BUILDING SUSTAINABLE TRANSITIONS OF CARE FOR PEOPLE WITH ADDICTIONS

Ventura County Community Process Improvement Event

May 21-22, 2019

HEALTH MANAGEMENT ASSOCIATES

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HMA
HEALTH MANAGEMENT ASSOCIATES

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Executive Summary

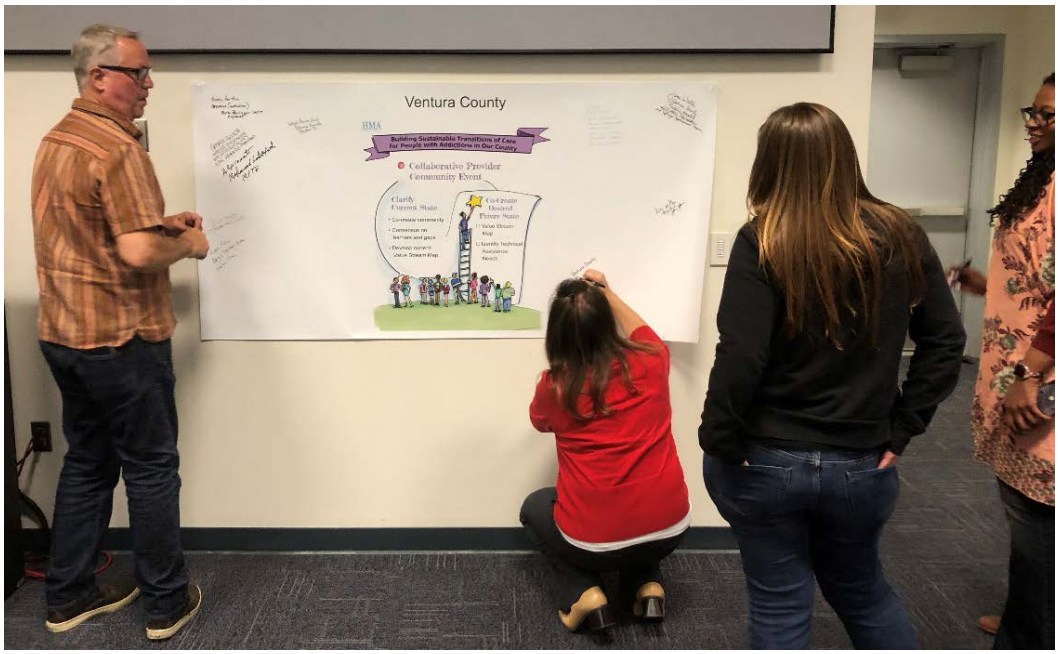
Overdose is the leading cause of accident-related death in the United States. The vast majority of these overdoses come from a combination of prescribed opioids and heroin. As we have watched the opioid crisis worsen over the last 10 years, we have reached a point where the treatment system, in its current 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. Ventura County, one of the 10 counties selected, participated in a large-scale process improvement event on May 21-22, 2019 that included members from different aspects of government, healthcare, health plans, and addiction 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 Ventura County residents in need of addiction treatment and support services.

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

The two-day event concluded with the development of a group-based consolidated vision of the future that includes, but is not limited to, 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. 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.



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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 Ventura 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 Ventura 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 Ventura County Behavioral Health (VCBH), specifically Anita Catapusan and staff, to launch the process improvement event and subsequent ongoing technical assistance program. VCBH identified key stakeholders to engage and developed an invitation list. HMA then distributed invitations and conducted outreach at the request of VCBH.

B. County Leadership/ Key Change Agents

Ventura County Behavioral Health

- Loretta Denering, Chief of Alcohol and Drug Programs Division
- Brian Taylor, Medical Director, Adult Division
- Sevet Johnson, Director
- Richard LaPerriere, Clinic Administrator III
- Anita Catapusan, Behavioral Health Manager
- Jessica Davis, Clinic Administrator
- Sharon Gassett, Clinic Administrator
- Chris Huey, Clinic Administrator
- Jennifer Stuart, Senior Mental Health RN
- Luis Tovar, Senior Program Administrator
- Destiny James, Program Administrator
- David Tovar, Program Administrator

C. Who Was Involved

- Ventura County Behavioral Health
- Ventura County Public Health
- AEGIS Treatment Centers
- Tarzana Treatment Centers
- Community Memorial Health System
- Evalcorp
- Gold Coast Health Plan
- Hospital Association of Southern California
- Ventura County Office of Education
- Ventura County Perinatal Advisory Council
- Sterling Care Psychiatric Group
- UCLA Center for Healthier Children

- Ventura County Health Care Agency
- Ventura County Probation Agency
- Ventura County Sherriff's Office
- Vista Del Mar Hospital

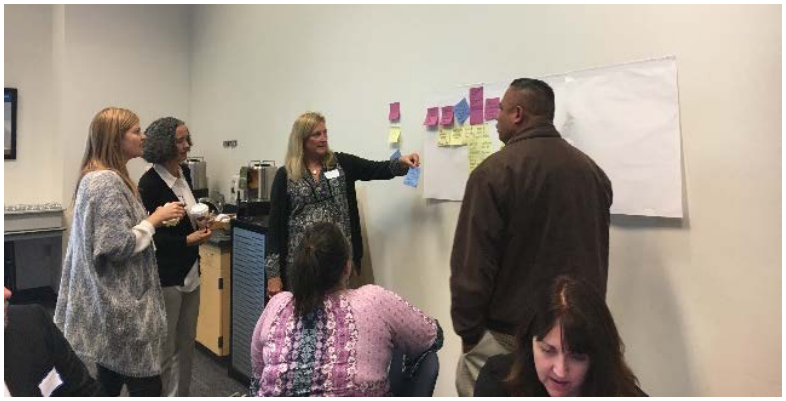
D. Structure of the Intervention

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 (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.

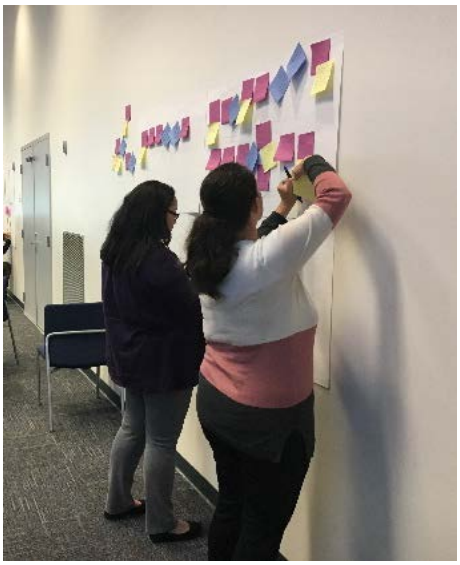
Prior to the event, HMA worked with the county to electronically gather high-level information on addiction treatment capacity in Ventura in preparation for two days of intensive on-site value stream mapping, presentation, and discussion.

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 divided themselves into smaller groups by organization/addiction treatment program area to map and discuss current states.



Participants were tasked with developing a current state value stream map that included 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 Ventura County. However, there were treatment providers and other stakeholders missing from the discussion and their input will be necessary in order to obtain a complete picture of the current state of addiction screening, placement, and treatment in the 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.

On day two, we began with a full group discussion of the barriers identified on day one, focusing on solutions for overcoming barriers in integration, capacity, policy, and culture. Then, the group worked to develop an evidence-based 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.

As mentioned, there were providers and stakeholders not in attendance and their input would be important to the finalizing of a future state map. The participants in attendance were an engaged group representing primarily decision makers and doers. Unfortunately, there were not identified clients to provide input to the development of the future state map. The future state map was developed based on the input of the groups in attendance and begins to address the barriers and gaps identified. While not every treatment organization was present, the group was able to identify important

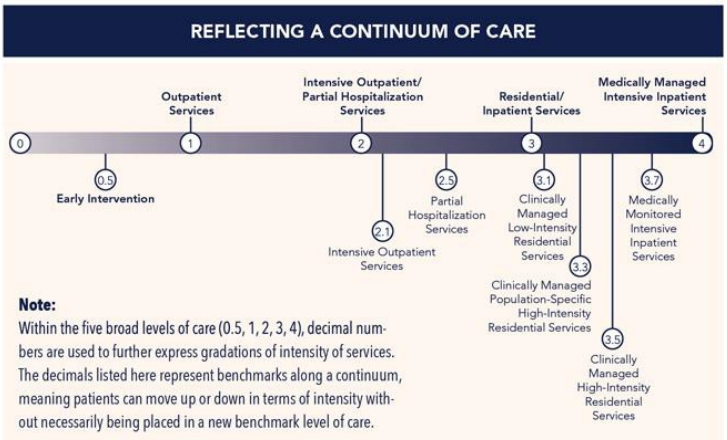
components of the future state map, as well as the partners that still need to be engaged.

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:

- Integrate mental health issues and trauma, and understanding of addiction, build an integrated system of care that considers diagnosis and early life trauma- provide whole person care
- Have change agents that educate treatment providers about effective treatment of substance use disorders (SUD)
- Facilitate larger community connection, community connection as part of the eco-system, engage more people in an "open system"
- Create a therapeutic environment through sense of community connection
- All prescribers adhere to safe prescribing guidelines and are skilled in tapering short-term opioid use in primary care
- Identification of individuals-increase number of providers willing to screen patients, mandatory universal screening
- System integration: SUDs are as well integrated into system of treatment, prevention, primary care as type II diabetes
- No child is separated from their parent due to their parent having SUD
- Get rid of SUD stigma
- Integrated system to effectively address co-occurring disorders
- No wrong door- no matter where someone comes into the system, they can access the appropriate level and form of treatment
- Be proactive- identify early childhood trauma as the root cause for many people to seek dopamine and address the trauma
- Ensure other providers who are not MDs do not "practice medicine" on patients before entering a residential treatment facility
- Integration- have standardized protocols so everyone is using the same language (e.g., release of information, standardized screening tool)
- Have capacity to provide levels of treatment for everyone who needs it
- People who do not have financial means to access care can access care without stigma, segment in Ventura that is uninsured
- Have unlimited resources for SUD- no matter what a person can pay, they can get the care they need
- Have a health care navigator/care coordinator so that regardless of insurance status, at any point in transitions of care a person has a point person to help guide them- feeling connected to treatment
- Increase capacity- with new 1152 waiver mandating a place for warm hand off, need more capacity and more housing
- Transitions of care 2.0 and have other justice partners at the table
- Expand accessibility for clients in justice system, having co-located integrated services
- Education with schools, starting at a young age teach kids about addiction, so they can recognize it in family members and also avoid it themselves, engage young people as part of the solution

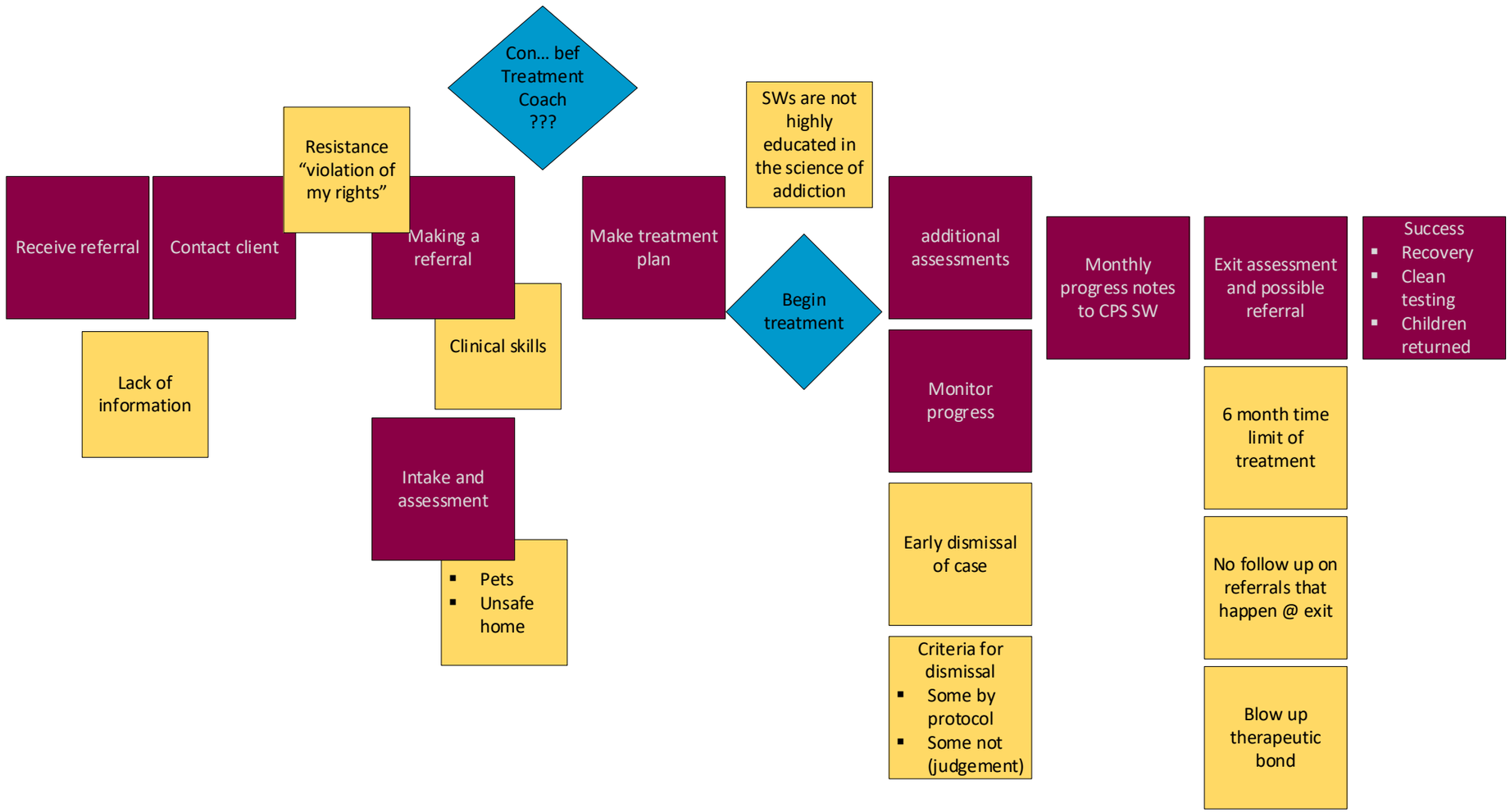
HMA recommends an overarching goal for Ventura County, under which all the goals named above can be placed.

THE OVERARCHING GOAL:

ELIMINATE ADDICTION-RELATED DEATHS IN VENTURA COUNTY

B. Current State Value Stream Maps (VSM)

Aspiranet Current State VSM

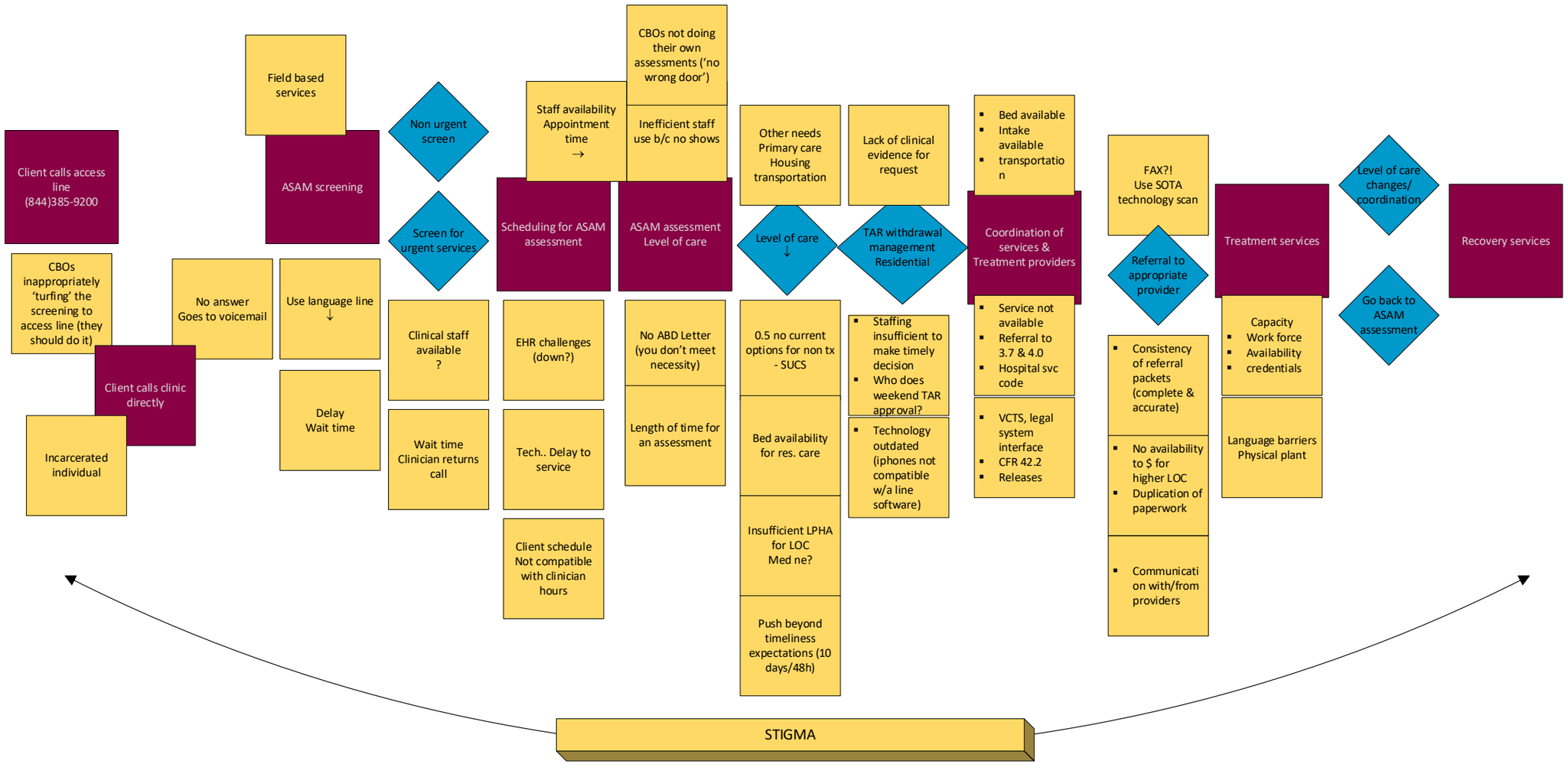


Aspiranet is a not for profit organization that provides foster family support, intensive case management, and other support services to children and families who are involved with Child Protective Services (CPS). The value stream map depicted above tracks the process Aspiranet uses to engage substance abusing parents whose children are in custody or for whom court-ordered treatment services are in effect.

This organization typically receives referrals from a CPS social worker on behalf of a parent with SUD. Organization staff attempt to contact the client to conduct an intake and assessment. From the time the assessment is started until the client is referred to a treatment provider, staff work to build rapport. During the assessment and initial treatment sessions, staff begin to conceptualize the patient's needs and build a treatment plan. If the patient is amenable, treatment begins. Over the course of the 6-month window during which contracted services are provided to the parent/client, the therapist is required to make monthly updates to CPS social workers. Additional assessments may be undertaken at any time during treatment as indicated by circumstances (e.g., suicidality, early trauma, etc.). Near the end of the contracted period, an exit assessment is undertaken to identify the need for and offer additional referrals.

There are numerous barriers along this process. During the initial referral and assessment process, there is often limited information about the client provided to Aspiranet, and the referred clients may be uncooperative and reluctant to offer additional information because they see the referral as a violation of their rights. The therapists conducting the assessments often lack clinical skills at developing rapport with the client. If home visits are conducted, there may be safety issues in accessing clients at their homes. Constraints from the CPS system may also affect treatment. For example, some of the social workers reviewing the status reports may not be knowledgeable about addiction. In some instances, the client may be terminated prior to the 6-month contract period for reasons determined by CPS, or based on the therapist's protocol, or professional judgment. Finally, the 6-month limit on these interventions means that hard won therapeutic bonds are disrupted. Often the clients are reluctant to start over with another therapist, and any subsequent referrals may be problematic because of this. Ultimately, the staff at Aspiranet are not provided with any follow-up on client outcomes and are unable to monitor whether clients have tested negative, completed recovery programs, and whether they have been reunited with their children.

Ventura County Behavioral Health Current State VSM



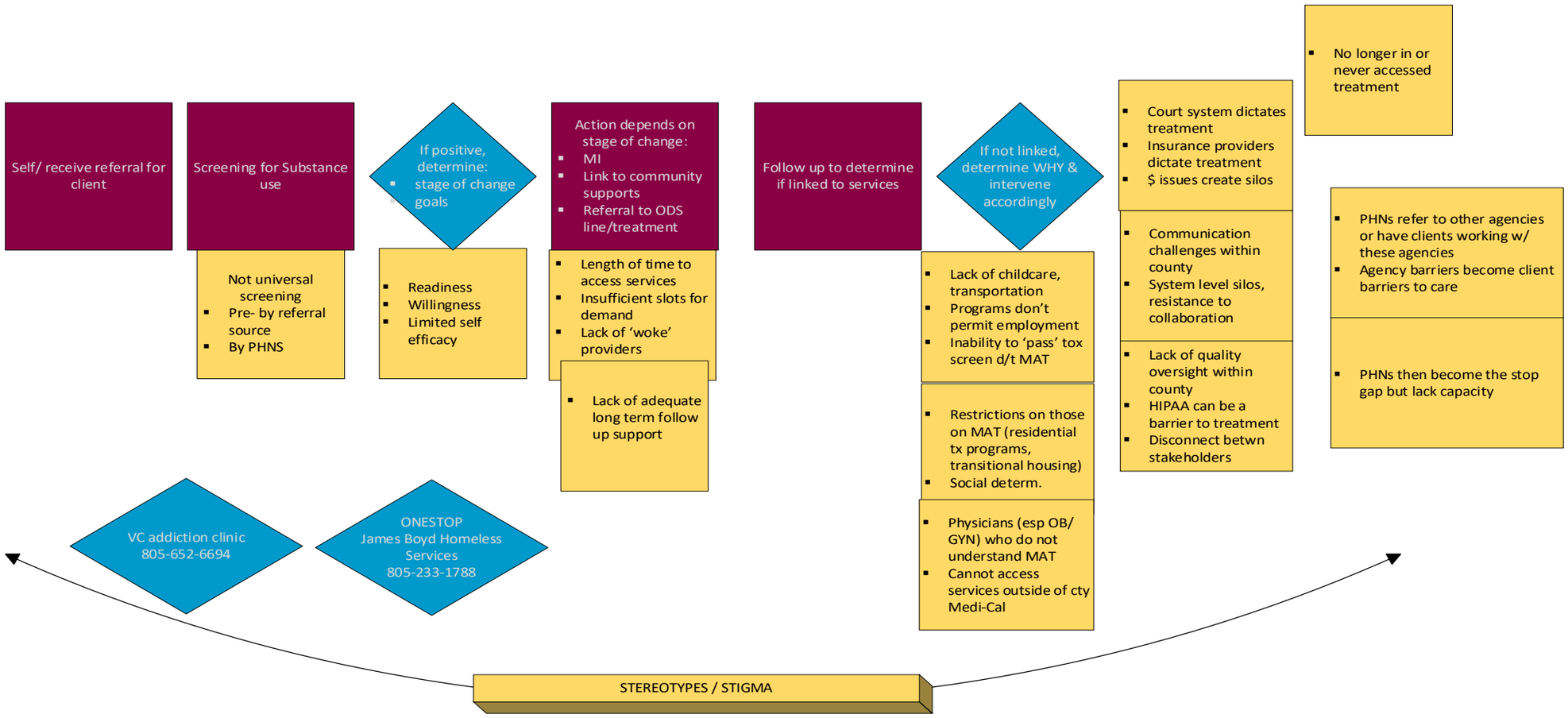
Ventura County Behavioral Health (VCBH) is the provider of outpatient drug treatment services for the entire county. There is a toll-free access line for client calls (844-389-9200). Most referrals come in through the access line, although some clients may call the VCBH clinics directly. Once a client makes contact, an assessment is conducted to determine the ASAM level of care, and whether the care need is urgent or not. Based on the assessment, a level of care determination is made. For withdrawal management, a treatment authorization request (TAR) must be made and reviewed by a Local Provider of the Healing Arts (LHPA). This TAR process is one that is internal to VCBH (i.e., this is not a state mandated review). Once services have been approved, a referral to an appropriate provider is made, treatment services are provided, and coordinated. Because of the chronic and sometimes relapsing nature of addiction, it is not unusual that there may be a level of care change during treatment, necessitating another assessment to determine the appropriate ASAM level of care. This process may progress over time allowing the patient to be stabilized, and ultimately to be referred to recovery services.

Barriers occur at every step of this process. That begins with the screening process. There is no consistent, field-based screening tool or process to identify individuals in need of treatment. Challenges with the access telephone line may be external or internal. The access line is sometimes abused by community-based organizations (CBOs) that sidestep responsibilities for client assessments by transferring client inquiries to VCBH. Although the access line is available to many, it is not available to individuals who are incarcerated. There are also internal challenges including lengthy answer times, dropped calls, and insufficient cultural and language access (i.e., limited bilingual/bicultural operators to take the calls).

These internal operational issues undermine the intake process, and cause delays in and missed opportunities to link clients to treatment. Once assessments are completed and referrals have been made, there are significant capacity issues – insufficient providers, and poor appointment template management (i.e., inefficient management of no-shows) – that impact appointment availability. Adverse benefit determinations by health insurance companies and local agencies and even the length of time required to complete assessments also may undermine access to treatment.

Barriers also exist in the determination and authorization of the appropriate ASAM level of care. Ventura has imposed a Treatment Authorization Request (TAR) process to handle these referrals/requests that is dependent on Licensed Practitioners of the Healing Arts (LPHA) for review and authorization. There are insufficient numbers of LPHAs to manage the TAR load, and there are no standard treatment necessity guidelines to guide their reviews. Ventura simply does not have certain levels of care as part of the ecosystem (0.5, 3.7, 4.0). There are limited residential care beds, insufficient numbers of credentialed providers, and capacity issues with other levels of care, which means linkages often exceed expectations (48 hours and 10 days depending). There are other socioeconomic barriers that affect treatment access and effectiveness including lack of housing, transportation issues, and lack of co-located primary care services. Data and information exchange from start to finish hamper coordination of care including constraints in 42 CFR, lack of interoperable technology systems, and reliance on facsimile as the main mode of information sharing. Language barriers affect nearly all aspects of this process stream. The most significant barrier, which permeates the entire system as well as related systems, is stigma.

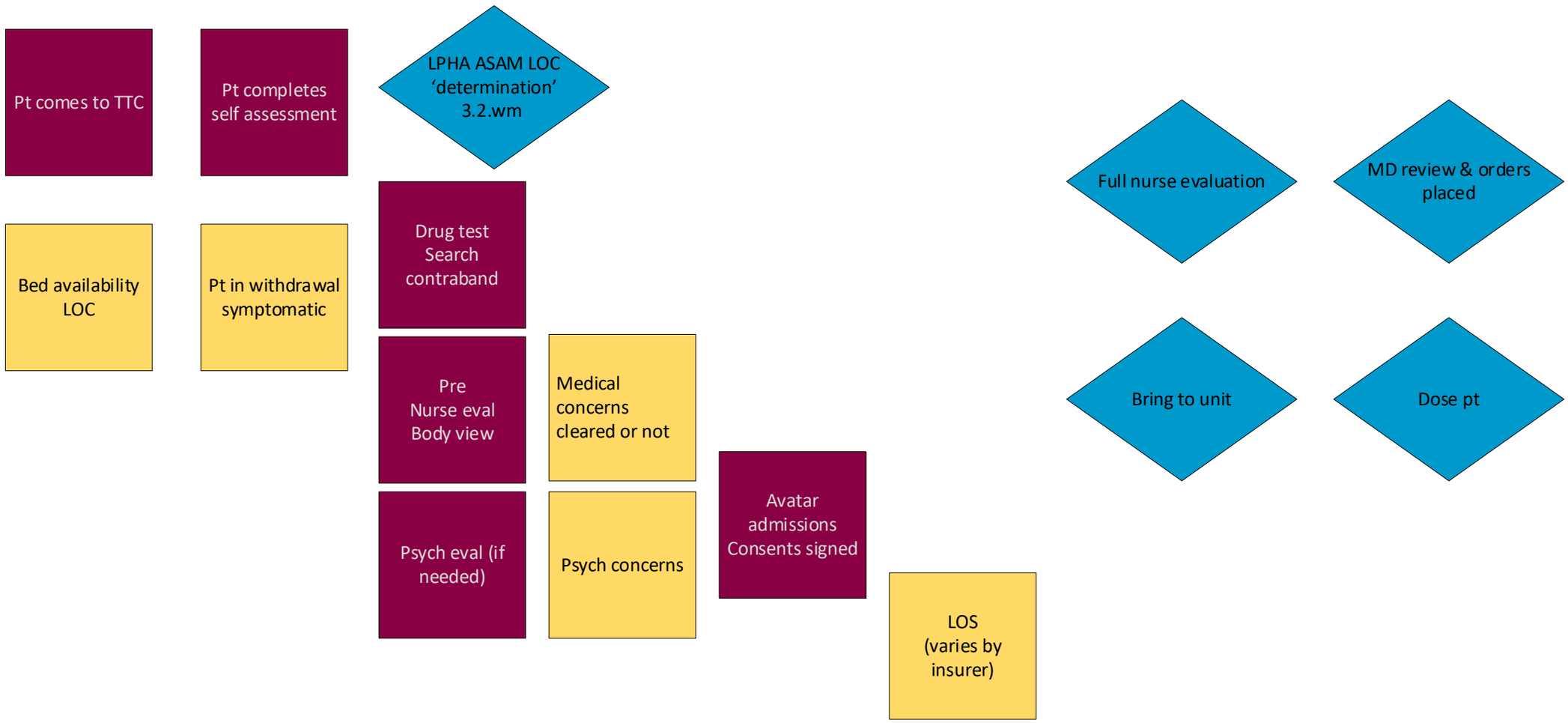
Ventura County Public Health Current State VSM



The value stream for Ventura County Public Health (VCPH) represents the overlap in two separate public health programs: Maternal Child and Adolescent Health (MCAH), and HIV/ AIDS needle exchange. In both instances, clients self-refer for assistance, often coming in for an unrelated service (e.g., in WIC offices, schools or primary care provider offices). Once a client comes into a public health-based service, the hope is that they are screened for substance use. That screening may be done by the service provider (e.g., PCP, or WIC staff), or by a public health nurse (PHN). It should be stated that PHNs are often the stop gap for screening, but there are insufficient numbers of PHNs to carry that load. (Implicit, but not expressly identified in the value stream map is the occurrence of an assessment for severity after a positive screen). Action taken on the assessment depends on the client's stage of change and may include use of motivational interviewing in subsequent appointments, linkage to community supports, referral to the Organized Delivery System (ODS) access line, or referral directly to treatment. There is or should be follow-up with the client by VCPH to determine if the appropriate linkage occurred. If linkage did not occur, public health staff take steps to determine the cause of the linkage failure.

The following barriers undermine the effectiveness of the public health system as a conduit for linking clients with OUD/SUD to treatment. Screening is not universal, so clients coming in for services where screening is not yet ubiquitous, will not be identified in these settings. Client characteristics, such as willingness/readiness to change and limited self-efficacy affect the effectiveness of these linkages. Capacity issues in the treatment system were also identified by this group including: lack of trained, activated providers, and insufficient treatment slots, resulting in long wait times for treatment. Insurance companies place limits on treatment modalities and duration. Judicial officers in the court system dictate treatment modalities with incomplete information about a client's severity assessment, and sometimes a lack of awareness about how to match treatment modalities to client's needs. There is resistance to collaboration both within and across agencies and departments. And these are exacerbated by communication challenges including HIPAA and other limitations of client information sharing. Some key elements of the broader system are not aligned on strategy and approach. That is particularly the case with law enforcement, the mayor's office and treatment providers. Social determinants and rigid practices among treatment providers make it difficult for clients to take advantage of treatment services while they are trying to engage in socially responsible activities such as work and child rearing. Those barriers include lack of transportation, lack of child care, limited hours of treatment availability that preclude clients from working, and lack of portability of treatment services across counties (e.g., for patients who work in adjacent counties). More education is required to encourage employers to allow workers on MAT to become or stay employed despite having expected positive toxicology results (the expected result is the MAT medication or metabolite). Finally, many medical providers, especially OB/GYNs, are ill-informed about the benefits and evidence base behind MAT, and hence reluctant to become MAT providers, or even to accept patients on MAT into their practices.

Tarzana Treatment Center (Rehabilitation) Current State VSM

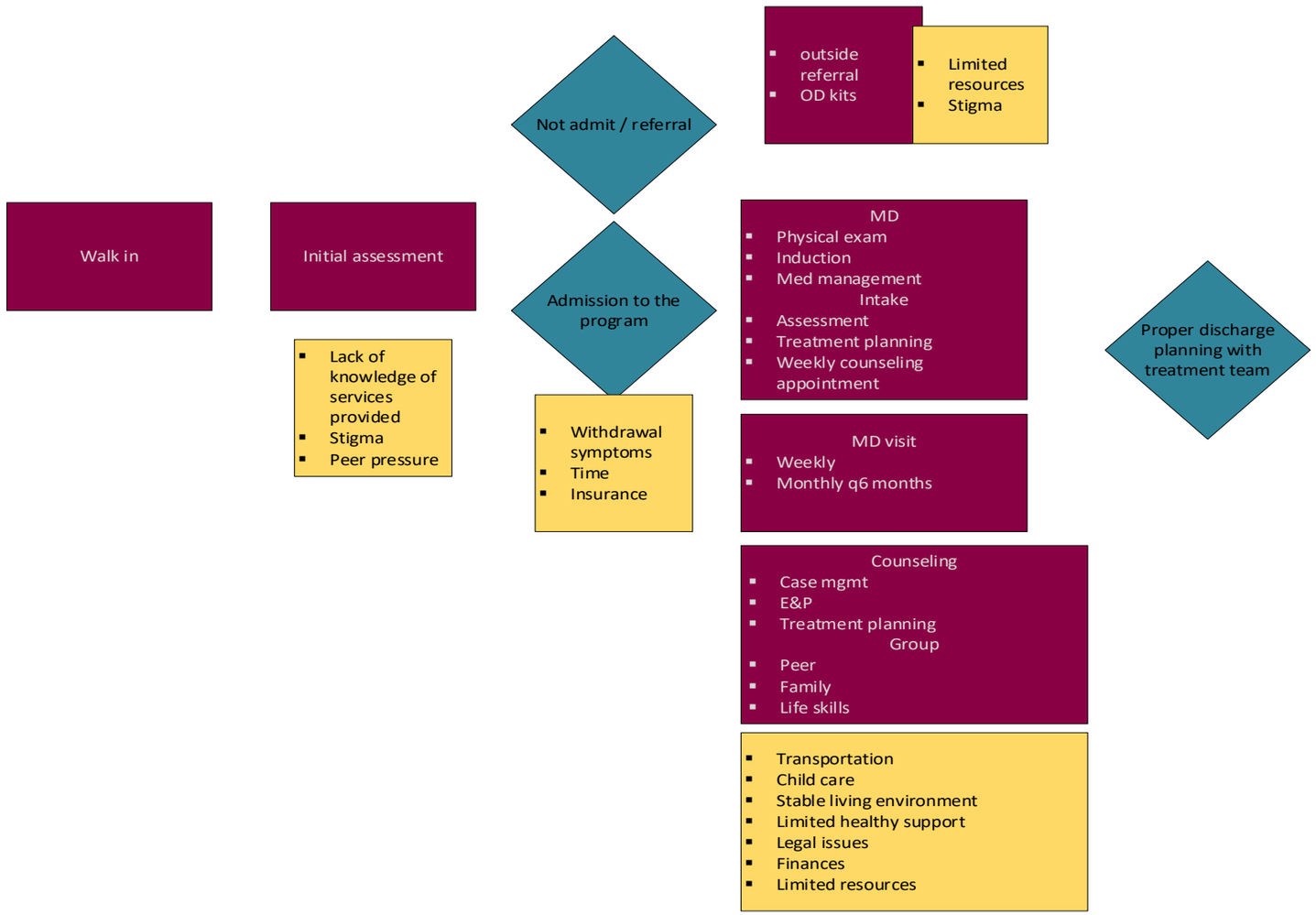


Tarzana Treatment Centers (TTC) is a non-profit organization that provides full-service behavioral health and Drug Medi-Cal Organized Delivery system services in locations throughout California, including a 60-bed detox and treatment, and withdrawal management services in Ventura. The value stream map for TTC inpatient withdrawal management (3.2 or 3.7 ASAM level of care) and related barriers are described below.

TTC accommodates patients who come in as self-referrals, are referred in by another source (TTC has contracts with several county behavioral health departments), or simply walk-in. The receptionist who greets the client asks the client to complete a self-assessment, medical history, and a psychiatric symptom checklist. An LPHA then completes an ASAM level of care determination. Once referred to a treatment site, the client must provide a specimen for toxicology analysis, and submit to a search for contraband. A nurse performs a body scan to identify wounds, and anything requiring emergency medical attention. A psychiatric evaluation is performed if indicated by the symptom checklist or client behaviors (the client may be referred out for management of psychiatric needs if indicated). Client information is entered into Avatar (their electronic medical record system) to facilitate the admission. Consents are signed, and the client is admitted to the appropriate unit. On the unit, a full evaluation is performed by the nurse. The patient is seen by a physician, and orders are written and carried out to address withdrawal or other SUD treatment needs. A treatment plan is developed with the counselor and additional behavioral health treatment begins. The typical length of stay is 3-10 days.

The barriers related to inpatient SUD treatment are relatively predictable. Bed availability for inpatient care is limited and inadequate for the need. Clients sometimes “load up” on opioids or use in the parking lot prior to presenting for withdrawal management. Consequently, they may experience withdrawal symptoms during the intake process. In those instances, clients are referred directly to the TTC clinic so they can get immediate treatment, enough to get them through the admission process and onto the appropriate unit. The presence of significant medical or psychiatric needs take precedence and may delay admission to inpatient SUD treatment.

AEGIS Treatment Center Current State VSM

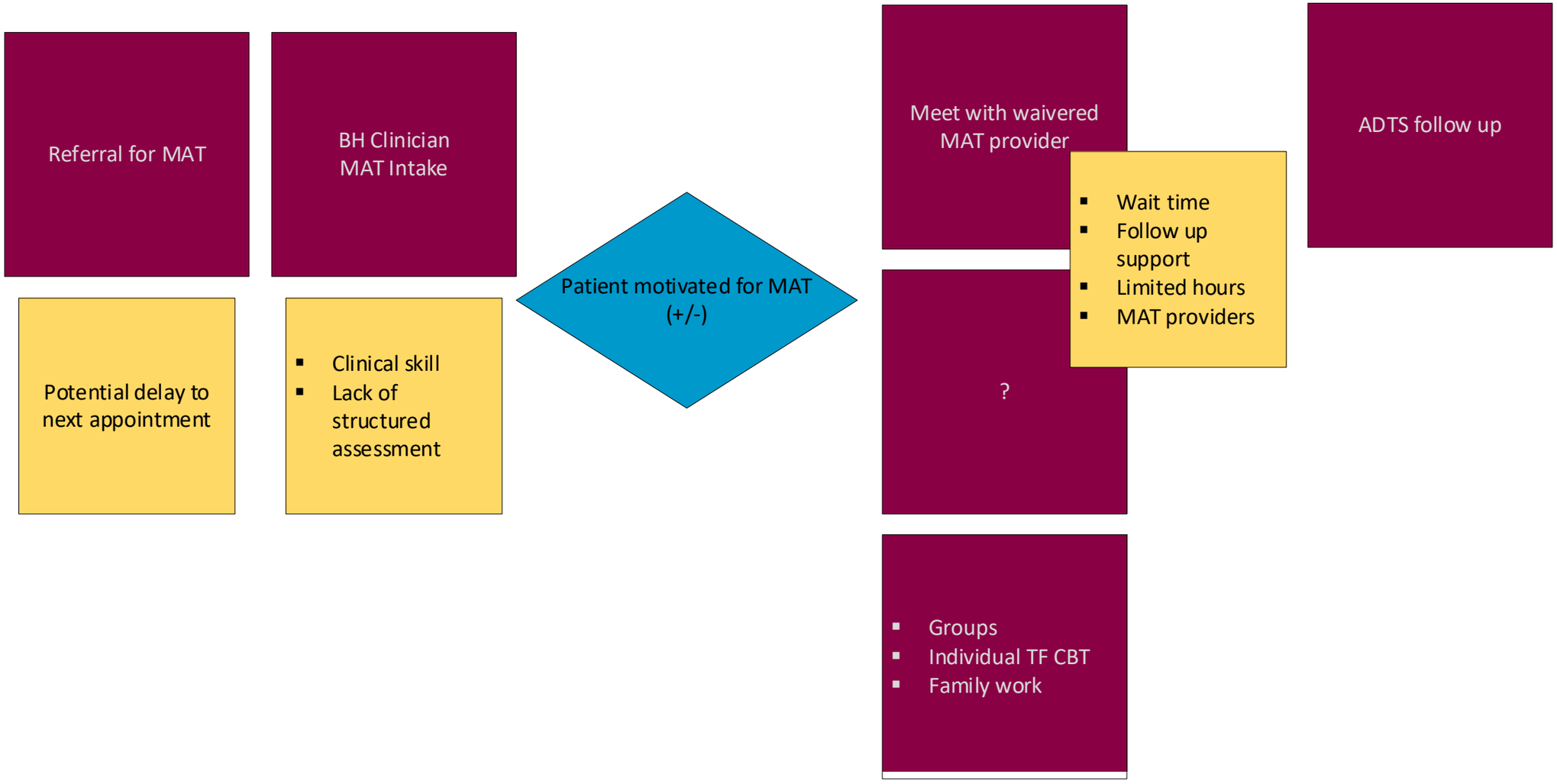


AEGIS treatment centers are integrated opioid treatment centers throughout the state of California with a location in Ventura County. Approximately 85% of their patients are self-referred with the remainder coming from outside referral sources. Once a patient arrives an initial assessment is completed. Many times, initiating treatment can be a barrier given the communities lack of knowledge about the services provided, the stigma surrounding the use of methadone and/or peer pressure to not use MAT at all. If the patient is not admitted into the program, they will be referred out to other local resources along with a naloxone kit. If it is decided that they will remain in the program, they receive their initial assessment by a physician who does a physical exam, induces them on the medication most appropriate for them (methadone or buprenorphine), completes a full intake assessment including level of care determination and follows with appropriate treatment planning documentation. The initial intake process takes approximately two hours at which time the patient is set up and scheduled for continued dosing of the medication as well as integration into both individualized and group-based counseling services. There are number of barriers that arise to the delivery of this service including:

1. Transportation issues
2. Childcare
3. Stable living environment
4. Legal issues
5. Finances
6. Etc.

Many of these barriers will be addressed and stabilized through ongoing case management, the continued integration into family therapy, coordination with the peer and the teaching of life skills through internal programming. If the patient is going to move, change treatment pathways, or wean off methadone then appropriate discharge planning is completed, and the patient is given follow-up with ongoing services as needed.

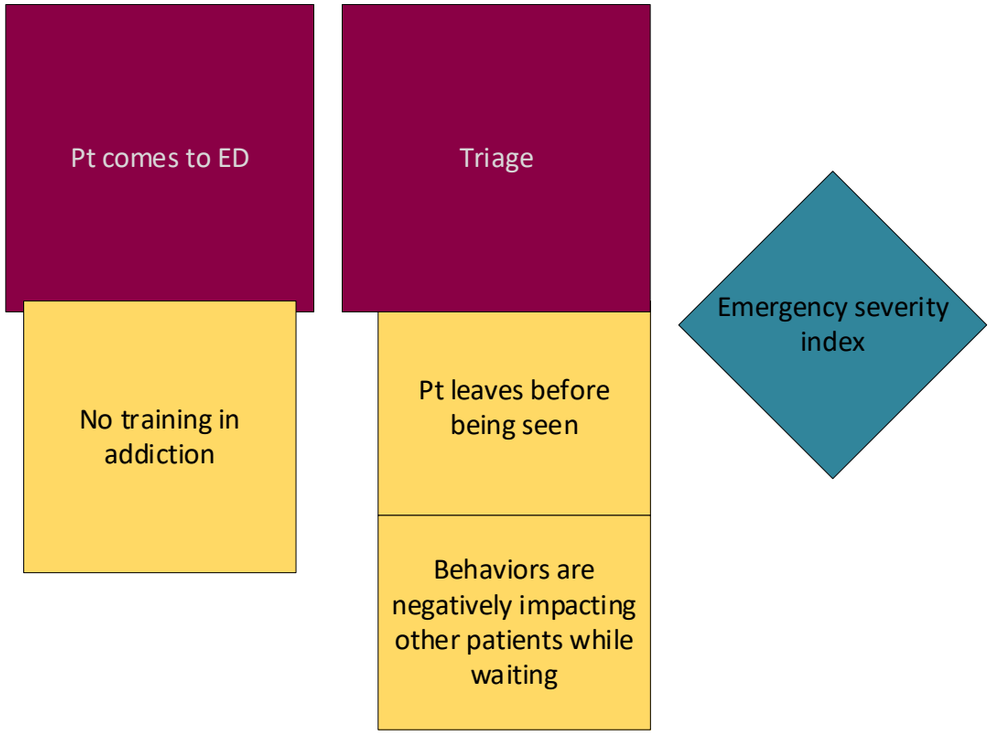
Ventura County Health Care Agency- Health Care for the Homeless MAT Clinic Current State VSM



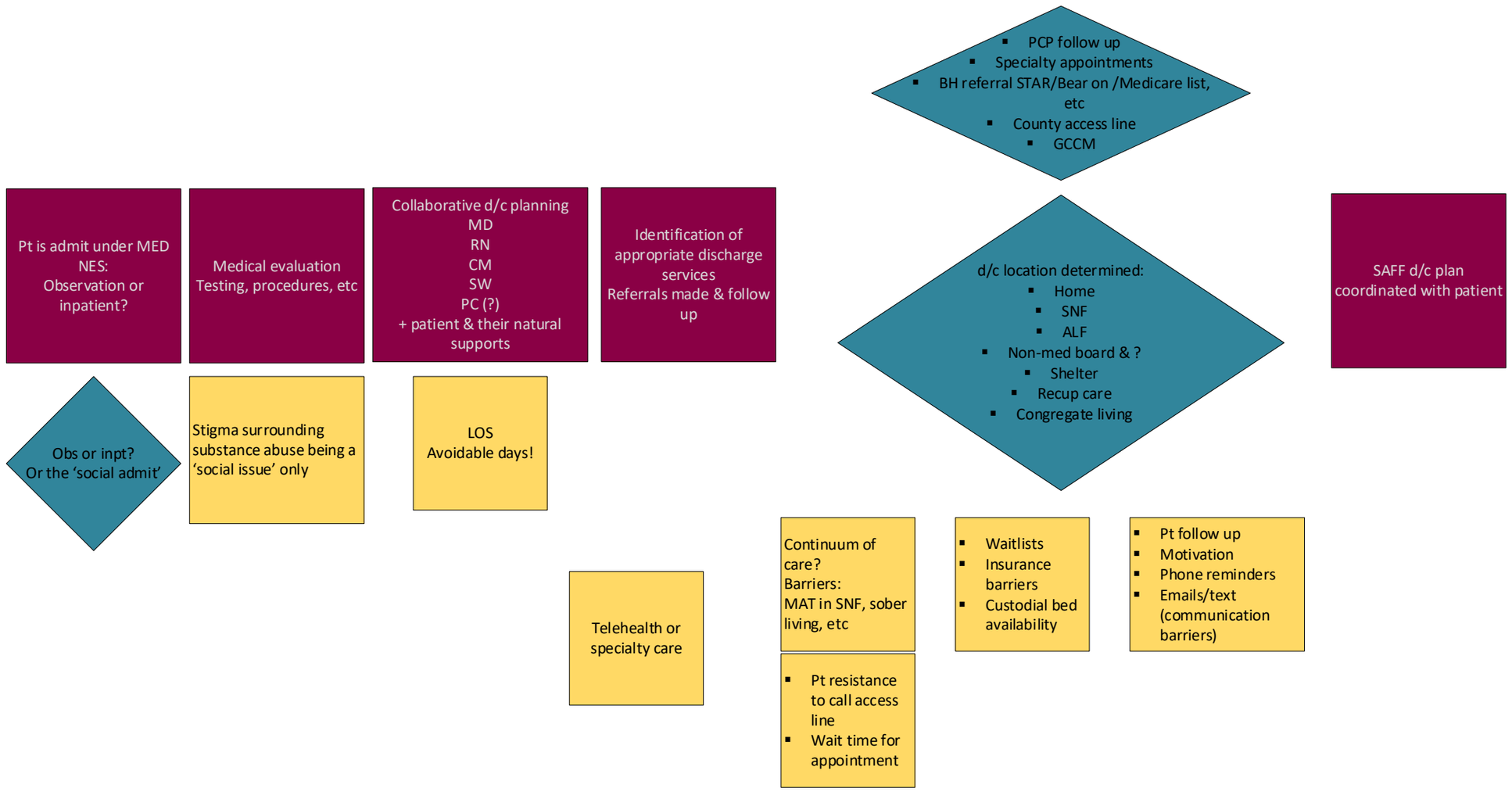
The Health Care for the Homeless MAT Clinic was mapped out by the local health care agency and started with an internal referral for MAT services. Despite there being a referral placed, many times there is a significant delay in the next available appointment. However, once made the patient arrives for assessment by a behavioral health clinician who completes an assessment. After this initial assessment the patient will be able to meet with the waivered provider and MAT can begin. The clinic itself has very little follow-up support, limited hours and a small number of MAT providers. However, an addiction medicine fellowship will be starting this year and should provide for more stable and predictable treatment capacity. Once the provider access is enhanced there may be enough volume to support a coordinating behavioral health counselor, peer or case manager.

Community Memorial Health System Current State VSMs

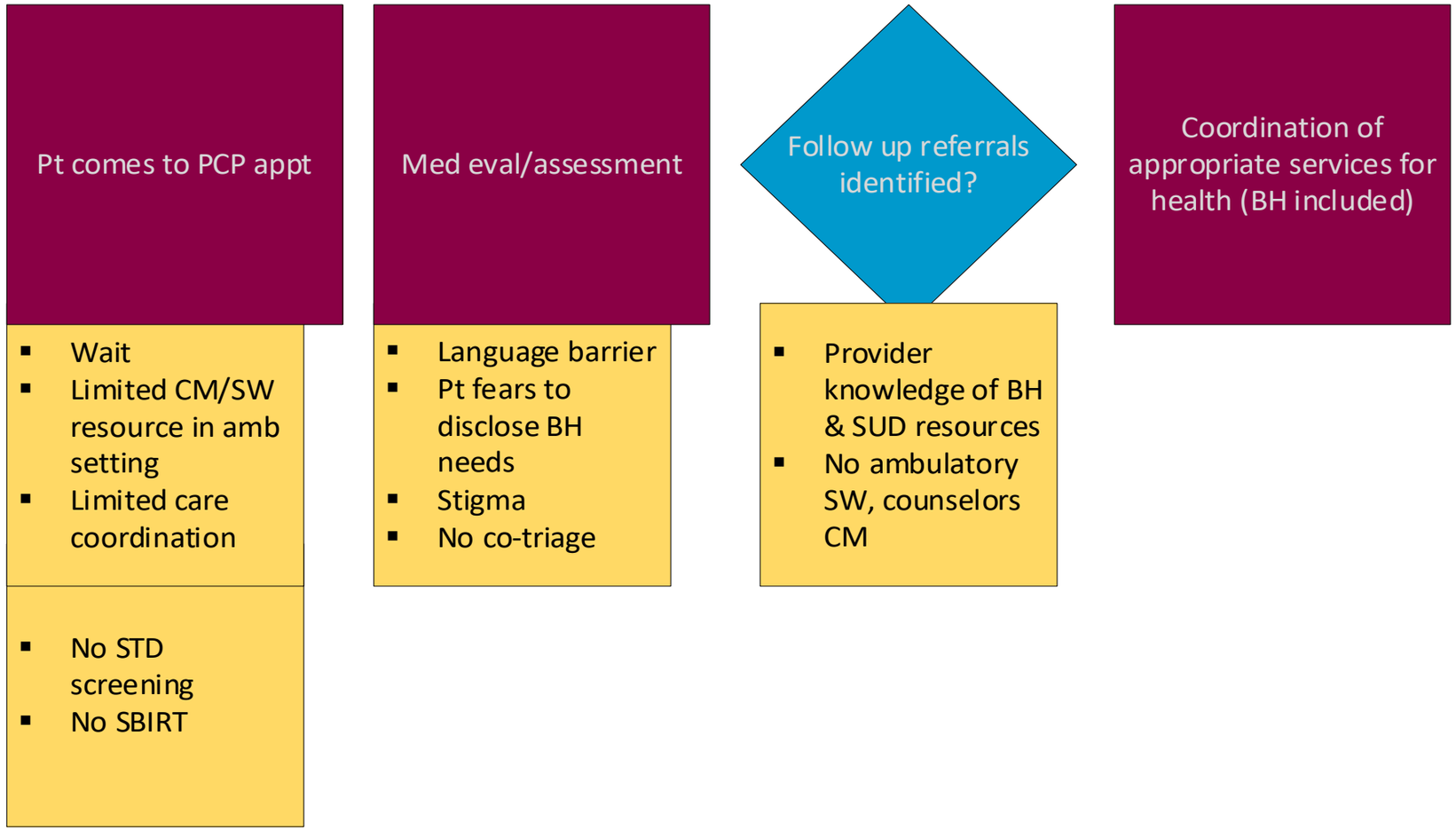
Hospital Emergency Department



When a patient comes to the Community Memorial Hospital's Emergency Department, initial interaction is no different than any other patient who arrives. Patients are triaged and after being assigned an emergency severity index number they are picked up by the next available provider. Given that there is no consistent training or formal pathway evaluation and intervention, the patient will receive varying levels of treatment for their addiction. Generally speaking, there is no MAT started in the emergency department nor any formal capacity for social work to do a screening, assessment or level of care determination. There seems to be a significant amount of stigma toward these patients in the emergency department which may directly affect the capability to have patients stay until the completion of their treatment. After standard working hours there are even less available options. If the patient seems to be severe enough in their disease or medical instability they may be admitted to the inpatient status.

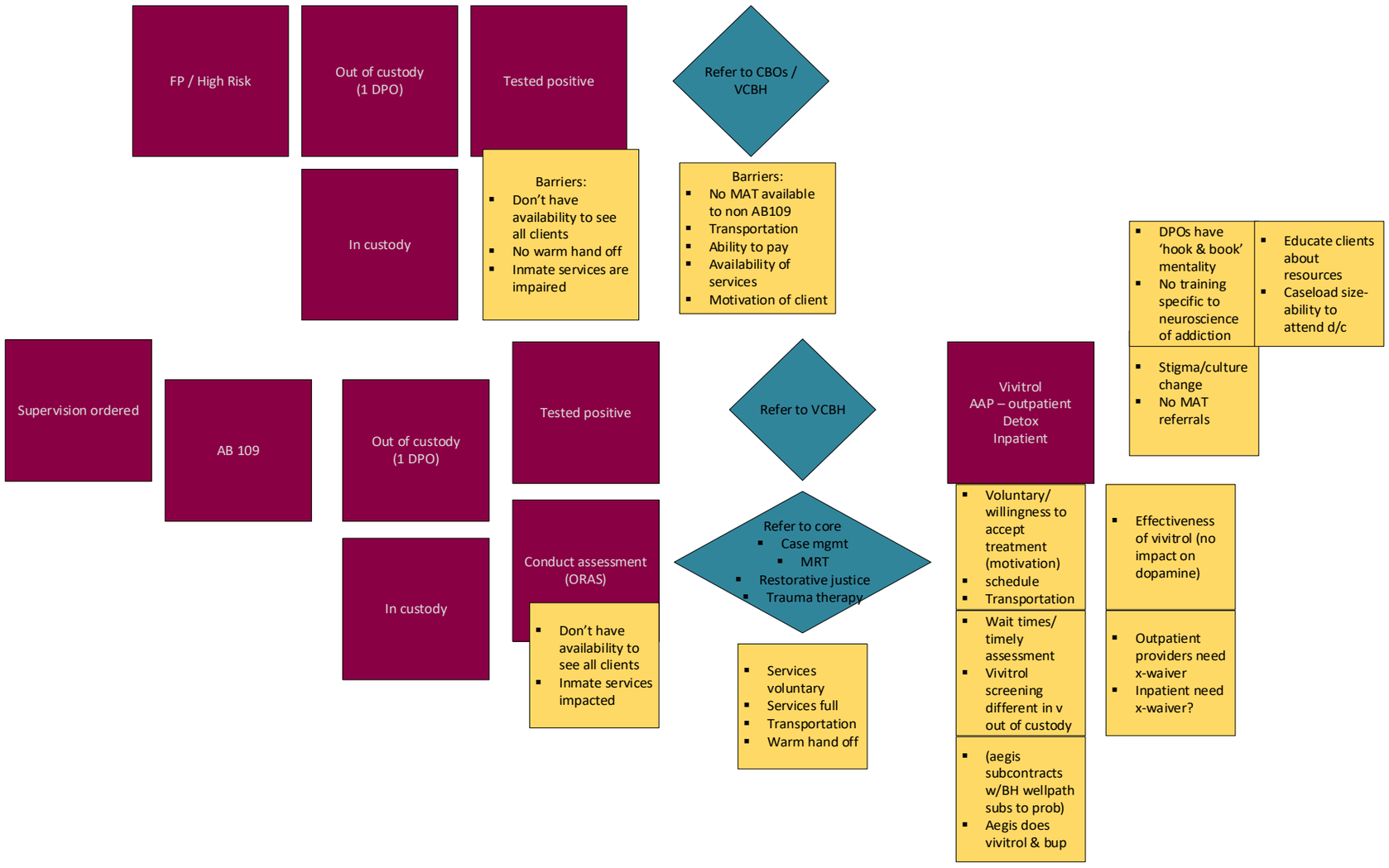

Pt is admit under MED NES:
Observation or inpatient?
Medical evaluation
Testing, procedures, etc
Collaborative d/c planning
MD
RN
CM
SW
PC (?)
+ patient & their natural supports
Identification of appropriate discharge services
Referrals made & follow up
PCP follow up
Specialty appointments
BH referral STAR/Bear on /Medicare list, etc
County access line
GCCM
d/c location determined:
Home
SNF
ALF
Non-med board & ?
Shelter
Recup care
Congregate living
SAFF d/c plan coordinated with patient
Obs or inpt?
Or the 'social admit'
Stigma surrounding substance abuse being a 'social issue' only
LOS
Avoidable days!
Telehealth or specialty care
Continuum of care?
Barriers:
MAT in SNF, sober living, etc
Waitlists
Insurance barriers
Custodial bed availability
Pt follow up
Motivation
Phone reminders
Emails/text (communication barriers)
Pt resistance to call access line
Wait time for appointment

If the patient meets criteria for admission either for observation or inpatient status, they will be transferred upstairs to a hospital bed. Treatment starts with a typical medical evaluation including whatever testing and procedures need to occur. There seems to be an overarching level of stigma associated with patients admitted secondary to addiction related issues. Despite having a collaborative approach to discharge planning, there is not a consistent intervention related to an addiction diagnosis. This includes a lack of starting patients on MAT and/or assigning them to the appropriate level of care upon discharge. Patients will be continued on MAT if admitted. However, being on buprenorphine or methadone presents significant barriers if the patient needs to be discharged to a skilled nursing facility or sober living facility. During attempts to transition patients to outpatient care issues such as wait lists, insurance barriers and the patient's own readiness to change exacerbate the already complex issues.


Pt comes to PCP appt
Med eval/assessment
Follow up referrals identified?
Coordination of appropriate services for health (BH included)
Wait
Limited CM/SW resource in amb setting
Limited care coordination
No STD screening
No SBIRT
Language barrier
Pt fears to disclose BH needs
Stigma
No co-triage
Provider knowledge of BH & SUD resources
No ambulatory SW, counselors CM

In the ambulatory care setting the patient arrives after having had an appointment made. However, after arrival there is no standard screening, assessment or level of care determination for patients with addiction. There seems to be common issues with language barriers and patient's fear to disclose behavioral health needs. If it is identified that the patient has a SUD, there are no resources for the initiation of MAT and there is a lack of knowledge about what community resources are available for these patients. There is some intensive case management available, however this is inconsistent, and many times not enough given the lack of MAT and poor connection to other resources in the community.

Probation Current State VSM

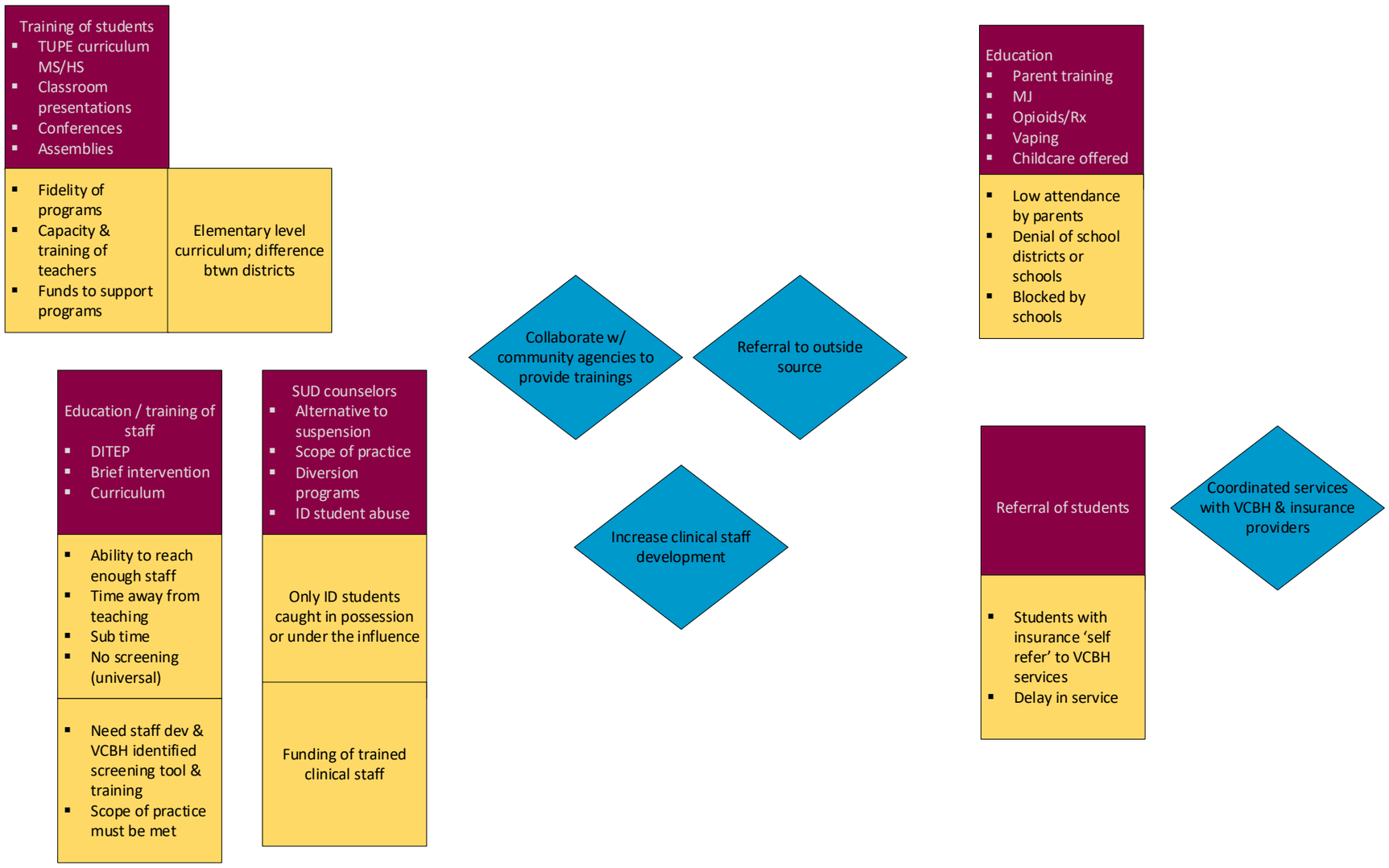


Multiple members of the probation team in Ventura County developed the map of the current state within the probation department. Two primary streams were identified: high risk probation and those assigned to AB109 probation. There are similarities in challenges in each as well as differences. In the high-risk pathway an individual is assigned to probation and may be in or out of custody when the probation department first contacts the individual. At this time an assessment is made of needs and referrals to community services. Barriers identified include having only one probation officer assigned to in custody inmates and a lack of resources, many of which have long waiting lists even if they are available. Out of custody individuals are likewise assessed by a community probation officer. Those with SUD issues are referred to CBOS or VCBH. Unfortunately, they are generally not able to receive MAT services. Other barriers identified include frequent issues with transportation, inability to pay for recommended services, and overall lack of engagement from the individuals on probation.

A second stream identified are those individuals assigned to AB109 probation. Many more services are available for this group, but multiple barriers also exist. Like the high-risk probation group, only one officer is available for all in custody individuals resulting in a very large case load and the need to prioritize cases. Many resources for referral are available including case management, behavioral health and SUD services. For SUD services individuals are referred to VCBH. Naltrexone injection is the only MAT available to in custody individuals while methadone treatment and injectable naltrexone are available to individuals in the community. Different agencies evaluate suitability for and approval of MAT while in custody and in the community resulting in situations where decisions are in conflict. These different criteria result in considerable difficulty in coordination of care.

A final significant barrier identified is an overall lack of understanding of the science of addiction. This is present throughout the system. One example is the heavy reliance on injectable naltrexone for opiate use disorder which does not address dopamine depletion and is not the most appropriate treatment for many individuals. Unfortunately, this is the only MAT treatment offered in most cases.

Education Current State VSM



Interventions for substance use disorders occur at multiple points in the educational system in the current state. These include large scale interventions to students on prevention, education of teachers and school staff on SUD, community education and services for students identified with SUD.

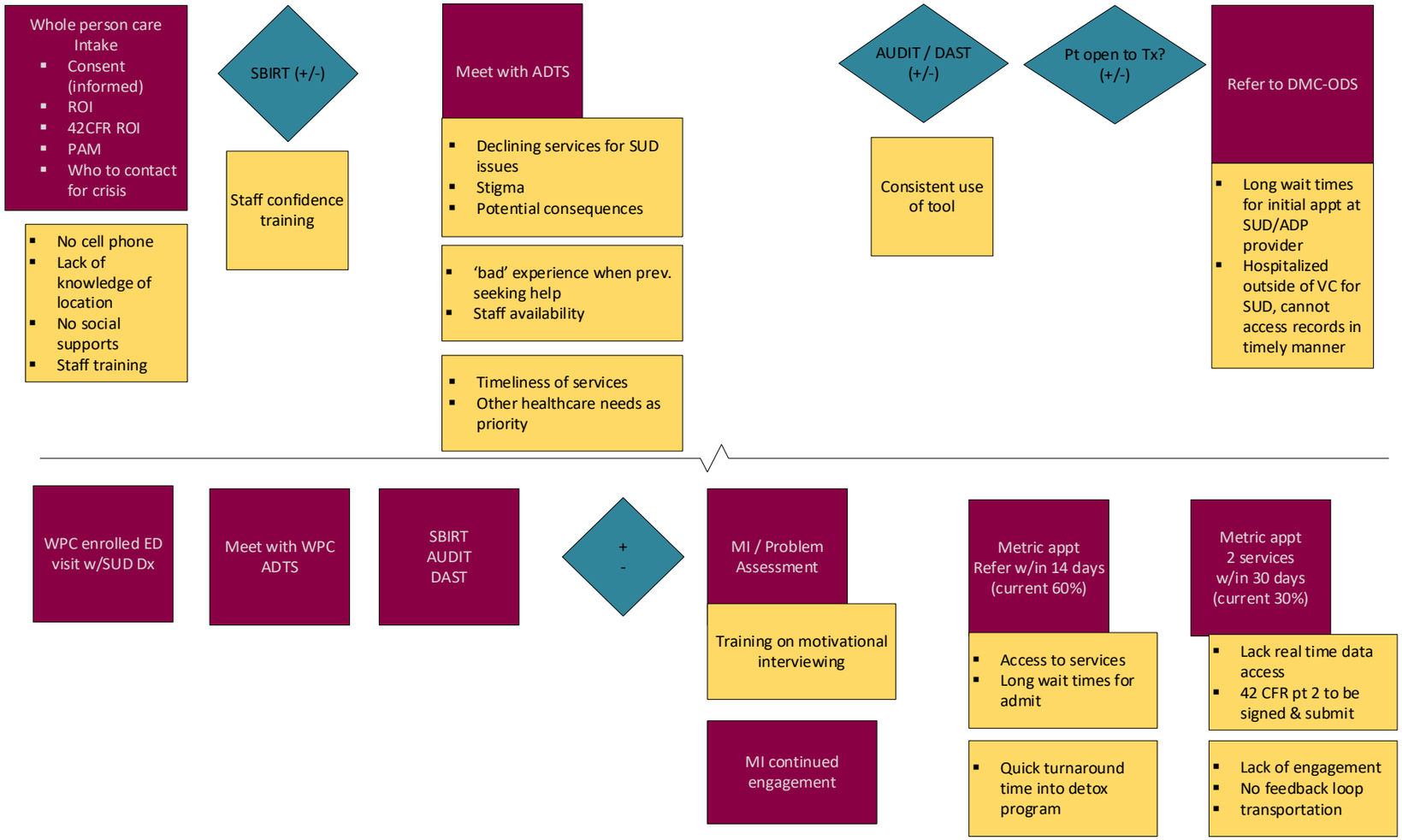
Prevention efforts begin at the middle school level and continue into high school. These programs are offered in most school districts but there is no consistent program and funding is often tenuous as it is typically grant funded education. There are also concerns about fidelity and quality with the decentralized interventions. Additionally, no recommended curriculum is available for the elementary school age group, therefore, no widespread intervention is in place for this group. There are questions about the overall effectiveness of these interventions to the students.

Training is also offered to teachers and other school personnel. This is offered by the county board of education on a wide variety of topics including trauma informed interventions and brief intervention for SUD. Several barriers exist for this group of interventions. Although the training is free the school district still needs to provide substitute teachers to back fill in the classrooms. Currently there are issues of scale and difficulty making the intervention available to enough teachers. Finally, a conflict exists over the scope of practice of teachers in intervention in issues of SUD and this is something that will need further attention going forward.

Community interventions directed at parents are also presented in Ventura County by the board of education. These have included trainings on many topics including marijuana, opioids, and vaping. School districts often make childcare available, so parents can attend. Barriers have included very low attendance by parents and resistance by school districts to allow these interventions as they either feel the issues do not exist in their community or they do not want to draw attention to the issues.

SUD counselors are available in most school districts to serve as an alternative to suspension from school. Challenges for these counselors include that they are typically only involved when a student is caught in possession or comes to school under the influence of a substance. They have also had difficulty coordinating care with both VCBH and private insurance carriers to arrange treatment. These counselors also have goals of limited assessment and intervention and do not have the training or scope of practice to provide more comprehensive treatment. As with the other areas of intervention funding of these positions remains an ongoing challenge.

Ventura County Whole Person Care Current State VSM



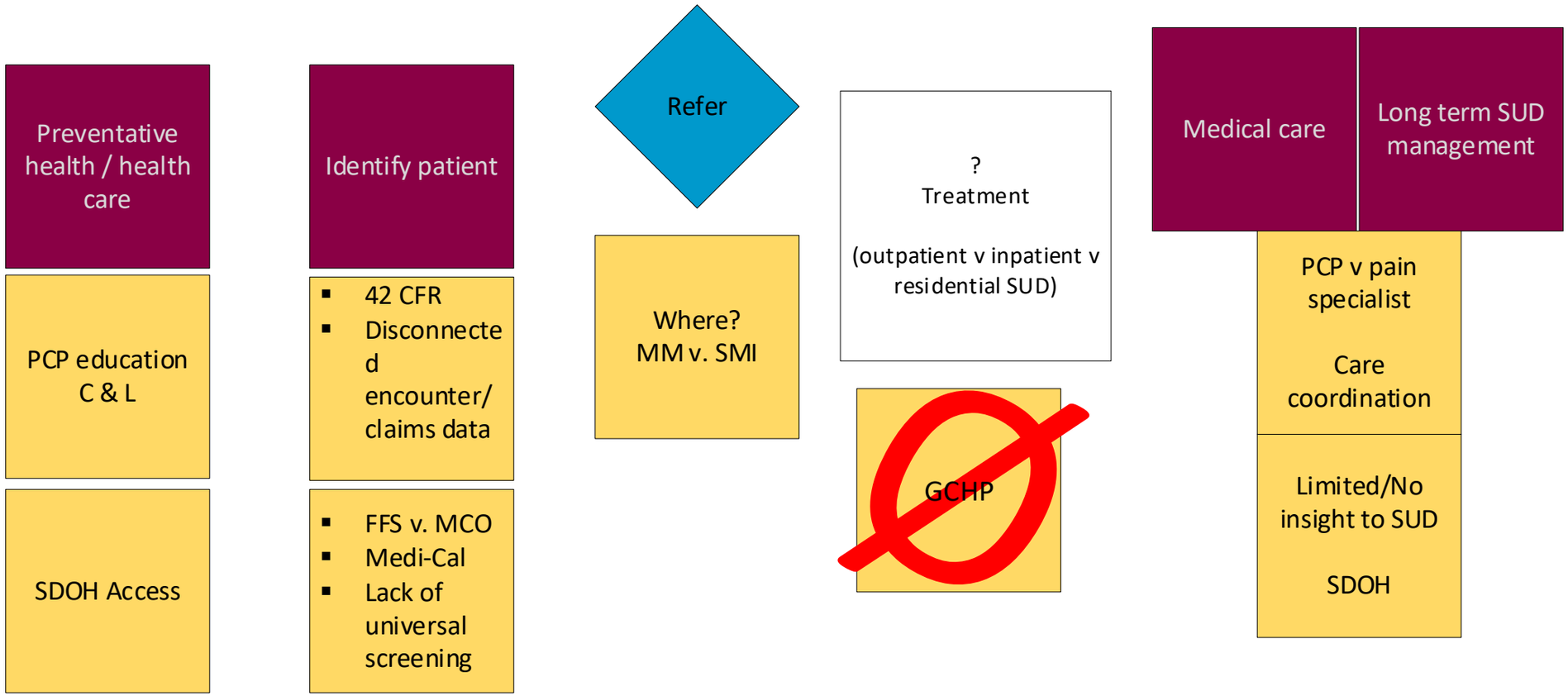
The Ventura County Whole Person Care (WPC) program works with complex high-needs participants (patients) that require a lot of health care services and case management. The program works to connect enrollees with services, focuses on the reduction of Emergency Department (ED) utilization, and aims to improve the overall health outcomes of complex patients.

The WPC program can receive referrals from both the community and providers within the health care and county social service systems. Referrals come from both hospitals and CBOs. Patients who have four or more ED visits and/or two or more hospitalizations are referred to the WPC program for assistance.

WPC participants have two intake appointments in the program. During the initial WPC intake appointment, the program receives full consent from the participant and has the participant provide a release of information that includes a release of BH and SUD related information. The release of information allows the WPC program to coordinate with other healthcare providers and CBOs. Program participants receive an orientation to the program and contact information for who to call for crisis services. Most program participants are hard to contact, lack a physical street address and telephone/cell phone makes connecting with participants difficult. Participants tend to have few social and family supports. During the second intake visit a more detailed assessment is performed capturing additional client-specific information. Participants who identify a SUD issue will meet with an Alcohol and Drug Treatment Specialist and are screened with a Drug and Alcohol Screening Test (DAST) assessment. If they have a positive DAST screening, they are referred to a Drug Medi-Cal Organized Delivery System (DMC-ODS) program for services. An average of 60% of all participants are connected to DMC-ODS services within 14-days of screening. It is difficult getting participants to their appointments, and there are long wait times for treatment programs, however, turnaround time is quick for detox program admission.

There is a lack of real-time data access for information. Participants often do not follow-up with their providers. Only 30% of participants follow-up on their treatment plan goals.

Gold Coast Health Plan Current State VSM



Gold Coast Health Plan is Ventura County's single Medi-Cal County Operated Health System (COHS) Health Plan. Gold Coast Health Plan doesn't directly provide behavioral health and SUD treatment services to its members; instead they contract with Beacon Health Options to provide mild to moderate behavioral health services to health plan members. The treatment of SUD and Severe Mental Illness (SMI) is coordinated by VCBH.

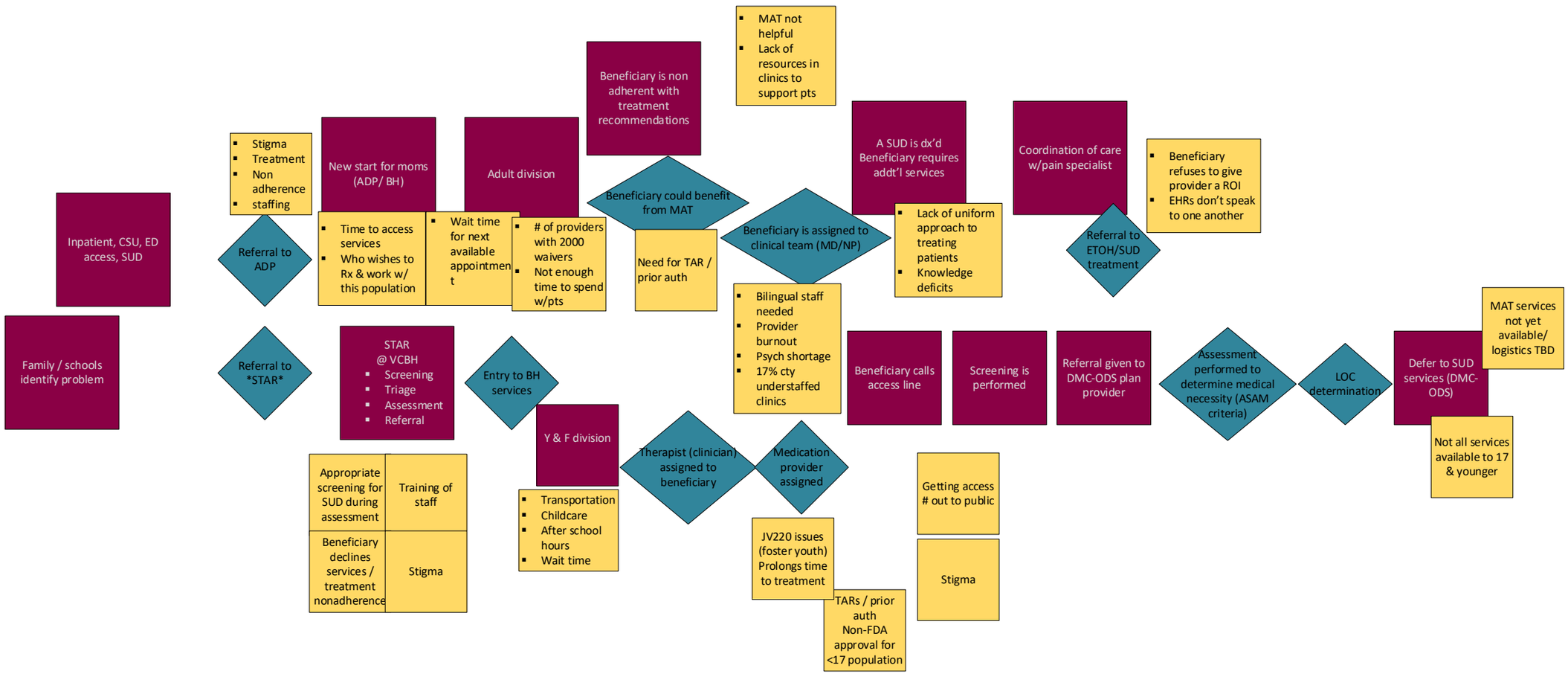
Gold Coast struggles in coordinating SUD and behavioral health services for its members as both services are carved out of the health plans physical health services and provided by separate organizations. SUD services are provided by both Beacon Health Options and VCBH. The determination of which entity provides the services can be difficult. Beacon provides mild to moderate behavioral health services and limited SUD prevention services. They perform initial screenings using SBIRT but often have to refer the patient to VCBH for more intensive services. This disconnect makes it difficult for Gold Coast and its providers to coordinate the physical health care needs of plan members who have SUD and behavioral health needs. It is also hard to get health plan members into the county systems when they need to see a SUD or behavioral health provider(s) for treatment. Physical health providers struggle in coordinating their patient's care within these separate systems.

The level of member education provided by physical health providers can vary. Providers struggle with educating their patients in all the important aspects of information and service coordination requirements related to the various behavioral health and SUD related programs. Providers also struggle to address the education about behavioral health and SUD services because of the limited time they have with patients during office visits. There are also cultural issues and barriers related to addressing the social determinants of health and perceptions and stigma related to needing behavioral health and SUD services.

Data limitations and sharing of information also make it difficult for both Gold Coast and its providers to coordinate care with the perceived restrictions and silos related to the sharing and receiving of behavioral health and SUD data at the patient level. There is limited information available at the state level within the fee-for-service utilization data shared with health plans. Restriction related to sharing of information related to 42 CFR Part 2 and accessing coordinated data exists none the less. There are also limitations within the screening process; the county and health plan do not use or share a standard universal screening tool, and there is not a clear access point at which people can enter the system. The access points can vary based on where a member receives services. Access points can include the health plan, Beacon Health Options, or VCBH. There is no clear navigation of services amongst the three entities. Gold Coast is not always aware that their members are receiving behavioral health and/or SUD treatment as the systems are separate and utilization data is limited. This barrier creates issues when a member is discharged or transitions to a different level of care within the system.

Gold Coast is not aware of what long-term treatments are available to members. There may be a long-term treatment available for behavioral health and SUD conditions, but the health plan has little to limited insight into the available services and their member's plan of care for such services. When a health plan member is on MAT, the PCP may not want to treat the member's SUD related issue or may be limited in doing so by not having an X waiver to prescribe and treat patients on MAT. The health plan struggles in coordinating the care of members who have behavioral health and SUD conditions.

Ventura County Health Care Agency Ambulatory Psychiatric Care Current State VSM



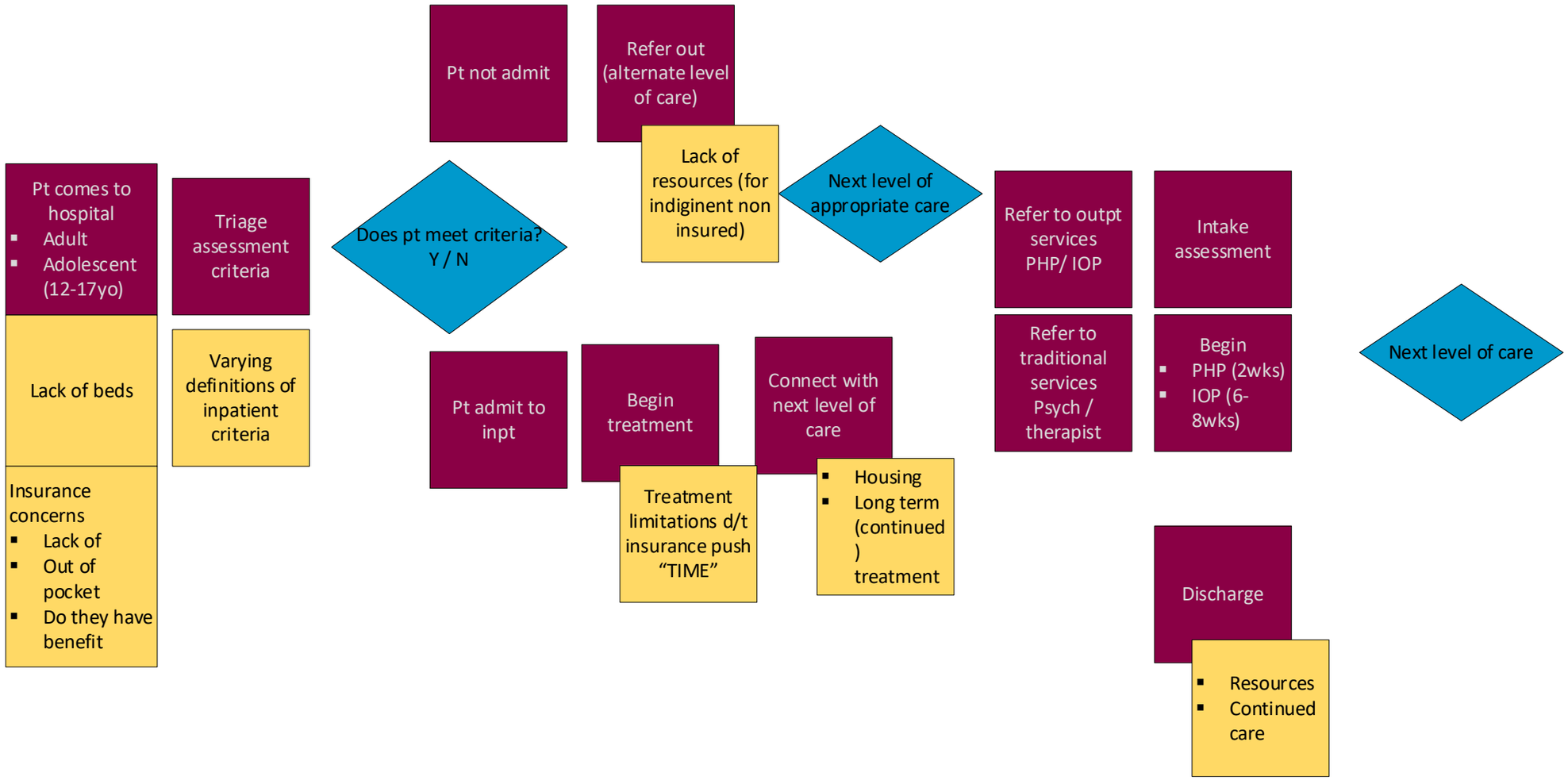
Youth and Family

Patients can be referred by family, from schools or from an inpatient facility for all outpatient services. There is also a direct referral route through STAR unite, however, there is no centralized area to go to for identification of the proper resources. Once a referral is made, an assessment is done to determine if they are eligible to receive services. It was identified that the staff would need more training in order to be able to do a thorough SUD assessment. Sometimes the beneficiary will decline the full assessment or youth will come into the youth and family division and has significant issues with transportation, childcare or need to have some availability after school, which does not occur. Wait time to get in is quite extensive and the initial provider seen is unable to provide any MAT if warranted. Any child under the Medi-Cal kids program needs a TARS or prior authorization in order to take any medications. This is made even more difficult given that medications for the treatment of SUD are rarely FDA approved for people under 17. There is an access line they can call if they have additional needs, however, the call usually ends in a further referral and need for a different assessment for the client to be able to obtain consistent services. If the patient is identified as needing services for SUD, there are significant gaps in the levels of treatment for adolescent patients. Overall, the approach to adolescents through the service line seems to be relatively convoluted, filled with redundancy with no trackable outcomes.

Adult division ADP VCBH

Referrals can come from multiple sources including acute care and psychiatric hospitals, the county Crisis Stabilization Unit, outpatient clinics and individuals who walk in. At this point the individual is screened and a determination is made of the most appropriate treatment facility. This process is very lengthy, at times being up to eight hours of assessment. Considerable variability exists between different evaluators and the overall value of this level of assessment is questioned at times. This long process results in up to 50% drop out during the assessment process. Significant co-occurring SPMI also complicates the process. There is considerable variability of whether MAT is offered as some clinicians have waivers and others do not. Another barrier was the lack of availability of UDS testing. The program had hoped to start consistent outpatient MAT by December 2018 after the beginning of DMC-ODS but that did not occur due to a lack of physician participation. They anticipate it may be another several months at least until they are ready to ramp up providing this service. Currently there are multiple barriers surrounding difficulty getting approvals for recommended treatment without the patient failing a different treatment first. An overall lack of consistency in knowledge base of providers was also identified. A final significant barrier involves coordination of information. A lack of electronic health record (HER) integration exists as well as a lack of consistent release of information policies and forms.

Vista Del Mar Inpatient Psychiatric Care Current State VSM



The Vista Del Mar inpatient psychiatric facility is in the process of recovering from a devastating fire that destroyed most of the facility. Given the length of time it is taking for full recovery of the institution, many of the employees had to seek other means of employment. From this, approximately 250 seasoned staff have left the facility with only ¼ of those returning. Most patients are referred from the hospital inpatient, crisis center, or the emergency department. There is a significant lack of bed availability given that the facility used to have 87 beds and now only has 55 beds. Many times, insurance can dictate the type and length of treatment which creates a large amount of paperwork and inconsistent approaches to care for patients. Upon arrival the patient is triaged and assessed, and if they meet the medical criteria for inpatient care, treatment will be started. However, there seem to be varying definitions of eligibility based on which insurance the patient has or which provider the patient is seeing. The length of stay varies anywhere from two to seven days for most patients. If the patient is determined to need discharge to intensive outpatient treatment there are challenges with housing given that most do not accept patients on MAT. There are many pathways that require a "fail first" model for patients to receive a higher level of care. Given the lack of consistent housing, transportation and access to identifiable community services patients will have multiple disruptions in their care delivery. There are currently no means of tracking whether patients referred to follow-up services were ever seen, evaluated or continued in care.

C. 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 Ventura County to address addiction, stakeholders agreed there were many challenges that cut across structural barriers and inefficiencies, as well as stigma, lack of funding, siloed systems, complex or prohibitive payer issues, and capacity and skill deficiencies. While the range of barriers within the existing addiction treatment system varied depending on the stakeholder, there was broad consensus about many of them, and overall everyone agreed the challenges were great in number.

Full Group Barrier Discussion #1

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

Integration

- Separation in funding streams and approach between prevention and treatment, funding mechanism continually supports prevention, schools have difficulty seeking out funding
- No common language between systems, private industry, need them in the dialogue
- Not currently looking at ACEs from an early age and attaching to medical records, screening

Capacity

- Lack of housing, jobs after receiving services
- Follow up care- what happens after 6 months or a year, when patients are cut off
- Inadequacy of workforce, lacking capacity to sustain work moving forward
- No school-based health clinics in Ventura
- Childcare

Policy

- 42 CFR releases very limiting, get calls all the time and it would be great to call a provider to see them but can't
- Impact of HIPAA in delaying care, SUD is a carve out, hard to integrate into current available systems such as PCMH
- Reimbursement- social determinants are a big factor, but not recognized in MCO reimbursement

Culture

- Partners not at the table- need to engage people not in the room e.g. hospitals
- Need to ensure workforce is reflective of community, language is a huge barrier in Ventura, need to increase cultural sensitivity in workforce
- Stigma- how to educate community on recalcitrant stigmatization

Consolidated Barriers and Gaps

The first discussion described above heavily informed stakeholders as they met up at 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 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
Ventura County Behavioral Health	9	10	2	5	1	1	1	2		1	1
Ventura County Public Health	7	3	2	3	2	1	1	1	1	1	
Tarzana Treatment Centers				1	3					1	
Aspiranet		2	4	1	1	1					
Tarzana Treatment Centers	1	1	4	2	4		1			1	
Health Care For The Homeless MAT Clinic		2	2	2	1	1					
AEGIS Treatment Centers		1	1	3	1		2	7		1	
Whole Person Care	3	5	1	1	3	1	1	4			
Sterling Psychiatric Group	6	5		5	1	2	3	2			1
Vista Del Mar Inpatient Psychiatric Care	1			2		1		1		3	

Community Memorial Health System		9	3	7	3	1	4			1	1
Gold Coast Health Plan	3	2			2	1		2			
Aspiranet			3		2		1	2			
Probation	2	5	3	7	2	2	1	3			
Education	1	2		3	3	2	1		3	1	

Full Group Barrier Discussion #2

After reflecting on the many identified barriers on the first day, the group came together again on the second day to discuss solutions. They brainstormed ways to overcome barriers in integration, capacity, policy, and culture.

Integration

The group discussed many strategies to improve integration in the addiction treatment system in Ventura County. Suggestions included focusing more efforts on high-cost, complex patients, co-locating behavioral and physical health care services, increasing awareness of services across the County to ensure a "no wrong door" approach to care access, and implanting school-based health clinics. Participants also expressed a need for consistency across the system in terms of screening protocols, release of information and information sharing, policies on scope of practice and delivery of care, and knowledge and competency of staff for treating addiction.

Capacity

The group expressed a need for workforce development strategies across Ventura County to not only recruit more providers, but also to train existing providers to increase capacity to treat addiction appropriately and discussed a need for group trainings and classes with a certification for current staff. Participants also discussed ways to recruit more providers, including creative funding strategies such as public-private partnerships and grants to finance incentive programs.

Policy

Based on new 42 CFR Part II regulations soon to be released, participants discussed effective ways to have a central release of information, including switching from an "opt-in" form system to an "opt-out". The group also discussed ways to reimburse for services that address social determinants of health and explored the idea of working with County and City governments to improve the public transportation system in order to improve access to care.

Culture

Many participants expressed a need for group trainings in the County to improve the cultural competency of providers. In terms of addressing stigma, the group discussed

the importance of language training for providers, and the role that law enforcement can play in reducing stigma in terms of diversion to treatment and using naloxone. Finally, the group brainstormed a list of stakeholders who were not in attendance as a priority to engage:

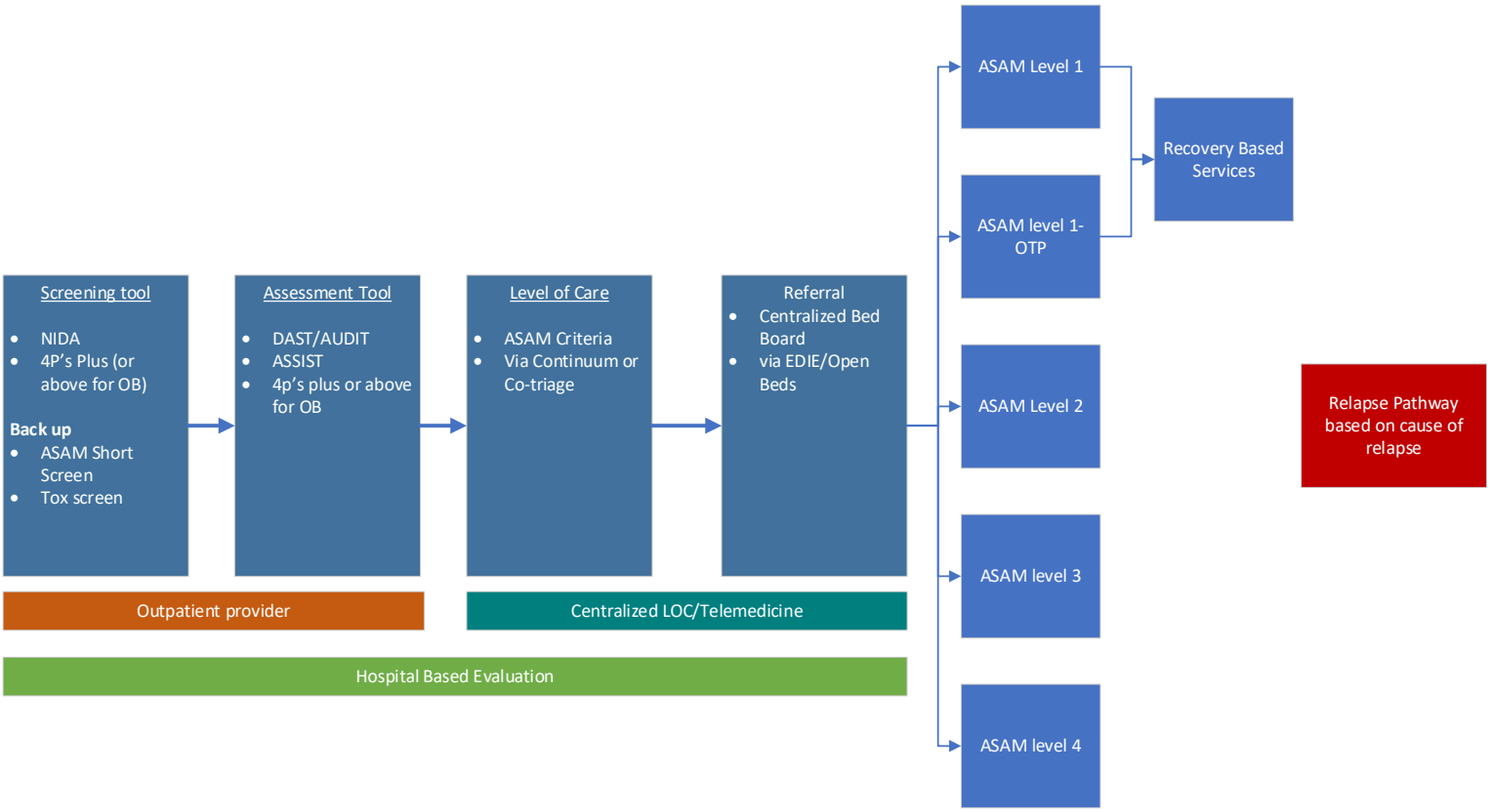
- Community collaborative conducting a shared needs assessment (includes Clinicas del Camino Real, Community Memorial, etc.)
- Prototypes Women's Center
- Lighthouse (faith-based organization)
- Kheppra House
- Salvation Army
- Rain Project
- City Center
- Casa Pacifica
- Interface
- Drug Court, Public Defender, DA, courts, sheriff, city police departments
- Hospitals, 2 with addiction medicine fellowship programs: VCMC
- Los Robles Regional Medical Center, Adventist Health Simi Valley
- Ambulatory health clinics
- Private businesses, business associations
- People with lived experience
- Advocacy groups: Mixteco Indigena Community Organization Program (MICOP)
- Dignity Health-St. John's RMC
- Tri-Counties Regional Center
- Clinicas del Camino Real (FQHC)
- Ventura County Healthcare Agency
- PAC-LAC
- Human Services: Child Welfare

D. Triggers

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

E. 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 Ventura County.

After each provider group developed a current state map, HMA deconstructed the maps into their basic components. Those basic components for all provider groups came down to identifying which patients to screen, screening patients, assessing patients, doing a level of care determination for patients, placing patients, treating patients and maintaining patients in recovery. As we started to delve further into 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 several 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. Adopting the NIDA 4 screening tool for general populations and the 4 P's screening tool for pregnancy was agreed upon. For assessment purposes, a combination of the DAST and AUDIT or the ASSIST was chosen. The state mandated level of care determination tool is the ASAM criteria. 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 amount of information provided and discussion about who is conducting screenings. HMA 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 1.5 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 trigger, an ASSIST could be done with the long screen done telephonically. However, all locations could adopt the practice of administering the ASAM CO-Triage allowing for a provisional level of care.

After the patient's level of care has been identified the next step would be placing them into the appropriate program. In the current state this would require several 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, 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.

03 Section 3: Implementation Strategy

A. Next Steps

In a matter of two days stakeholders from across Ventura 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 "scaffolding". 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 individuals and institutions who deliver care or are otherwise vested in addiction treatment in Ventura 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. Stakeholders also discussed the importance of including missing stakeholders as an important next step in moving forward. In closing dialogue to identify the priorities for action, there was consensus the stakeholders 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 Ventura 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 with HMA can provide coaching and input on this)
- Develop shared standards for using action plans for community members in crisis
- Get buy in from upper level decision makers-share draft report with those in leadership and invite them to contribute
- Approach business community, health care systems as partners
- Build strong bridges between systems to make this truly collaborative
- Identify important codes to increase reimbursement

Participants supported the idea that VCBH will "own" this effort and serve as the central purveyor of information to key stakeholders and outreach to stakeholders not in attendance at the event, including but not limited to other SUD providers, Ventura County Medical Center C Suite, health care agency CMO, addiction specialists in residency and training programs and family medicine.

B. Technical Assistance Program

Prior to the process improvement event, we collaborated with the VCBH to develop an attendee list and conduct outreach to invitees to encourage attendance. Also prior to the event, the VCBH completed a survey to document existing substance use disorder (SUD) capacity and resources in Ventura 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.

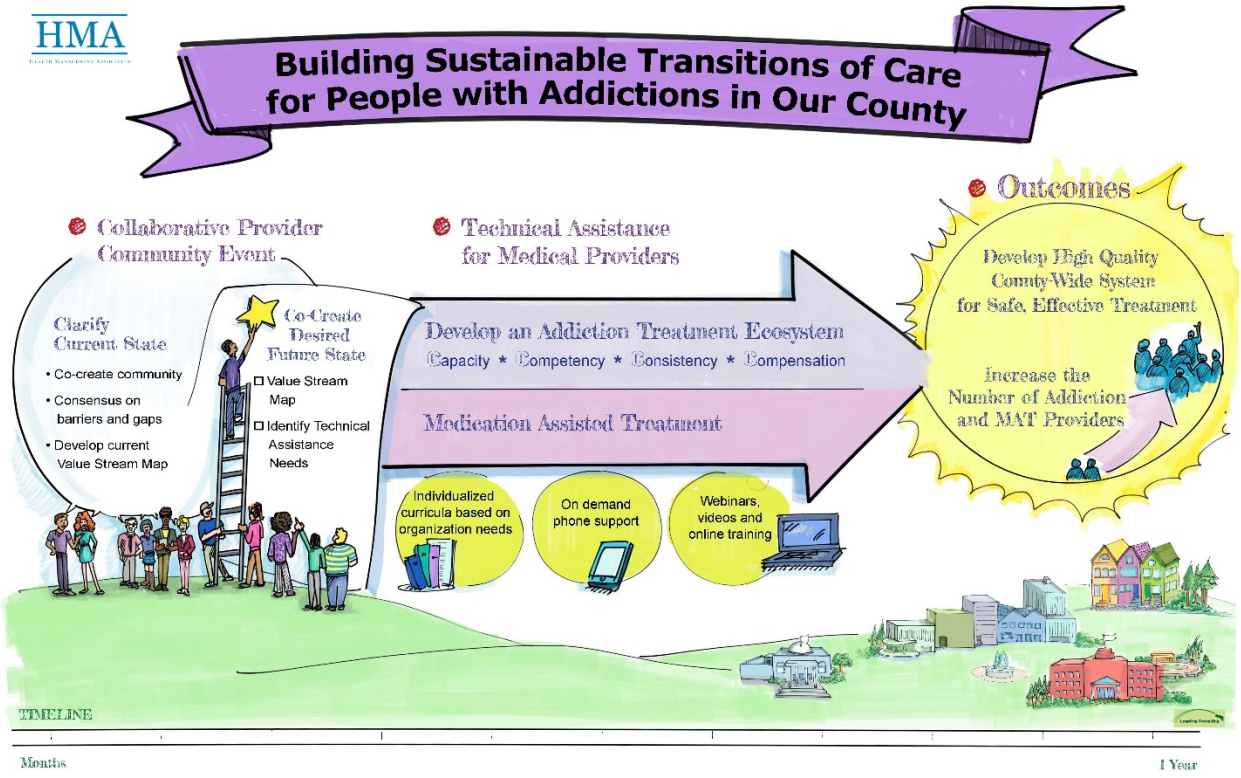
The following 17 organizations and one independent provider applied for TA:

- Hospital Association of Southern California
- Ventura County Public Health- Community Health Nursing
- Ventura County Public Health- HIV/ AIDS Program
- Community Memorial Health System
- AEGIS Treatment Centers
- Ventura County Behavioral Health
- Ventura County Office of Education
- Ventura County Probation Agency
- Aspiranet
- Vista Del Mar Hospital
- Evalcorp
- UCLA Center For Healthier Children
- Health Care For The Homeless MAT Clinic
- Gold Coast Health Plan
- Ventura County Overdose Prevention Program
- Ventura County Health Care Agency- Whole Person Care
- Sterling Care Psychiatric Group

The 17 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.	15
Improve our role in managing the transitions of care as residents in our community move within addiction system of care.	15
Learn more about caring for people with addiction and provide more information and training to our staff.	14
Scale up our current MAT program by increasing the number of patients treated.	7
Learn how to provide or improve addiction treatment to pregnant and parenting women.	10
Start providing MAT services at our organization.	6

C. Conclusion



In conclusion, HMA thanks the Ventura County community who turned out with their hearts and minds committed to this work. We hold the deep conviction that the Ventura 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 Ventura 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. Ventura County Data

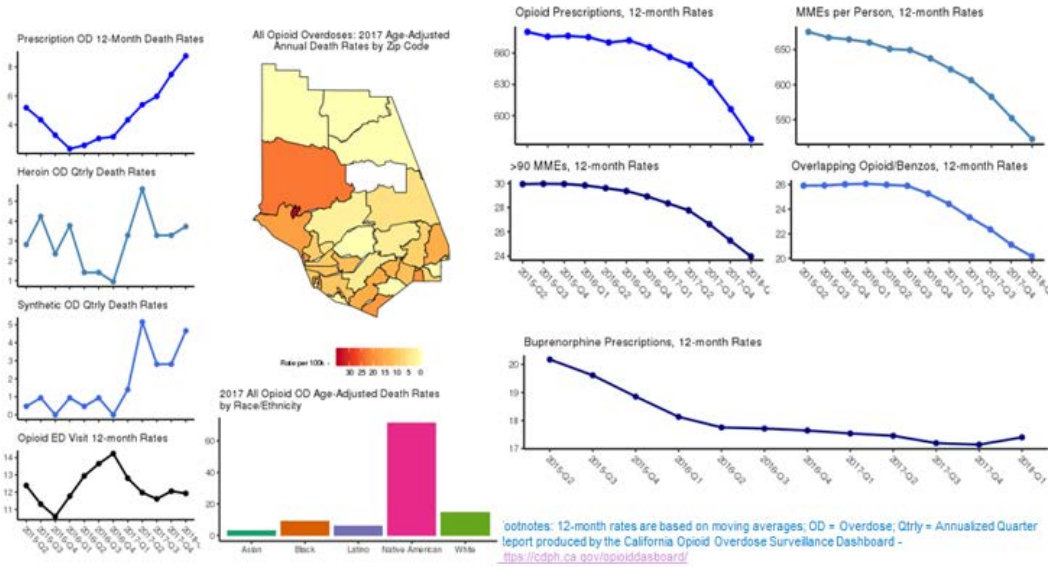
Ventura County: Southern CA, Population 823,318

ADDITIONAL FACTORS

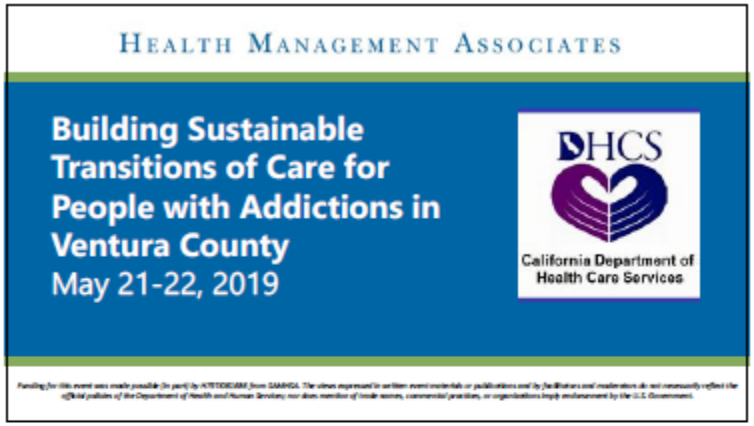
- Coalition: Ventura County Prescription Drug Abuse Workgroup
- SAMHSA Funds: $578,750
- Drug Medi-Cal Organized Delivery System? Yes
- Presence of CA Bridge: Yes

STATISTICS

- OUD Death Rate
  - 2017: 9.8, Rank 1/9
  - 2016: 5.0, Rank 6/9
- All Drug Death Rate
  - 2017: 16.5, Rank 2/9
  - 2016: 12.4, Rank 5/9
- ED Opioid Rate
  - 2017: 35.4, Rank 4/9
  - 2016: 29.6, Rank 4/9
- 8 Hospitals
- 174 Pharmacies
- 2 FQHCs
- Methadone Pt Rate 202.4: Rank 9/58



B. Process Improvement Event Slides



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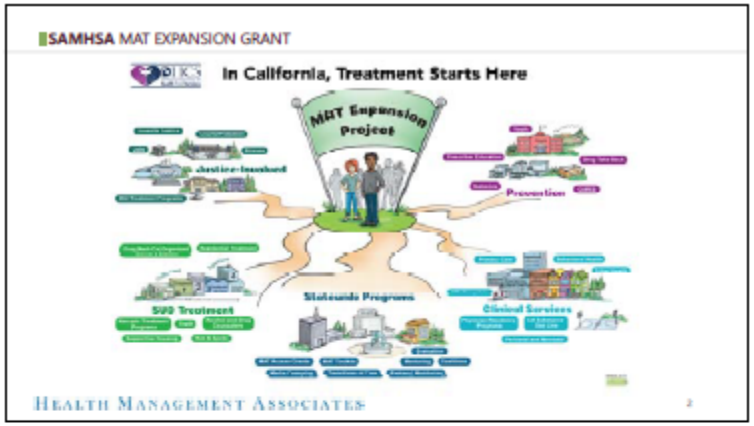

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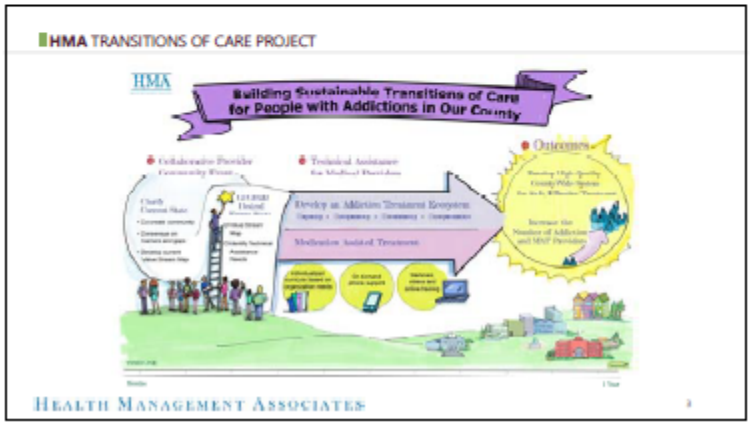

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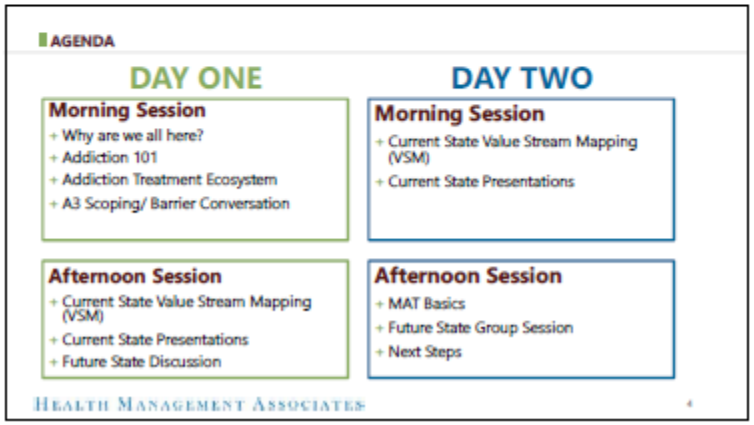

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TECHNICAL ASSISTANCE PROGRAM PLANNING GOALS

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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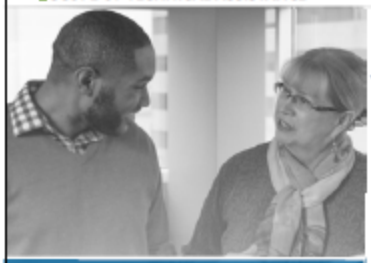
SCOPE OF TECHNICAL ASSISTANCE



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

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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

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VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

May 21, 2019

OPIOID TRANSITIONS EVENT

DHCS Training

Dr. Loretta L. Denering, DrPH, MS
Division Chief, Alcohol and Drug Programs

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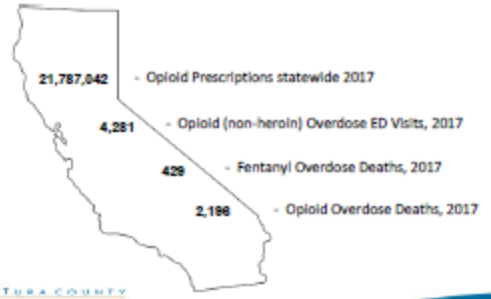
Overdose Prevention Program



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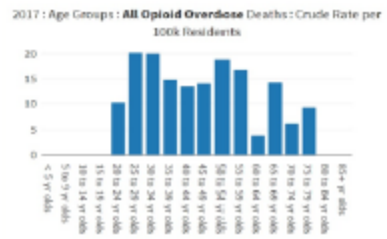
Local Landscape – Fatal ODs per 100k



VENTURA COUNTY BEHAVIORAL HEALTH

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A Two-Fold Problem

VENTURA COUNTY BEHAVIORAL HEALTH

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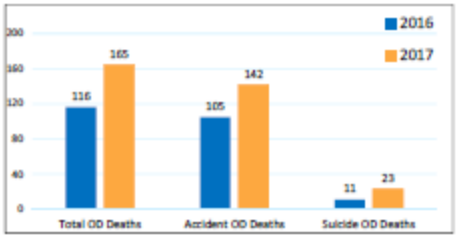
VC Medical Examiner Drug Death Comparison



VENTURA COUNTY BEHAVIORAL HEALTH

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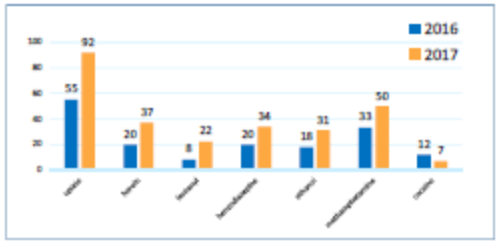
VC Medical Examiner Drug Death Comparison



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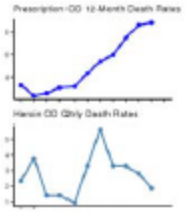
Overdose Rates – Heroin vs. RX

Ventura County Overdose Snapshot: 2015-Q4 to 2018-Q3



- In 2017, Ventura County ME Office recorded 92 deaths due to opioid-related overdoses.
- The annual crude mortality rate was 10.7 per 100k residents. This represents a 112% increase from 2015.*
- The charts present 12-month moving averages and annualized quarterly rates for selected opioid indicators.*

*Source: CA Dept. of Public Health, Opioid Dashboard

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Overdose Prevention Program - Ventura

- **Launched in 2014** through the county's Rx Abuse & Heroin Workgroup to reduce opioid-related deaths at a local level.
- **Addresses the epidemic** locally, providing response training and rescue kits.
- **Targets individuals** with an elevated risk of OD or those likely to come into contact with someone at risk.
- **Generates actionable data** from substance users, their families and key public agencies for use in refining efforts.
- **Expanding and adapting** to better respond to changing risks and realities.

VENTURA COUNTY BEHAVIORAL HEALTH

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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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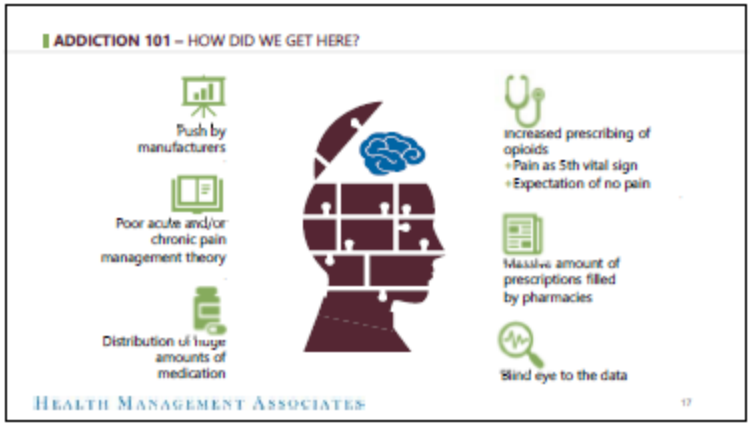
ADDICTION 101 – HOW DID WE GET HERE?
Push by manufacturers
Poor acute and/or chronic pain management theory
Distribution of huge amounts of medication
increased prescribing of opioids
+Pain as 5th vital sign
+Expectation of no pain
Massive amount of prescriptions filled by pharmacies
Blind eye to the data
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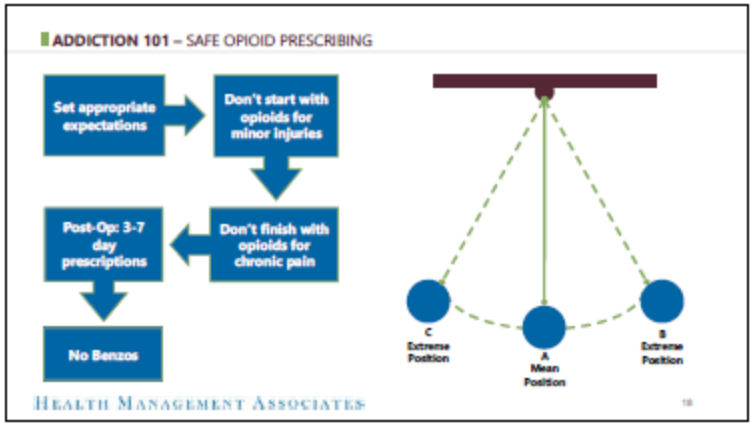
ADDICTION 101 – SAFE OPIOID PRESCRIBING
Set appropriate expectations
Don't start with opioids for minor injuries
Don't finish with opioids for chronic pain
Post-Op: 3-7 day prescriptions
No Benzos
C Extreme Position
A Mean Position
B Extreme Position
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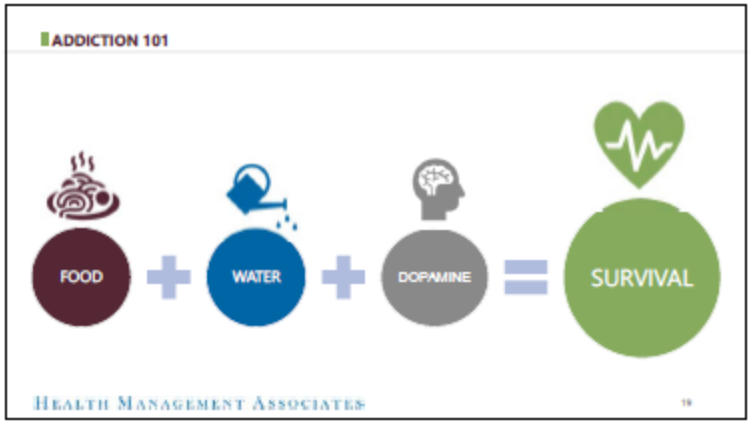
ADDICTION 101
FOOD
WATER
DOPAMINE
SURVIVAL
HEALTH MANAGEMENT ASSOCIATES
19

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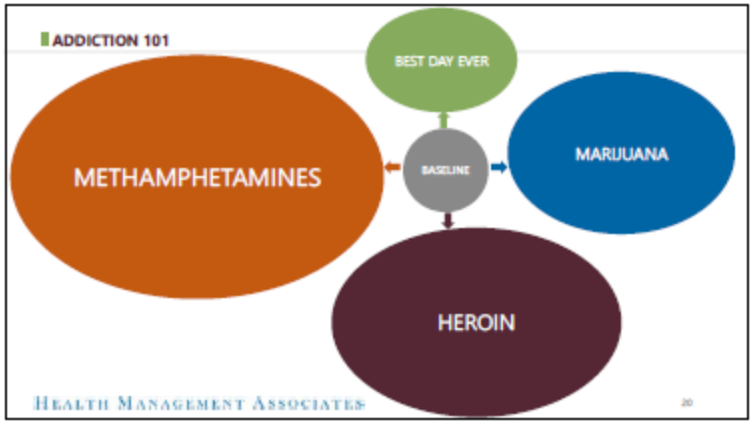
ADDICTION 101
BEST DAY EVER
METHAMPHETAMINES
BASELINE
MARIJUANA
HEROIN
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20

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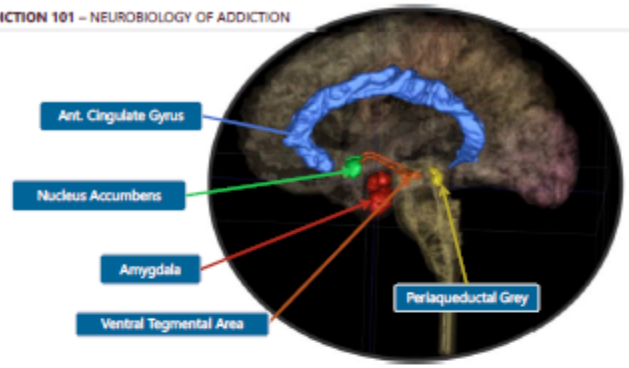
ADDICTION 101 – NEUROBIOLOGY OF ADDICTION



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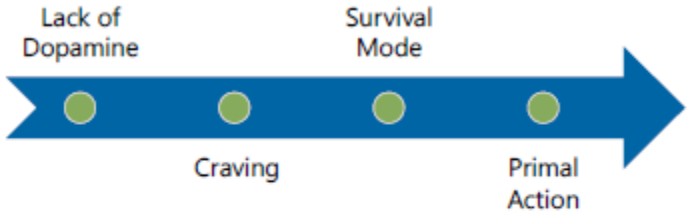
ADDICTION 101 – BEHAVIOR



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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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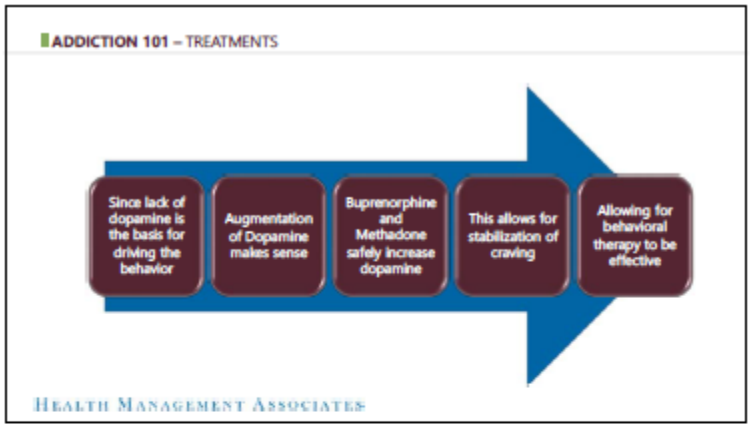
ADDICTION 101 – TREATMENTS
Since lack of dopamine is the basis for driving the behavior
Augmentation of Dopamine makes sense
Buprenorphine and Methadone safely increase dopamine
This allows for stabilization of craving
Allowing for behavioral therapy to be effective
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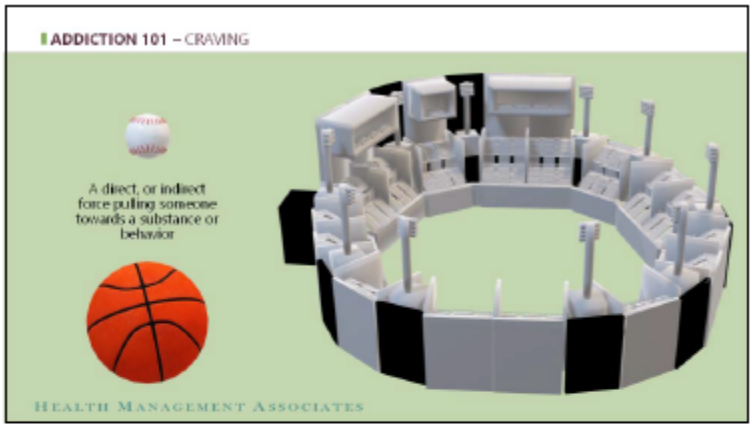
ADDICTION 101 – CRAVING
A direct, or indirect force pulling someone towards a substance or behavior
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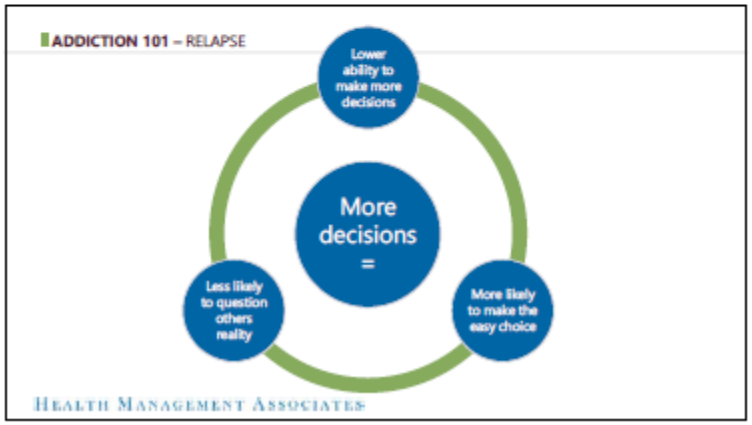
ADDICTION 101 – RELAPSE
Lower ability to make more decisions
More decisions =
Less likely to question others reality
More likely to make the easy choice
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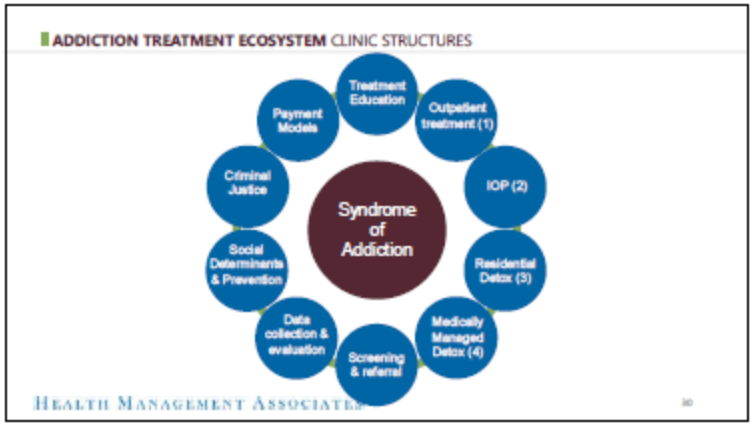
ADDICTION TREATMENT ECOSYSTEM CLINIC STRUCTURES
Treatment Education
Outpatient treatment (1)
IOP (2)
Residential Detox (3)
Medically Managed Detox (4)
Screening & referral
Data collection & evaluation
Social Determinants & Prevention
Criminal Justice
Payment Models
Syndrome of Addiction
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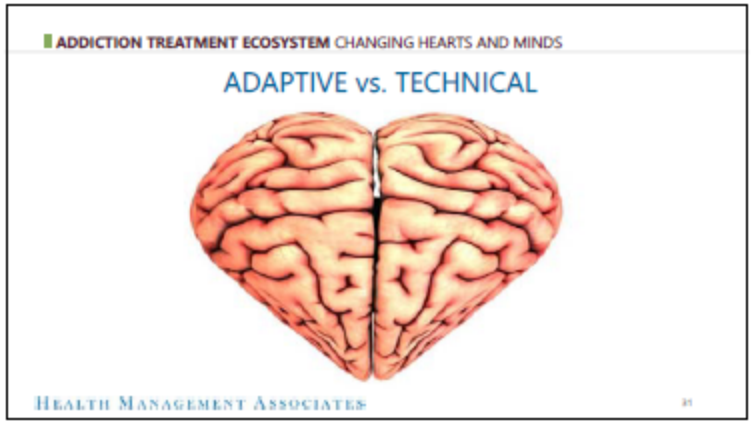
ADDICTION TREATMENT ECOSYSTEM CHANGING HEARTS AND MINDS
ADAPTIVE vs. TECHNICAL
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ADDICTION TREATMENT ECOSYSTEM IMPLEMENTATION
Capacity
Competency
Consistency
Compensation
Community
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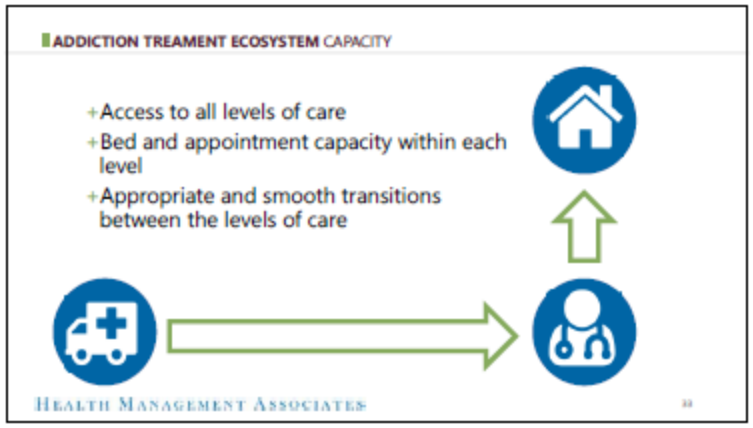
ADDICTION TREAMENT ECOSYSTEM CAPACITY
+Access to all levels of care
+Bed and appointment capacity within each level
+Appropriate and smooth transitions between the levels of care
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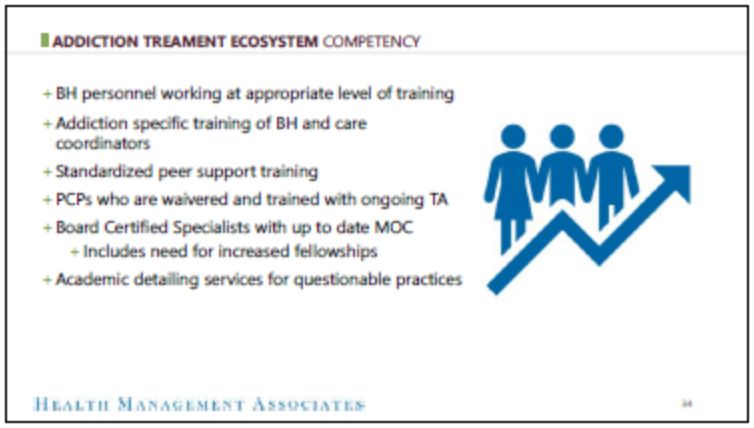
ADDICTION TREAMENT ECOSYSTEM COMPETENCY
+ BH personnel working at appropriate level of training
+ Addiction specific training of BH and care coordinators
+ Standardized peer support training
+ PCPs who are waivered and trained with ongoing TA
+ Board Certified Specialists with up to date MOC
+ Includes need for increased fellowships
+ Academic detailing services for questionable practices
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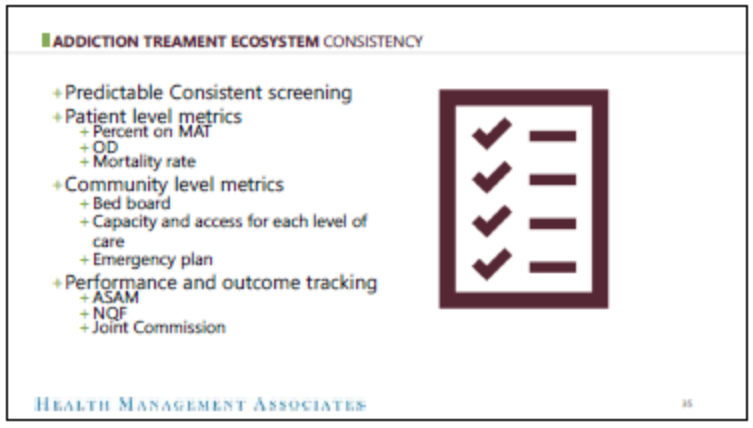
ADDICTION TREAMENT ECOSYSTEM CONSISTENCY
+Predictable Consistent screening
+Patient level metrics
+ Percent on MAT
+ OD
+ Mortality rate
+Community level metrics
+ Bed board
+ Capacity and access for each level of care
+ Emergency plan
+Performance and outcome tracking
+ ASAM
+ NQF
+ Joint Commission
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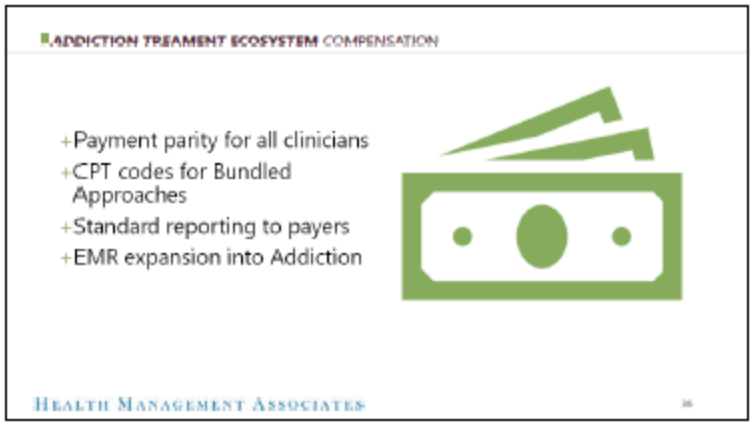
ADDICTION TREAMENT ECOSYSTEM COMPENSATION
+Payment parity for all clinicians
+CPT codes for Bundled Approaches
+Standard reporting to payers
+EMR expansion into Addiction
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ADDICTION TREAMENT ECOSYSTEM COMMUNITY

- 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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SCOPE

WHO IS IN AND WHO IS OUT?

HEALTH MANAGEMENT ASSOCIATES

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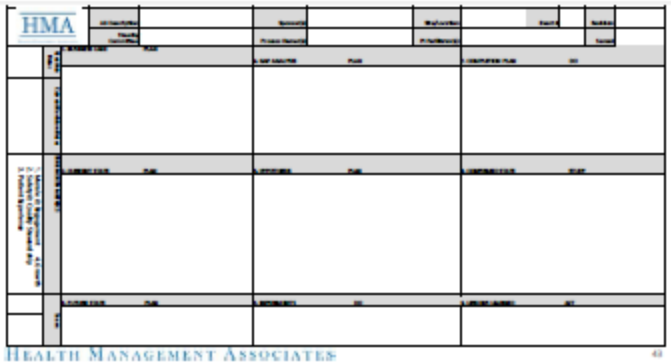
A3 BARRIER AND SCOPING



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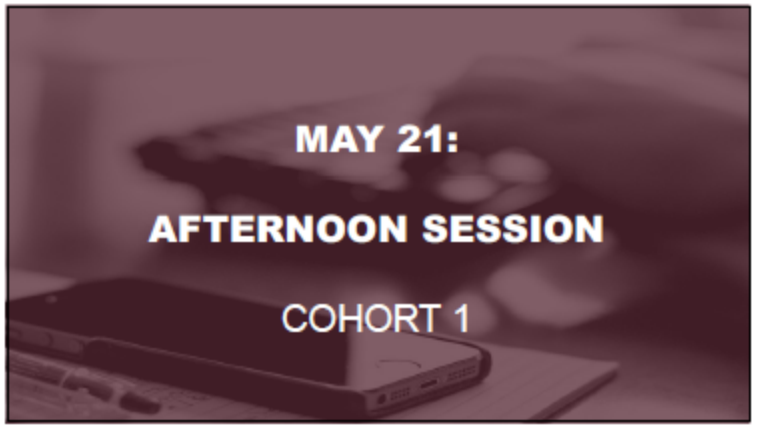

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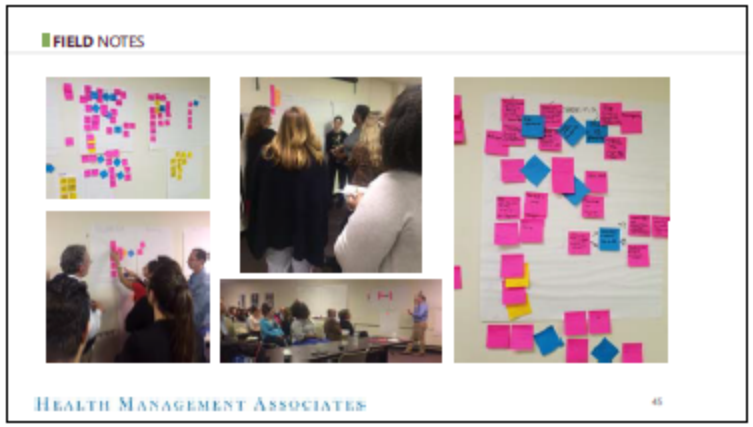
FIELD NOTES
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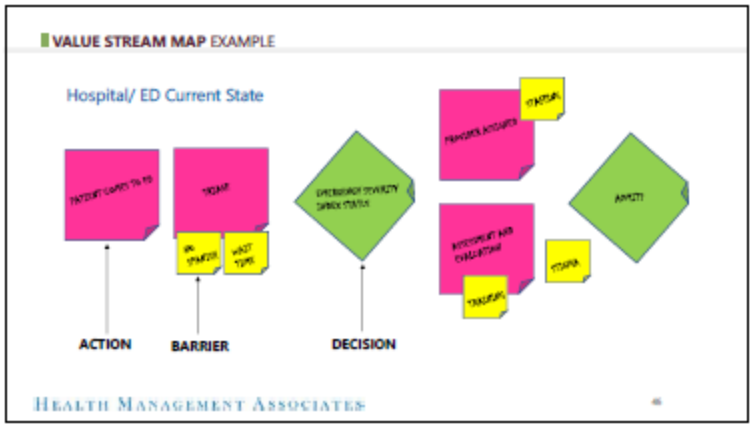
VALUE STREAM MAP EXAMPLE
Hospital/ ED Current State
ACTION
BARRIER
DECISION
HEALTH MANAGEMENT ASSOCIATES

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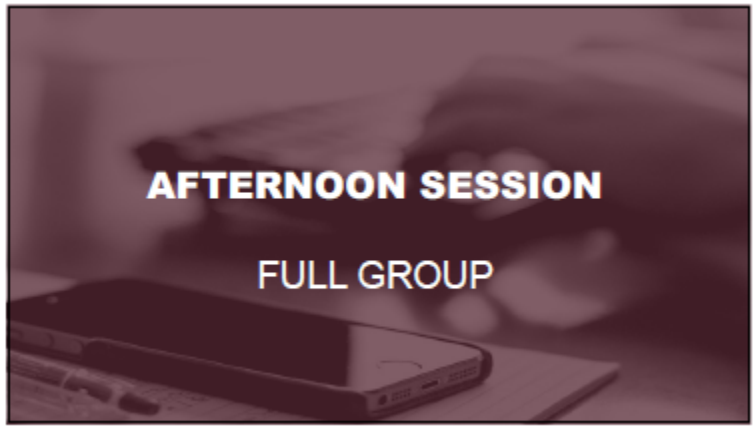
AFTERNOON SESSION
FULL GROUP

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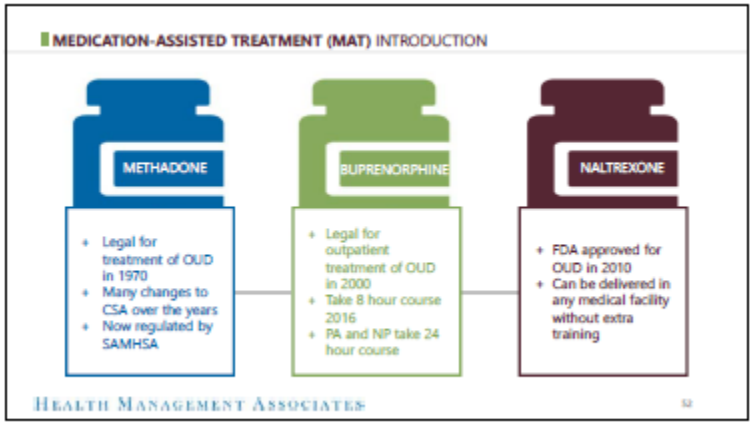
MEDICATION-ASSISTED TREATMENT (MAT) INTRODUCTION
METHADONE
Legal for treatment of OUD in 1970
Many changes to CSA over the years
Now regulated by SAMHSA
BUPRENORPHINE
Legal for outpatient treatment of OUD in 2000
Take 8 hour course 2016
PA and NP take 24 hour course
NALTREXONE
FDA approved for OUD in 2010
Can be delivered in any medical facility without extra training
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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 (UDS) 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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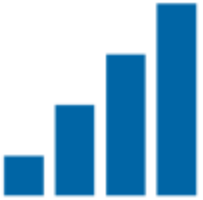
METHADONE OUTCOMES

- 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 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

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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/nl of 6-beta-Naltrexol)

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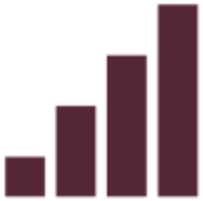
NALTREXONE OUTCOMES

- 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?**
    - Opportunity to collaborate with other community agencies to develop shared goals; meeting key players
    - Assembling a plan for treatment focused on action
    - Scoping and barriers discussion
    - Knowledgeable and informative presenter
    - Interactive and inclusive
2. **What did you like LEAST? What changes would you recommend?**
    - Would've liked to integrate prevention perspective
    - Some stakeholders missing
    - Not enough breaks; too much sitting
    - Have a stronger idea of local services
    - Food and venue feedback
3. **Give an example of something new you learned about addiction.**
    - Best practice approaches to addiction
    - Dopamine's role in SUD
    - Treatment method dos and don'ts
    - MAT-different medications for different populations
4. **What topics would you like to learn more about?**
    - Creative ways to generate funds
    - Perinatal services
    - 42 CFR and changes
    - MAT for adolescents
    - Communication pathways between organizations
    - Specific requests based on organizations represented
5. **Other comments/questions.**
    - *"I'm honored to be a part of the process/solution. I hope the powers that be can be as enthusiastic and encouraged as I feel now."*
    - Worthwhile two days
    - HMA should explain why they are doing this

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