of the participants.

On the afternoon of day two, we brought the full group back together to brainstorm desired features in a future state and create consensus to build a future state "scaffolding" map. The "scaffolding" is the part of the future state map that all providers have in common and can build on for their specific setting.

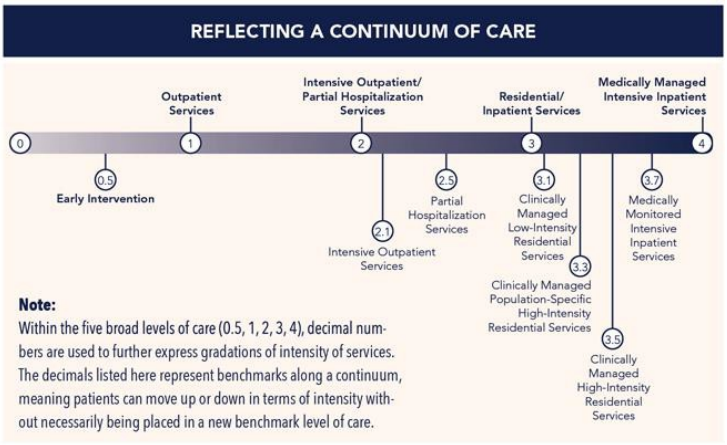
It is worth mentioning that the participants in attendance were an engaged group representing a wide cross-section of decision makers, doers, and people with lived experience. The future state map was developed based on the input of the group and addresses the barriers and gaps identified. While not every treatment organization was present, the buy-in from the different groups was substantial and it was their voices that created the product.

E. Screening and Level of Care Determination

The "long form" of the American Society of Addiction Medicine (ASAM) Criteria

ASAM's criteria, formerly known as the ASAM patient placement criteria, is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. Today the criteria have become the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer/discharge of patients with addiction and co-occurring conditions. ASAM's criteria are required in over 30 states*.

ASAM's treatment criteria provide separate placement criteria for adolescents and adults to create comprehensive and individualized treatment plans. Adolescent and adult treatment plans are developed through a multidimensional patient assessment over five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided, and the intensity of treatment services provided. Oversight and revision of the criteria is a collaborative process between ASAM leadership and the Steering Committee of the Coalition for National Clinical Criteria. The coalition represents major stakeholders in addiction treatment and has been meeting regularly since the development of the first ASAM Patient Placement Criteria in 1991. The coalition addresses feedback and ensures that the Criteria adequately serves and supports medical professionals, employers, purchasers and providers of care in both the public and private sectors.



The "short form" of the ASAM Criteria

CONTINUUM™ Triage (CO-Triage™) is a provisional level of care determination tool for alcohol and substance problems. The CO-Triage questions help clinicians identify broad categories of treatment needs along the six ASAM Criteria Dimensions. The decision logic in CO- Triage calculates the provisionally recommended ASAM Level of Care (ASAM Levels 1, 2, 3, 4 and Opioid Treatment Services) to which a patient should proceed to receive a CONTINUUM™ Comprehensive Assessment – the definitive, research-validated level of care placement recommendation.

With CO-Triage™, clinicians as well as other health care service providers can:

- Make provisional ASAM Level of Care treatment recommendations
- Easily identify ASAM dimensional needs that require immediate attention including any withdrawal management, co-occurring, or bio-medical enhanced services
- Increase the likelihood that patients are referred to the correct ASAM Level of Care
- Build from and easily synchronize with the research-validated CONTINUUM™ ASAM Criteria comprehensive assessment tool

(Above directly from www.ASAM.org with permission)

**California is not one of these 30 states.*

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Section 2: Event Results

A. Goals of the Participants

On day one of the process improvement event participants started with a simple question: In a perfect world, what would you like this event to do? The answers presented to that question are as follows:

- Treatment is viewed as more welcoming, viewed as a gift rather than a punishment
- Adequate treatment beyond just OUD, more service capacity
- Reinforcement for the client at each step in the treatment process
- More partners engaged with this issue, more motivation to all work together to solve this
- More treatment options for different levels of care
- Better rehabilitation, in better locations, places to not just get treatment but good treatment— treatment is not situated in wide variety of locations
- People with lived experience are more involved
- Integration across all spectrums- facing 2 waiver renewals, one for medical and one for SUD, this will be renegotiated in the county and the key is integration with mental health, physical health, and go even further beyond this to law enforcement and other systems
- Connection to rural areas, services are integrated across a big county
- Residential services for both men and women that are Spanish speakers- cultural competency
- Quality care for people who are uninsured or on Medi-Cal, not just for private insurance
- More medical aspects, engagement of medical community in treatment
- A greater cross-section at the table- we have great representation here, but in Kern County the strength is faith-based community so how to leverage that? Can tap into what we have for prevention, education, etc.
- Adequate medical detox for underinsured and uninsured
- Connect the dots better in terms of what efforts are already going on in the communities, learn about what other people are doing and communicate about what resources are already available
- More community awareness of addiction and its impact
- Data: be able to collect data from multiple agencies easily and share
- Technology to better reach rural areas
- Engage business community in this effort
- Stigma reduction
- Funding reform- want to be able to use MHSA dollars for SUD, documentation reform so providers don't have to spend so much time justifying providing services instead of providing them, requirements in SUD are a far greater burden than in primary care, medical, etc.
- A safe place for victims of domestic violence to be referred
- Services for adolescents and children- there is currently no treatment for them at all
- Treatment providers would be able to coordinate care and share information- overcome challenges with 42 CFR
- Develop more peer to peer support and advocacy networks across care systems
- Children addicted to nicotine because of vaping/ e-cigs
- More education at community level about changing the substance abuse climate, change the language within the community so that there is buy in
- Increase collaboration with law enforcement, communication and discussion on what happens to community members who get "picked up" under the influence, understand how the community itself works
- Programs for justice-involved population beyond just people on probation

- Better ways to engage people with OUD and reach them, leveraging "dopamine intervention moments"
- More transitional housing, work experience/ job training, SDOH, greater ability to meet basic needs
- More proactive outreach and engagement, before law enforcement gets involved
- Changing the culture within primary care
- Wraparound services, screening and referral
- Focus on professions where OUD is prevalent- oil fields, agriculture
- More training and mentoring resources
- More early intervention at a younger age, leverage education system
- Credible data on how effective all areas of the system are
- Make better use of available resources through coordination
- Overnight shelter with OUD services for people experiencing homelessness, 24/7 hotline, outreach, stabilization for OUD- compassionate relationship with people

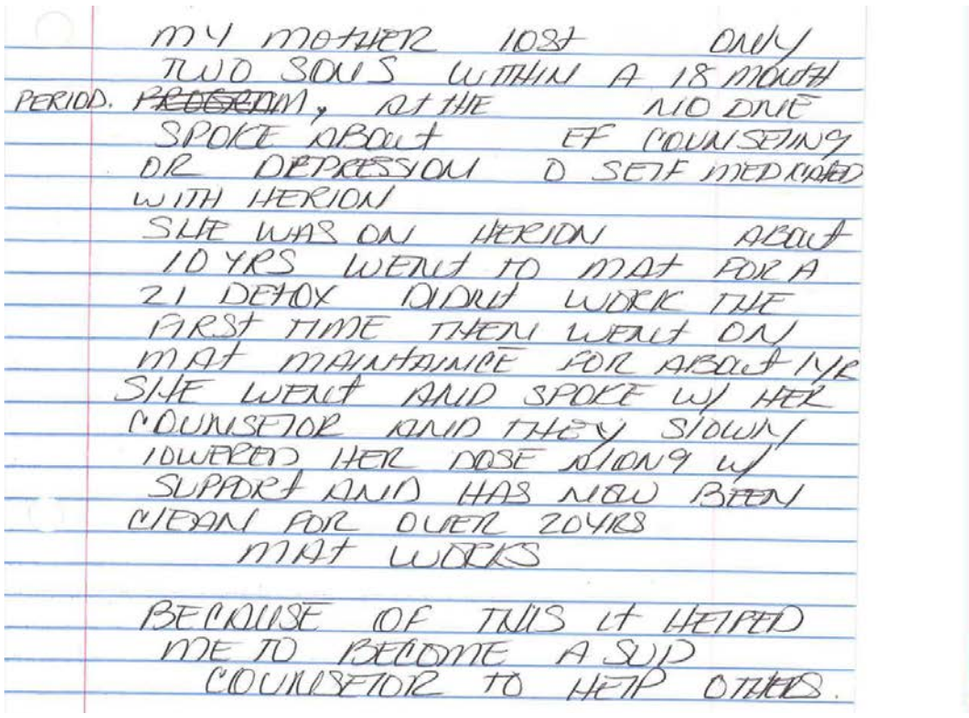
HMA recommends an overarching goal for Kern County, under which all the goals named above can be placed.

THE OVERARCHING GOAL:

ELIMINATE ADDICTION-RELATED DEATHS IN KERN COUNTY

B. Stories of Experience with Addiction in Kern County

Building a person-centered system of addiction treatment in Kern County must be driven by the voices of those with lived experience. During the event, we asked participants who have experience with addiction (either first-hand or that of a family member or loved one) and the addiction treatment system in Kern to share their stories with us if they were willing. Below are responses we received:


MY MOTHER LOST ONLY
TWO SONS WITHIN A 18 MONTH
PERIOD. ~~PROGRAM~~, AT THE NIO DIVE
SPOKE ABOUT EF COUNSELING
OR DEPRESSION O SELF MEDICATED
WITH HEROIN
SHE WAS ON HEROIN ABOUT
10 YRS WENT TO MAT FOR A
21 DETOX DIDN'T WORK THE
FIRST TIME THEN WENT ON
MAT MAINTAINCE FOR ABOUT 1YR
SHE WENT AND SPOKE W/ HER
COUNSELOR AND THEY SLOWLY
LOWERED HER DOSE ALONG W/
SUPPORT AND HAS NOW BEEN
CLEAN FOR OVER 20YRS
MAT WORKS

BECAUSE OF THIS IT HELPED
ME TO BECOME A SUD
COUNSELOR TO HELP OTHERS.

MEMO

My daughter became a drug addict at 14. By 15 she was on heroin. The day she turned 18, she left. (She had been 4 assisted treatment programs.)
She got pregnant, and we had her back home at 5 months pregnant, after she withdrew. The baby was born full-term, but she left us with the baby 2 months later. (We now had Dad, had he 18).

His bio dad died of a drug overdose when the child was 6 months old. His bio mom (our daughter) continued as a drug addict for 4 years more and had another child, which she kept.

Had there been a Good Samaritan, bio dad may not have died. We have grieved over the losses, and are still challenged with a relationship with daughter and her bio son (very negative).

Growing up from a single parent family youngest of 4 kidz. I got involv in drugs at a young age at 14 years old. Being addicted for nearly 18 years, went from snorting meth to shooting meth. I was arrested in 2016. Looking at the years I had lost from spending time with my children now ages 18, 15, 11. years I knew i couldnt do this alone.

I asked to be place in a sober living home being there for 4 month was quite difficult but i still felt the need to do more.. Asking to be place in a program where i started this class in Jail called MRT

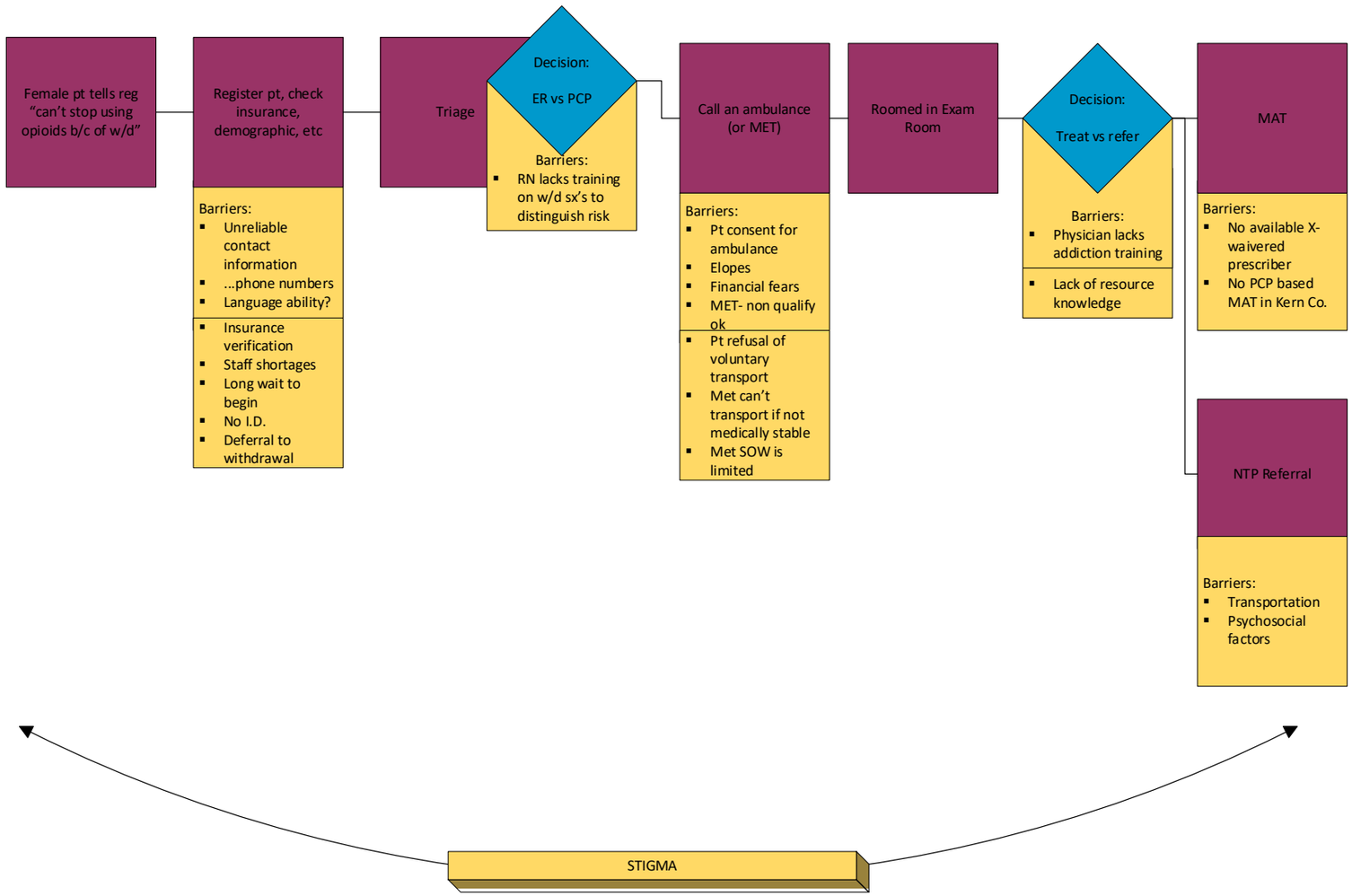
- During the process of starting this Program i became in engage with different specilist helping me from learning to Identify my triggers, emotions, & problem to helping me set goals in life.

I also was tied to a mentoring Program called garden pathways, & a community mentor name Amy. now today I have more than 3years clean, hold two jobs as well a very close relationship with not only these amazing people have been Gods place in my path.

My Connection with
having my oldest son, who was addicted
to [illegible], his addiction lasted 4
(four) years. It was a battle mother
should go thru many
attempts at patient program methadone
and attending battles
ended 12/18/18 d to a [illegible]
arm [illegible] into MRSA
went Septic & passed [illegible]
there reaching to him
Criminal Justice system. He
was arrested on and I feel
if addressed his drug while
incarcerated) & mandatory
attend any program out
could of went Better grieving
mother. I must someway
the Justice, Behavior Health would go and
reach these young adults [illegible] in parks
& abandoned buildings instead jail time

C. Current State Value Stream Maps (VSM)

Clinic/ Primary Care Current State VSM



At Clinica Sierra Vista, a primary-care medical home in Kern County, patients are able to receive integrated services including substance use disorder (SUD) counseling from age 13 and over, as well as substance use services for adults.

Barriers to treatment begin prior to visiting the clinic, with a person's sociocultural norms, such as their family and friend's cultural beliefs about those who live with substance use disorder. Many do not seek out treatment for these reasons.

In the example of a pregnant woman visiting the clinic for treatment of withdrawal symptoms, the next barriers occur at registration such as with contact information, language barriers, identification or insurance verification, and wait times to be seen. Initial triage includes the assessment of withdrawal symptoms. A challenge experienced through the clinical triage is nursing lack of knowledge of withdrawal presentation and appropriate assessment of this medical emergency. If the patient is experiencing a medical emergency, they may be deferred to the Emergency Room (by way of emergency medical services (EMS) transportation) due to the acuity of withdrawal. Finances are a concern for many patients who ultimately may decline the EMS transport or leave prior to its arrival against medical advice. If the patient is hospitalized, discharge planning and handoff to appropriate services is another barrier.

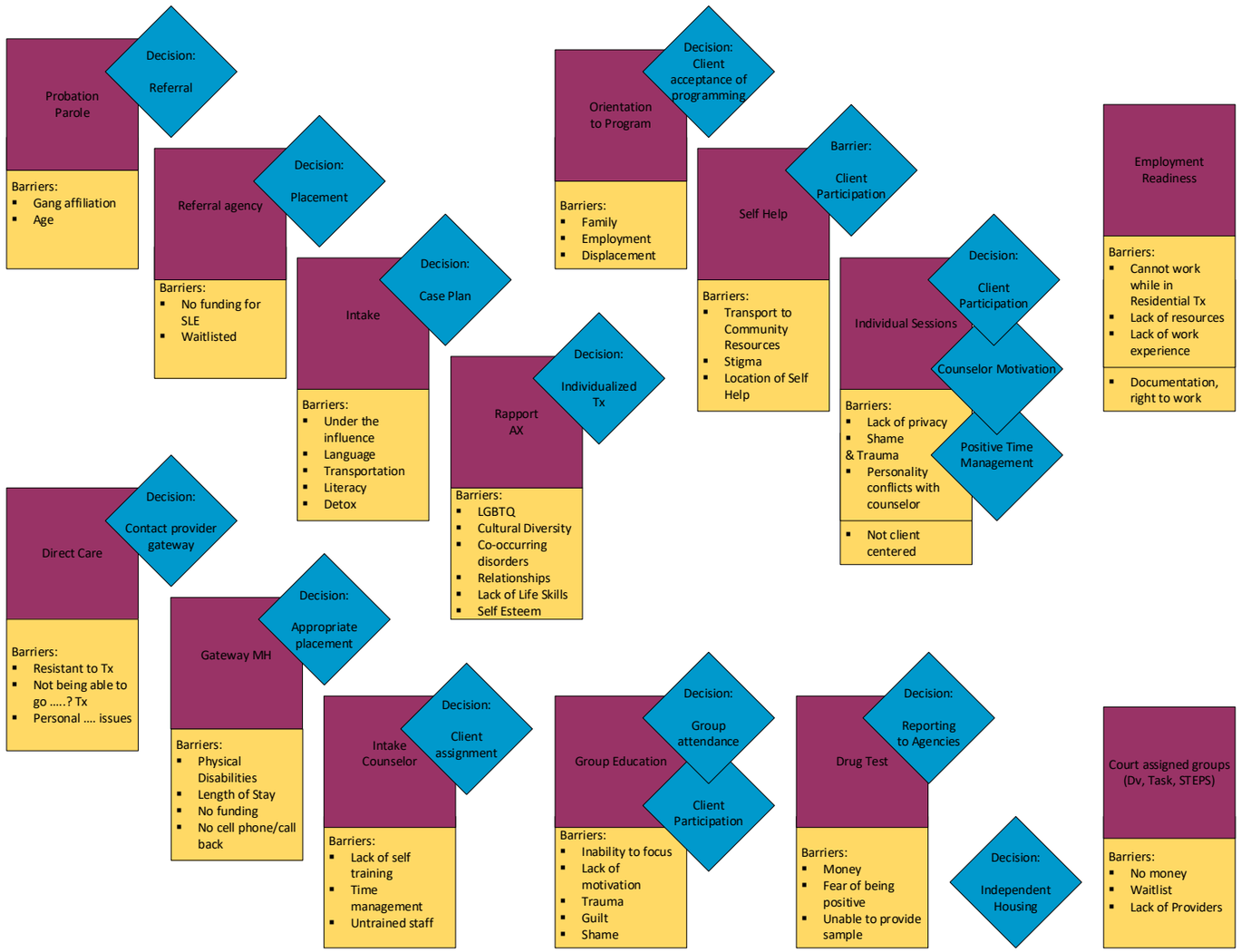
If the decision is made not to transport and the patient is to be treated at Clinica Sierra Vista, the first barrier encountered is if the individual provider responsible for their treatment has specialty addiction training and/or knowledge of resource availability. If the provider does have MAT capability, then the patient is able to receive MAT, however, there is no
available x-waivered provider in a community health center setting in Kern
County, and coupled with a provider network shortage, and no Narcotic Treatment
Program in the rural area, patients face the challenge of traveling long distances to
access services. Stigma is a large barrier faced by patients who do use the
Narcotic Treatment Program, and this is especially true for pregnant women.

If a patient receives MAT, they are connected with the central hub for care coordination known as Gateway. With this connection, there are patients who do not engage or are unable to get their preferred provider. With the outpatient treatment team, a barrier to care coordination is encountered with 42 Code of Federal Regulations part 2, which ensures patients privacy and confidentiality are protected.

For pregnant patients receiving SUD treatment, coordination with the OB/GYN is another challenge encountered. In the quest for treatment, often expected with behavioral health services is the disclosure of life events, or explanation of circumstances, which is not clinically justified in terms of treatment and oftentimes another deterrent for patients. Additional barriers patients face include: childcare, housing, qualification and lack of treatment locations for recovery services, further stigma, and relapse potential.

Throughout this treatment pathway, social linkages such as family and friends, counseling and faith-based organizations are crucial for support to the patient.

Residential Treatment Current State VSM



Clients may enter residential treatment programs from various points of entry, such as probation, parole, Child Protective Services (CPS) or dependency court, via direct care, or through Gateway referral. A barrier prior to arrival is resistance to treatment itself. Oftentimes, clients may not want to go through withdrawal symptoms, or they may not be able to come due to co-occurring medical conditions. Another barrier prior to arrival is financial constraints. Recently, residential treatment facilities have been able to work to facilitate clients on Medi-Cal receiving MAT while in care. Further barriers which may influence a person's ability to get treatment are familial bias, employment conflicts, waitlists, transportation, communication barriers such as language, literacy, or lack of a phone, self-esteem, and stigma.

After probation or parole, the client is placed in the program, and is processed through intake with the intake coordinator. Barriers for probationers/parolees may include issues with withdrawal, difficulty answering questions, not answering questions truthfully because they don't want probation officers to know or are afraid that the information will get passed on and they will be penalized. When clients go through the detox process, whether rapid or long term, there are often difficulties focusing in group sessions due to an inability to focus.

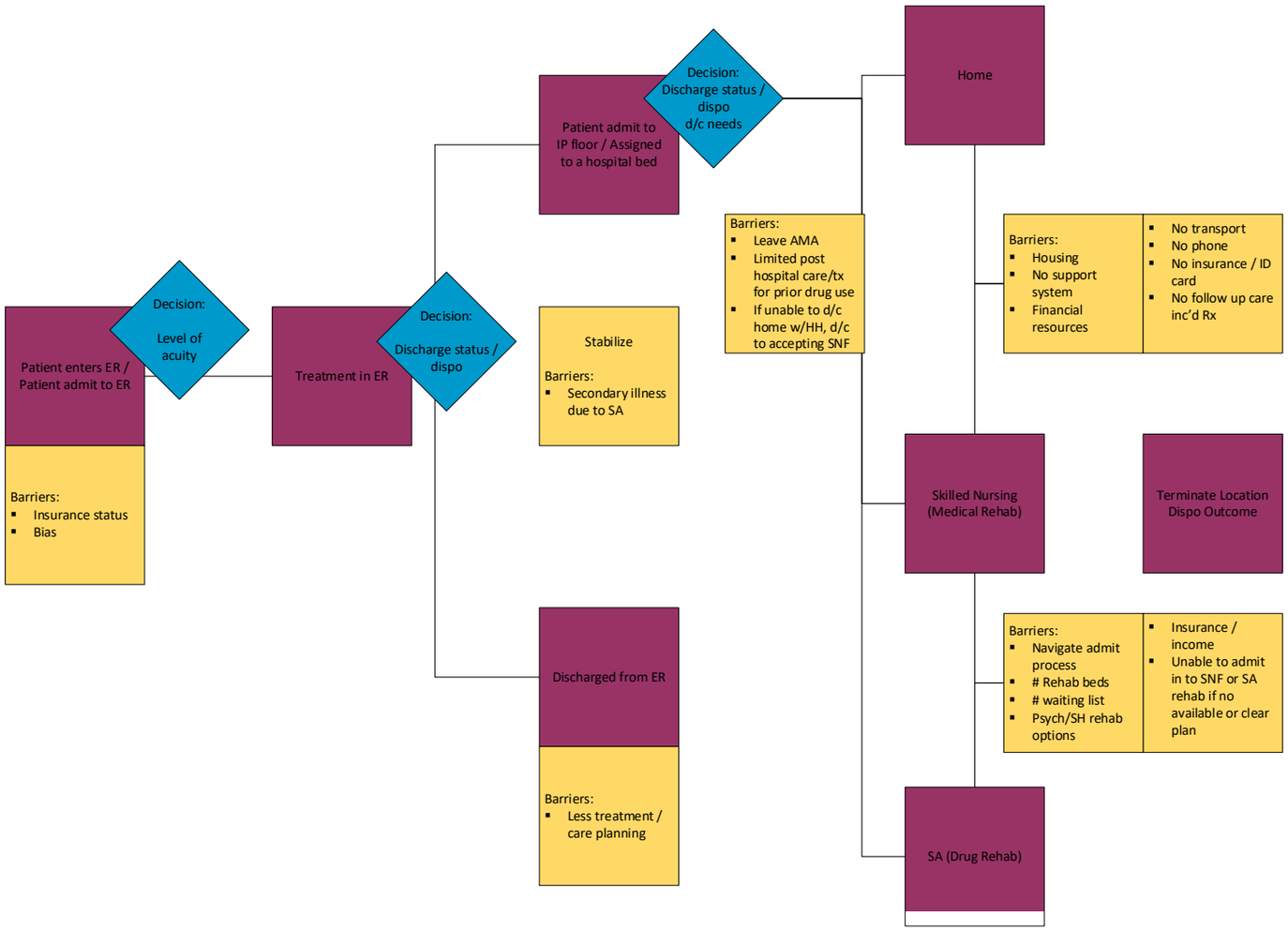
During the clinical assessment process, clients meet with a therapist before seeing a counselor, but oftentimes there can be issues with the client being forthcoming. Barriers encountered through the assessment process include lack of training for the counselor, discomfort with the client, balancing the enforcement of rules with nurturing the client, and providing compassionate care. An individualized care plan is essential to the client's success, however, barriers to this include staffing issues, time management skills of counselors and variance in client needs. The client is oriented with house staff at the facility.

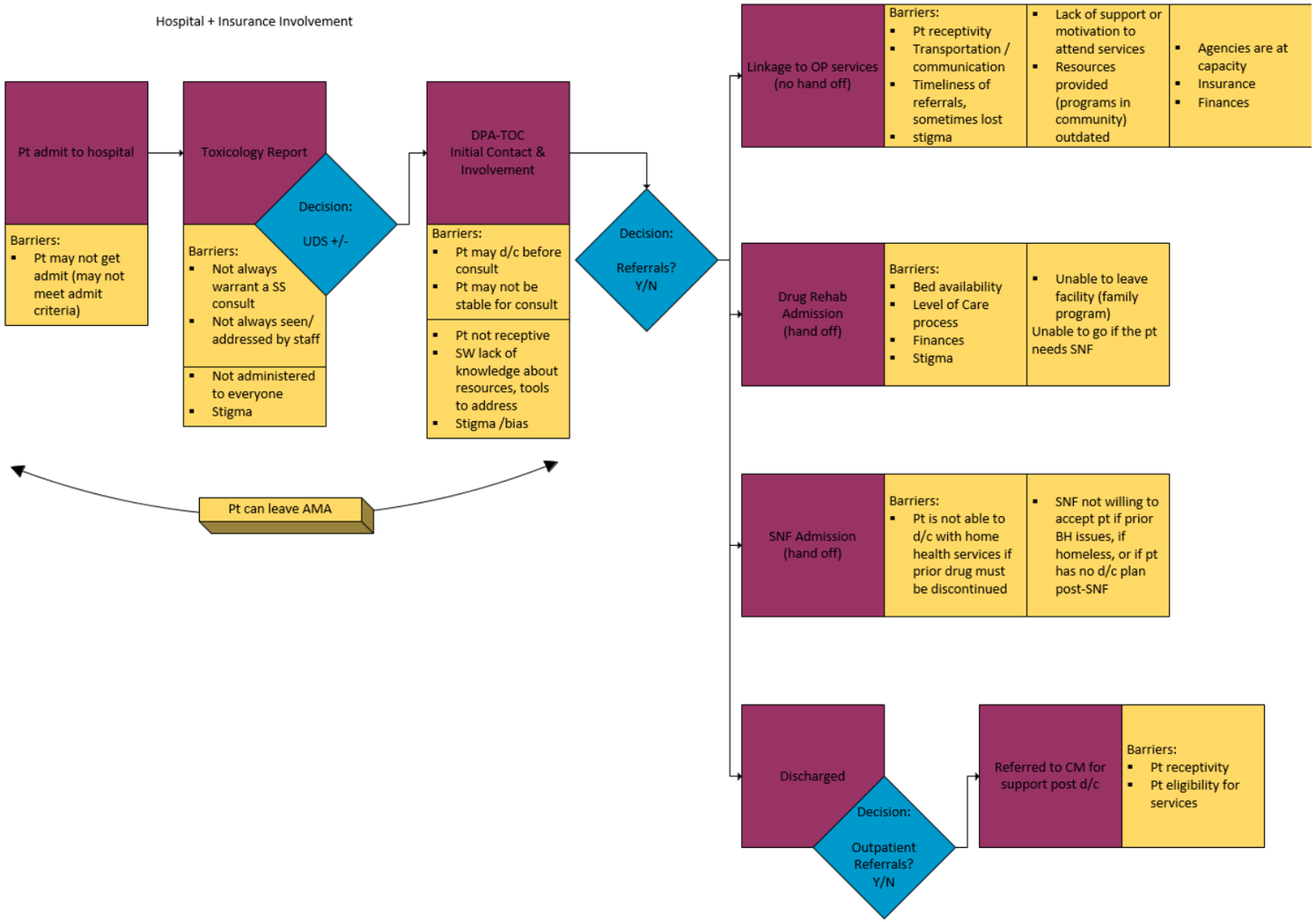
Once the client has begun the program, they are engaged in group education, self-help individual sessions, court assigned groups and routine drug testing. The dosing of MAT can hinder the client's ability to focus on the session. Barriers to group sessions include personal trauma, lack of motivation, guilt and shame. A significant risk with group sessions is trigger for relapse.

Employment readiness is another skill for clients while in residential treatment. Job coordinators work with individual clients to prepare them for work once discharged. Many resources are provided to prepare the client.

An additional barrier throughout this pathway is a lack of resources, specifically for the LGBTQ community.

Hospital Emergency Department Current State VSM

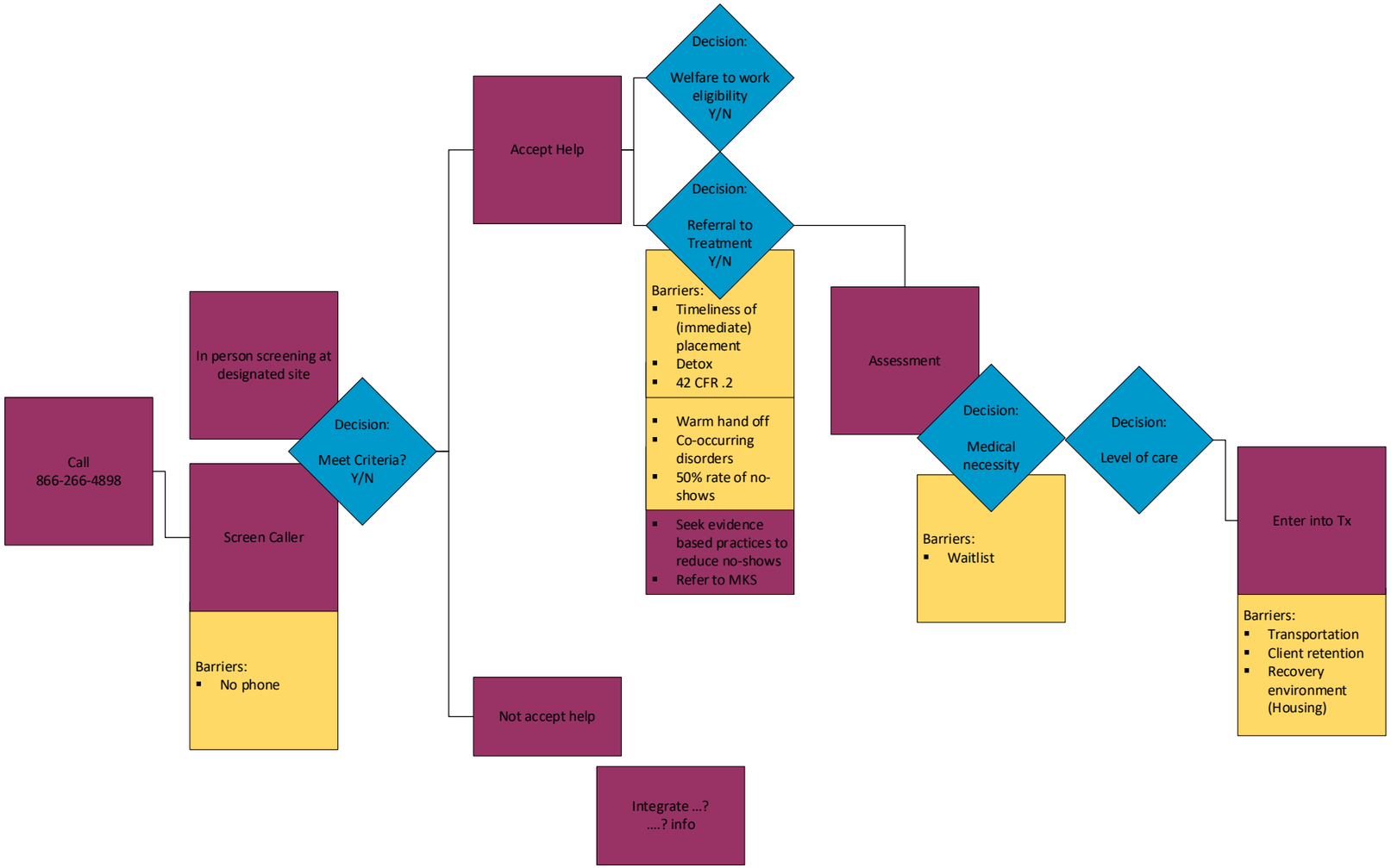



Hospital + Insurance Involvement
Pt admit to hospital
Barriers:
Pt may not get admit (may not meet admit criteria)
Toxicology Report
Decision:
UDS +/-
Barriers:
Not always warrant a SS consult
Not always seen/ addressed by staff
Not administered to everyone
Stigma
DPA-TOC Initial Contact & Involvement
Barriers:
Pt may d/c before consult
Pt may not be stable for consult
Pt not receptive
SW lack of knowledge about resources, tools to address
Stigma /bias
Decision:
Referrals? Y/N
Pt can leave AMA
Linkage to OP services (no hand off)
Barriers:
Pt receptivity
Transportation / communication
Timeliness of referrals, sometimes lost
stigma
Lack of support or motivation to attend services
Resources provided (programs in community) outdated
Agencies are at capacity
Insurance
Finances
Drug Rehab Admission (hand off)
Barriers:
Bed availability
Level of Care process
Finances
Stigma
Unable to leave facility (family program)
Unable to go if the pt needs SNF
SNF Admission (hand off)
Barriers:
Pt is not able to d/c with home health services if prior drug must be discontinued
SNF not willing to accept pt if prior BH issues, if homeless, or if pt has no d/c plan post-SNF
Discharged
Decision:
Outpatient Referrals? Y/N
Referred to CM for support post d/c
Barriers:
Pt receptivity
Pt eligibility for services

When a patient visits the hospital by way of the Emergency Room, they are first triaged by a clinician to determine the level of acuity. The first barrier in this regard is the personal bias of the employee completing the screening on the patient due to insurance status. Ultimately, this person is responsible for determining whether a patient will be treated in the urgent care or in the Emergency Room. Another barrier during this timeframe of intake is bed availability or capacity at the hospital. These factors affect the length of stay for the patient as well. Once a patient is discharged from this point, they are given a discharge plan, which may be very brief due to a general lack of discharge planning from the Emergency Room. If a patient has a high acuity, they may stay in the Emergency Room for a few days, but the discharge planning is still not thorough. Although an attempt is made to have the Gateway team visit to assess the patient, sometimes the patient may discharge before the team arrives. This gap in linking to services to the community is a significant concern.

When a patient is admitted to the hospital due to substance abuse or co-occurring disorders, they often encounter caregiver burnout or caregiver bias due to stereotypes surrounding SUD. Insurance is verified for those who have it, but for many, they are homeless or uninsured. From admission to inpatient until discharge, planning is occurring to discharge the patient. For patients with SUD, symptoms for admission are stabilized and the discharge needs are identified. Challenges in discharge planning include acceptance at outpatient facilities and communications with community providers.

Outpatient SUD Current State VSM



The Gateway Team provides screening and placement services for self-referred individuals, misdemeanor probationers and parolees, Calworks, CPS, and felony probationers. In addition to self-referrals, the Gateway works closely with community contract providers, Probation, Department of Rehabilitation, the courts, and the Department of Human Services.

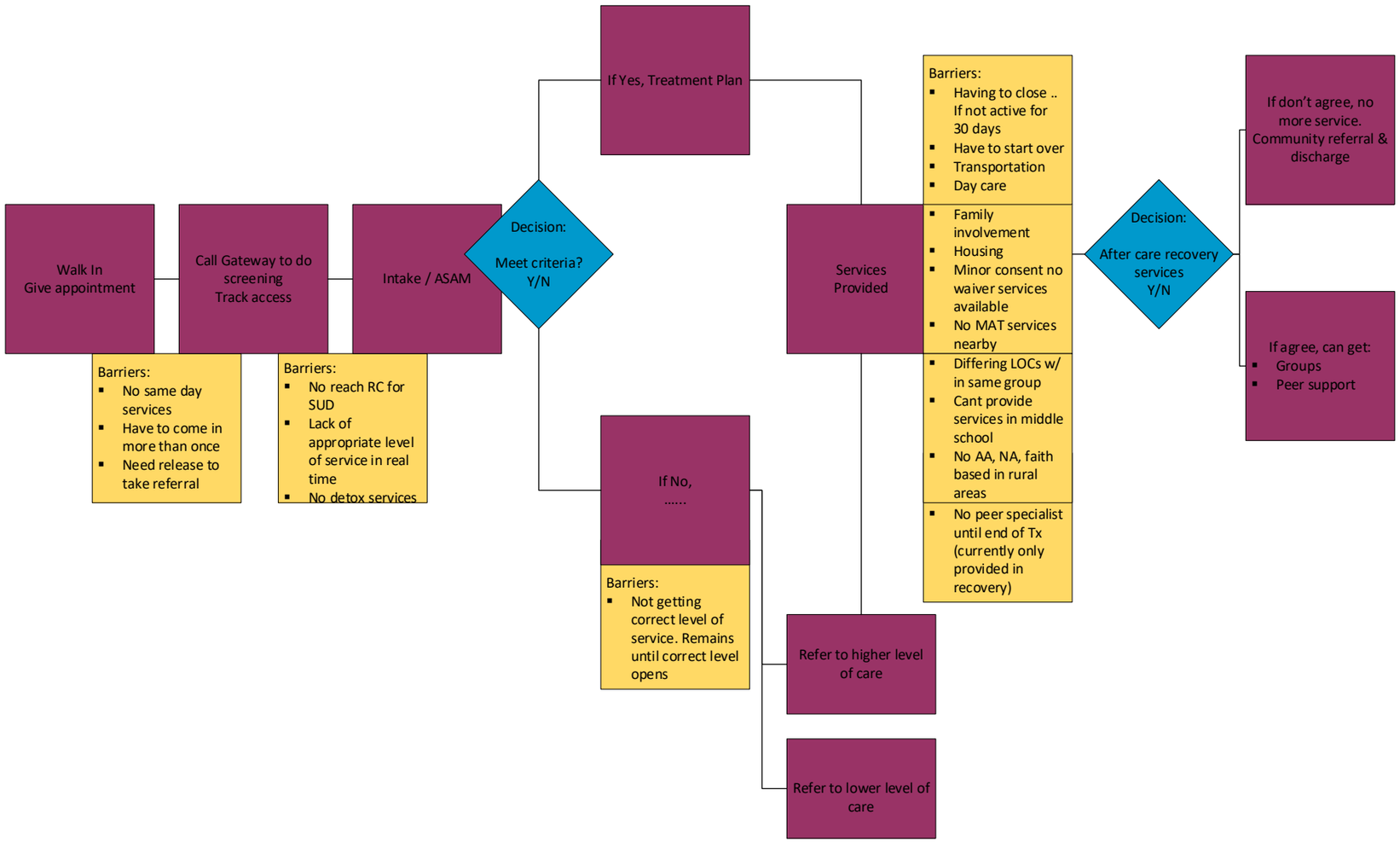
An individual is able to self-refer through Gateway. If an individual is unable to call the call center due to lack of a phone, there are designated in-person sites as well. The client is assessed for receptivity to services, and then using a modified short form of the ASAM Criteria for screening, is assessed. After a client is assessed and accepts help, determination of insurance, level of care, and Calworks welfare to work eligibility are performed.

The appropriate level of care is determined, and the client is referred to intensive outpatient, outpatient, residential treatment or a Narcotic Treatment Program with attention to timeliness of service, geographic location and transportation barriers. A placement barrier encountered is availability of providers, such as specialty providers for pregnant mothers or those who use intravenously, and waitlists for residential treatment facilities. There is an identified need for detox services in Kern County. A care coordination barrier has been encountered with 42 Code of Federal Regulations part 2, which ensures patients privacy and confidentiality are protected. Now, a warm handoff is performed to transfer the individual to the treatment provider. Unfortunately, there is a significant no-show rate experienced.

Once the client can see the treatment provider, they are assessed by the provider and determination for medical necessity is made to either confirm the level of care that Gateway recommends, or the provider may recommend a higher or lower level of care, based on the appropriateness for the individual.

As the patient enters into treatment, they face barriers such as transportation, client retention, and the environment for recovery, such as housing or domestic violence.

Level 1.0/ 1.2 Rural Outpatient (College Community Services) Current State VSM

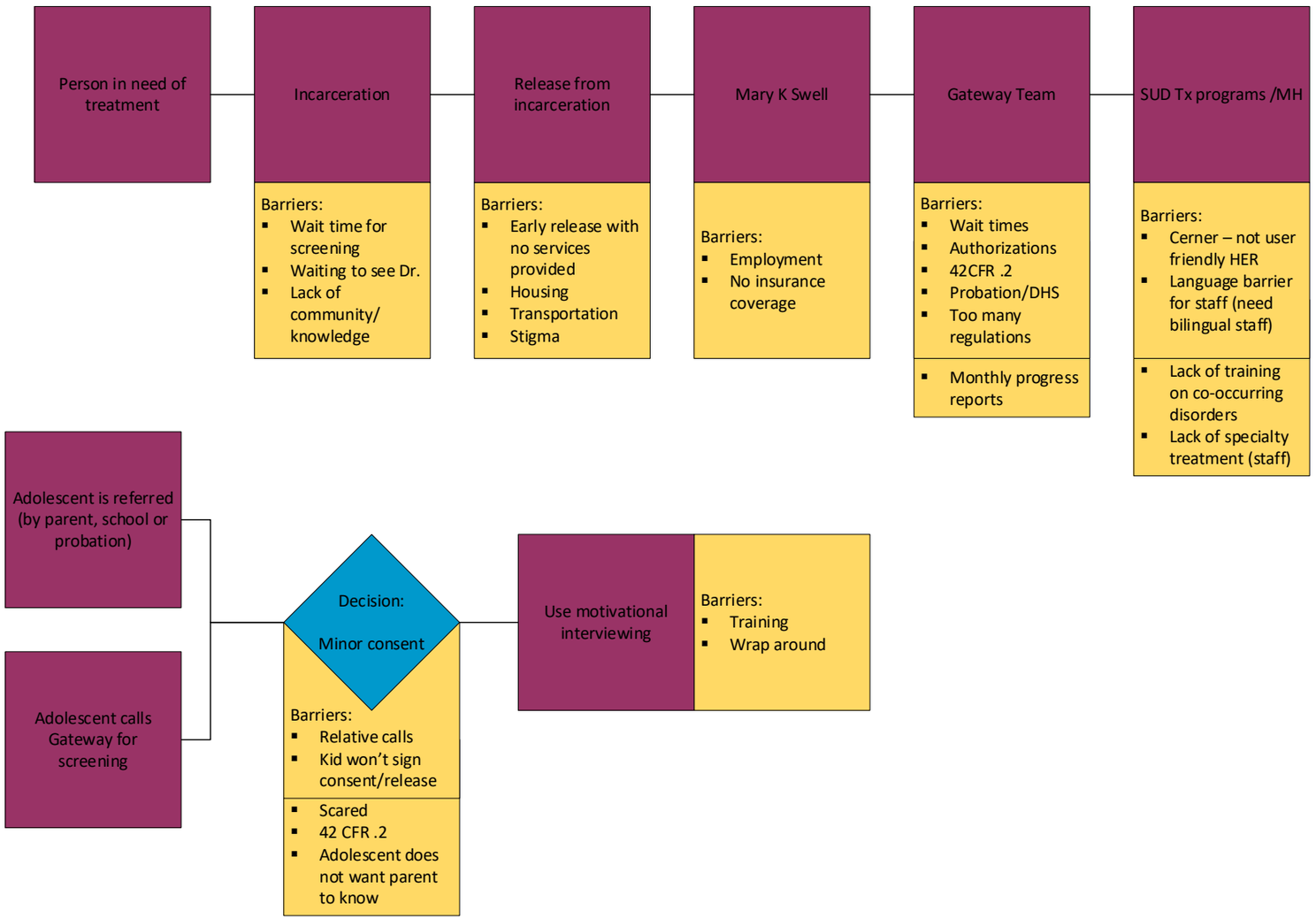


College Community Services specializes in behavioral health and integrated care services in community and home settings.

CCS accepts patients as referrals from Gateway, but also accepts walk ins. When a patient comes to CCS, they are given a walk-in appointment on the basis of availability. There is no guarantee of same day service. At this point, Gateway is called to perform screening. Tracking access is completed, and the patient goes through the intake process. During the intake process, the ASAM criteria is used to assess the patient. If the patient meets criteria, services are provided. If in the intake process, the patient does not meet criteria, the patient is referred to the appropriate level of care to receive services. A barrier is the lack of MAT facilities locally.

In both cases, after-care recovery services are available to the patient, which the patient may agree to or forgo. If they forgo recovery services, they are referred to community services. Currently, peer support specialists are not available during the program, only after it has been completed. Other barriers encountered include transportation, housing, limited family involvement and childcare.

Kern Behavioral Health and Recovery Services Current State VSM



Kern County Behavioral Health's Substance Use Treatment services cover a continuum of care from primary prevention to treatment and recovery. Through this pathway, an individual encounters the providers, plans and the Gateway screen.

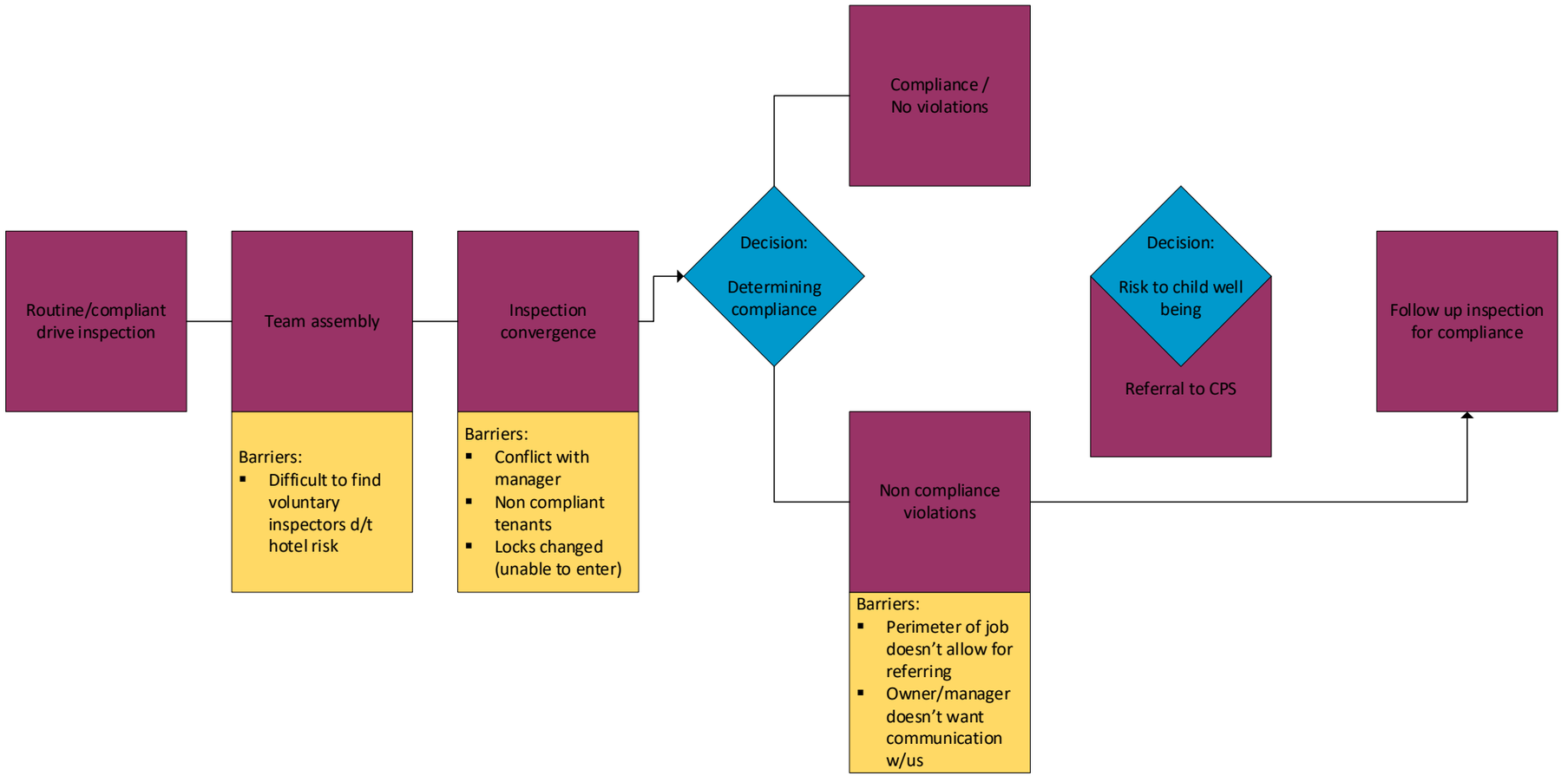
When a person coming out of incarceration needs treatment, they face many barriers and are often unemployed and without insurance. They may go to Mary Kay Shell Mental Health Center or be referred to the Gateway team and ultimately receive treatment from a SUD treatment provider or a mental health provider.

Barriers include access, wait times, housing, cultural competence, language, transportation, stigma, staffing and lack of knowledge about the system. Additionally, 42 CFR part 2 presents challenges around care coordination. Finally, not all ASAM levels of care are available within Kern County.

Adolescents may be referred to KCBHRS by a parent, school or probation officer for treatment. Gateway is called to perform the screening. Motivational Interviewing is used to engage the adolescent throughout services.

A barrier for the adolescent pathway is minor consent/obtaining consent, minor fear of parents finding out, provider/staff training and a need for wraparound services.

Environmental Health Services



Kern County Environmental Health Services (EHS) not only oversees food facilities and restaurants, but also hotels, including the five highest risk hotels in the county.

Based on the state of individuals at a hotel, EHS determines area, prior violations, housing code and inspections. Three routine inspections are completed per year (every 4 months) for a high-risk, or they can get a complaint. A barrier to inspections is getting volunteers to assist in the inspection due to risk.

Inspections should be unannounced, but managers at hotels often request 24 hour notice of inspection.

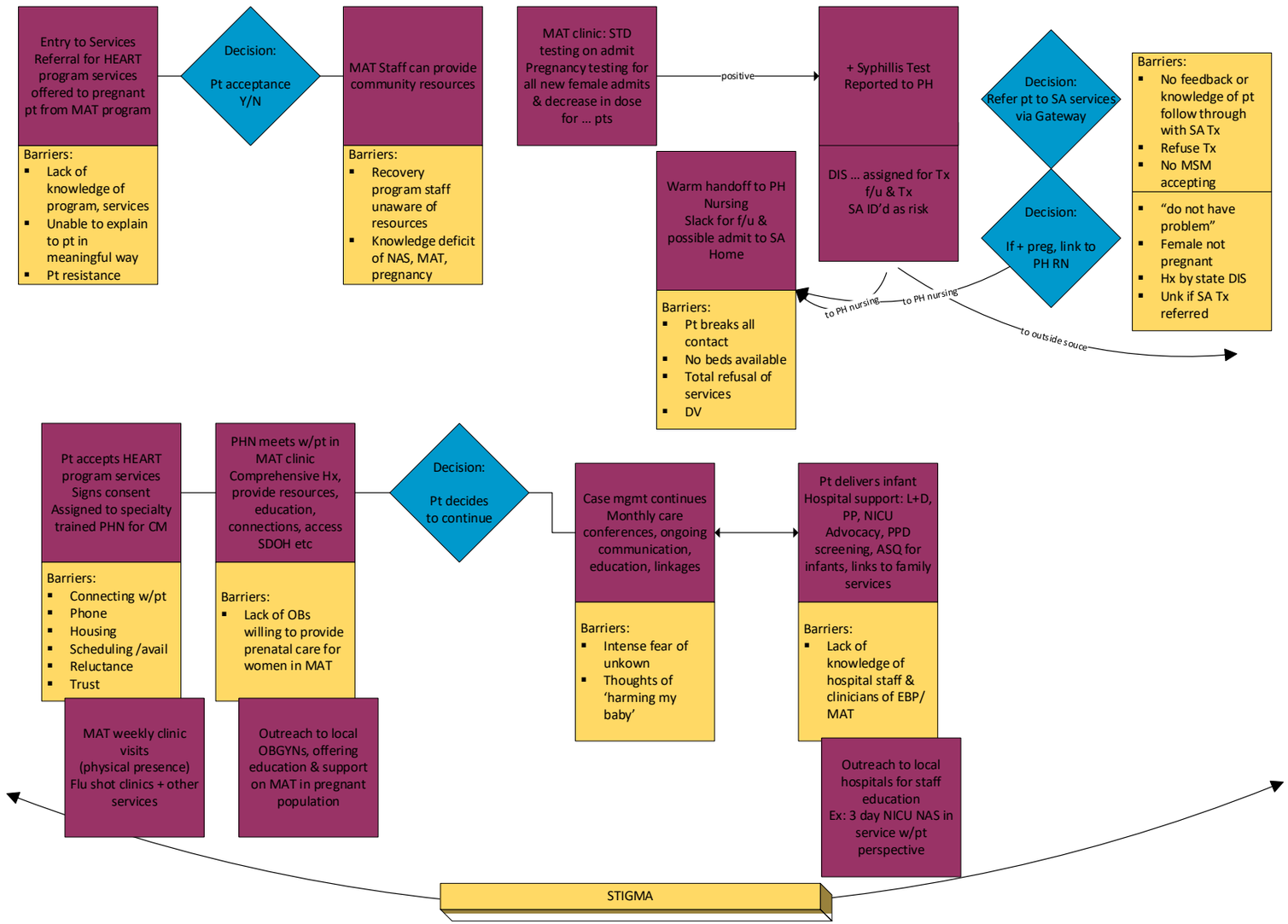
At inspection convergence, barriers include conflicts with the manager, non-compliant tenants and changed locks, causing inability to enter the premises.

Once the inspection is complete, compliance is determined. In cases of non-compliance, tenants are often fearful of losing housing, and the hotel staff does not want communication with EHS.

In cases where appropriate, a referral to CPS may be completed to assess the welfare of the child and the living situation.

EHS would like an opportunity to refer people to agencies, or otherwise provide support to the community.

Kern County Public Health/ Nursing Current State VSM



The Kern County Department of Public Health's (KCDPH) Health Education and Advocacy During Recovery and Treatment (HEART) Program is a prevention program for women of childbearing age. The primary goal is to prevent unintended pregnancy and provide services to women who are pregnant and on MAT. KCDPH RNs have proactively informed all MAT programs in the county of the work they are doing, and the HEART Program has been offered to them.

When a female comes into the MAT clinic, they are tested for pregnancy and STDs; when they are being titrated down in dosage, a pregnancy test is also performed. If the pregnancy test is positive, they are offered a referral to the HEART program. If a patient refuses services, MAT staff is given community resource information to pass on, but the patient has no contact with the HEART program. If the patient accepts the HEART referral, they sign a consent form to allow their MAT program to talk to HEART, at which time a public health nurse is assigned for case management. Barriers throughout this pathway include: MAT clinics are not aware of the program or can't explain it, stigma, communication issues, housing, readiness for change and self-esteem.

The patient first meets with the public health nurse at the MAT clinic until the rapport is built. Additional services such as the flu shot are provided. Once there is an established rapport, the visit location can be public or residential, whichever the patient prefers. Extensive information is provided on MAT during pregnancy and Neonatal Abstinence Syndrome. There is an attempt to engage the father as well as connect with the SUD provider and provide any additional support or encouragement needed. The major barrier through this phase of the pathway is a lack of OB providers willing to provide prenatal services to women who are on MAT. To combat this barrier, a lot of outreach has been done to increase provider awareness and knowledge of MAT and pregnancy.

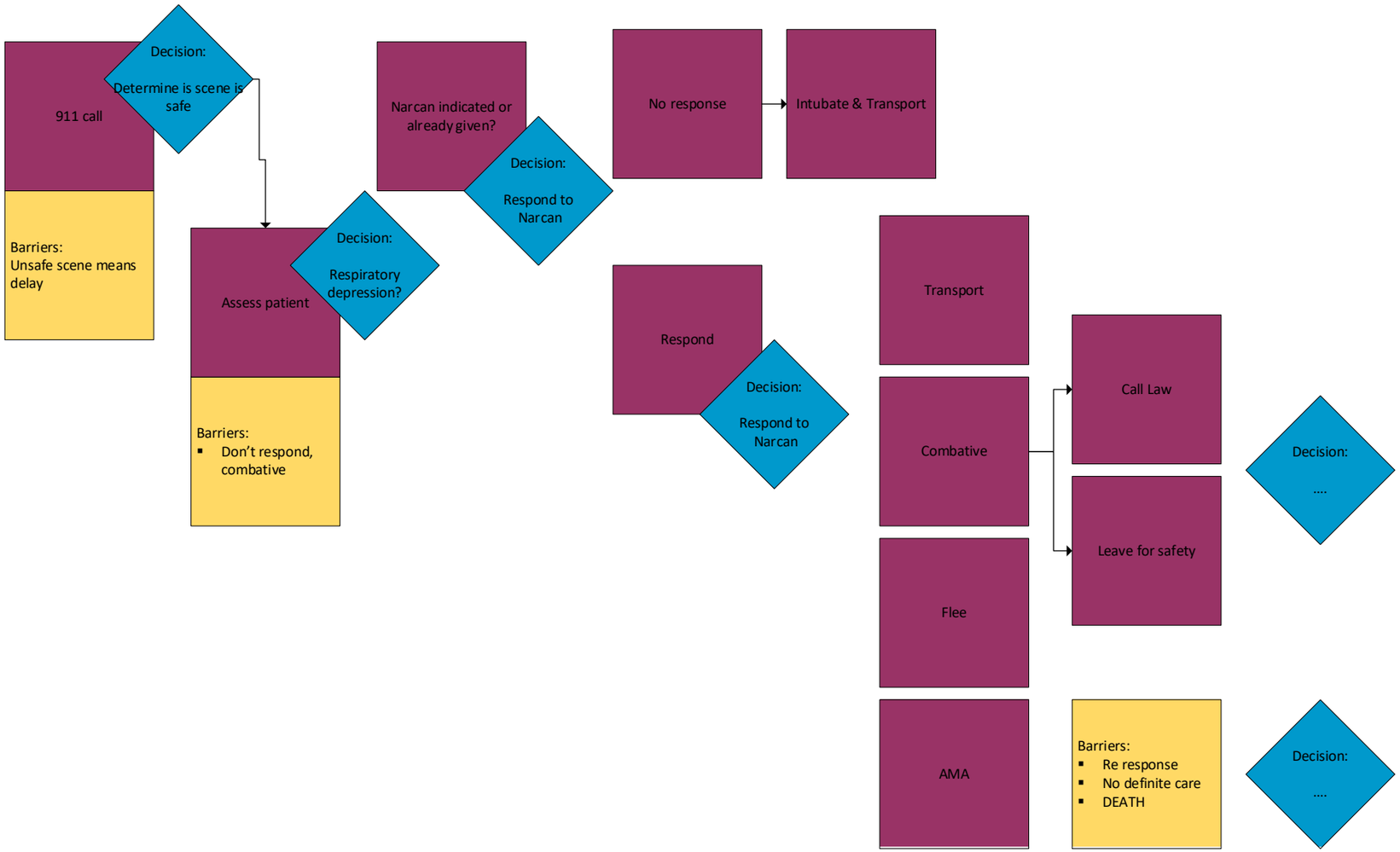
Case management, monthly conferences with MAT staff, comprehensive education and linking to social services are continued throughout the pregnancy. Public health nurses will also refer out to KCBHRS or other specialty providers as needed. After delivery, more support is provided in the NICU, including postpartum depression screening and support, linking to services for the whole family.

Barriers while in the hospital include lack of knowledge for staff on evidence-based treatment and stigma surrounding SUD. To address this, local NICU staff trainings are scheduled.

In addition to providing services to pregnant women who receive MAT, medical investigation of syphilis is a priority. If an individual tests positive for syphilis, the patient is referred to public health and an interview is conducted by a medical investigator who provides outreach, education and treatment resources, as well as information on needle exchange, harm reduction, talk about treatment options or MAT.

Cases of congenital syphilis are referred into the public health nursing program. Barriers to the syphilis initiative include loss of follow up, treatment refusals and LGBTQ community comfortability in the SUD facilities.

Kern County EMS Current State VSM



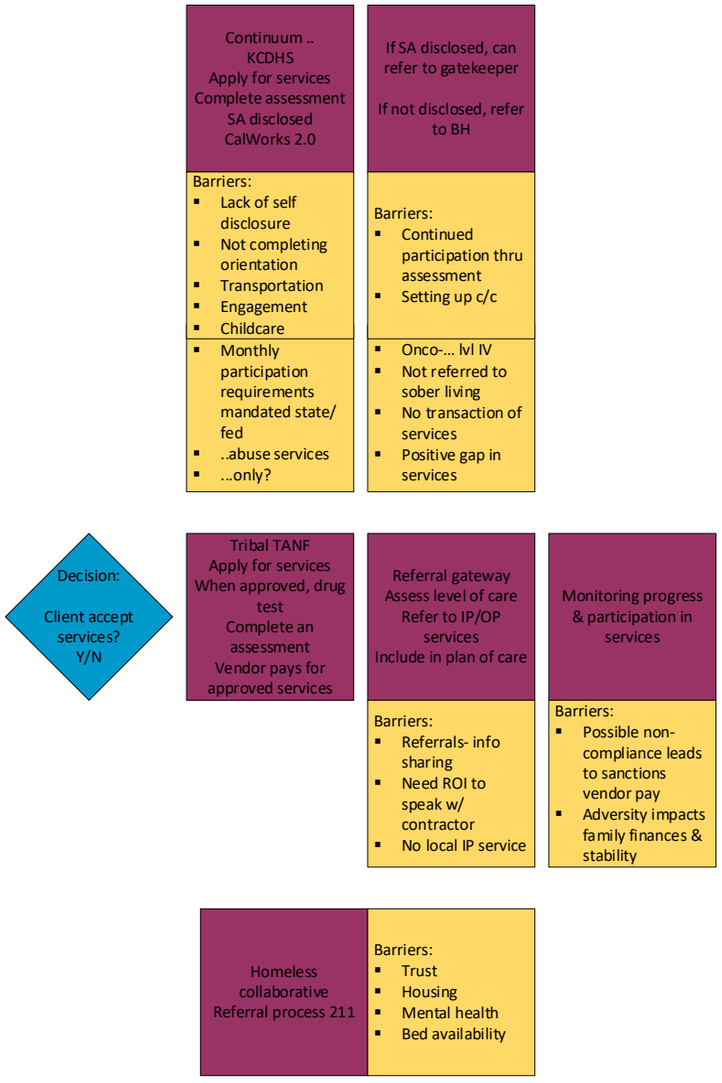
Kern County Emergency Medical Services ensures the safety and health of its residents by setting and enforcing standards; providing training, outreach, and education; establishing partnerships; and encouraging continual quality improvement in emergency medical service care.

When a member of the community calls 9-1-1, they are connected with a dispatcher, who assesses the urgency of their call and dispatches the appropriate unit to the scene. If there are concerns about the safety of the scene, such as in an assault or domestic violence call, the dispatcher will instruct the ambulance to wait nearby until local law enforcement is able to secure the scene. Once the ambulance is on scene, the EMTs/Paramedics complete the medical assessment of the patient. If Narcan is indicated, it is then administered. If the patient does not respond, Narcan is readministered. If the patient responds to the Narcan, they can then be transported to the hospital and/or linked to treatment and recovery.

In the event the patient expires, the coroner is called.

Some barriers to transport to the hospital include refusal by the patient, the patient being combative (law enforcement required) or leaving against medical advice.

Department of Human Services Current State VSM



Kern County Department of Human Services (KCDHS) identified three involvement pathways to when a patient accesses services. The first pathway is through the county services, the second is through Tribal Temporary Assistance for Needy Families (TANF), and the third is for the homeless.

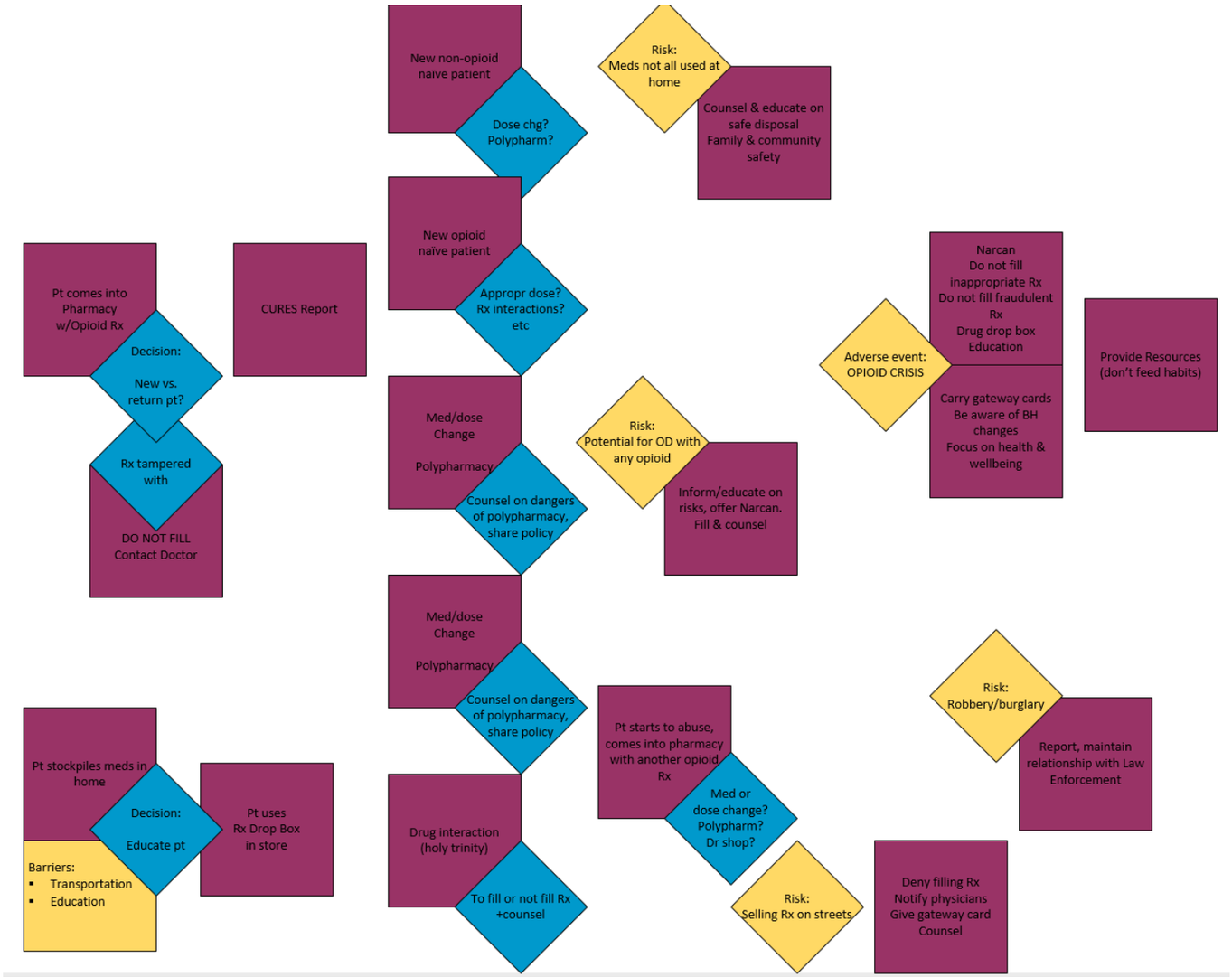
When an individual seeks services via the KCDHS pathway, they can receive cash aid through fulfillment of work requirements, such as hours and training. Once cash aid is granted, they are referred to welfare to work. After the welfare to work orientation, there is a meeting with the social worker to complete the CalWorks online assessment. This assessment helps to determine barriers to employment such as SUD, lack of education, mental health, disabilities, etc.; at this assessment, the disclosure of need for SUD services would be made. Once this disclosure is made, a referral is made to Gatekeeper for services.

Barriers within the first pathway include transportation, child care, no-shows/low engagement, readiness to change, truthfulness during the assessment and fear of child welfare involvement. KCDHS is implementing numerous new trainings and strategies to work around these barriers.

Through the Tribal TANF pathway, tribal members can apply for services. A drug test is mandatory as part of the application, triggering for SUD services as well. The positive drug test will be used to complete an additional level of care assessment and a referral to Gateway is completed. The patient is referred to the appropriate level of care. Progress and participation are monitored. Barriers encountered along this pathway include non-compliance and lack of information sharing after the referral.

In the homeless pathway, the Homeless Collaborative's primary focus is securing housing. SUD becomes secondary to this in the acute phase. Barriers in this pathway include trust, communication (no address, no phone), mental health/mental health crises, lack of shelter beds and housing resources.

Pharmacy Current State VSM



Your Drug Store sees patients at every step along the treatment pathway.

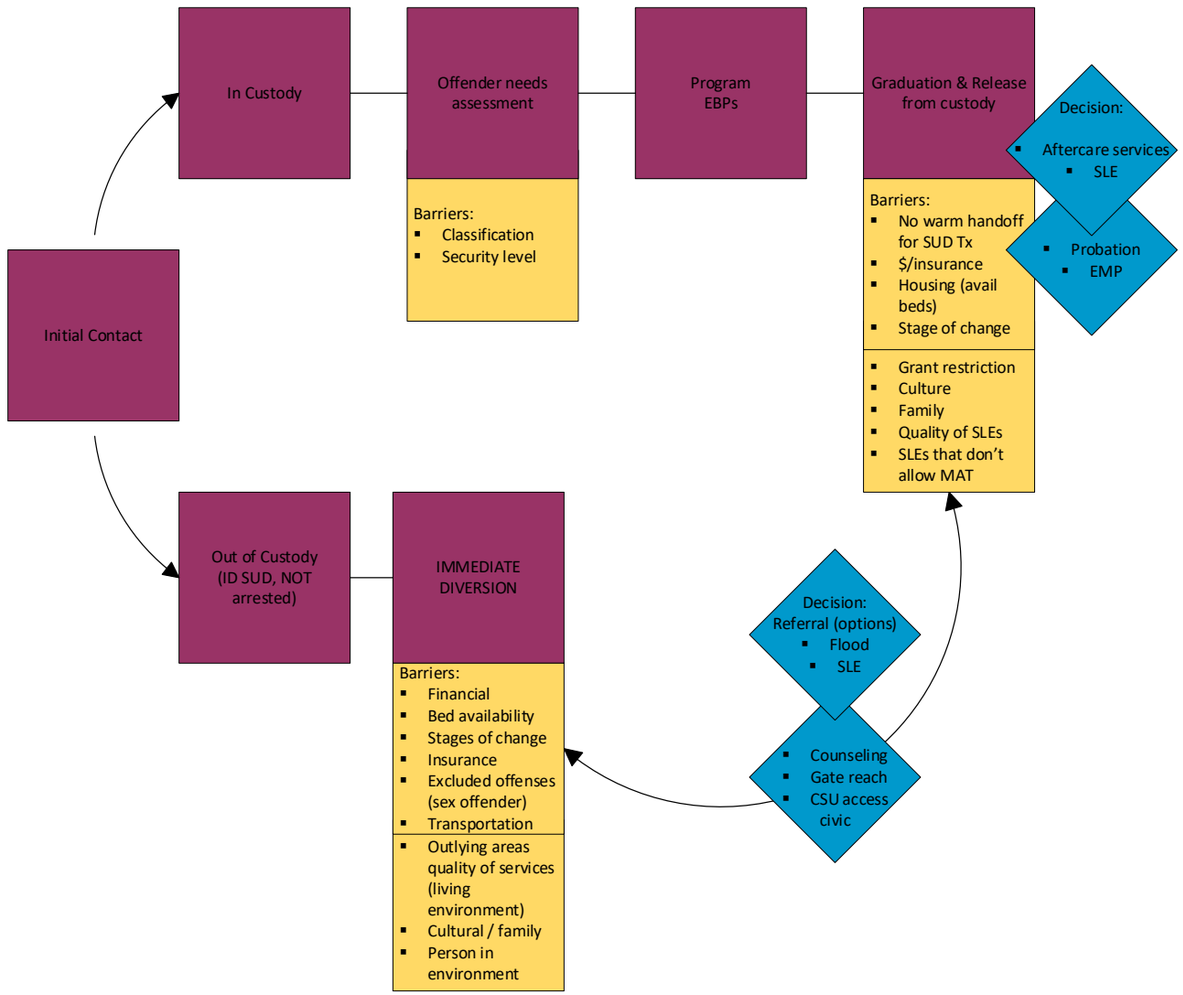
The current state map begins when a patient comes into the pharmacy with an opioid prescription. Whether a new or returning patient, a CURES report, which specifies dispensing information to the Department of Justice, must be completed. CURES 2.0 is part of California's Prescription Drug Monitoring Program and is a database of Schedule II, III and IV controlled substance prescriptions dispensed in California- serving the public health, regulatory oversight agencies, and law enforcement.

Your Drug Store will not fill prescriptions for patients who visit multiple pharmacies. If a prescription is tampered with, it will not be filled, and the pharmacist contacts the prescribing provider. There are numerous internal safety protocols in place such as these to prevent prescription abuse, and more specifically, opioid overdose.

Similar measures that are available to the community include: a drug drop box in the pharmacy, as well as counseling and education for safe disposal of prescriptions, safe handling and storage of prescriptions, and Narcan education and provision.

With observed risks in the community such as the indication a patient may be selling their prescription, the pharmacy will deny filling the prescription, notify the prescribing physician, give the patient a Gateway card and counsel on risks and resources.

Justice Current State VSM



The current state value stream for the justice involved pathway, which includes the Bakersfield Police Department, Kern County Sherriff's Office and Kern County Probation begins with an individual's initial point of contact with an officer. In the case that the initial officer determines no arrest will be made, the contact then becomes an immediate

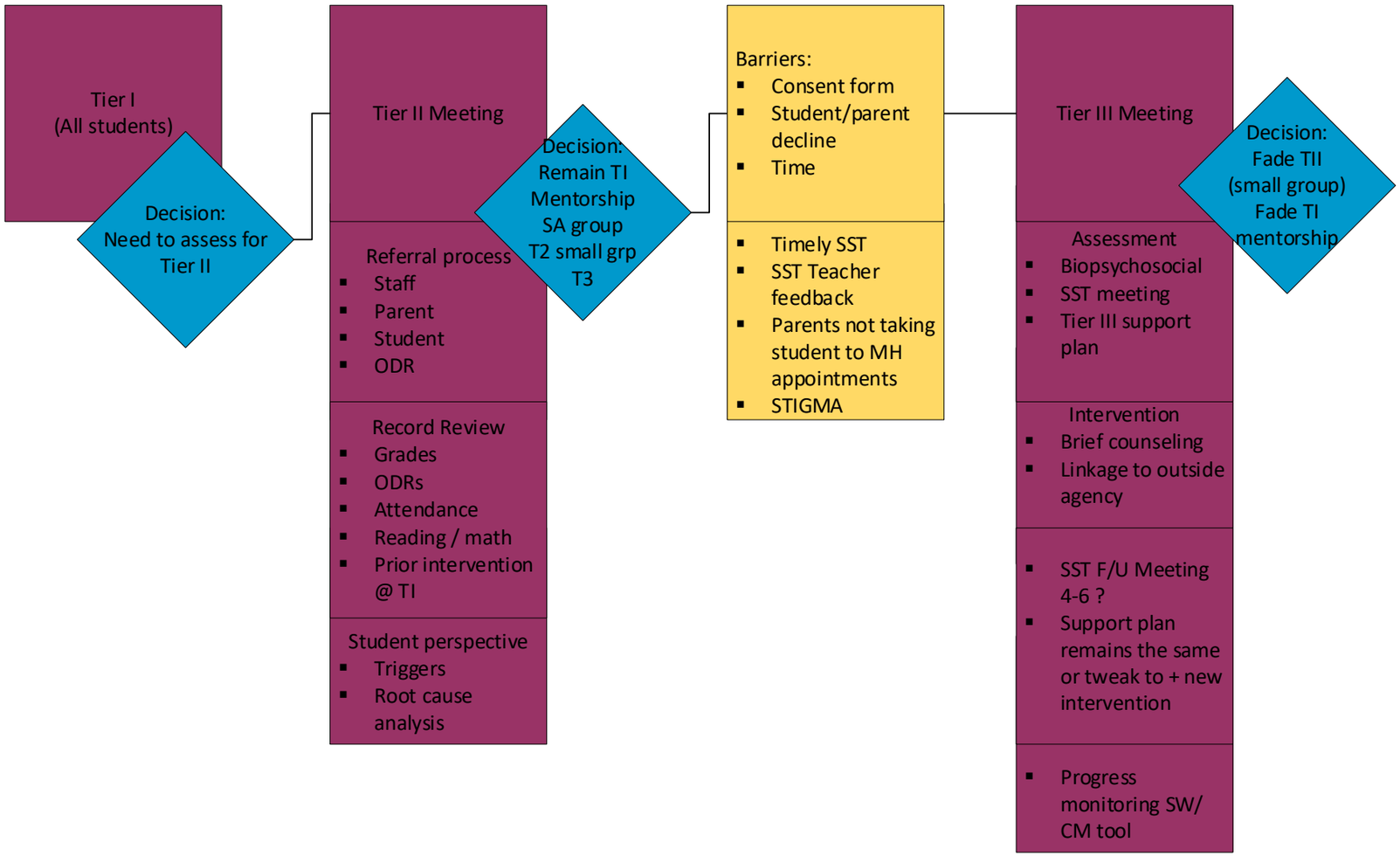
diversion. Through the diversion pathway, the individual is admitted to a residential facility to access treatment and other behavioral health services. Consideration is given to resources needed as well as potential barriers, such as financial concerns and insurance, readiness to change, insurance, transportation and housing. Those who have committed certain offenses, such as sexual or violent crimes, may be excluded from eligibility to this diversion pathway.

Individuals who are kept in custody have already completed the out of custody process. Once in custody, there is a Case Management Program Team who is specifically trained to provide services to the incarcerated individual. Using an evidence-based assessment tool, the Offender Needs Assessment, which includes a 45-minute interview, the team identifies new inmates and assesses each individual for classes which will be most influential to their criminogenic needs.

Some barriers in placing certain individuals into classes may be their classification level or security. Previous to AB 109, there was a partnership with Bakersfield Adult School, but evidence-based programming (EBP) and Motivational Interviewing are now utilized to facilitate more effective programs. Upon completion of the course, achievement is celebrated with events including achievement in EBPs and graduation ceremonies. A barrier to the programs is grant funding and the utilization of grant funds. Currently, there is only one grant funded class.

Post release/re-entry into the community, the formerly incarcerated individual is referred to after care services. However, the individual must meet eligibility criteria such as the Electronic Monitoring Program (EMP). Some offenses are excluded from eligibility for EMP.

Education Current State VSM



Broken into tiers, Kern High School District provides behavioral supports on an individual basis. All students receive these services in tier one. If a problem is identified, other students, parents or staff can refer a student to be assessed for tier two.

A tier two meeting is held to assess and facilitate the decision-making process for the student to move on to tier two. At this meeting, a record review is completed. A professional team is involved, including a school psychologist, social worker, interventionist, and counselor. The student's grades are reviewed, including a focus on reading and math levels, office disciplinary review is completed, attendance and prior interventions during tier one are all reviewed. The student's perspective is taken into consideration and a root cause analysis is performed to try to understand what is causing the behavior.

In tier two, there are various forms of engagement for the student, including mentorship cognitive behavioral therapy, and small evidence-based intervention (EBI) groups to encourage positive behavior change. Additionally, the student meets with the school psychologist and/or certified SUD counselor. A drug screen is completed, it is determined if the student is moderate high or severe level. Barriers throughout tier two include consent for small group, parent or student receptivity, and stigma. The student is monitored for progress on a success plan, during which they work on emotion regulation and problem-solving skills. If the student responds, they move back down to tier one.

If a student does not respond and/or they are considered severe, they may move up to a tier three meeting. During this phase, the social worker is involved for an intensive case management intervention. In addition to the mental health component, the student will receive a SUD intervention, and if appropriate, linked to an outside agency. A full biopsychosocial assessment is completed, including a full snapshot of student's background, including mental health, trauma, and family mental health.

A collaborative meeting is held to decide the best intervention for the student, look at the student's strengths and concerns to inform the intervention. The social worker constructs a support plan, which is similar to an IEP, helps to monitor the student's interventions based on this support; in 4-6 weeks another meeting is held to evaluate progress. If the student is responding well to this plan, it is continued, but if there is still concern, a reevaluation is done to determine another layer of intervention. If appropriate, a referral will be completed for a mental health provider.

When a student is moved back to tier one, they are assigned a mentor for a full year. At the end of the year, another reevaluation is completed.

Throughout the tiered system, stigma was a recurring barrier for students.

D. Barriers and Gaps – Inventory and Discussions

In order for any community-wide transformation to take place, it is a powerful and important exercise for the community stakeholders to identify clearly where they are currently. While there is much good work and effort happening in Kern County to address addiction, stakeholders agreed there were many challenges, particularly around system integration, communication, stigma, and access to services in more rural areas of the County.

Full Group Barrier Discussion #1

In a full group dialogue, the Kern County stakeholders identified the following as top barriers within their treatment ecosystem:

- Lack of residential treatment capacity
- Limited MAT capacity in county
- Lack of funding and resources
- Inadequate exchange of information across agencies
- Lack of team approach/fragmentation between agencies
- Lack of structured programming for community members not linked to rehab or corrections
- Substandard housing in residential treatment
- Transitional living space: lack of beds, poor living conditions
- Organized crime is profiting from SUD
- Lack of recognition of the importance of social networks
- Senior isolation
- Policy barriers/ lack of alignment among agencies for policy reform
- Provider bias, particularly for pregnant women
- Marijuana legalization
- Misinformation on policies
- Weaponization of Narcan – administering even when not medically necessary
- "Cookie cutter" treatment plans
- Fear and stigma: MAT and addiction, fear of seeking prenatal care while on MAT
- Homes that accept registered sex offenders
- Transportation
- Adolescents not able to use waivered services
- Detox model doesn't work, provider burnout
- Lack of safe prescribing of opioids in medical sector
- Fear of CPS involvement/ family separation
- Pharmacies refuse to provide naloxone

Consolidated Barriers and Gaps

The first discussion described above heavily informed stakeholders as they met up at stakeholder-type breakout groups to discuss their current state within the ecosystem. Each group developed their own current state value stream map as shown above. In the table below, we have aggregated all the barriers documented on the current state value stream maps that need to be removed for improvements to treatment and movement toward the goal of eliminating addiction deaths. The barriers and gaps are categorized in the table below by type.

	Structural Barriers	Structural Inefficiencies	Structural Gaps	Capacity	Knowledge/ Training	Inconsistency	Stigma/ Decriminalization	Social Correlates	Funding	Insurance	Cultural Competency
Clinic	3	2	2	3	2		1	2		1	1
Outpatient SUD	1	3		2		1		2			
Residential Treatment	3	3	2	1	3		4	7	3	2	2
Hospital ED	1	2	2	3	1		1	5	1	2	1
College Community Services	2	3	4	2	2			3	1	1	
KCBHRS	3	4	2	2	2	1	1	3		1	1
EHS	3	1	2		3			3		1	
Public Health	3	2	2	3	2	3	4	3			1
EMS	2	2	1	1		2	1	2			1
DHS	1			2		1		1		3	
Pharmacy					1				1		
Justice			1	3	2	1	2	3	1	1	
Education		3					2				

Breakout Discussions: Solutions to Barriers

While half of the group developed their current state maps, the other half convened for a more focused discussion on solutions. Small groups were asked to discuss one barrier and brainstorm a solution, and then share their solutions with each other. The following is a consolidated list of proposed solutions to top barriers from both group discussions:

- A resource navigator or an app that would link agencies an share information
- Collaboration around funding; concerted fundraising (state/community)
- Data for EVP funding
- Tapping other sources for funding
- Linkages across sectors (providers; faith-based; business
- Multi-pronged campaign to increase awareness of services (***strong agreement that resource navigator would be important***)
- Assessing youth for ACEs ongoing
- Structured programming for community members not linked to rehab or corrections
- Local and federal advocacy
- ****strong agreement that resource navigator would be important***
- Advocacy efforts for safe/sanitary housing and linkages to address social determinants
- Educate responders with trauma informed care
- Custom treatment plans that address specific needs
- Fund more bed space
- More communication between agencies
- Tap creative funding sources
- Connect social media platforms between agencies
- Provider education for CME credit to overcome bias
- Education, PSAs, newsletters, health fairs, outreach to overcome stigma
- Resources for homelessness

E. Future System Goals

As the group came back together in the afternoon of day 2 and began to think about moving from their current states to an improved future system of addiction treatment, they were asked to participate in a table activity. Each table discussed their most desired feature in a future system, and the positive impact it would have on the Kern County community. As each table shared what they would most like to see, some clear consensus emerged:

Integration/ Coordination

Almost every group mentioned that they would like to see more integration and care coordination across the system of addiction treatment. This includes integration of physical health, mental health, SUD treatment and community resources and systems. Participants expressed a desire for better communication and information sharing

across systems, alignment between public and private insurance. Many groups discussed collocating services in order to be able to meet all needs in one place at one time.

Access to Care

Many groups mentioned a desire for a "no wrong door" approach to addiction treatment so clients could engage with any organization in the addiction treatment system in Kern County and be referred to the correct level of services. Three different groups presented ideas for mobile apps in order to facilitate streamlined entry and access to a comprehensive list of resources.

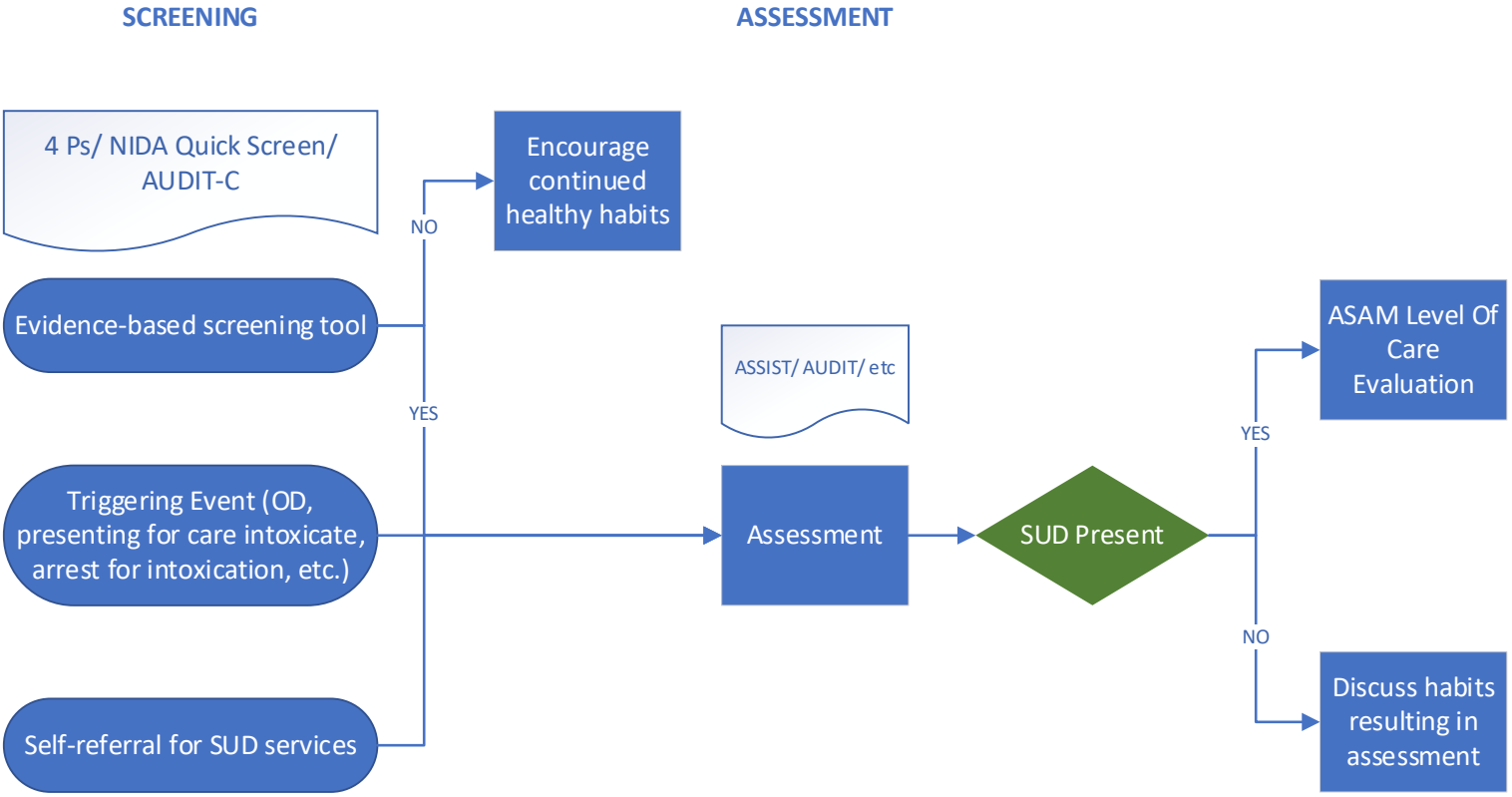
Evidence-Based Care

Groups stated that they would like to see more MAT resources in the county, more training for providers, and more data and evaluation to drive strategic capacity building at the appropriate levels of care.

Resources for People Living with Addictions

Many groups mentioned the importance of investing in Social Determinants of Health (SDOH), particularly permanent and transitional housing, transportation, and employment support, in order to achieve "whole person care".

G. The "Scaffolding"



The "Scaffolding" is the unit of service which is consistent across all locations that a patient with addiction encounters. It represents the culmination of the process improvement event: an agreed-upon future state for Kern County.

Screening, Assessment, and Level of Care Determination

Within an effective SUD treatment ecosystem it is essential that effective systems are in place to provide evidence-based screening, assessment and Level of Care determinations. These terms are often misunderstood, and a clear understanding is important to allow all participants to communicate regarding the same thing.

Screening is the application of a simple test to identify individuals who have or are at risk for developing a substance use disorder. Multiple effective evidence-based screening tools are available. These include the NIDA4, 4P's, CRAFFT, AUDIT-C among many others. These tools allow for rapid evaluation of risk for SUD and the need for further assessment. Trigger events, such as overdose, presenting for care while intoxicated and

the presence of needle tracks negates the need for screening as these events identify the need for assessment.

Given the difficulty of ubiquitous screening for addiction, HMA recommends using "triggers" to determine when a given individual would be assessed for severity of addiction. Likely triggers include:

- Overdose (OD)
- DUI
- High Intoxication
- Needle marks
- Positive screen via NIDA 4
- Arrest – for jails specifically

Assessment is the process of developing a clearer picture of the nature of the problem as well as often establishing an accurate diagnosis. Like with screening, many quality tools are available, including ASSIST, AUDIT, DASH, and many others. The most appropriate tool is often determined by practice setting. A complete listing of screening and assessment tools can be found on the NIDA website (www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools).

Finally, individuals identified to have a substance use disorder should have an evaluation for most appropriate *level of care* for treatment. Currently the only evidence-based tool available for this evaluation is use of the ASAM Criteria.

Each participant group completed a value stream map of their current state. These maps were deconstructed to identify common themes in Kern County. As most of the stakeholders represented at the event provide treatment few provide screening services with the exception of the county's SUD services. Although not a part of the workflow for individuals at the event there was widespread consensus that further screening and identification of individuals with a SUD was an important goal.

Identification of assessment as a distinct step was at times difficult to identify and often was mixed with elements of the ASAM evaluation. In some cases, workflows resulted in patients being evaluated with the ASAM criteria prior to an actual diagnosis of a SUD. One recommendation for improvement would be a consistent linear workflow involving screening, then assessment followed by determination of most appropriate level of care. In many cases this is already occurring, but development of clear procedures would ensure a consistent process is in place.

Significant progress has been made in Kern County in recent months with a strong push by the county to use ASAM level of care criteria. Adoption of this evidence-based standard will result in individuals receiving the right care in the right setting for the right

duration. Like most changes there have been some challenges with adoption, but these have continued to be addressed. A Gateway team has been formed to increase access to SUD services as well as work with treatment providers to coordinate appropriate care.

One challenge identified in the current state is having individuals referred to treatment providers for completion of the ASAM Level of Care determination and having this information provided to the Gateway team for authorization. Two difficulties exist with this workflow. First, most treatment providers do not offer multiple levels of care which can result in referral to an inappropriate level of care. For example, an individual may be referred to, or just present to residential treatment. Without completing the level of care evaluation this may result in someone completing the intake process for residential treatment only to find out that is not the most appropriate level of care. These false starts are likely to be discouraging to individuals seeking treatment and are contrary to the stated goals of streamlining the process of getting services. A second concern with this process is an inherent bias in evaluation to "make the patient fit" into the level of care where they are being assessed. Many factors may influence this desire to make sure the patient meets criteria for placement at the level for which they are being assessed.

HMA recommends two changes to improve the process of determining the most appropriate level of care. First, the initial evaluation for level of care should ideally be done prior to referral to a treatment provider. This could be accomplished by having the ASAM evaluation consistently done by the Gateway team. This would ensure a most objective evaluation as well as avoiding referrals to providers who are not able to provide the identified level of care. Second, we would recommend adopting the use of the computerized ASAM Criteria Continuum evaluation in place of the structured interview format. The computerized evaluation has several strengths. First, the computerized assessment allows the evaluation to be most accurate by eliminating bias from different evaluators. Also using the computerized evaluation allows easy sharing of the results with the provider accepting the referral resulting in much less duplicated work. Finally, the computerized evaluation will allow a longitudinal record of evaluations, allowing a more robust database both of clinical information as well as preventing the individual from undergoing another evaluation when seeing another treatment provider.

03 Section 3: Implementation Strategy

A. Next Steps

In a matter of two days stakeholders from across Kern County were able to identify major aspects of the systems that touch patients with addiction, determine what the major gaps and barriers are, and develop a viable future state. HMA recommends that the future state include standardized movement of protected patient health information, standardized screening pathways, greatly increased information sharing and public communication, increased capacity for providing access to all levels of addiction treatment care, and further development of evidence-based treatment required to conquer the disease of addiction.

All the information above in this report was pulled from the generous participation of individuals and institutions who deliver care or are otherwise vested in addiction treatment in Kern County. Given this, we know there is a highly motivated group of people to build stronger transitions of care for individuals suffering from the disease responsible for the number one cause of injury related death in our country (opioids) and an enormous source of tragedy and suffering for any community to have to endure.

Commitment amongst stakeholders to continue to work both within their organizations as well as collaboratively across the County was a clear outcome of the event. Multiple members voiced the benefits of meeting together on an ongoing basis to better understand what other programs were involved in as well as using the group for resolution of larger systems issues. Kern County is large geographically and in person participation may not be possible for all members so virtual meeting technology may be necessary to enable maximal participation. Kern County has a SUD task force which may be leveraged to begin this process and HMA will work with county leadership to identify existing resources and help facilitate the initial meetings, seeking to transfer leadership of the ongoing meetings to group members.

B. Technical Assistance Program

Prior to the process improvement event, HMA collaborated with the KBHRS to develop an attendee list and conduct outreach to invitees to encourage attendance. Also prior to the event, the KBHRS received a survey to document existing SUD capacity and resources in Kern County, as well as understand barriers to coordinated care for SUD. At the event, one “champion” per organization/team completed a paper technical assistance (TA) application with guidance from the Central California Team Lead (Shannon Breitzman). Following the process improvement event, information collected

through the TA application will be entered into Qualtrics, an online survey and data collection platform. Each organization/team will receive an individualized link to the Provider Assessment, which will be pre-populated with information from the TA application. The Central California Team Lead will work with each organization/team to facilitate completion as necessary. Following completion of the assessment, the Team Lead and Subject Matter Expert(s) will review the information provided through the TA application and Provider Assessment, to determine the appropriate TA track and curriculum for each organization/team. Once the TA needs and goals are reaffirmed by the coach and SME, the organization/team is assigned to a track and TA can begin and will continue for 12 months.

The three TA Tracks are as follows:

1. Sites that are unlikely to provide MAT but are seeking general TA
2. Sites that can potentially provide MAT and are interested in learning more
3. Sites that already provide MAT and want more specific TA to scale up services

TA resources include live and recorded webinar series, videos addressing addiction basics, additional resources and tools, and one-on-one coaching. Organization/teams can move to different tracks as their goals change.

Organizations/teams were asked to sign up for TA during the process improvement event and provided initial goals for the TA program.

The following 29 organizations and one independent provider applied for TA:

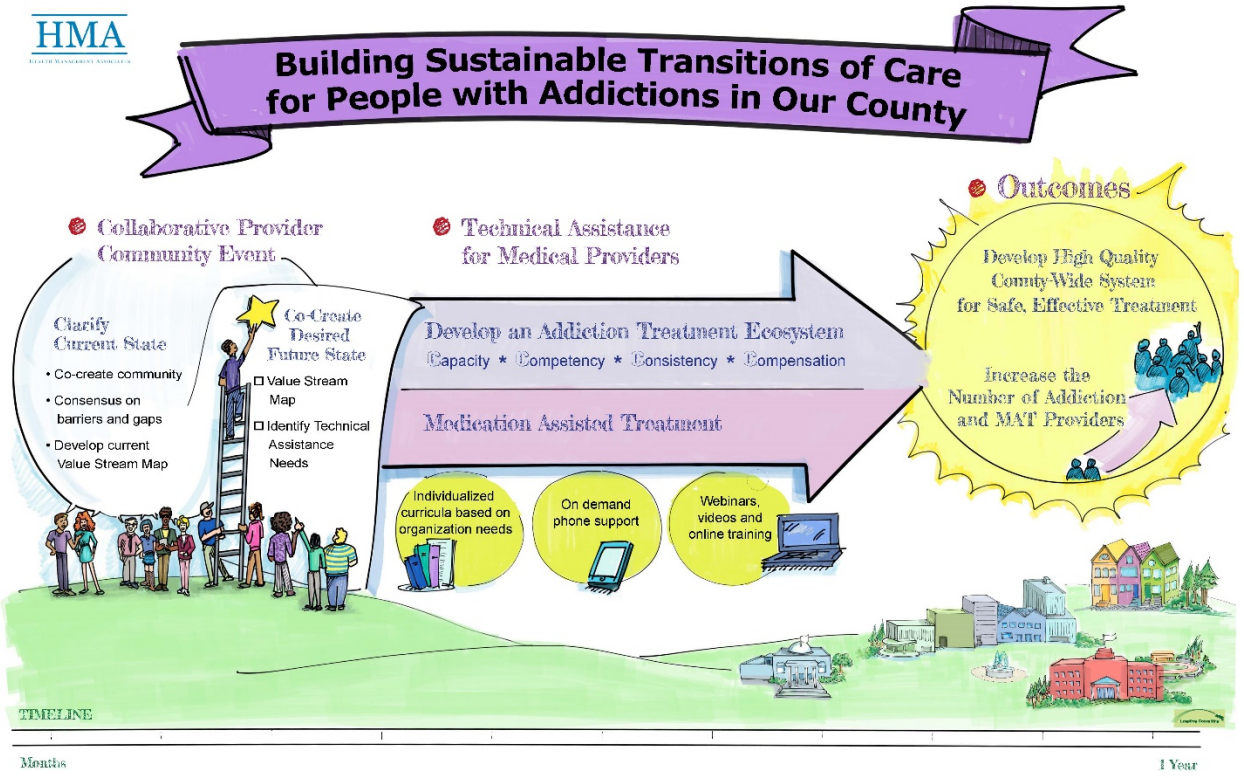
+ Kern County Public Health-
+ Kern County Department of Human Services
+ STEPS
+ New Life Residential
+ Clinica Sierra Vista
+ Kern Medical Hospital
+ Kern Health Systems
+ AEGIS Treatment Centers
+ Kern County Behavioral Health and Recovery Services
+ Kern County Office of Education
+ Kern County Probation Department
+ Kern County Sheriff's Office
+ Bakersfield Police Department
+ Kern County Public Defender
+ Bakersfield Recovery Services Inc.
+ The Brown Family Home
+ Kern Valley Healthcare District

- Your Drug Store, Inc.
- College Community Services
- Heather Berry, Private Practice Provider
- Synergy Recovery Services
- Kern High School District
- Westcare Bakersfield
- Cigna Healthcare
- Owens Valley Career Development Center
- One Door Recovery
- Omni Family Health
- Arc Point Labs

The 29 organizations/teams who requested TA requested the following specific goals:

Goal	Frequency
Learn more about how our organization can participate in a community wide solution to the opioid epidemic.	26
Improve our role in managing the transitions of care as residents in our community move within addiction system of care.	24
Learn more about caring for people with addiction and provide more information and training to our staff.	26
Scale up our current MAT program by increasing the number of patients treated.	9
Learn how to provide or improve addiction treatment to pregnant and parenting women.	11
Start providing MAT services at our organization.	14

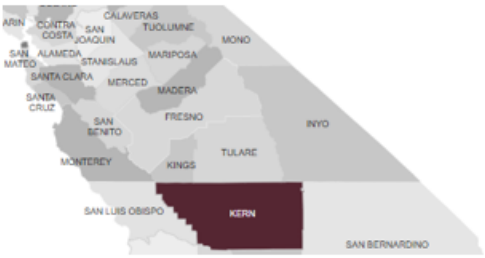
C. Conclusion



In conclusion, HMA thanks the Kern County community who turned out with their hearts and minds committed to this work. We hold the deep conviction that the Kern County community has what it takes to rethink one of the most complex medical conundrums in modern history. With resources mobilizing throughout the state and within the county, and the strong leadership of Kern County Behavioral Health, the envisioned future state pathway could be fully implemented and working within the next two to three years. Together, we have the power to normalize the disease of addiction, better care for the community members suffering from this disease and eliminate addiction related deaths in the County.

Appendix

A. Kern County Data

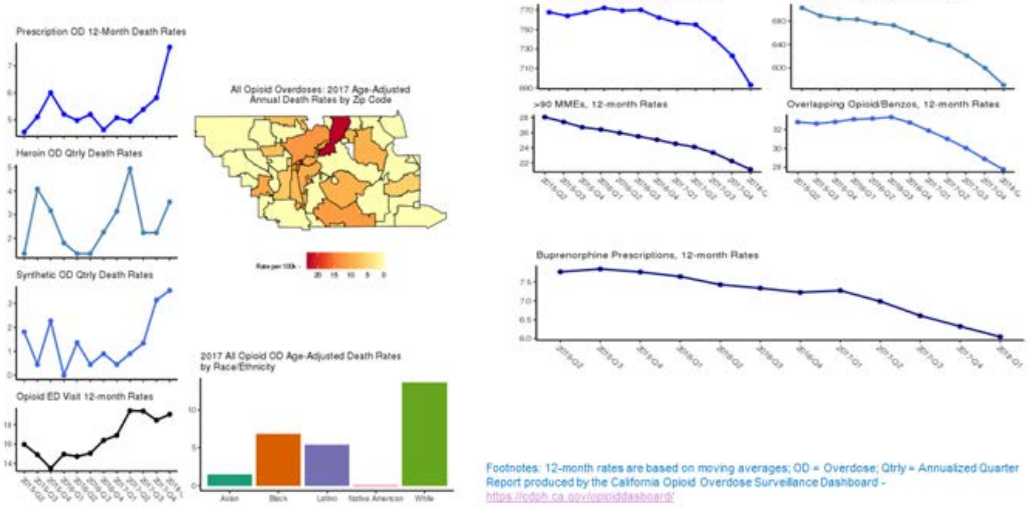


STATISTICS

- OUD Death Rate
  - 2017: 8.5, Rank 2/8
  - 2016: 5.9, Rank 6/8
- All Drug Death Rate
  - 2017: 26.2, Rank 1/8
  - 2016: 23.6, Rank 1/8
- ED Opioid Rate
  - 2017: 33.6, Rank 1/8
  - 2016: 25.9, Rank 2/8
- 11 Hospitals
- 20 Pharmacies
- 2 FQHCs
- Methadone Pt Rate 143.1: Rank 15/58

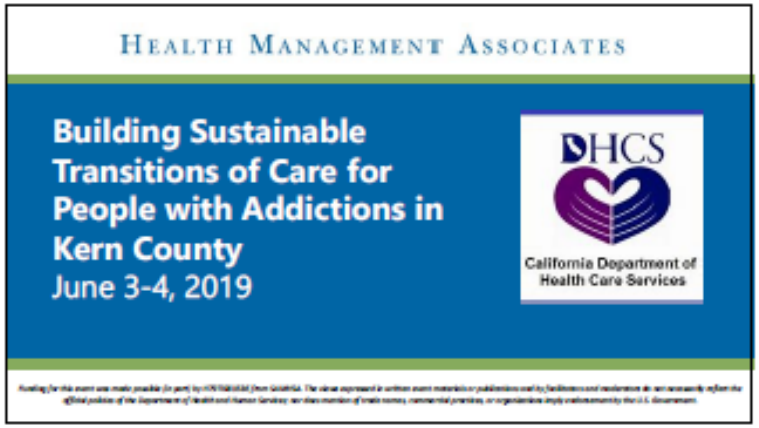
ADDITIONAL FACTORS

- Coalition: None
- SAMHSA Funds: $285,000
- Drug Medi-Cal Organized Delivery System? Yes
- Presence of CA Bridge: Yes



Footnotes: 12-month rates are based on moving averages; OD = Overdose; Qtrly = Annualized Quarter
Report produced by the California Opioid Overdose Surveillance Dashboard -
https://cdph.ca.gov/opioiddashboard/

B. Process Improvement Event Slides



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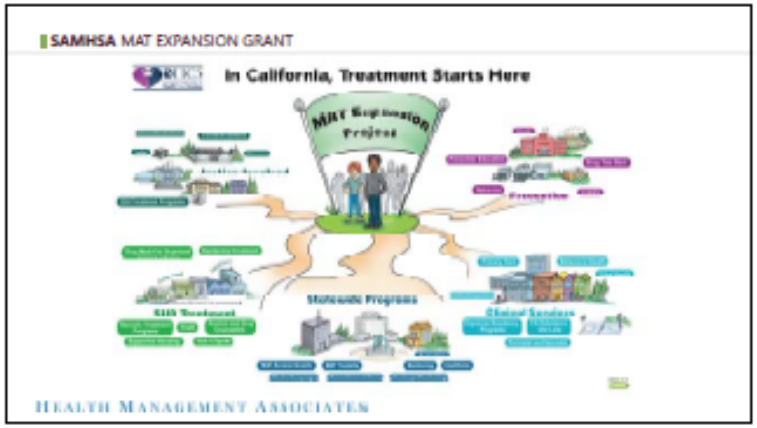

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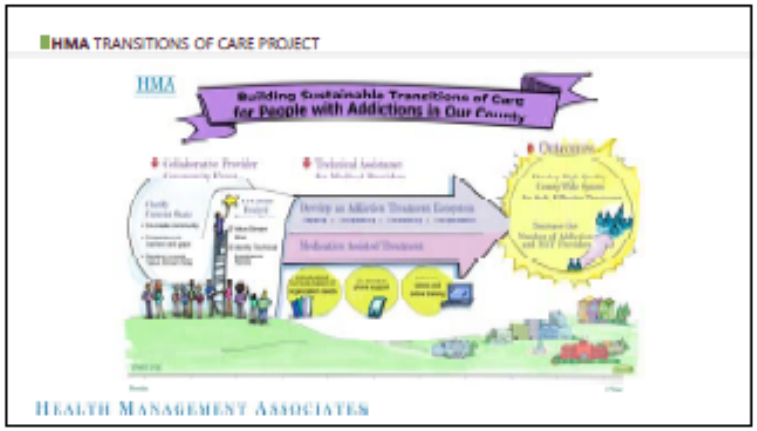

3

4

TECHNICAL ASSISTANCE PROGRAM PLANNING GOALS

HMA will reduce wait times for MAT treatment starts by increasing the number of MAT providers through the promotion and delivery of comprehensive technical assistance.

HMA will strengthen addiction treatment practice methods through comprehensive technical assistance that increases the level of local expertise available, establish a system-wide understanding and use of best treatment practices, and establishes a shared vernacular.

This work will be accomplished through:

- Comprehensive provider assessments that result in detailed TA plans to address areas of greatest learning need
- Learning collaboratives that strategically group stakeholders for maximum shared learning and efficiency in program delivery
- A minimum of 12 months of TA delivered through recorded modules, webinars, on-demand telephonic TA, and recurring site-specific coaching
- Regional learning events

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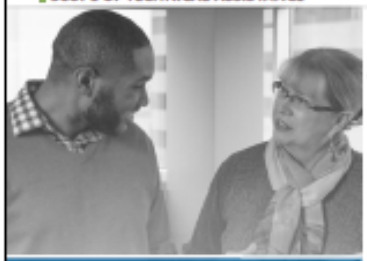
SCOPE OF TECHNICAL ASSISTANCE



WHAT DOES TECHNICAL ASSISTANCE **MEAN FOR PARTICIPANTS?**

"HOW CAN OUR TEAM RECEIVE SUPPORT AFTER TODAY'S EVENT?"

- Complete the TA Application in your folder
- Form your TA team, identify the team lead and select your goals
- Gather signatures on the TA application from all team members
- Complete and submit the assessment that arrives by email to the team lead
- Join the kick off call with your HMA coach and together, select the TA plan and tools to meet your team goals

6

ADDICTION 101 – THE PROBLEM

What is Addiction?

It is a **chronic neurobiological disorder** centered around a **dysregulation of the natural reward system**

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ADDICTION 101 – HOW DID WE GET HERE?

Push by manufacturers

Poor acute and/or chronic pain management theory

Distribution of large amounts of medication

Increased prescribing of opioids
+Pain as 5th vital sign
+Expectation of no pain

Massive amount of prescriptions filled by pharmacies

Blind eye to the data

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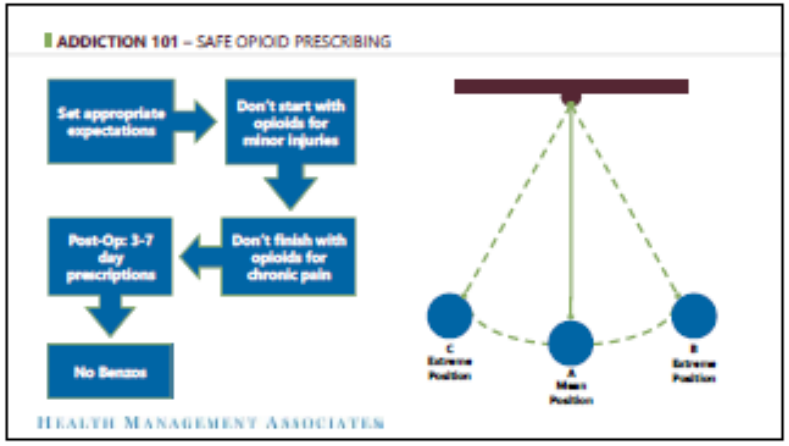
ADDICTION 101 – SAFE OPIOID PRESCRIBING
Set appropriate expectations
Don't start with opioids for minor injuries
Don't finish with opioids for chronic pain
Post-Op: 3-7 day prescriptions
No Benzos
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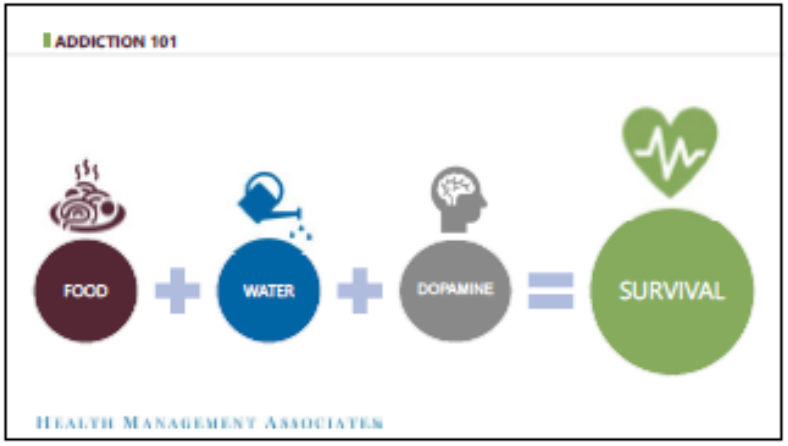
ADDICTION 101
FOOD
WATER
DOPAMINE
SURVIVAL
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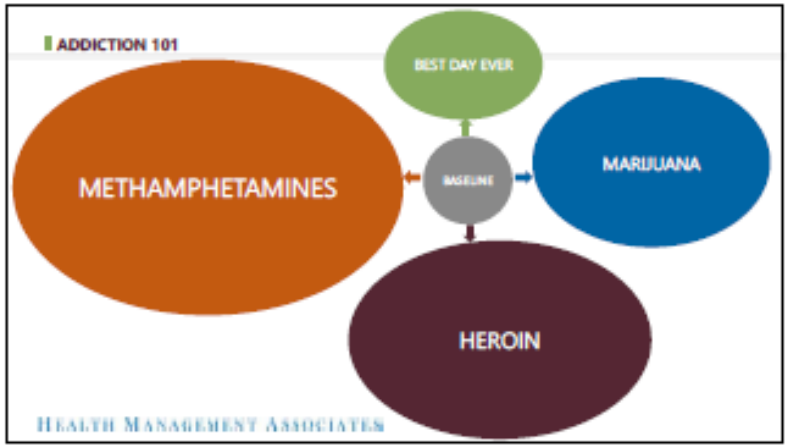
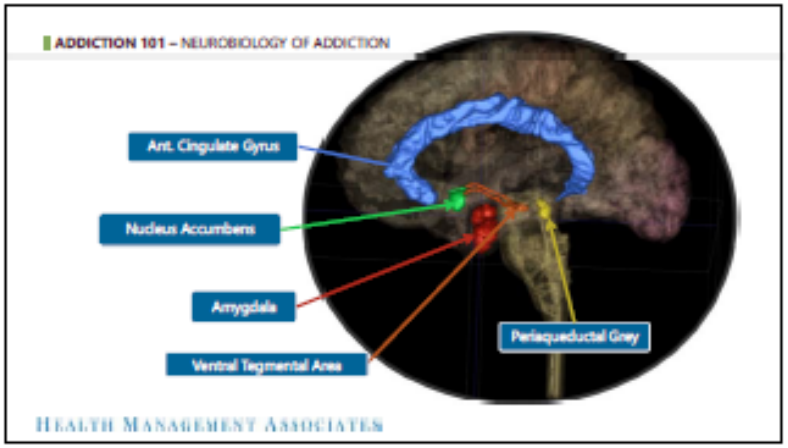
10


ADDICTION 101
BEST DAY EVER
METHAMPHETAMINES
BASELINE
MARIJUANA
HEROIN
HEALTH MANAGEMENT ASSOCIATES

11


ADDICTION 101 – NEUROBIOLOGY OF ADDICTION
Ant. Cingulate Gyrus
Nucleus Accumbens
Amygdala
Ventral Tegmental Area
Periaqueductal Grey
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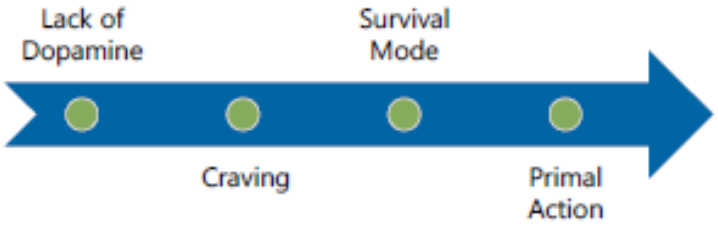
ADDICTION 101 – BEHAVIOR



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DSM-V DIAGNOSIS OF OUD

TABLE 1 Summarized DSM-5 diagnostic categories and criteria for opioid use disorder

Category	Criteria
Impaired control	• Opioids used in larger amounts or for longer than intended • Unsuccessful efforts or desire to cut back or control opioid use • Excessive amount of time spent obtaining, using, or recovering from opioids • Craving to use opioids
Social impairment	• Failure to fulfill major role obligations at work, school, or home as a result of recurrent opioid use • Persistent or recurrent social or interpersonal problems that are exacerbated by opioids or continued use of opioids despite these problems • Reduced or given up important social, occupational, or recreational activities because of opioid use
Risky use	• Opioid use in physically hazardous situations • Continued opioid use despite knowledge of persistent physical or psychological problem that is likely caused by opioid use
Pharmacological properties	• Tolerance as demonstrated by increased amounts of opioids needed to achieve desired effect; diminished effect with continued use of the same amount • Withdrawal as demonstrated by symptoms of opioid withdrawal syndrome; opioids taken to relieve or avoid withdrawal

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ADDICTION 101 – BEHAVIOR

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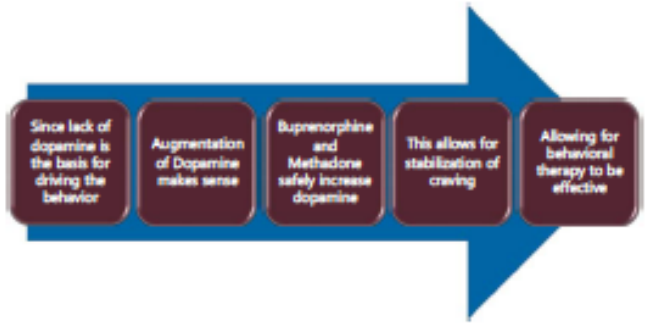
ADDICTION 101 – TREATMENTS



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ADDICTION 101 – CRAVING
A direct or indirect force pulling someone towards a substance or behavior
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ADDICTION 101 – RELAPSE
Lower ability to make more decisions
More decisions =
Less likely to question others reality
More likely to make the easy choice
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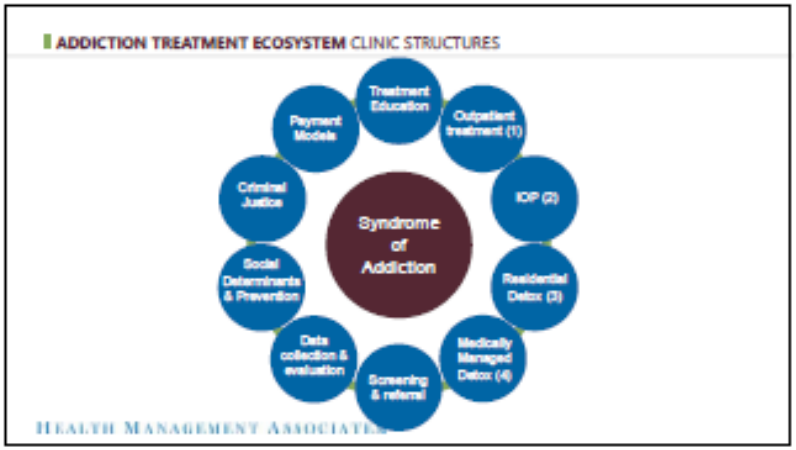
ADDICTION TREATMENT ECOSYSTEM CLINIC STRUCTURES
Syndrome of Addiction
Treatment Education
Outpatient treatment (1)
IOP (2)
Residential Detox (3)
Medically Managed Detox (4)
Screening & referral
Data collection & evaluation
Social Determinants & Prevention
Criminal Justice
Payment Models
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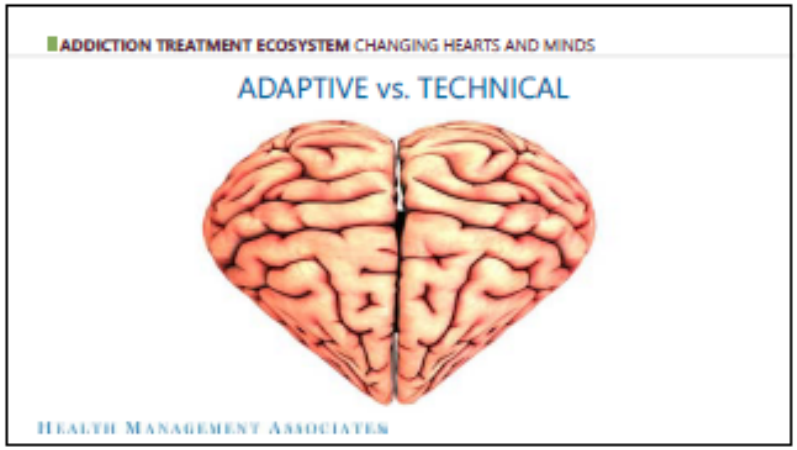
ADDICTION TREATMENT ECOSYSTEM CHANGING HEARTS AND MINDS
ADAPTIVE vs. TECHNICAL
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ADDICTION TREATMENT ECOSYSTEM IMPLEMENTATION
Capacity
Competency
Consistency
Compensation
Community
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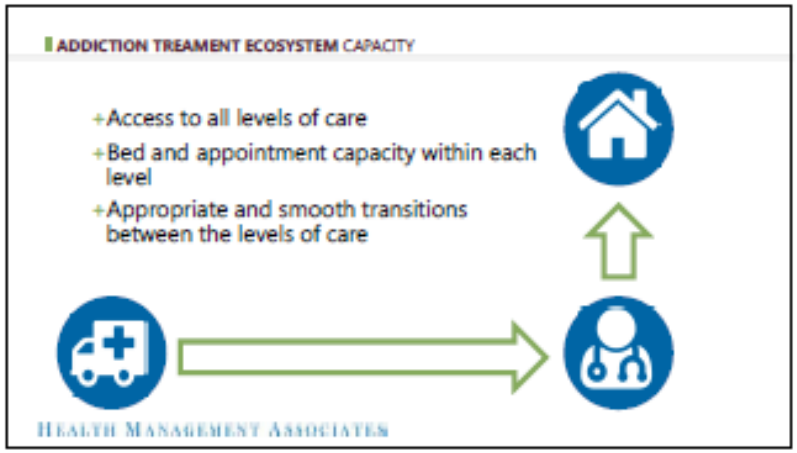
ADDICTION TREAMENT ECOSYSTEM CAPACITY
+Access to all levels of care
+Bed and appointment capacity within each level
+Appropriate and smooth transitions between the levels of care
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ADDICTION TREAMENT ECOSYSTEM COMPETENCY

- BH personnel working at appropriate level of training
- Addiction specific training of BH and care coordinators
- Standardized peer support training
- PCPs who are waivered and trained with ongoing TA
- Board Certified Specialists with up to date MOC
  - Includes need for increased fellowships
- Academic detailing services for questionable practices

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ADDICTION TREAMENT ECOSYSTEM CONSISTENCY

- Predictable Consistent screening
- Patient level metrics
  - Percent on MAT
  - OD
  - Mortality rate
- Community level metrics
  - Bed board
  - Capacity and access for each level of care
  - Emergency plan
- Performance and outcome tracking
  - ASAM
  - NQF
  - Joint Commission

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ADDICTION TREAMENT ECOSYSTEM COMPENSATION

- Payment parity for all clinicians
- CPT codes for Bundled Approaches
- Standard reporting to payers
- EMR expansion into Addiction

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ADDICTION TREAMENT ECOSYSTEM COMMUNITY

- Holding each other accountable for NIMBY
- Recognizing that almost everyone has been affected
- Educational events that are community facing
- Teaching teachers about addiction

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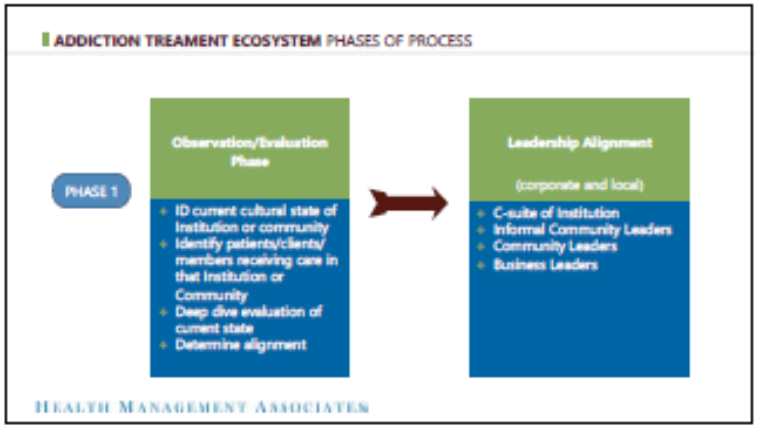
ADDICTION TREAMENT ECOSYSTEM PHASES OF PROCESS
PHASE 1
Observation/Evaluation Phase
ID current cultural state of institution or community
Identify patients/clients/ members receiving care in that institution or Community
Deep dive evaluation of current state
Determine alignment
Leadership Alignment
(corporate and local)
C-suite of Institution
Informal Community Leaders
Community Leaders
Business Leaders
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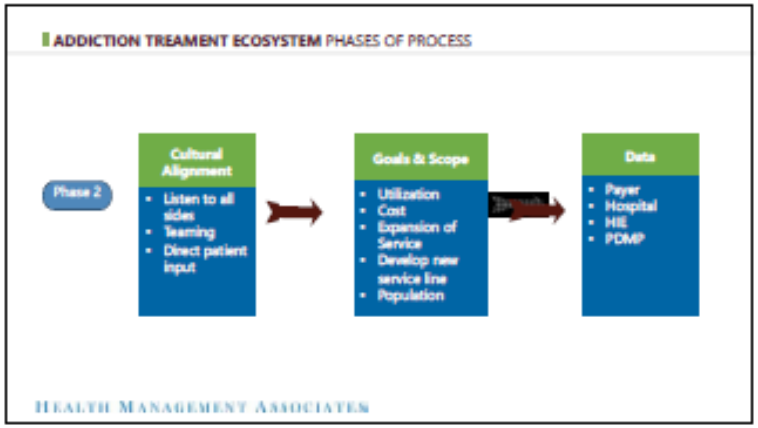
ADDICTION TREAMENT ECOSYSTEM PHASES OF PROCESS
Phase 2
Cultural Alignment
Listen to all sides
Teaming
Direct patient input
Goals & Scope
Utilization
Cost
Expansion of Service
Develop new service line
Population
Data
Payer
Hospital
HIE
PDMP
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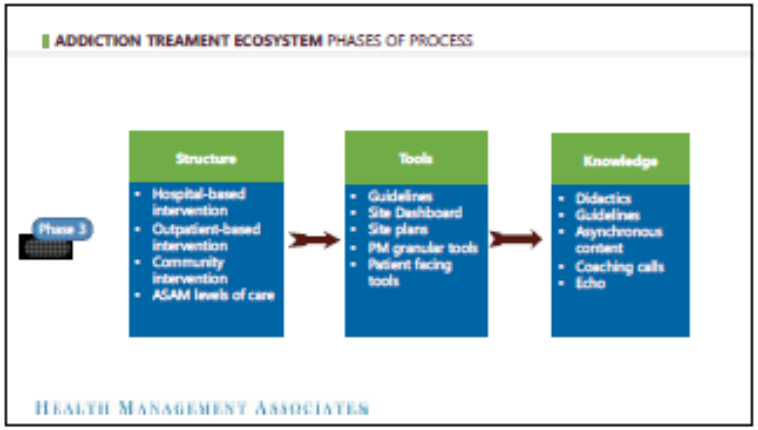
ADDICTION TREAMENT ECOSYSTEM PHASES OF PROCESS
Phase 3
Structure
Hospital-based intervention
Outpatient-based intervention
Community intervention
ASAM levels of care
Tools
Guidelines
Site Dashboard
Site plans
PM granular tools
Patient facing tools
Knowledge
Didactics
Guidelines
Asynchronous content
Coaching calls
Echo
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GOAL
IN A PERFECT WORLD WE WOULD LIKE TO....
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32

SCOPE

WHO IS IN AND WHO IS OUT?

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33

A3 BARRIER AND SCOPING

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34

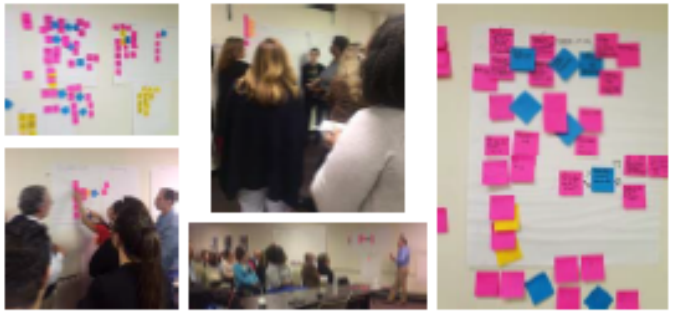
MAY 21:

AFTERNOON SESSION

COHORT 1

35

FIELD NOTES



HEALTH MANAGEMENT ASSOCIATES

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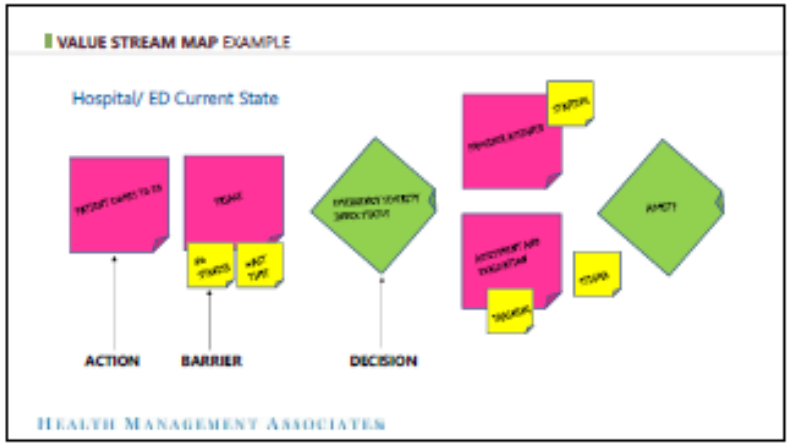
VALUE STREAM MAP EXAMPLE
Hospital/ ED Current State
ACTION
BARRIER
DECISION
HEALTH MANAGEMENT ASSOCIATES

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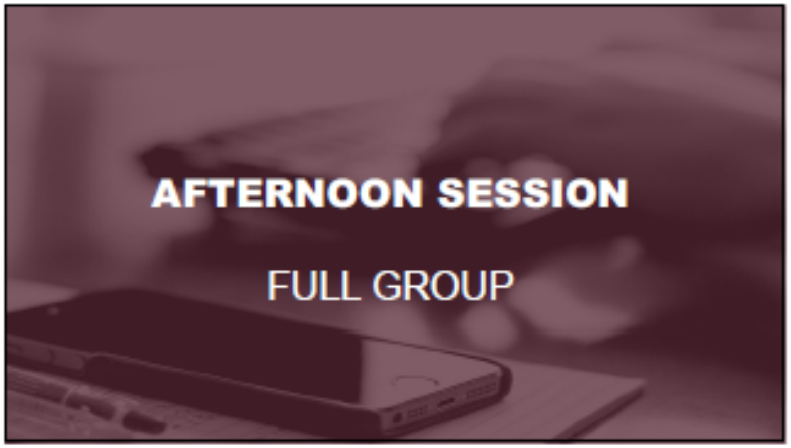
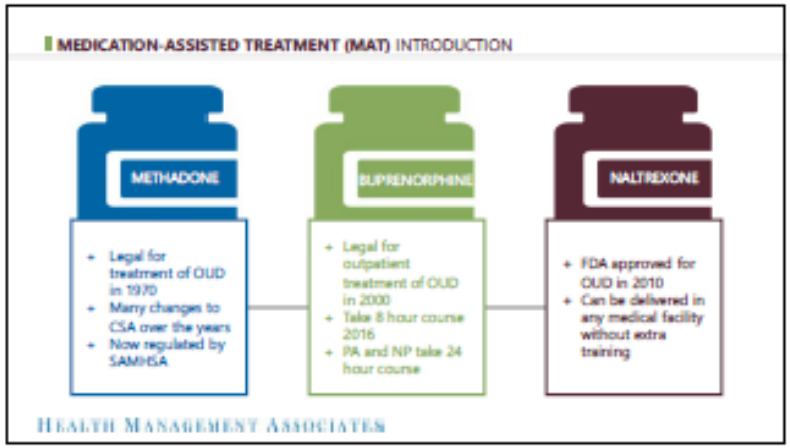

AFTERNOON SESSION
FULL GROUP

38


MEDICATION-ASSISTED TREATMENT (MAT) INTRODUCTION
METHADONE
Legal for treatment of OUD in 1970
Many changes to CSA over the years
Now regulated by SAMHSA
BUPRENORPHINE
Legal for outpatient treatment of OUD in 2000
Take 8 hour course 2016
PA and NP take 24 hour course
NALTREXONE
FDA approved for OUD in 2010
Can be delivered in any medical facility without extra training
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MAT ASSOCIATED WITH...
Reduction in the use of illicit drugs
Reduction in criminal activity
Reduction in needle sharing
Reduction in HIV infection rates and transmission
Cost-effectiveness
Reduction in commercial sex work
Reduction in the number of reports of multiple sex partners
Improvements in social health and productivity
Improvements in health conditions
Retention in addiction treatment
Reduction in suicide
Reduction in lethal overdose
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METHADONE WHO IS APPROPRIATE?

- Patients with greater than a year of an OUD
- Patients who have been injecting opioids
- Patients who have transportation available
- Patients with a more severe OUD

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METHADONE GENERAL REGULATIONS

- Delivered via observed dosing
- Once patient is stable and after 6 weeks, can be given take-home doses (varies by state)
- Highly monitored in an Opioid Treatment Program setting (OTP)
- Many requirements for treating patients

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METHADONE CLINIC REQUIREMENTS

- Required counseling for substance use disorders (not synonymous with psychotherapy for mental health issues)
- Documented full treatment planning
- Diversion control processes
- Drugs screens (urine, oral swabs). Drug testing for confirmations if necessary.
- Urine collections may be observed or unobserved.
- Call backs for both random urine drug screens (UDC) and to check that any take home medications are accounted for

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METHADONE PARTICULARS

- As the dose goes up so does retention in treatment
  - Best dose range 90-120 mg
  - Not considered therapeutic until at least 60 mg per day
- Common misunderstanding is that if you are on methadone you are covered for pain.
  - Methadone for pain is 3x a day
  - Illegal to write prescription for methadone to treat OUD unless covering a gap in treatment.
  - Still no more than 3 days are allowed

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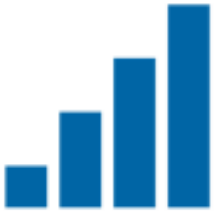
METHADONE OUTCOMES

- The most studied of the three medications
- Retention in treatment is the main outcome and has ranged between 60 and 80% among RCTs
- Possibly due to combination of high intensity treatment and medication
- Still standard of care for patients with Severe Opioid Use Disorder



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METHADONE CAVEATS

- Not really available in Rural areas
- Despite having the best outcomes, it has the highest level of stigma
- Requires good geographic association to patients
- Hard to get patients off after a few years of treatment

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BUPRENORPHINE WHO IS APPROPRIATE?

- Positive DSM 5 with a score of 2 or greater
- Positive DAST (6 or greater)for opioids
- Can make it to clinic for evaluation
- Can afford the medication

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BUPRENORPHINE GENERAL REGULATIONS

Approved in the 90's for pain via an injectable form

Approved in 2000 for use in maintenance treatment for OUD

Now multiple forms:

- SL tablet
- SL film
- Buccal Film
- SL Oral dissolvable tablet
- Implantable rods
- Long acting injectable

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BUPRENORPHINE TRAINING REQUIRED

- MD or DO
  - 8 hour course
  - 30 patients in first year then can apply to go to 100
  - If want up to 275 patients
    - board certification in addiction medicine or addiction psychiatry by the American Board of Addiction Medicine (ABAM) or the American Board of Medical Specialties (ABMS) or certificati[on] by the American Osteopathic Academy of Addiction Medici[ne], ABAM or ASAM
    - Or work in a qualified practice setting
- PA, NP, APN
  - 24 Hour Course
  - 30 patients in first year then can apply to go to 100
  - Held to state oversite rules

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BUPRENORPHINE OUTCOMES

- Retention in treatment at 1 year have ranged from 55% to 65% using the sublingual medication
- High degree of variability in the delivery models and patient severity
- Most rapid stabilization of dopamine

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BUPRENORPHINE CAVEATS

- Many different ways to do an induction
- Watch for diversion
- Can be tough to wean and there are questions about if you should even try
- Need to keep good records for possible DEA evaluation

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NALTREXONE WHO IS APPROPRIATE?

- Patients with a high degree of motivation (dopamine)
- Patients leaving the criminal justice system with a history of OUD and AUD
- Patients who had poor results with methadone or buprenorphine

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NALTREXONE GENERAL REGULATIONS

No Federal regulations inhibit the use

Newer implants not FDA approved

Some payer restrictions make it difficult to obtain the long acting injectable form

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NALTREXONE MEDICATION FORMS

- Pills at 25mg and 50 mg
- Long acting injectable 380mg (28-30 days)
  - Vivitrol
- Implantable beads
  - 6 months of coverage of 0.9 ng/ml naltrexone
  - 3.5 ng/ml of 6-beta-Naltrexol)

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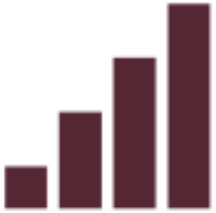
NALTREXONE OUTCOMES

- Least studied of the 3 medications
- Retention in treatment rates ranging from 23-60% depending on the study.
- Injection has better retention than oral pills
- Implant seems to show promise however needs more study



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NALTREXONE CAVEATS

- Best in patients with high motivation (i.e. increased or normalized dopamine)
- Retention in treatment may be hard for many patients
- Current head to head trial of buprenorphine and naltrexone is underway
- Difficult to get started due to need for 7 days of abstinance

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MAT CONCLUSIONS

+Methadone and Buprenorphine seem to have no difference if efficacy whether patient is injecting or using oral pills

+Using medications is the standard of care

+There is no perfect answer!

+Involve your patients and have access to all of the medications

+Building an addiction treatment ecosystem is the way. Not just and opioid treatment system.

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C. Summary of Evaluation Results

1. **What did you like MOST about this forum?**
    - Explanation of MAT medications
    - Bringing together of partners working on addiction
    - Mapping barriers and finding solutions
    - Interactive
    - Informative
2. **What did you like LEAST? What changes would you recommend?**
    - Too long
    - Need more structure in the group work for size of audience
    - Extended periods of sitting
    - Mapping exercises were too lengthy
    - Rural community and specific barriers were not addressed adequately
3. **Give an example of something new you learned about addiction.**
    - Services in the community
    - Dopamine's role in SUD
    - Barriers that agencies face
    - MAT and percent of success on MAT
4. **What topics would you like to learn more about?**
    - Data sharing
    - MAT in jails
    - How would this benefit minors?
    - Insurances
    - Connecting resources
5. **Other comments/questions.**
    - *"Exceeded my expectations, instructor was extremely knowledgeable and a good orator"*
    - *"Great event"*
    - *"I feel like I am headed in the right direction"*
    - Offer CEUs

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