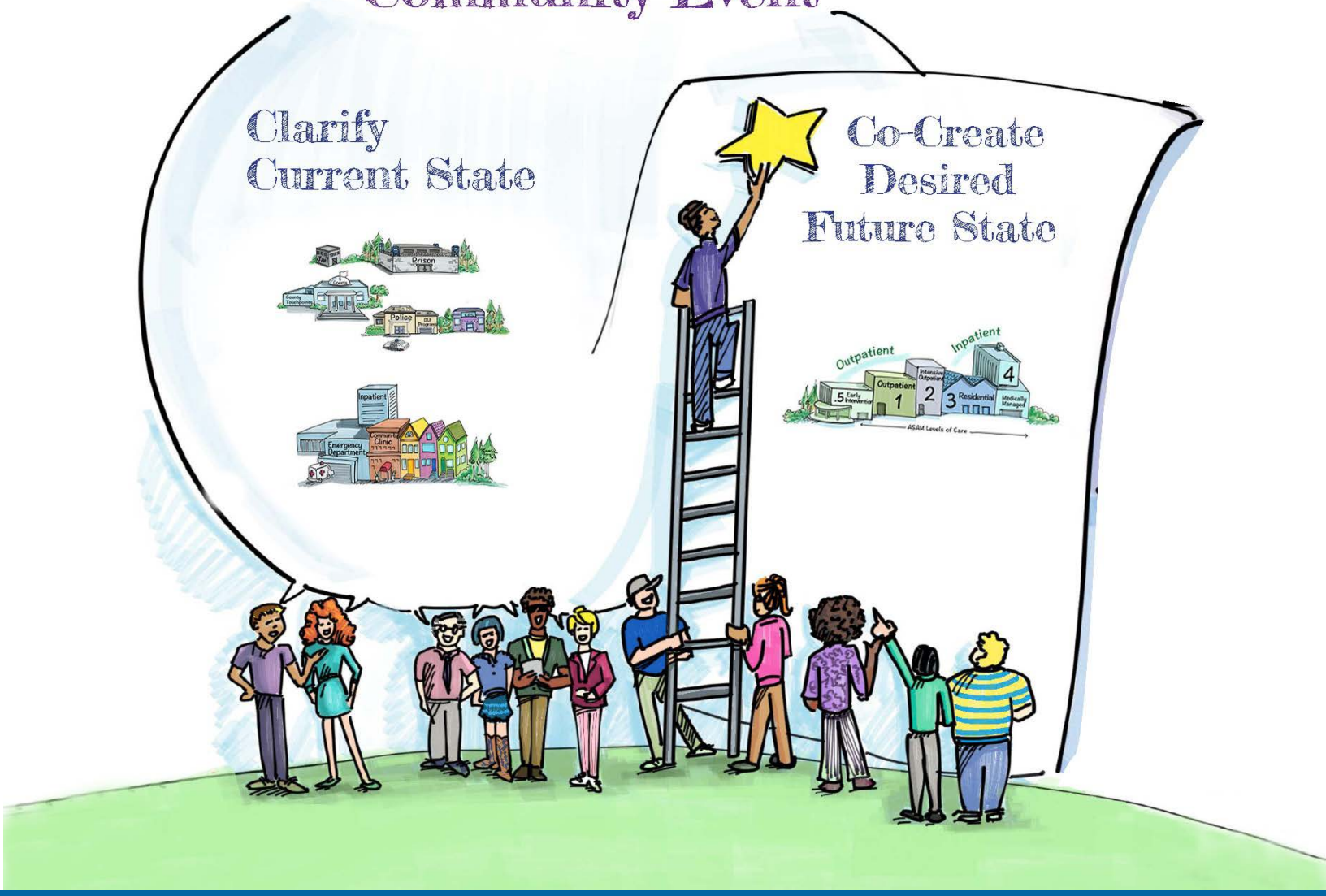

BUILDING SUSTAINABLE TRANSITIONS OF CARE FOR PEOPLE WITH ADDICTIONS

Imperial County Community Process Improvement Event

April 8-9, 2019

HEALTH MANAGEMENT ASSOCIATES

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Executive Summary

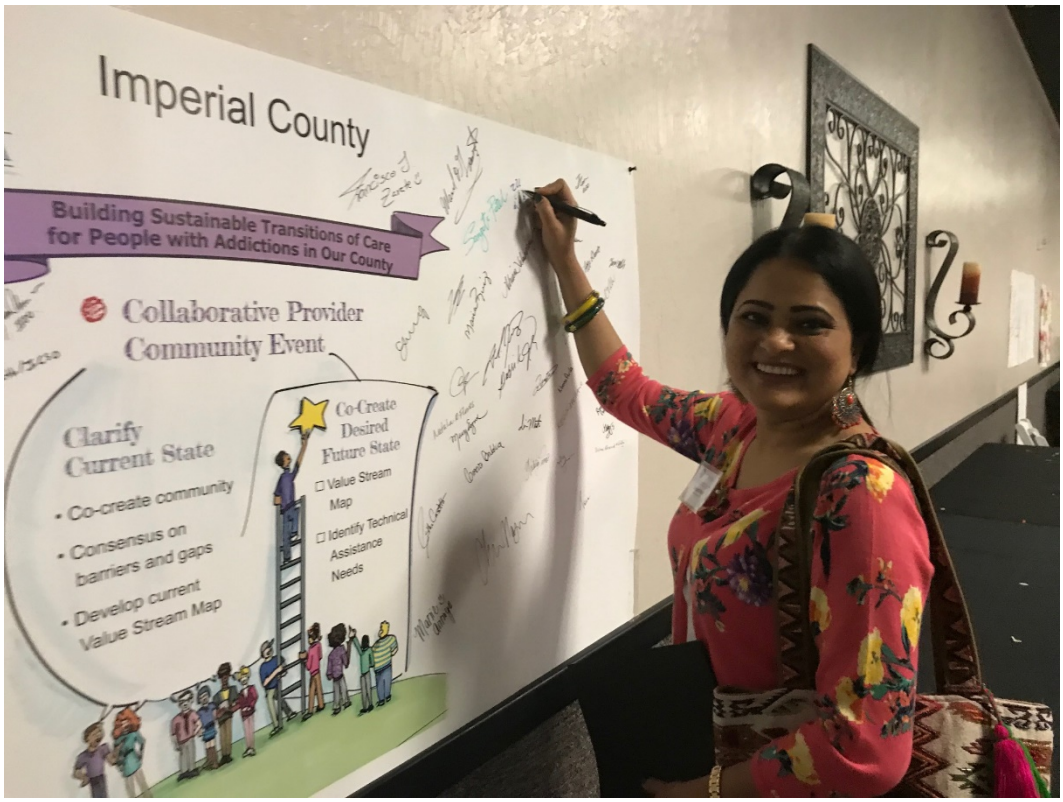
Overdose is the leading cause of injury-related death in the United States. The vast majority of these overdoses come from a combination of prescribed opioids and heroin. As we have watched the opioid crisis worsen over the last 10 years, we have reached a point that the treatment system, in its current 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 – the State Treatment Response (STR) and State Opioid Response (SOR) grants. California received STR and SOR grants which are being used for the California Medication Assisted Treatment (MAT) 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. Health Management Associates (HMA) received an SOR grant focused on developing predictable and consistent transitions of care to sustain addiction treatment from locations such as the emergency departments, jails, primary care clinics, the community at large and/or inpatient hospital stays. The Transitions of Care project will engage stakeholders in each selected county in a two-day countywide process improvement event followed by 12 months of ongoing technical assistance to achieve the county's ideal future state for addiction treatment. Imperial County, one of the 10 counties selected, participated in a large-scale process improvement event on April 8-9, 2019 that included members from all aspects of government, healthcare, addiction treatment, and those who pay for that treatment. During the event, intense work sessions were held with a focus on the identification of the population we aim to treat.

Imperial County Behavioral Health Services embarked on an educational campaign examining the disease of addiction, evidence-based treatments, and an evaluation of the entire addiction treatment system in and around Imperial County, CA.

The group-based consolidated vision of the future includes, but is not limited to, a ubiquitously used release of information form and a universal standardized screening based on NIDA developed severity tools (the ASSIST) and the American Society of Addiction Medicine's (ASAM) addiction treatment levels of care. This 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.



01

Section 1: Introduction

A. Level Setting

Overdose is the number one cause of death for people under 50 years old. It kills more people annually than car accidents or gun violence. The vast majority of these overdoses are due to opioids, including prescription pain medication and heroin. 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. The State Treatment Response (STR) and State Opioid Response (SOR) funds are being utilized in the state of California to fund the California Medication Assisted Treatment (MAT) 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 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 Project 2.0 project is funded by SOR and builds upon the existing STR funded work. California MAT Project 2.0 runs for two years beginning in September 2018.

HMA received an SOR grant focused on developing predictable and consistent transitions of care to sustained addiction treatment from locations such as the emergency department, jails, primary care, the community at large and/or inpatient

hospital stays. Through rigorous assessment of all 58 counties, Imperial County was identified 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 Imperial County, nine counties were identified as key locations to focus these efforts.

The Transitions of Care project will engage stakeholders in each selected county in a two-day countywide process improvement event followed by 12 months of ongoing technical assistance to so that 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 for ongoing individualized technical assistance from a team of national experts covering all aspects of knowledge required to build and sustain an evidence-based ecosystem of care.

HMA worked closely with the Imperial County Behavioral Health Services (ICBHS), specifically Gabriela Jimenez and staff, to launch the process improvement event, and subsequent ongoing technical assistance program. ICBHS identified key stakeholders to be engaged, developed an invitation list, distributed invitations and conducted outreach, and reviewed materials and provided feedback. HMA conducted targeted outreach to stakeholders at the request of ICBHS.

B. Goals of the Participants

On day one 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:

- Increase Collaboration
- To get on the same page
- Continuity of care
- Understanding the dynamics of the different systems – what role does everyone play
- Have everyone know what services exist
- Knowing what we can do to help; overcoming stigma
- Make sure programs are not stagnant; collect and do something with data
- Having a residential treatment center; "getting well where you live"
- Effective and appropriate training and education – providers, patients, families
- Medical detox; and "no wrong door"
- Build the system required to bring a person back into the fold of society; job training and placement for those who are exiting treatment; addressing this and other social determinants of health; engage local business
- Decreasing the number of people who die in the community
- Collaboratively understanding we need to develop a solution and hold each other accountable

- Let community know they are doing this – communicate with the community about the work
- Innovative evidence-based models that help patients gain insight into their addiction so that they can make change
- Real/true cognitive behavioral therapy training for providers (as opposed to eclectic therapy or DBT-like therapy)
- Breaking down barriers/silos between agencies; solidifying ways in which patients are transferred between agencies for example
- Streamlining pathways/transitions of care
- Prevention programs; in schools, with families, etc.; training among teachers to make it sustainable
- Create an app/tech solution to help patients ID services and connect providers
- Solution to 42 CFR part 2; streamline the way data is shared (42 CFR part 2); have patients sign a common release
- Holistic approach to recovery; nsure there is follow up medical care for people who are addicted to deal with damage as result of substance use
- Harm reduction strategies; difficult in a conservative community
- Technical Assistance to obtain appropriate certifications
  - Center certifications
  - Service certifications

THE BIG GOAL

ELIMINATE ADDICTION-RELATED DEATHS

IN IMPERIAL COUNTY

C. County Leadership/ Key Change Agents

Imperial County Behavioral Health Services

- Andrea Kuhlen, Director
- Gabriela Jimenez, Deputy Director
- Bushra Ahmad, Medical Director
- Ana Contreras, Behavioral Health Manager
- Victoria Mansfield, Program Supervisor
- Christen Magana, Program Supervisor

- Gabriela Izaguirre, Analyst
- Jonathan Garcia, Analyst
- Roberto Romero, Analyst

D. Who Was Involved

- Clinicas de Salud del Pueblo
- Desert Pharmacy
- DSS-Child Welfare Services
- El Centro Pharmacy
- El Centro Police Department
- El Centro Regional Medical Center
- Emergency Medical Services
- Foundations in Recovery, Inc.
- GEO Group Reentry Services
- Health Management Associates
- Imperial County Veterans Service Office
- Imperial County Probation Department
- Imperial County Behavioral Health Services
- Imperial County Department of Social Services
- Imperial County Juvenile Hall
- Imperial County Office of Education
- Imperial County Public Administrator
- Imperial County Public Health
- Imperial County Sheriff
- Imperial Valley Behavioral Health Services
- Imperial Valley College
- Molina Healthcare
- Pioneers Memorial Healthcare District
- Psychological Support Services Inc.
- Reliance Public Relations Inc.
- Self-Management and Recovery Training

- Imperial County Behavioral Health Services Substance Use Disorder Treatment Programs
- Superior Court of California, County of Imperial
- VALLEY MEDICAL PHARMACY
- Wellpath.us
- WomanHaven

E. Structure of the Intervention

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 (aka 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, a hybrid process was used to obtain the current state structure and wrap around the proposed new pathways and future state.

The event consisted of electronically gathered pre-work followed by two days of information and gathering, culminating in a 50-minute presentation of the current state on day one and a one-and-a-half-hour presentation of the agreed upon future state on day two.

Day one was used to develop the scope of the project and help develop the problem statement that would drive the entire process. We also identified the desired outcome from any intervention/future state plan. The participants were organized into two cohorts based on role in the addiction treatment ecosystem.

Cohort 1 met on the afternoon of day one to discuss current state while Cohort 2 discussed the barriers identified in the morning, set priorities amongst them, and discussed solutions to communication amongst addictions treatment stakeholders as well as community-focused communication. Cohort 2 met on the morning of day two to discuss the current state. Cohort 1 groups included Hospital/ Emergency Department, Primary Care/ Pharmacy, and Justice. Cohort 2 groups included Crisis evaluation/triage, ASAM Level 1 Medical, ASAM Level 2 Behavioral (Intensive Outpatient or IOP), and Non-provider Community Stakeholders. While each of these sessions had a unique "flavor", the concept was straightforward: develop a current state value stream map that includes all interventions, who performs them, and how long they take. They 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 great sense of the current state of addiction screening, placement and treatment in Imperial 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, they presented their map to the rest of their cohort. Then, the full group worked together to develop a future state map "scaffolding". The "scaffolding" is the part of the future state map that all providers have in common and can build on for their specific setting.

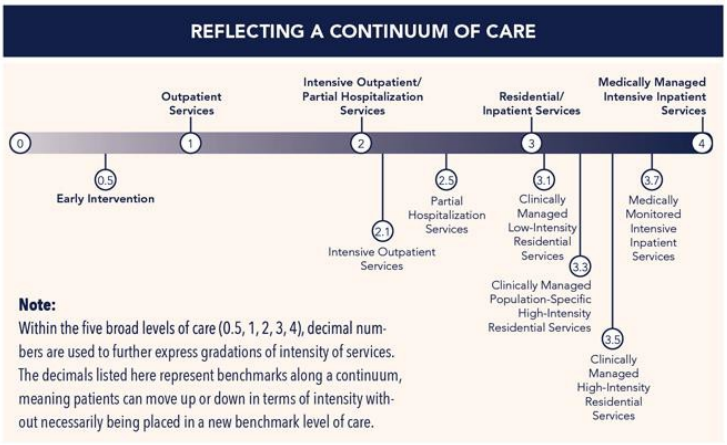
It bears mentioning that this was a very engaged group with all levels of people involved including administrators, doers, and clients. The future state map was developed based on the input of the groups and addresses the barriers and gaps identified. While not every treatment organization was present, the group would be considered a quorum (two-thirds or greater representation was the standard). Given this, the buy-in from the different groups was substantial and it was their voices that created the product.

F. Screening and Level of Care Determination

The "long form" of the 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 referral 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

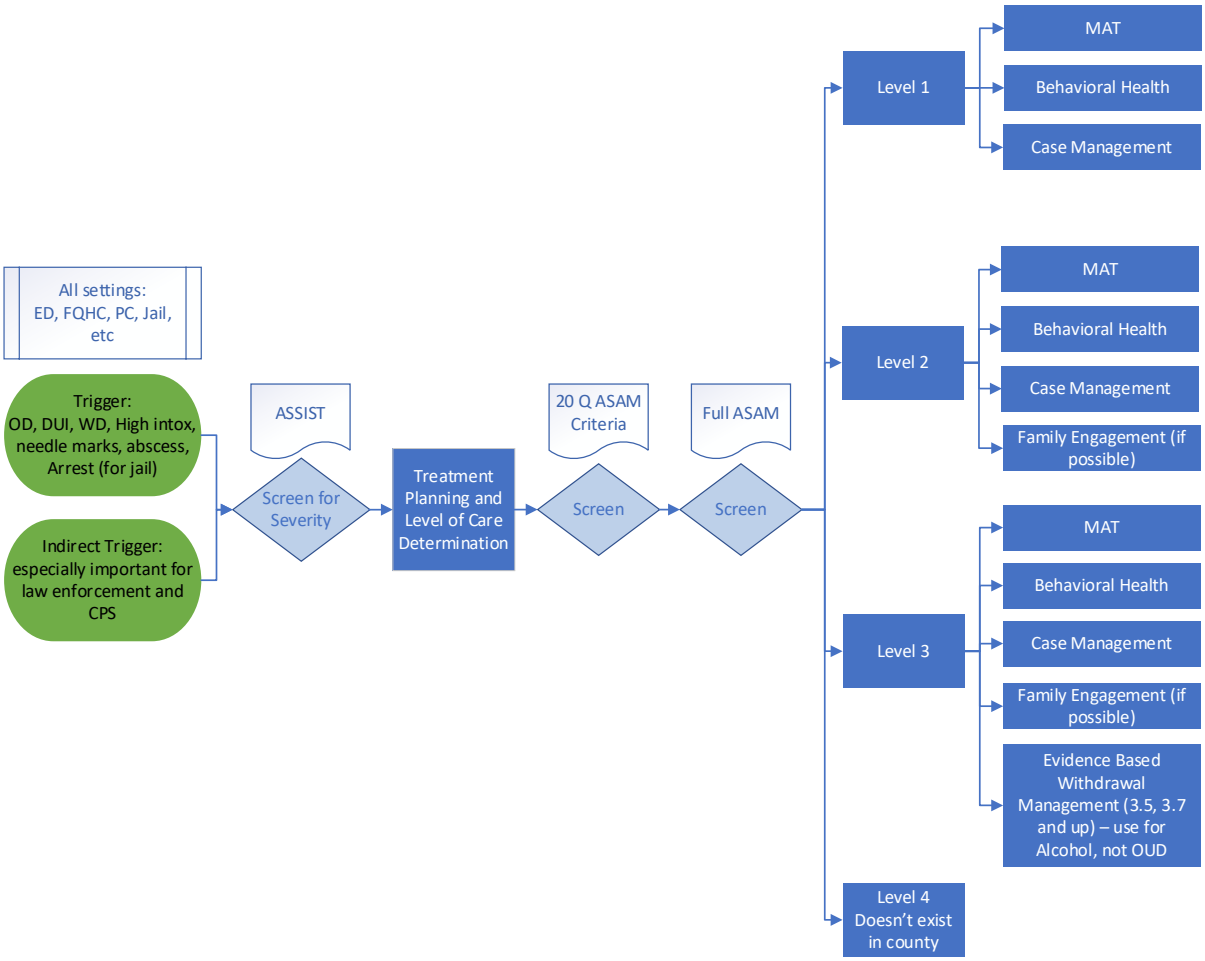
(Above directly from www.ASAM.org with permission)

G. Triggers

Given the difficulty of ubiquitous screening for addiction, the group decided on using "triggers" to determine when a given individual would be screened for addiction with the ASAM criteria. The group identified the following triggers:

- Overdose (OD)
- DUI
- High Intoxication
- Needle marks
- Abscess
- Arrest – for jails specifically

H. The "Scaffolding"



The "Scaffolding" is the unit of service which is consistent across all locations that a patient with addiction encounters.

Each provider group developed a current state map. After the development of the current state map we deconstructed it into its basic components. Those basic components for all six provider groups came down to identifying which patients to screen, screening patients, placing patients, and treating patients. As we started to delve further in the development of the future state map for the participants, we found that there were consistencies amongst all providers. The first consistency we found was a subset of what we called triggers. The definition of these are described above. We also found that there were a number of different ways that patients were screened for the presence of addiction. A wide range of screening tools or methodologies are used and many of these are done in paper format, not placed into any electronic format,

repeated multiple times, and not made accessible to other providers for informing treatment considerations. This created both the problem of significant rework as well as patient frustration. Dr. Waller recommended using the ASAM criteria as the base screening tool for addiction. There is an option to use the online form of this tool called Continuum that was also described for participants. As described in the previous section there is a short form, or CO-Triage, as well as the standard longform of the ASAM criteria.

There was a significant information provided and discussion about who does screenings. Dr. Waller provided guidance on this and where the short vs. the long screening should be done. Given that the long ASAM criteria can take as much as two hours to complete, this should be accomplished only in specific settings or telephonically rather than completed by everyone. Therefore, in the outpatient setting, the emergency department, or in the inpatient hospital setting, if a patient met for a major trigger the long screen could be done telephonically. However, all locations could adopt the practice of administering the ASAM CO-Triage at minimum.

After the patient's level of care has been identified the next step would be placing them into that appropriate level of care. In the current state this would require a number of phone calls, availability of an admitting physician at the moment of the phone call, as well as a willing party on the other end of the line to accept the patient. Treatment options are more often than not in San Diego County, presenting an additional barrier in the way of transportation and willingness of the patient to travel far.

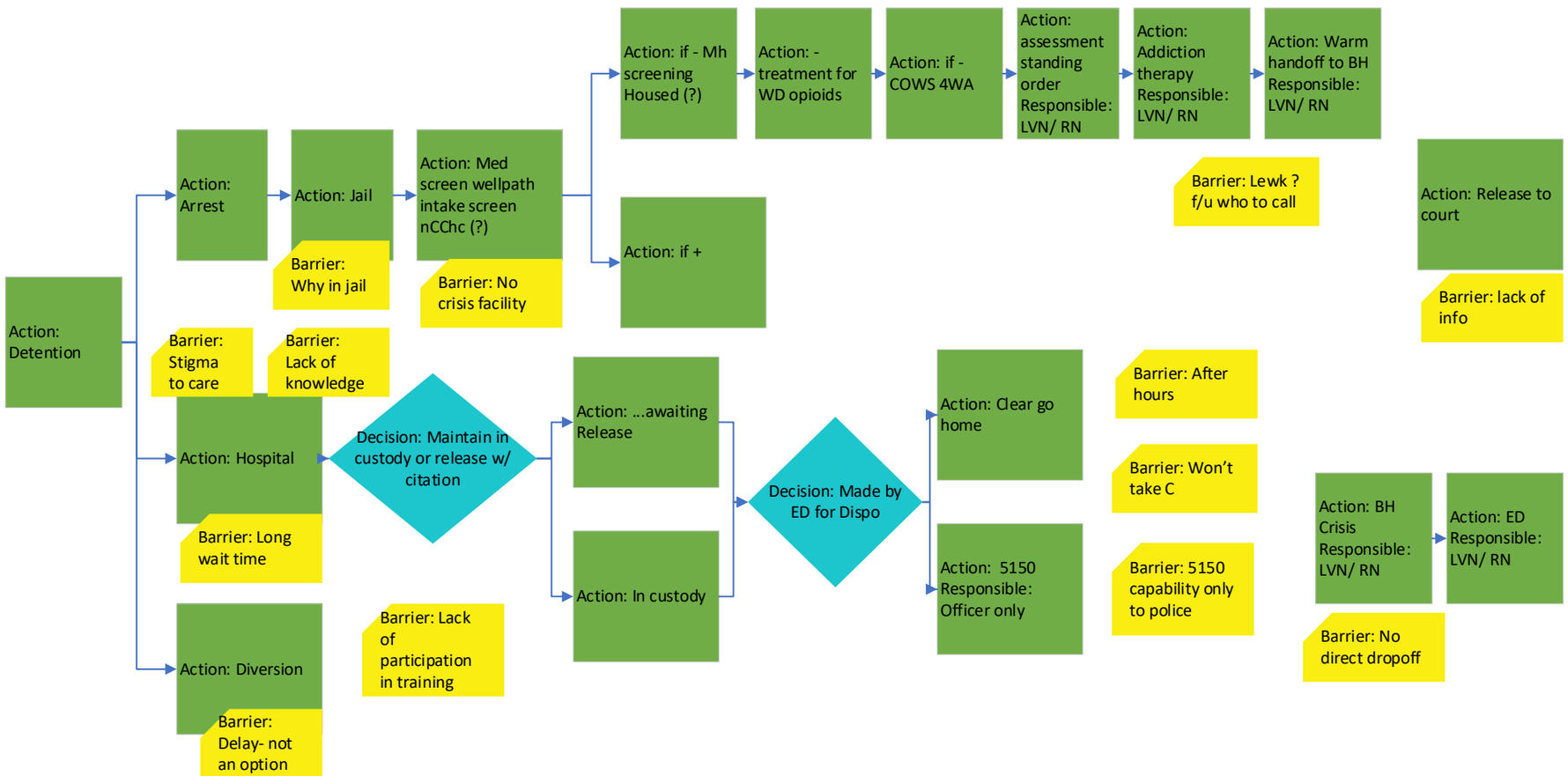
The development of a "scaffolding" that can be ubiquitously applied to all care delivery locations will allow for all future state maps to have a significant component of consistency. This will not only decrease the overall workload, it will allow us to track which levels of care are under the greatest demand, have consistency in billing pathways, and be able to communicate with all treatment providers utilizing the same language and pathway.

02

Section 2: Value Stream Maps (VSM)

A. Justice

Current State VSM



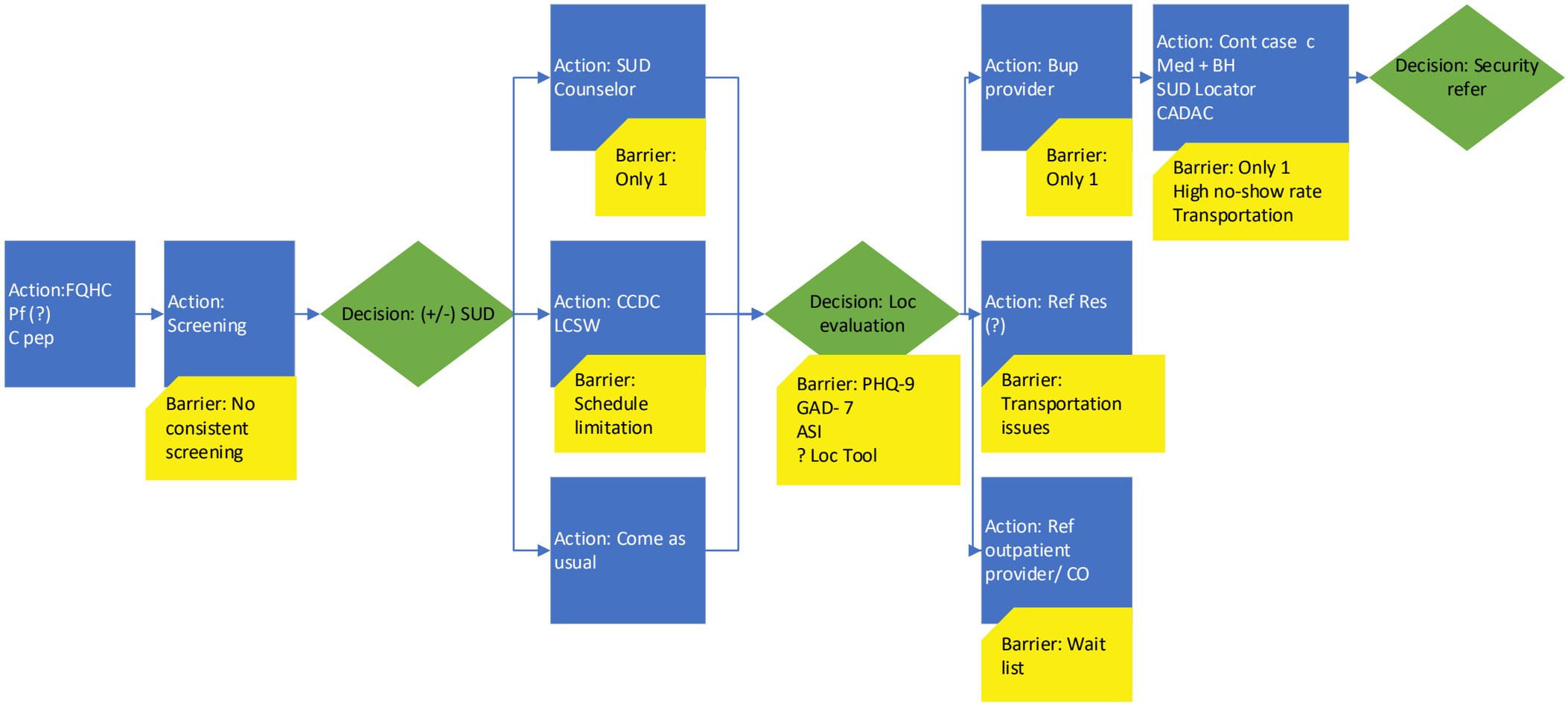
This VSM focused on the initial event of contact with an individual in the community. This results in a decision point resulting in 1)Arrest, 2)Transport to ED, or 3)Diversion. Arrest results in booking at the Imperial County jail where a medical assessment is conducted. If no medical issue prevents staying at the jail a mental health evaluation is performed. This assessment includes use of CIWA and COWS evaluations. Interventions for a positive screen of the CIWA or COWS is based on standing protocols. A barrier identified is often individuals are arrested as an intervention of last resort as no other more appropriate services are available. Another barrier is coordination of transfer of individuals back and forth from the jail to the ED.

The second disposition after contact is transportation to the emergency department by law enforcement. Barriers identified include stigma around SUD, long waiting times and difficulty balancing having an officer stay with the individual vs. returning to duty to answer additional calls. This leads to the decision point of continuing to maintain custody vs. issuing a citation and releasing from custody. After medical disposition is determined and no reason for admission is identified, often the individual requires an evaluation of risk of harm to self or others (5150). In Imperial County this is only done by law enforcement, which is identified as a significant barrier. The county is currently evaluating the 5150 process.

The third identified decision outcome, diversion, is currently not available in Imperial County much of the time. The greatest barrier identified is the lack of resources available both within the existing crisis services as well as other resources in the community.

B. Primary Care/ Pharmacy

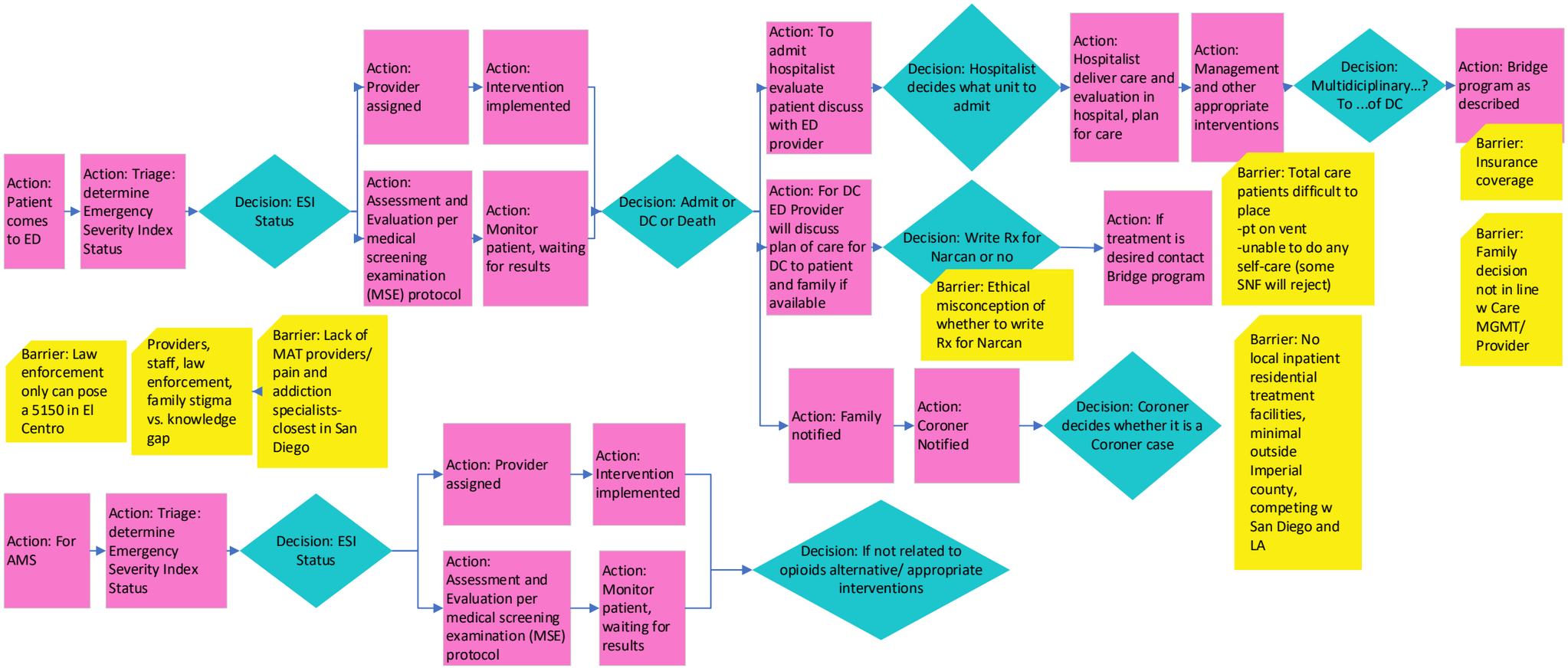
Current State VSM



The care delivered at the federally qualified health center in Imperial County generally started with existing patients being seen by in-house primary care providers. If these patients are identified as having an addiction they would be referred for evaluation either by the licensed chemical dependency counselor or a licensed clinical social worker. Many barriers became evident in this pathway, including no consistent screening modality utilized by the primary care provider and lack of access on a consistent basis to either the licensed clinical social worker or the chemical dependency counselor. Once a patient had been engaged by the behavioral health provider, the patient would be referred to the one medical provider who has an X waiver license allowing them to write for buprenorphine. The largest barrier in this situation the fact that there is only one provider capable of prescribing buprenorphine within the federally qualified health center and that their schedule did not allow for same-day evaluation and initiation of treatment. Another barrier that was identified for these patients was the lack of consistent transportation to get to the appointment, further decreasing the chances of initiation of medication assisted treatment. There is currently no clear pathway for consistent toxicological evaluation or delineation of what types of evidence-based behavioral therapy would be utilized to stabilize a patient with an opioid use disorder let alone other forms of addiction.

C. Hospital/ Emergency Department

Current State VSM



In the hospital setting, patients with or suspected of having OUD present to the emergency department (ED) with two categories of symptoms: overdose known to be related to OUD; altered mental status (AMS) of unclear etiology. These patients are all submitted to some form of triage per protocol to determine their emergency severity index (ESI), followed by a medical screening exam by a provider to determine immediate additional diagnostic or treatment interventions and monitoring required to stabilize the patient.

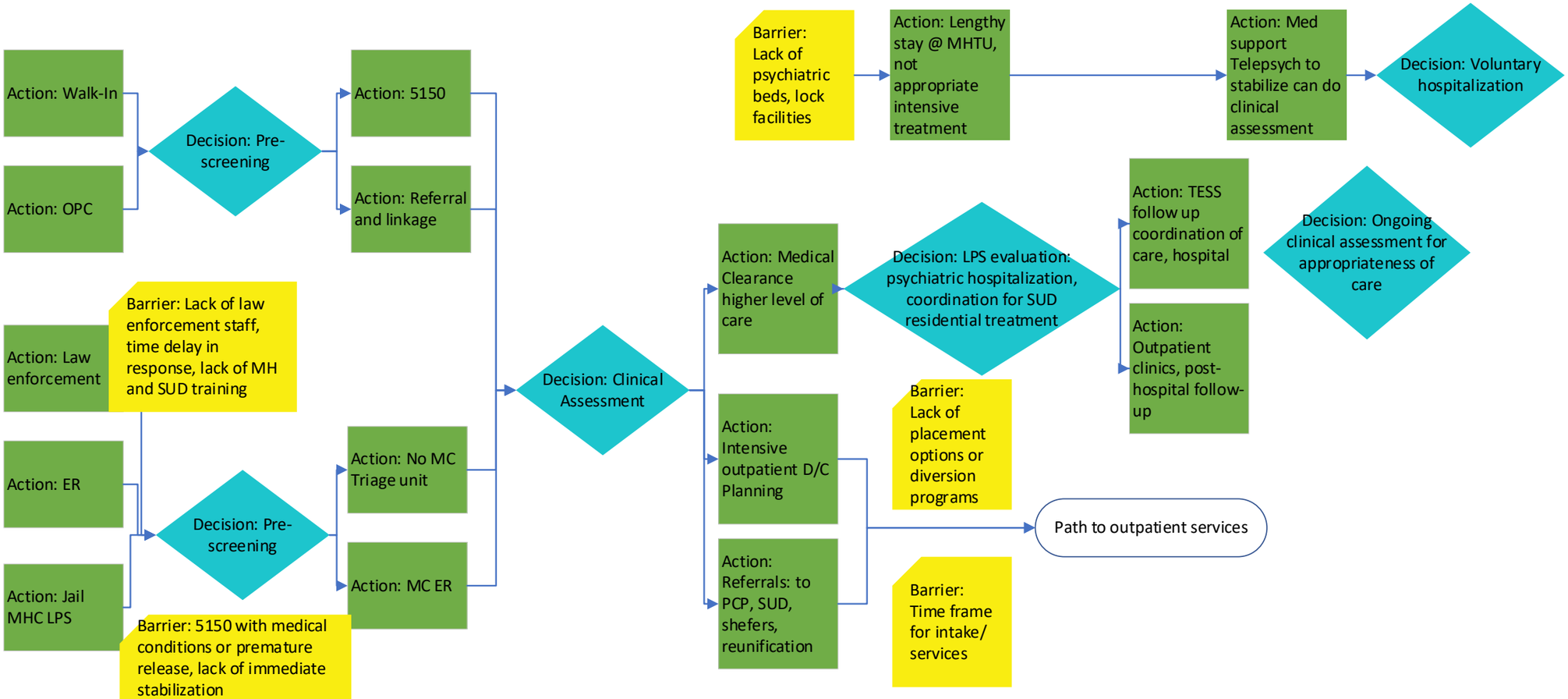
Some of these patients may expire in the ED, in which case the family and the County Coroner are notified. The Coroner then makes the following decisions: whether or not to make the death a coroner's case requiring a complete autopsy; and whether or not to send a van out to claim the body.

For those patients that survive, the ED provider makes the decision to admit or discharge the patient based on their assessment and related diagnostic work. If the patient is to be discharged, the provider then must decide whether or not to prescribe naloxone for OD rescue. The Provider also connects the patient with the ED BRIDGE program to facilitate a warm handoff to drug treatment. If the ED provider decides to admit a patient, they have a discussion with the Hospitalist who assesses the patient and decides whether or not the admission is warranted. For those patients who have a hospital stay, a multidisciplinary team is convened to determine disposition after discharge – hopefully with a plan for drug treatment facilitated by the BRIDGE program.

Barriers that come into play early in this pathway include the stigma and judgement the patients feel at the hands of law enforcement and ED staff and providers. This is often manifested by frustrations expressed directly or indirectly, especially from staff and providers who see the same clients and wonder why the patients just can't "stay clean". Additional barriers include the absence of adequate MAT providers in the hospital setting; the absence of any local inpatient residential treatment options; and placement challenges faced by patients with Medi-Cal or who are undocumented (these are most challenging for patients requiring total care in a skilled nursing facility [SNF], and residential inpatient care). Another barrier that may occur at the time of discharge, after hospitalization occurs, when family members do not agree with the discharge plan.

G. Crisis Evaluation/ Triage

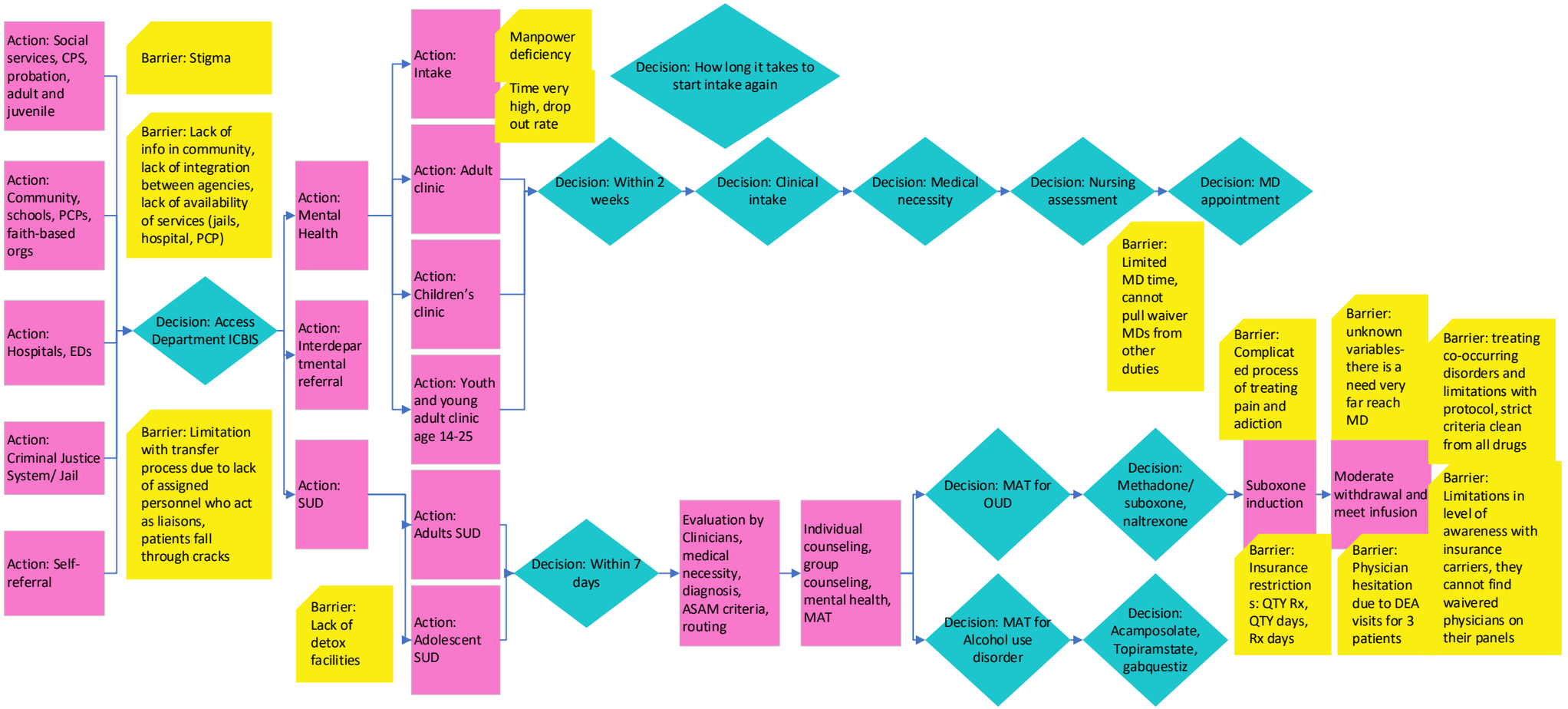
Current State VSM



In Imperial County there is one location for crisis evaluation dedicated to those individuals needing the most acute services. In their current state they can receive patients from a number of different avenues including a walk-in clinic, outpatient referral, law enforcement, emergency department or a referral from jail. Once the consumer arrives to the crisis evaluation center they are screened with a tool that was developed in-house and a decision is made whether the patient should have a 5150 applied so that they may be mandated to treatment and evaluation, a referral and linkage to outpatient treatment, or admission to an inpatient psychiatric unit voluntarily. If the patient requires medical clearance prior to the final disposition they will be sent to the emergency department where they are medically cleared based on the individual staffing the emergency department and no clear protocol. Once medically cleared the patient will be admitted to an inpatient psychiatric facility and/or residential treatment facility for addiction. A number of barriers arise with this pathway including lack of consistent approach to medical clearance and lack of rapid access to inpatient treatment services. In fact, most patients will need to be transferred out of county to San Diego for continued evaluation and treatment. There is a lack of consistent access for the patient to be evaluated in the emergency department by a behavioral health professional. Many times, this is determined based on how busy the crisis center is and/or time of day or day of the week. Even if a patient is evaluated rapidly with a good medical clearance, they may still need to stay in the emergency department for an extended period of time awaiting transportation and placement into an available bed in San Diego. The patient requires a locked facility they have to be transferred out of county which creates difficulty for both coordination of care as well as payment. While developing this current state map it was determined that we needed to reevaluate the validity of the tools being used currently for assessment and placement. There would also need to be new onboarding and training for those utilizing those tools.

H. ASAM Level 1 Medical

Current State VSM



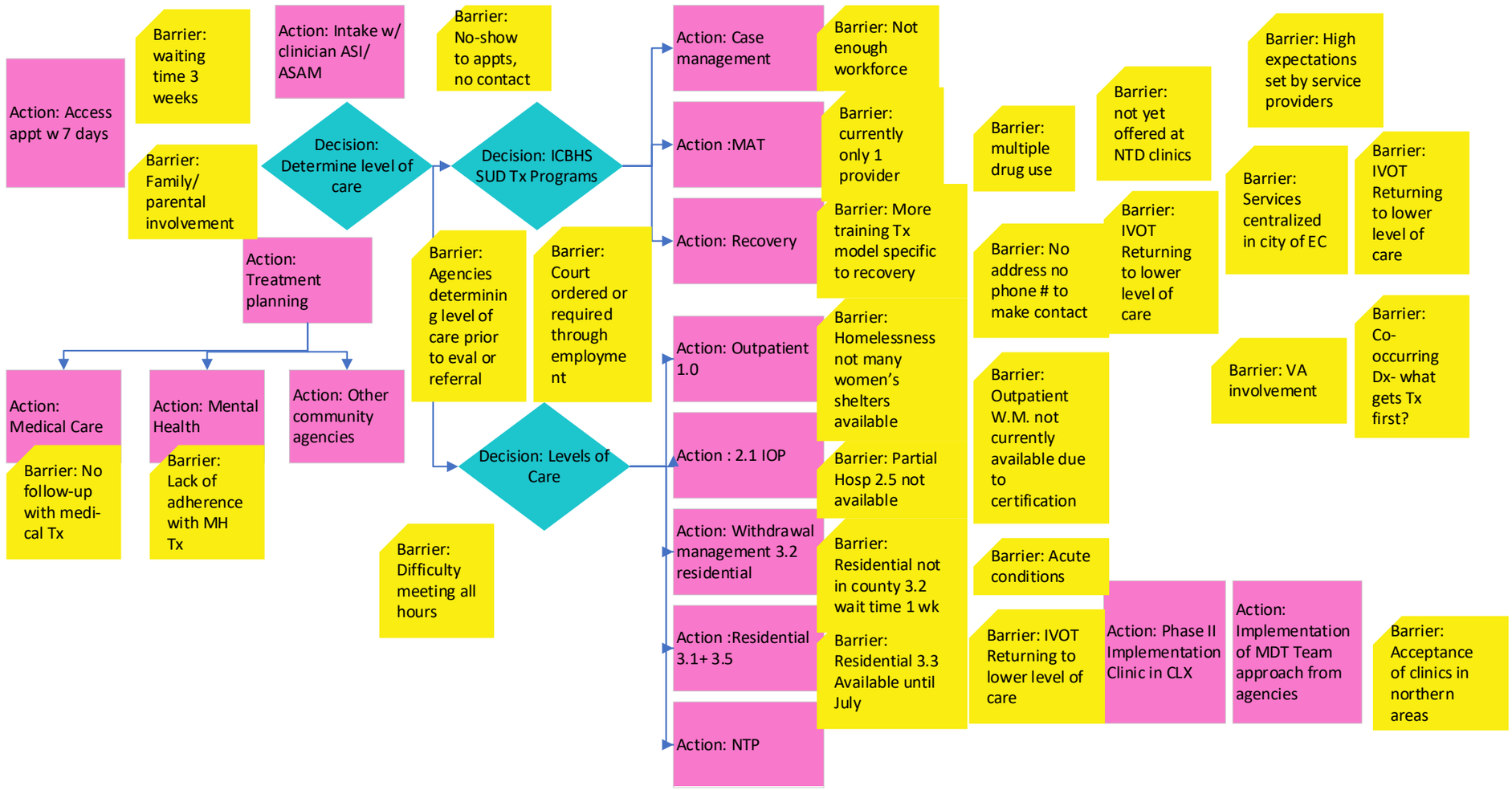
The ASAM Level 1 Medical group identified multiple referral sources for addiction services including Adult Protective Services, Child Protective Services, medical service providers including the emergency department and community providers, and referrals from the criminal justice system including court and probation department. Individuals can also self-refer for treatment. These individuals present to the access department and are currently screened with the ICBIS tool. Multiple barriers were identified which complicate this process. A major barrier identified is the stigma of addiction both within the community and in families. An overall lack of integration of community resources was also identified as an ongoing barrier. Currently there is very limited coordination between the behavioral health providers and the criminal justice system, hospitals, and primary care providers in the community. Detox facilities are not easily accessible within the local community.

The Access Department acts to triage a patient to either the Mental Health or SUD treatment program. In cases where a significant co-occurring disorder is present a consultation between program staff is coordinated to discuss disposition. Within the Mental Health pathway individuals are assessed within 2 weeks and undergo a clinical intake, screen for medical necessity, and a nursing assessment. This leads up to an intake appointment with a physician. As is often the case the lack of available resources is a difficult barrier leading to prolonged wait times to get into care resulting in high levels of drop out from treatment.

For patients triaged to the SUD pathway, they are assessed within 7 days for medical necessity and SUD using the ASAM criteria. For patients with an identified alcohol or opioid use disorder, treatment with Medication Assisted Treatment is considered. Multiple barriers to MAT were identified. These include difficulty finding a willing provider to prescribe these medications. Specifically, a lack of waivered prescribers of buprenorphine was identified. Prescribers have been hesitant due to past DEA involvement as well as concerns about overlapping addiction with chronic pain. Another barrier identified surrounds the need for a patient to have a urine drug screen negative for any other substances. Significant barriers with insurance were also identified. These include the need for prior authorization as well as a lack of knowledge by the insurance carriers about SUD.

I. ASAM Level 2 Behavioral Health (Intensive Outpatient)

Current State VSM: Imperial County Behavioral Health Services

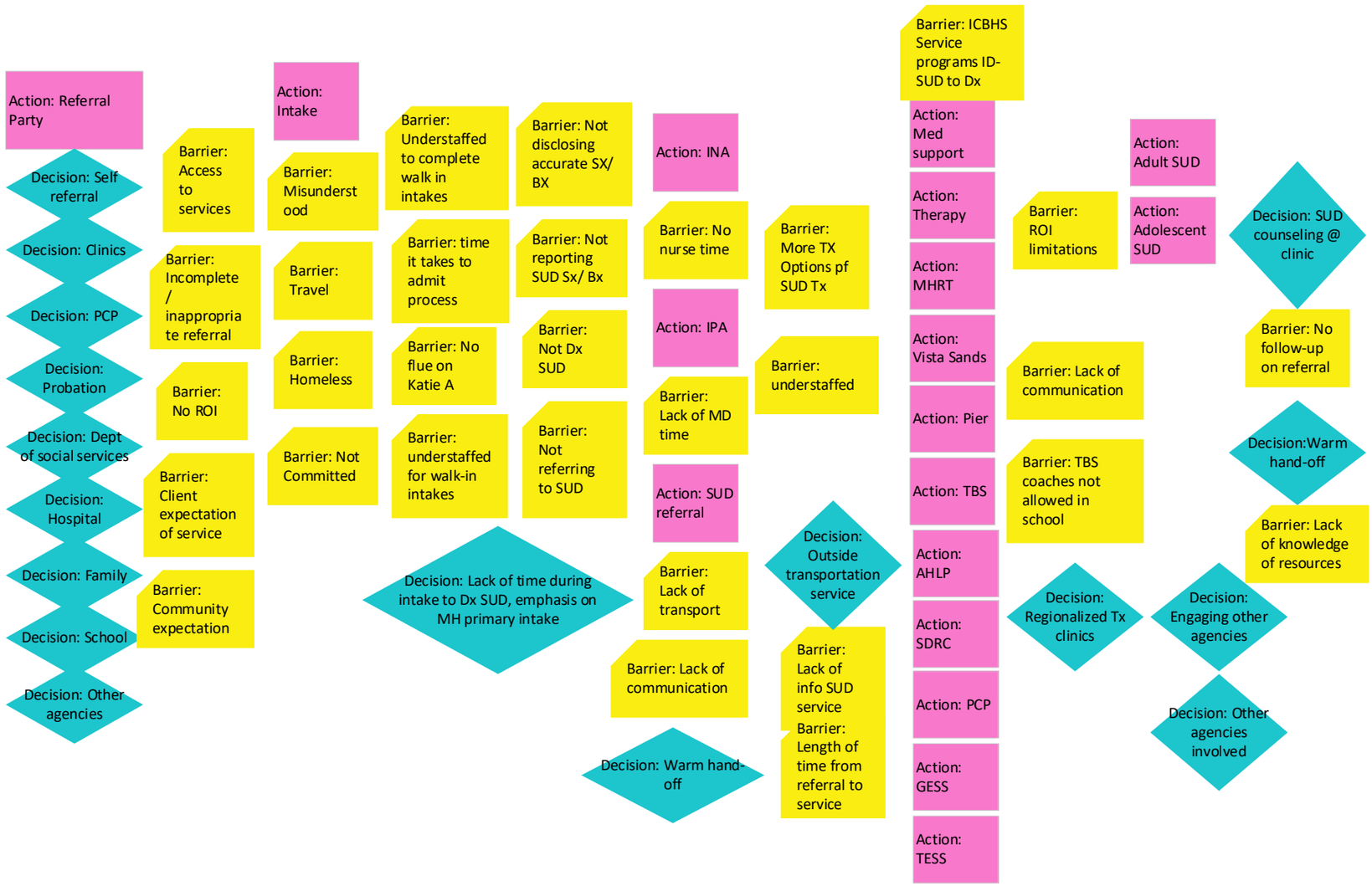


The identified triggering event is an appointment with the Access Department. This leads to a clinical assessment with the ASI and ASAM criteria to determine level of care needs. This assessment leads to a referral to the ICBHS SUD program or other community resources. Within the ICBHS SUD program case management, MAT and recovery management services are offered. Several barriers to effective treatment were identified. These include lack of resources for both case management and MAT prescribers. Another barrier identified was outside agencies, including the court, dictating a level of service which is not supported by the clinical assessment.

A large number of barriers to effective access to addiction treatment services were identified at multiple levels of the ASAM treatment continuum. These include communication barriers between service providers as patients transition from one level of care to another as well as difficulties with knowing the most effective method to reach treatment providers. Individuals also frequently encounter barriers related to geography. Many service levels are not available in Imperial County including residential partial hospitalization. Geography is also seen as a barrier as no treatment provider is available in the northern area of the county. Services are also centralized in El Centro making transportation from outlying areas necessary although frequently not available.

A final set of barriers identified relate to the services which are provided in Imperial County. Currently buprenorphine is not offered by the NTP. Co-occurring disorders are also very common and present a challenge of which issue to address first. Treatment is also complicated by what many saw as unrealistically high expectations from treatment providers as well as use of additional substances, most frequently methamphetamine. This makes treatment of the underlying OUD much more difficult.

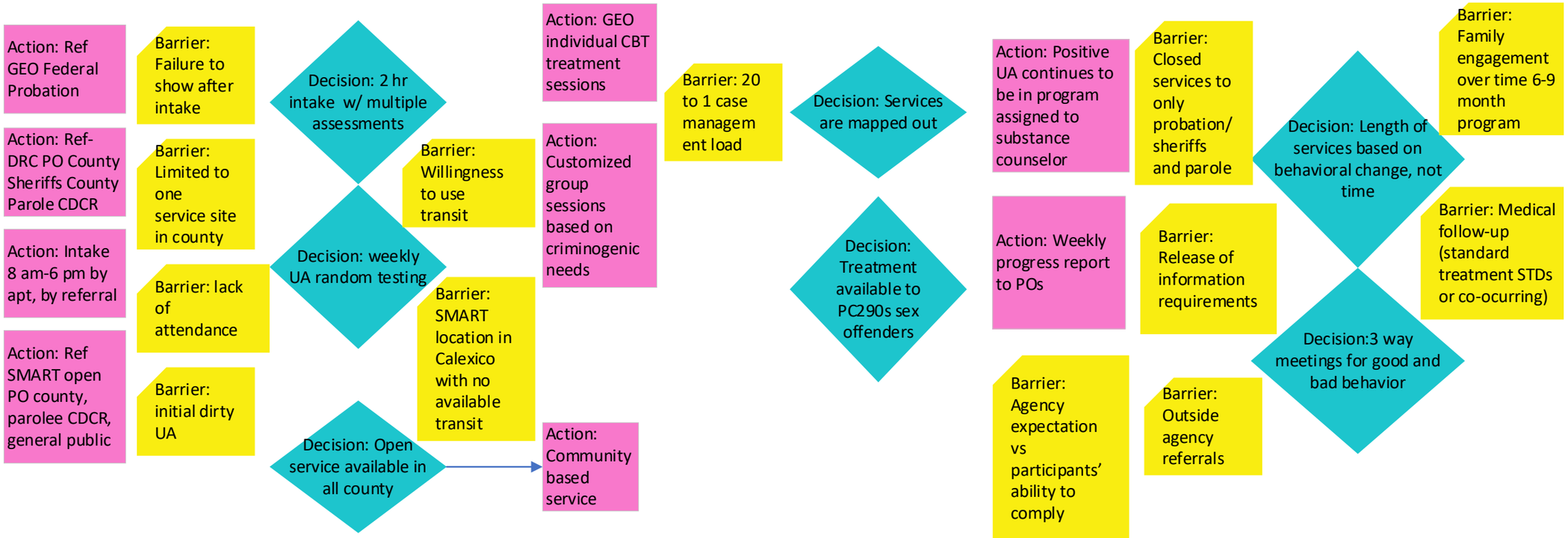
Current State VSM: Mental Health



This VSM begins with a referral for service. Multiple referral sources were identified including the probation department, Department of Social Services, hospitals, community PCP's, as well as self-referral. This referral leads to an intake appointment. Multiple barriers were identified between the initial referral and the intake appointment. These included factors involving the patient such as lack of commitment to treatment and a lack of understanding in the community about what services are available. Many systemic issues also act as barriers to intake. These include housing status and difficulty with transportation to the appointment. In addition to these barriers difficulty with information processing were identified. These barriers included patients minimizing substance use or not disclosing previous treatment as well as lack of information being sent from previous providers of services.

A large number of resources were identified in the community and listed on the VSM. A common barrier noted throughout these resources involves communication. This lack of communication involves both communication of resource availability as well as patient specific information needed for coordination of care. In addition to communication the long waiting time before beginning treatment was identified as a considerable barrier. Inadequate staffing was also identified as a significant barrier to effective treatment.

Current State VSM: GEO Group Reentry Services and Self-Management and Recovery Training (SMART)

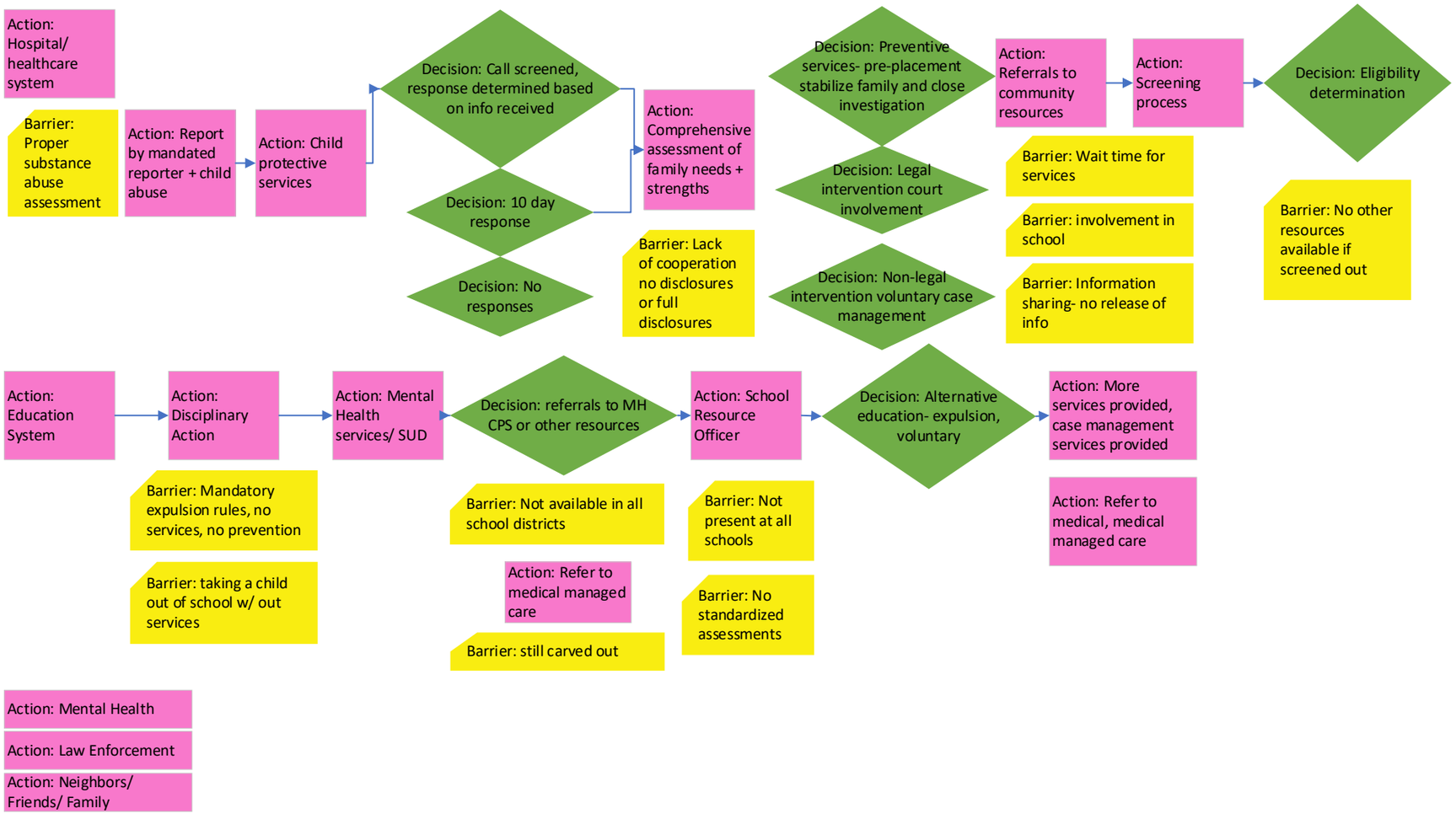


Individuals are referred to the GEO program by the corrections system including federal probation, CDCR, or Imperial County parole. This results in a two-hour intake appointment with several assessments and urine toxicology testing. After being admitted to the program individuals participate in individualized counseling as well as group sessions with ongoing urine testing. Weekly reports are sent to the referring agency.

Several barriers to effective treatment were identified. Geographic barriers frequently interfere with treatment as services are only offered at one site and transportation is often not available. Individuals referred to the program often do not show for the intake appointment or drop out of treatment, which is also seen as an ongoing barrier. In addition, structural barriers such as difficulty with release of information forms, case management limits, and limits on accepted referral sources frequently interfere with effective ongoing treatment.

J. Non-Provider Community Stakeholders

Current State VSM: Imperial County Behavioral Health Services



While there are a number of entry nodes for children and families affected by Opioid Use Disorder (OUD) into the system, the group focused on the hospital entry node and the education entry node (others such referrals of children and families may occur from friends/families, mental health, and law enforcement, with similar final common pathways). In the hospital setting, children affected by OUD may come to the attention of a mandated reporter by virtue of a positive toxicology screen on a parent or child (e.g., a newborn), or because the parent is obviously under the influence. Once the report is made to Child Protective Services (CPS), a standardized telephonic intake assessment is completed and a decision is made to respond immediately; in 10 days; or not to open a case. In those cases that warrant a response, a comprehensive assessment is undertaken to determine the families' strengths and needs. That assessment drives the decision to involve the courts (involuntarily) or to have the family accept voluntary case management. In either case, there are usually community resource referrals made by CPS for other support services. The child and family are followed over time to determine the intensity and duration of both community resource support and the involvement of the courts.

Barriers that come into play early in this pathway include the lack (or variability) of proper substance abuse screening and assessments in the hospital setting. Once a CPS case is opened, another barrier is the lack of candor and cooperation from the family during the comprehensive assessment. The consequence is often prolonged CPS involvement, and the provision of inadequate or inappropriate services, and perhaps a failure to provide needed services (because the need wasn't identified). Additional barriers include long wait times for services (after referrals are made); and inadequate information sharing due to privacy rules and lack or signed information releases. Another significant barrier is that for children and families who are screened out (i.e., no CPS case is opened), there are no provisions for referring them to support services even if there is a sense that they are at risk.

K. 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 Imperial County to address addiction, stakeholders agreed there were many challenges that cut across structural barriers and inefficiencies, as well as stigma, lack of funding, complex or prohibitive payer issues, and capacity and skill deficiencies. While the range of barriers to a system that eliminates unnecessary addiction deaths varied depending on the stakeholder, there was broad consensus about many of them, and overall everyone agreed the challenge were great in number.

In a full group dialogue, the Imperial County stakeholders itemized the following barriers as existing within their treatment ecosystem:

- Lack of inpatient and residential treatment facilities in Imperial County
- Inappropriate referrals
- Lack of communication between faith-based and other treatment providers
- Lack of evidence-based treatment within faith-based treatment providers
- Restrictions around controlled substances within faith-based treatment providers
- Lack of appropriate workforce, including case management, nurses, psychiatrists, SUD counselors, social workers, and DATA (X) waivered physicians/prescribers
- Lack of knowledge among patients, families, and providers about treatment options
- Inappropriate level of care assigned/mandated by courts
- Information on service provider availability, including level of care
- Access to care for incarcerated population
- Rapid intake from probation and emergency department
- Revolving door of relapse
- Stigma among providers
- Cultural differences in understanding of addiction and treatment (i.e., family sends individual with OUD/SUD to Mexico for expensive injection but relapses upon return)
- Lack of programs providing family support and education
- Confidentiality and information sharing between providers
- Stigma around sexual orientation and addiction for LGBTQ population
- Mental health services for LGBTQ population

- Comorbidities for LGBTQ population (HIV, HCV, etc.)
- Lack of resources for LGBTQ population
- Lack of cultural sensitivity/understanding of LGBTQ population
- Lack of alignment in the ecosystem of care results in delays and inability to develop complex care treatment plans that can be executed on
- Pregnant women and mothers with OUD/SUD
- Generational addiction issues are fostered by people with addiction issues live in the same area

In a breakout discussion Monday afternoon, while Cohort 1 was developing its current state value stream maps, Cohort 2 had a small group dialogue that further discussed the community's gaps and barriers. Participants included representatives from behavioral health adult services clinic, prison re-entry services, adult SUD services, Molina Managed Health Care, aging services, behavioral health triage units, the Department of Public Education, county psychiatrists, behavioral health child services, the Board of Education, and county EMS services. Everyone agreed they are all part of the ecosystem of addiction treatment care and therefore all need to be part of the solution.

The group spent its time selecting which of the many barriers are the priorities for the community, why, and some ideas on how they address the barriers. The prioritized barriers that this group discussed most were: 1. Communication on needs, capacity, resources and ways for community members and treatment stakeholders to stay interconnected; and 2. Reducing stigma.

The group's ideas on ways to address better communication included:

- Attend staff meetings/multi-disciplinary meetings (this would help with understanding of what everyone does)
- Provide mental health courts with education
- Increase collaboration/teaming with referrals
- Integrate the 211 service better into the coalition of Imperial care providers
- Share brochures amongst agencies
- Increase direct phone calls to one another
- Follow-up on referrals/care coordination between agencies
- Send release of information with referral
- Create a directory of services with ASAM levels designated
- Have ongoing quarterly workgroup meetings
- Engage as a coalition

The group's ideas on ways to better address stigma included:

- Use GEO map technology to show addiction needs
- Increase public education efforts
- Improve CPS referrals to include all background information
- Normalize treatment as medical, like any other disease
  - Invigorate community-focused communication in church groups, schools, community centers, newspapers/ads/radio, announcements at movie theatres, and social media
- Provide information at pharmacies
- Conferences

In a breakout discussion Tuesday morning, while Cohort 2 was developing its current state value stream maps, Cohort 1 had a small group dialogue that further discussed the community's gaps and barriers. Participants included representatives from criminal justice and the county's federally qualified health center. The conversation focused on issues specific to criminal justice in its unique community role, as that sector was the majority of the group.

The barriers prioritized included:

- Lack in awareness on who to contact county-wide
- Lack of knowledge of the treatment system
- No access to resources
- Once they identify a problem (assessment), they have no place to refer
- No crisis protocol/understanding of mental health and addiction
- Frustration about not having a solution
- Some current pathways are quick fixes but only a "band aid"
- No activity with Laura's Law
- Behavioral Health is not inside the jail
- No medical reimbursement for "inmate" status
- No telemedicine available at their locations
- Staffing shortages and skillsets
- Need to educate judges/other staff – many mentions of courts ordering a certain ASAM level which is outside of scope
- Lack of communication between probation and Behavioral Health
- Release of information between agencies is difficult
- Need to be at the table with Behavioral Health more
- Stigma is high regarding clients around methadone clinic
- Slab City has complex problems, safety issues, is isolated, and lacks any resources

The potential solutions discussed by Cohort 1 included:

- More onsite interagency training/education
- Improve 211
- Improve linkage between corrections and DPSS
- Eligibility worker in jails
- Issue ID to inmates upon release
- Increase knowledge/understanding of MAT
- Community outreach on MAT

L. Consolidated Barriers and Gaps

The discussions described above heavily informed the cohorts as they met up as stakeholder-type breakout groups to discuss their part of the ecosystems current state. Each group developed their own current state value stream map as shown above. In the table below, we have aggregated all of 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	Lack Necessary Skills (includes knowledge)	Inconsistency	Stigma/ Decriminalizatio	Social Correlates	Funding	Insurance
Justice	2	1	1	2	3		1	1		
Primary Care/Pharmacy	3			3		1		1		
Hospital/ED	1	1		2	1		1	1		1
Crisis Evaluation/Triage		2	4	1	1	1				
ASAM Level 1: Medical	1	1	4	2	4		1			1
ASAM Level 2: Behavioral Health (ICBHS, GEO/SMART, MH)	10	2	9	9	8	2	3	15	2	
Non-provider Community Stakeholders (CPS and Education)	2	2	6	1		1		1		

03 Section 3: Implementation Strategy

A. Next Steps

In a matter of two days stakeholders from across Imperial County we 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 around which there was significant buy-in. The future state includes 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 the 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 the individuals and institutions who deliver care or are otherwise vested in addiction treatment in Imperial County, California. Given this, we know we have a highly motivated group of people to begin to own the disease that is 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.

A great enthusiasm amongst stakeholders for continuing to come together and work both within their organizations as well as collaboratively across the County was a clear outcome of the event. In closing dialogue to identify the priorities for action, there was consensus the stakeholder should:

- Increase the number of MAT providers in the addiction treatment ecosystem and increase the capacity and competency of all providers touching people with SUD (HMA is offering a program of technical assistance for this);
- More strongly leverage the 211 service or develop a specific Imperial County website/resource (The County Board of Supervisors is already working on addressing the need for an information clearing house and the support of these stakeholders is likely to encourage progress);
- Identify or create services for people who are not reimbursable under Medi-Cal, such as undocumented individuals or some community members involved with criminal justice;
- Continue and strengthen communication between stakeholders, first and foremost in advancing efforts to address the many barriers to addiction treatment identified;
- Implement collaborative efforts, such as everyone using the same validated screening tools;

- Negotiate with contract service providers to embrace changes being implemented in the community, voluntarily or through updating of contract requirements (Dr. Waller can provide coaching and input on this); and
- Develop shared standards for using action plans for community members in crisis.

B. Technical Assistance Program

Prior to the process improvement event, we collaborated with the ICBHS to develop an attendee list and conduct outreach to invitees to encourage attendance. Also prior to the event, the ICBHS completed a survey to document existing substance use disorder (SUD) capacity and resources in Imperial 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 Southern California Team Lead (Charles Robbins). Each organization/team also completed the Provider Assessment. Following the process improvement event, information collected through the TA application and Provider Assessment 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 Southern 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.

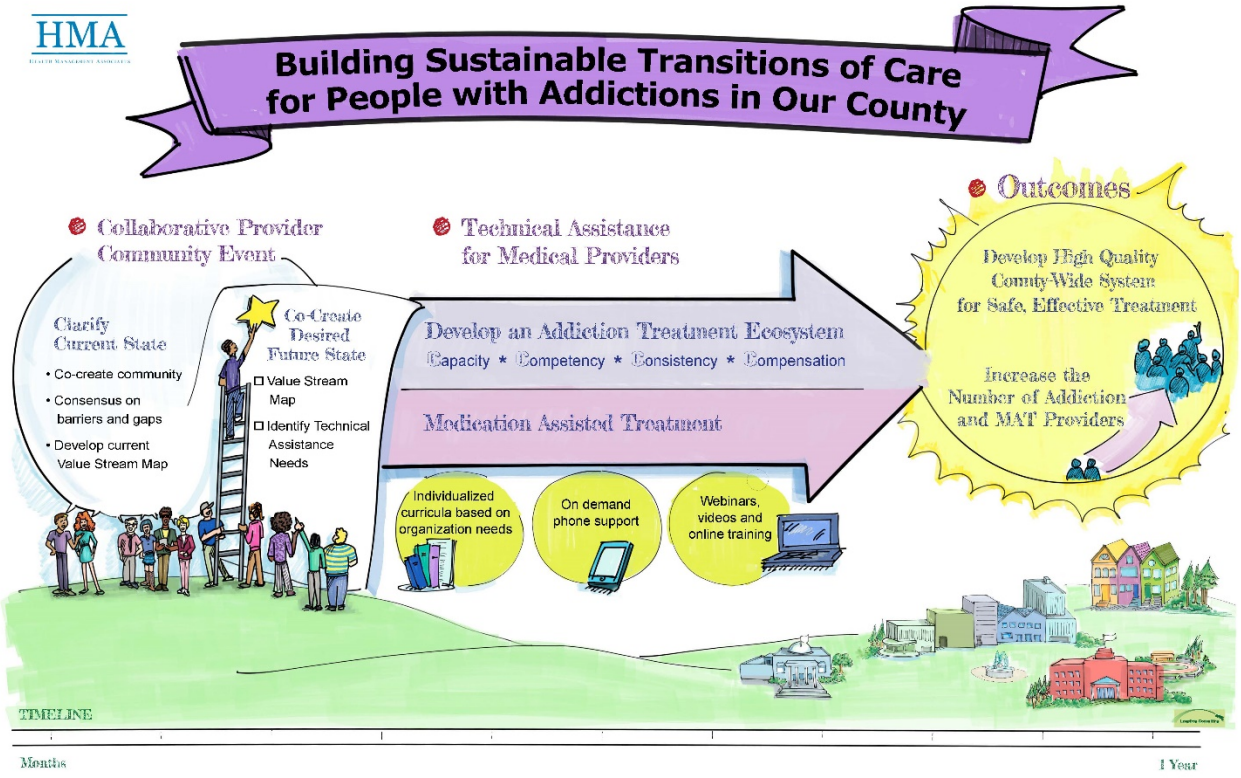
The following 14 organizations and one independent consultant applied for TA:

- Clinicas de Salud del Pueblo
- El Centro Police Department
- El Centro Regional Medical Center
- GEO Reentry Services Imperial County Day Reporting Center
- Imperial County Behavioral Health Services Adult and Older Adult Mental Health Services
- Imperial County Behavioral Health Services Children's Services
- Imperial County Behavioral Health Services Mental Health Triage and Engagement Services
- Imperial County Behavioral Health Services SUD Division
- Imperial County Department of Social Services
- Imperial County Office of Education
- Imperial County Probation Department
- Imperial County Public Administrator/Area Agency on Aging
- Imperial County Sheriff's Office
- Molina Healthcare of California

Among the 15 organizations/teams who requested TA, the following goals were requested:

Goal	Frequency
Learn more about how our organization can participate in a community wide solution to the opioid epidemic.	14
Improve our role in managing the transitions of care as residents in our community move within addiction system of care.	13
Learn more about caring for people with addiction and provide more information and training to our staff.	11
Scale up our current MAT program by increasing the number of patients treated.	6
Learn how to provide or improve addiction treatment to pregnant and parenting women.	6
Start providing MAT services at our organization.	5

C. Conclusion



In conclusion, Health Management Associates thanks the Imperial County community who turned out with enthusiasm, vision, and their hearts and minds committed to this work. We hold the deep conviction that the Imperial 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 Imperial County Behavioral Health Services, the envisioned future state pathway could be fully implemented and working within the next 2 to 3 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. Imperial County Data

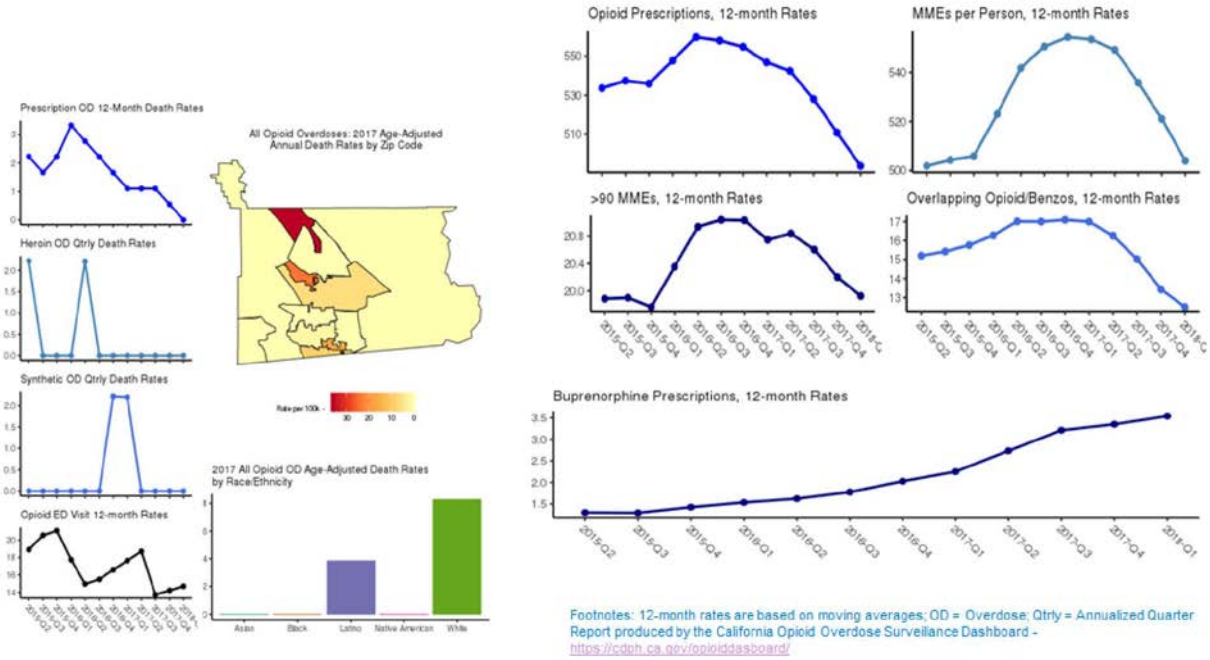
Imperial County: Population 174,528

ADDITIONAL FACTORS

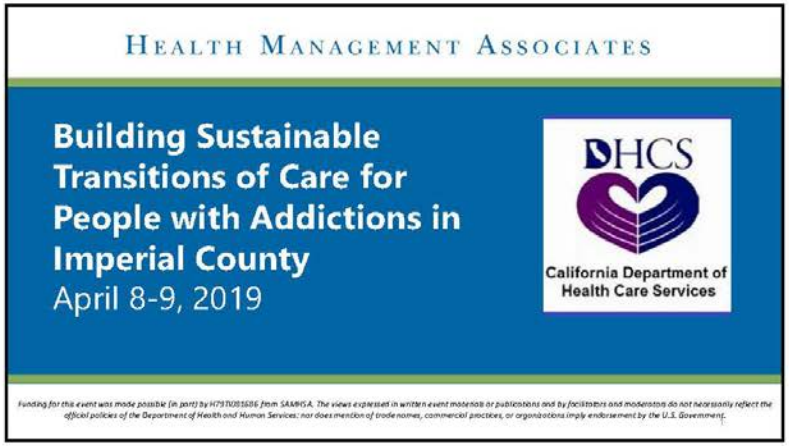
- Coalition: Imperial County Overdose Prevention Education
- SAMHSA Funds: $285,000
- Drug Medi-Cal Organized Delivery System? Yes
- Presence of CA Bridge: Yes

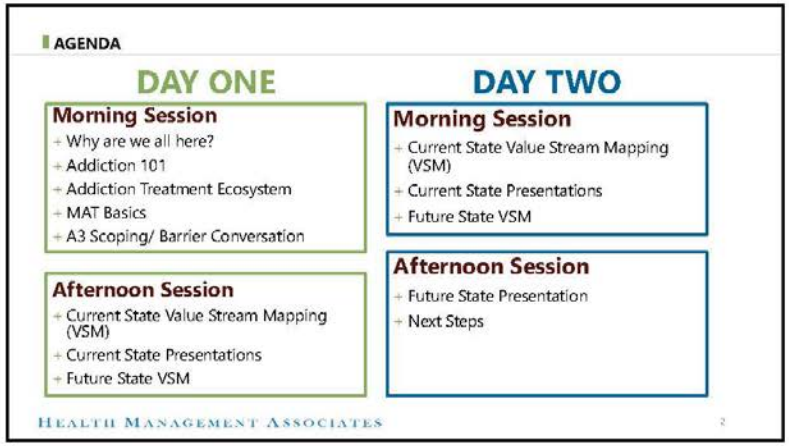
STATISTICS

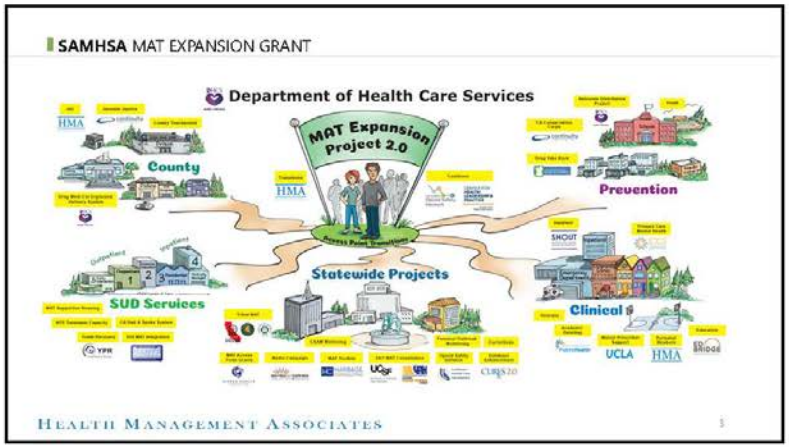
- OUD Death Rate
  - 2017: 4.6, Rank 7/9
  - 2016: 7.3, Rank 2/9
- All Drug Death Rate
  - 2017: 12.3, Rank 6/9
  - 2016: 23.2, Rank 1/9
- ED Opioid Rate
  - 2017: 41.5, Rank 2/9
  - 2016: 43.4, Rank 1/9
- 2 Hospitals
- 6 Pharmacies
- 1 FQHC
- Methadone Pt Rate 343.2: Rank 3/58

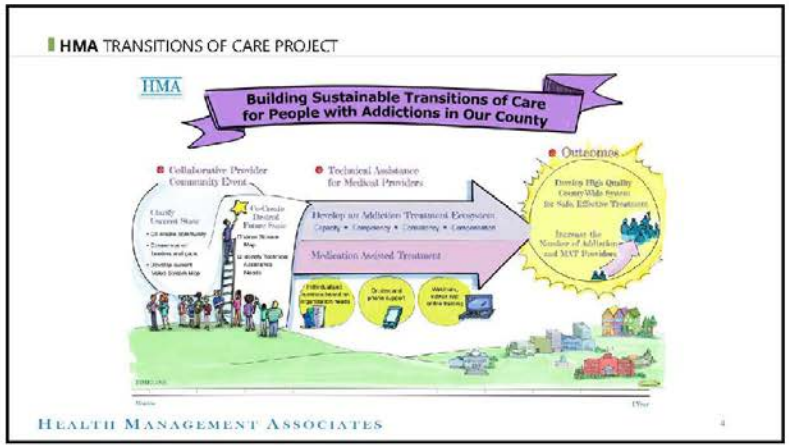

Prescription OD 12-Month Death Rates
Heroin OD Qtrly Death Rates
Synthetic OD Qtrly Death Rates
Opioid ED Visit 12-month Rates
All Opioid Overdoses: 2017 Age-Adjusted Annual Death Rates by Zip Code
2017 All Opioid OD Age-Adjusted Death Rates by Race/Ethnicity
Asian
Black
Latino
Native American
White
Opioid Prescriptions, 12-month Rates
MMEs per Person, 12-month Rates
>90 MMEs, 12-month Rates
Overlapping Opioid/Benzos, 12-month Rates
Buprenorphine Prescriptions, 12-month Rates
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









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

HEALTH MANAGEMENT ASSOCIATES 5

COUNTY SELECTION DATA POINTS CONSIDERED

NEED

- Opioid Use Disorder Death Rate (2017 and 2016)
- All Drugs Death Rate (2017 and 2016)
- Rate of ED Visits for Opioid (2017 and 2016)

READINESS

- Number of Hospitals
- Number of Pharmacies
- Number of FQHCs
- Methadone Patient Rate

OTHER CONSIDERATIONS

- Drug Medi-Cal Organized Delivery System
- Population
- Geographic Location
- Coalitions
- Presence of CA Bridge (ED Bridge + Project SHOUT)
- Stakeholder Input

HEALTH MANAGEMENT ASSOCIATES 6

IMPERIAL COUNTY DATA DIVE

ADDITIONAL FACTORS

- Coalition: Imperial County Overdose Prevention Education
- SAMHSA Funds: $285,000
- Drug Medi-Cal Organized Delivery System? Yes
- Presence of CA Bridge: Yes

STATISTICS

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- 2 Hospitals
- 6 Pharmacies
- 1 FQHC
- Methadone Pt Rate 343.2: Rank 3/58

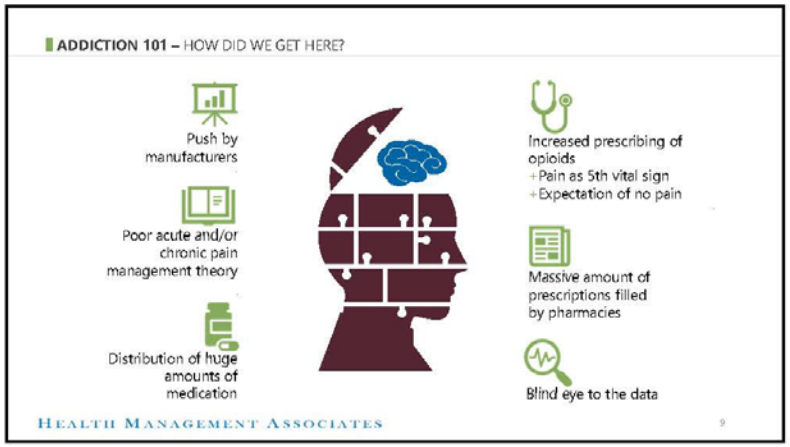
HEALTH MANAGEMENT ASSOCIATES 7

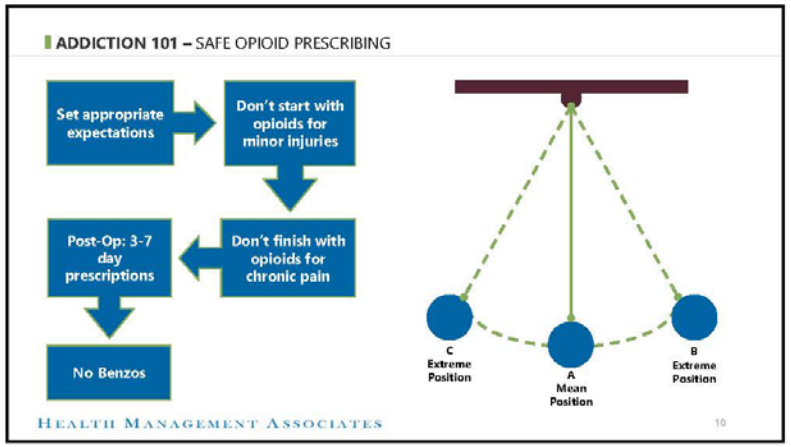
ADDICTION 101 – THE PROBLEM

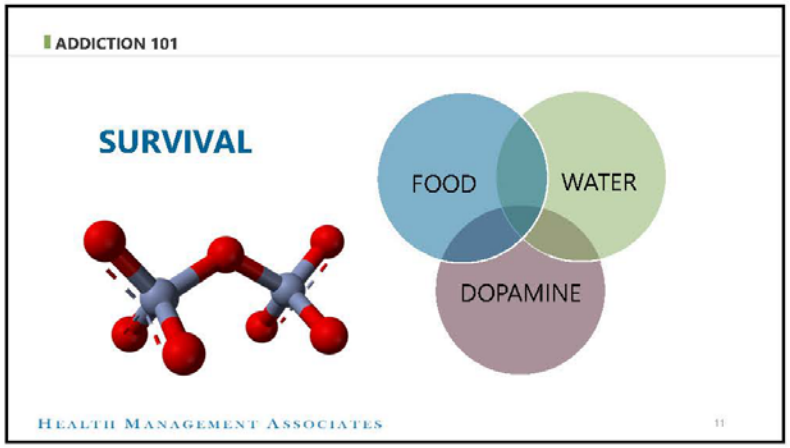
What is Addiction?

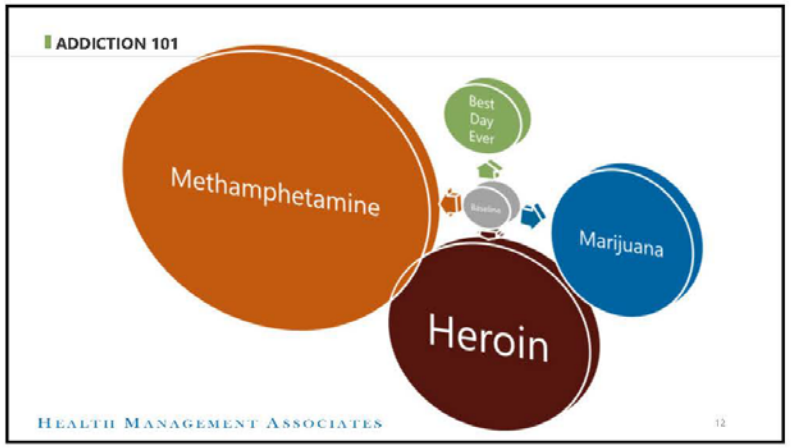
It is a **chronic neurobiological disorder** centered around a **dysregulation of the natural reward system**

HEALTH MANAGEMENT ASSOCIATES 8

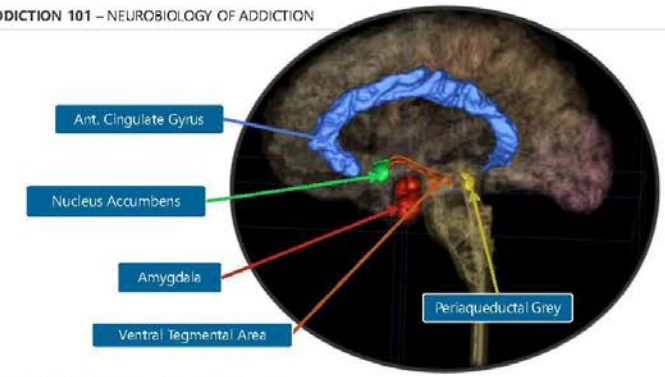

ADDICTION 101 – HOW DID WE GET HERE?
Push by manufacturers
Poor acute and/or chronic pain management theory
Distribution of huge amounts of medication
Increased prescribing of opioids
+Pain as 5th vital sign
+Expectation of no pain
Massive amount of prescriptions filled by pharmacies
Blind eye to the data
HEALTH MANAGEMENT ASSOCIATES
9


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
C Extreme Position
A Mean Position
B Extreme Position
HEALTH MANAGEMENT ASSOCIATES
10


ADDICTION 101
SURVIVAL
FOOD
WATER
DOPAMINE
HEALTH MANAGEMENT ASSOCIATES
11

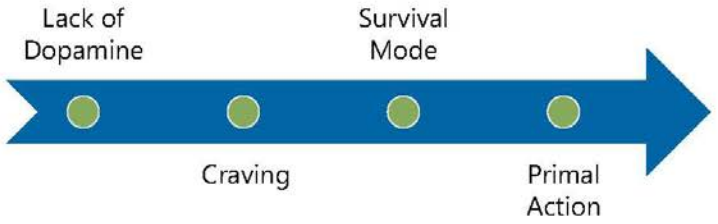

ADDICTION 101
Methamphetamine
Best Day Ever
Marijuana
Heroin
HEALTH MANAGEMENT ASSOCIATES
12

ADDICTION 101 – NEUROBIOLOGY OF ADDICTION



HEALTH MANAGEMENT ASSOCIATES 13

ADDICTION 101 – BEHAVIOR



HEALTH MANAGEMENT ASSOCIATES 14

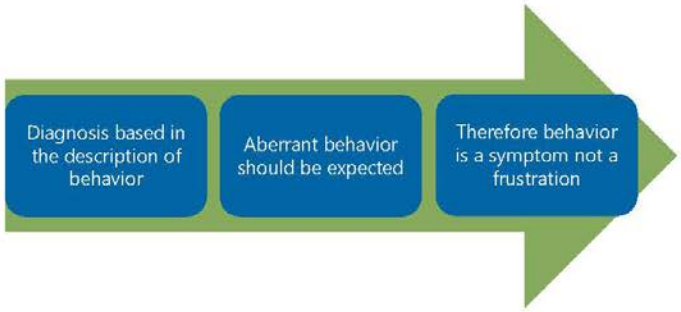
DSM-V DIAGNOSIS OF OUD

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

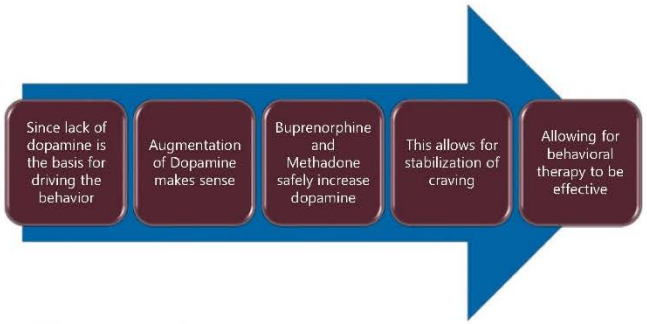
HEALTH MANAGEMENT ASSOCIATES 15

ADDICTION 101 – BEHAVIOR



HEALTH MANAGEMENT ASSOCIATES 16

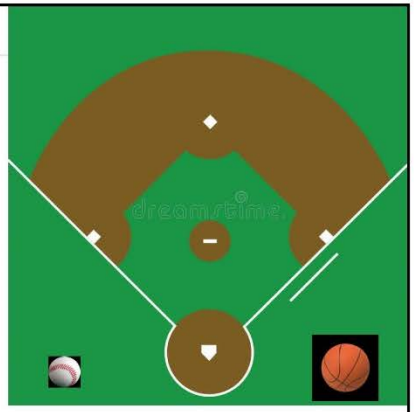
ADDICTION 101 – TREATMENTS



HEALTH MANAGEMENT ASSOCIATES 17

ADDICTION 101 – CRAVING

A direct, or indirect force pulling someone towards a substance or behavior



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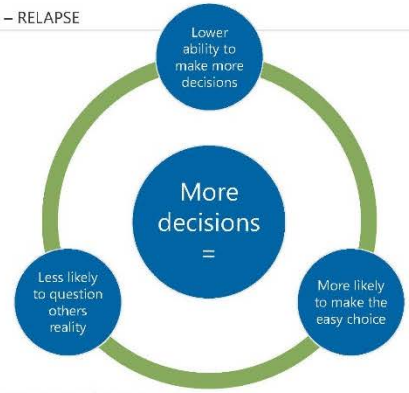
ADDICTION 101 – RELAPSE



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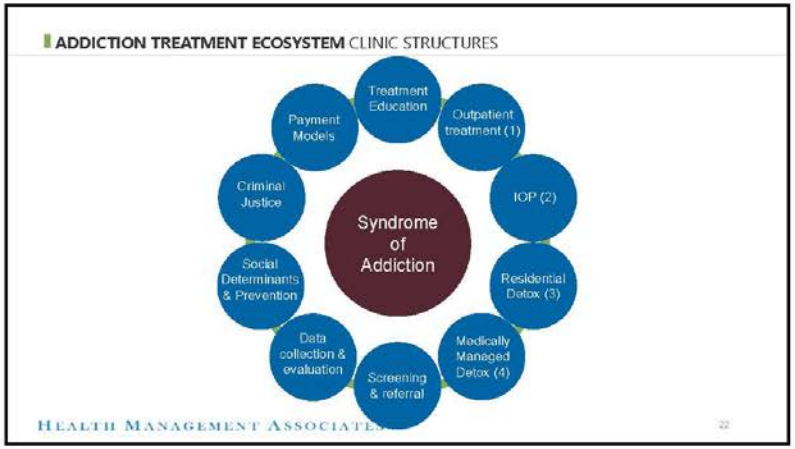
ADDICTION TREATMENT ECOSYSTEM CLINIC STRUCTURES
Treatment Education
Outpatient treatment (1)
IOP (2)
Residential Detox (3)
Medically Managed Detox (4)
Screening & referral
Data collection & evaluation
Social Determinants & Prevention
Criminal Justice
Payment Models
Syndrome of Addiction
HEALTH MANAGEMENT ASSOCIATES
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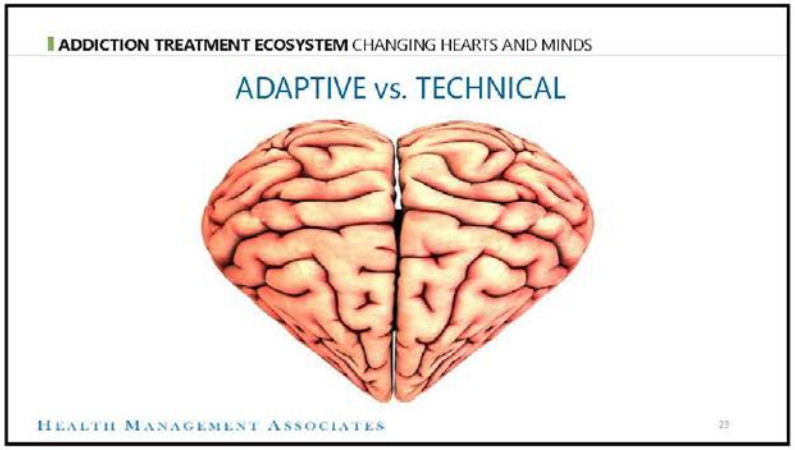
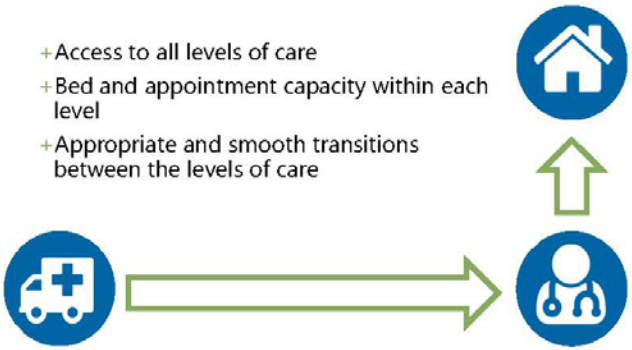

ADDICTION TREATMENT ECOSYSTEM CHANGING HEARTS AND MINDS
ADAPTIVE vs. TECHNICAL
HEALTH MANAGEMENT ASSOCIATES
23


ADDICTION TREATMENT ECOSYSTEM IMPLEMENTATION
Capacity
Competency
Consistency
Compensation
Community
HEALTH MANAGEMENT ASSOCIATES
24

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

HEALTH MANAGEMENT ASSOCIATES 28

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

HEALTH MANAGEMENT ASSOCIATES 29

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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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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MEDICATION-ASSISTED TREATMENT (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

HEALTH MANAGEMENT ASSOCIATES 34

MAT WHO IS APPROPRIATE FOR METHADONE?

- 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

HEALTH MANAGEMENT ASSOCIATES 35

MAT METHADONE GENERAL REGULATIONS

Delivered via observed dosing

Highly monitored in an Opioid Treatment Program setting (OTP)

Once patient is stable and after 6 weeks, can be given take-home doses (varies by state)

Many requirements for treating patients

HEALTH MANAGEMENT ASSOCIATES 36

MAT 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 (UDS) and to check that any take home medications are accounted for

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MAT 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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MAT 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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MAT 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

HEALTH MANAGEMENT ASSOCIATES 40

MAT WHO IS APPROPRIATE FOR BUPRENORPHINE?

- Positive DSM 5 with a score of 2 or greater
- Positive DAST (6 or greater)for opioids
- Can make it to clinic for evaluation AT4
- Can afford the medication AT5

HEALTH MANAGEMENT ASSOCIATES 41

MAT: 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

HEALTH MANAGEMENT ASSOCIATES 42

MAT: 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 certification by the American Osteopathic Academy of Addiction Medicine, 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

HEALTH MANAGEMENT ASSOCIATES 43

MAT: 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

HEALTH MANAGEMENT ASSOCIATES 44

MAT: 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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MAT: WHO IS APPROPRIATE FOR NALTREXONE?

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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MAT: 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

HEALTH MANAGEMENT ASSOCIATES 47

MAT: NALTREXONE MEDICATION FOMS

- 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/nl of 6-beta-Naltrexol)

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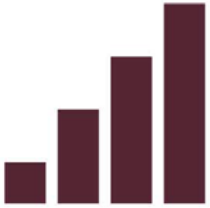
MAT: NALTREXONE OUTCOMES

- 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



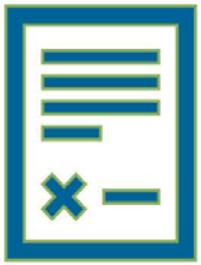
SH7

MAT: 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

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.



GOAL

IN A PERFECT WORLD WE WOULD LIKE TO….

SCOPE

WHO IS IN AND WHO IS OUT?

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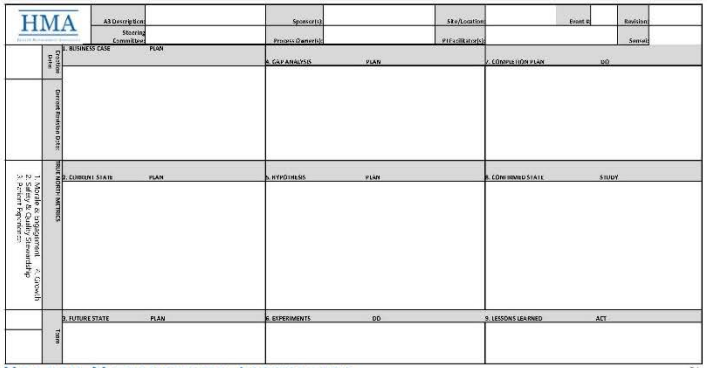
A3 BARRIER AND SCOPING



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AFTERNOON SESSION

COHORT 1

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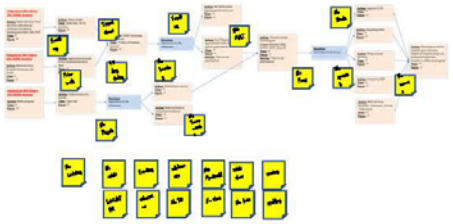
FIELD NOTES

HEALTH MANAGEMENT ASSOCIATES

HEALTH MANAGEMENT ASSOCIATES 56

OUTPATIENT SERVICES

14. Outpatient Mental Health Services



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HEALTH MANAGEMENT ASSOCIATES

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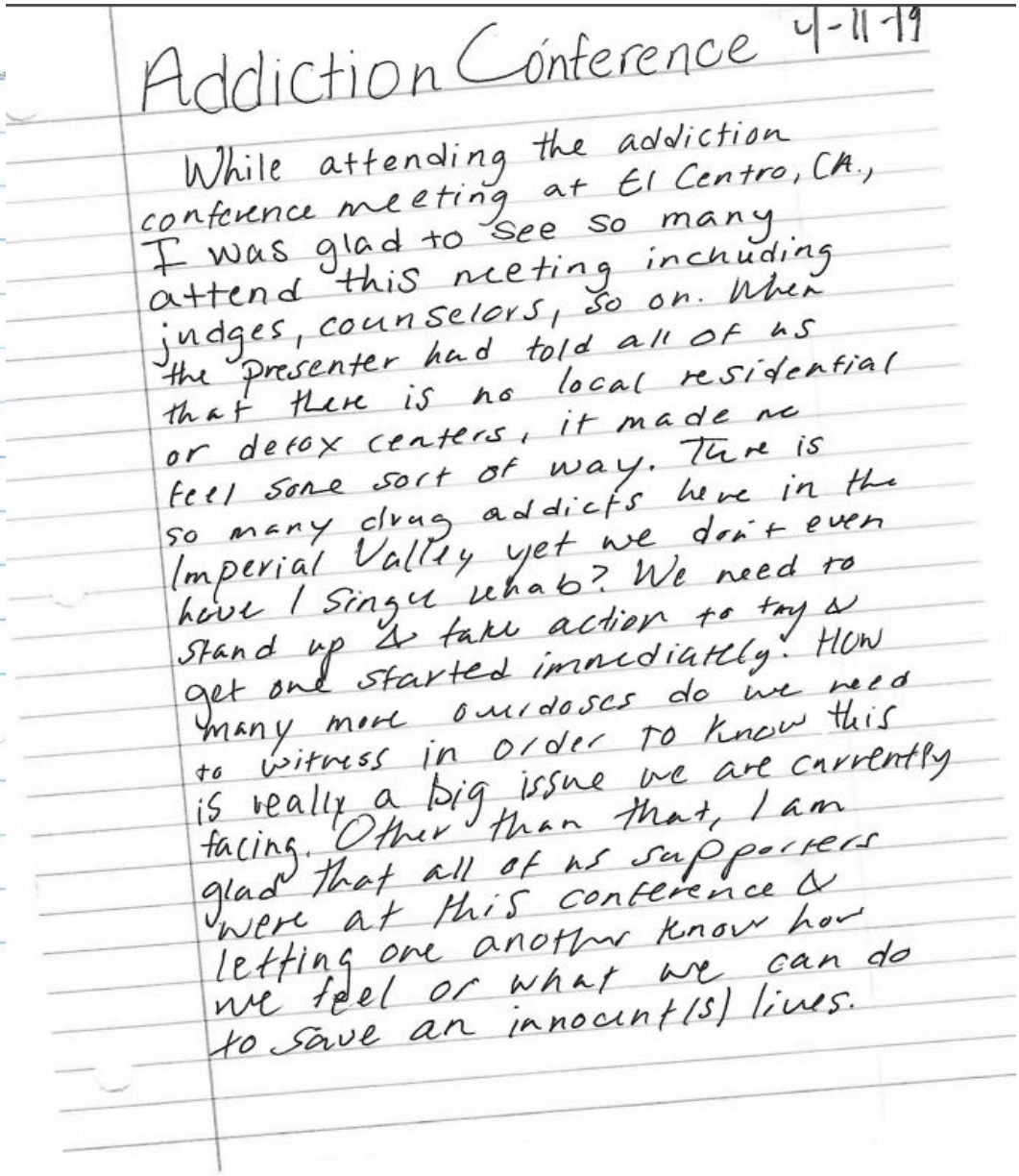
C. Summary of Evaluation Results

1. **What did you like MOST about this forum?**
    - Brought many partners to the table which created a useful opportunity to collaborate, learn from one another and about what others do
    - Very educational in many regards (MAT, how to collaborate, etc.)
    - Barriers and gaps discussion
2. **What did you like LEAST? What changes would you recommend?**
    - At least 14 people said "none" or responded only with great, fun, etc.
    - Some partners missing from the table; some encouraged more outreach prior to the event to ensure more participation from agencies missing or those with low participation
    - More breaks, more movement, lunch at noon
3. **Give an example of something new you learned about addiction.**
    - Dopamine and its effects
    - Addiction is an illness but is treatable
    - MAT
4. **What topics would you like to learn more about?**
    - MAT and other treatment options
    - Lots of specific TA requests
    - Varied responses primarily related to which group respondent was from
5. **Other comments/questions.**
    - Praise and thanks
    - *"What you all have done here in these two days is of great importance to our community. Thank you for presenting and for making this a comfortable course for everyone to work, learn and enjoy. I look forward for our department to work in collaboration with the organizations present and share the information on the ones that were not able to benefit from this."*



Addiction Conference 4-11-19

While attending the addiction conference meeting at El Centro, CA., I was glad to see so many attend this meting inchuding judges, counselors, so on. When the presenter had told all of us that there is no local residential or detox centers, it made me feel some sort of way. There is so many drug addicts here in the Imperial Valley yet we don't even have 1 Singel rehab? We need to stand up & take action to try & get one started immediately. How many more ouridoses do we need to witness in order to know this is really a big issue we are currently facing. Other than that, I am glad that all of us supporters were at this conference & letting one another know how we feel or what we can do to save an innocent(s) lives.

Lo que me gusta de este Programa R.L.S
es La teacher. Tabien me gusta Las Aramientas
que nos de La maestra. no enseya valores y coma
quereno S mos a nosotros mismos - tambien me
gusta que la maestra nonos Regaya y nos tiene
pasiensia y me gusta estar con los compageros
que nos yevamos bien, y le doy grasias a Dios
por que estos en esta programa.

R.M 4-17-19

lo que me gusta del programa
es que puedo compartir con mas
personas con los mismos problemas
y de esa manera aprendo a llevar
los mismos

lo que me gustaria que cambiara es
que no interrumpan tanto y que se
apegen al tema del grupo y no
esten jugando y bromeando con
cosas que no son del tema

Este programa Si me esta
ayudando porque yo vengo volumtaria
mente y aqui estoy tratando de
ser el bien un dia a la vez.
gracias.

BMP 4/27/2019

EL Pograma es muy importante para mi, por que me hace sentir muy bien en mi persona, laura nos da muchos Consejos como no recaer y como calma la ansiedad, y por que voy a recuperar a mis hijas y eso me hace sentir muy bien, y mi mes para que este programa esta muy bien yo estoy muy Contenta

CH 4/17/19

Lo que estoy aprendiendo del Programa es ha decir NO conocer las istorias de los compañeros La convivencia. Las platicas el apoyo de laura Los consejos de los compañeros del grupo.

CH

R T

el Programa me ayuda en primo a mantener
Mi sobriedad. me mantiene ocubado. Tambien
en los metodos para mantenerme
sin Alcol, si son muy Aplicales
en la vida diara. espero mantenerme
Asi sin Alcol.

This program is helpful in short term
and ~~is~~ it benefits All drug addicts that
want to better themselves to overcome
their addiction. Also for some drug
Addicts in Recovery A shorter time in
A Rehab facility should be Appointed
When they have been in prisow before.

Thank You

4/17/19

R R

My experience in the outpatient program with Behavioral Health Services has been absolutely positive. Initially, I did not know what to expect, but from the start it has been a collaborative experience. My counselor has guided me well throughout my recovery process and has aided me to dig deep and meet my person. I have gained insight and learned a lot about myself and have been provided with the tools to shape myself into a more self aware and better person. Having group meetings has allowed me to be more open and learn from others as well. The patience and interactions within these groups have been very helpful. I have thoroughly enjoyed the matrix model because it has given me the opportunity to examine myself. What I do like is how my counselor allowed myself and my group members to work at our own pace and apply the tools we learn into our own program individually.

Despite having a positive experience within the groups, I do recommend individual sessions as well. Due to lack of attendance from clients, I have had the opportunity to have multiple individual sessions. These individual sessions were of great assistance as well. I believe individual sessions would be beneficial to everyone at least once in a while in order to explore more in depth. What I would like to see more of is a more variety of meetings offered.

One thing that is beneficial in group sessions is learning from shared and different experiences. Although, in my experience it limits the opportunity that someone may have to voice their opinions, experience or concern. One can be more reserved to allow someone else to share and not feel like they are monopolizing the group.

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