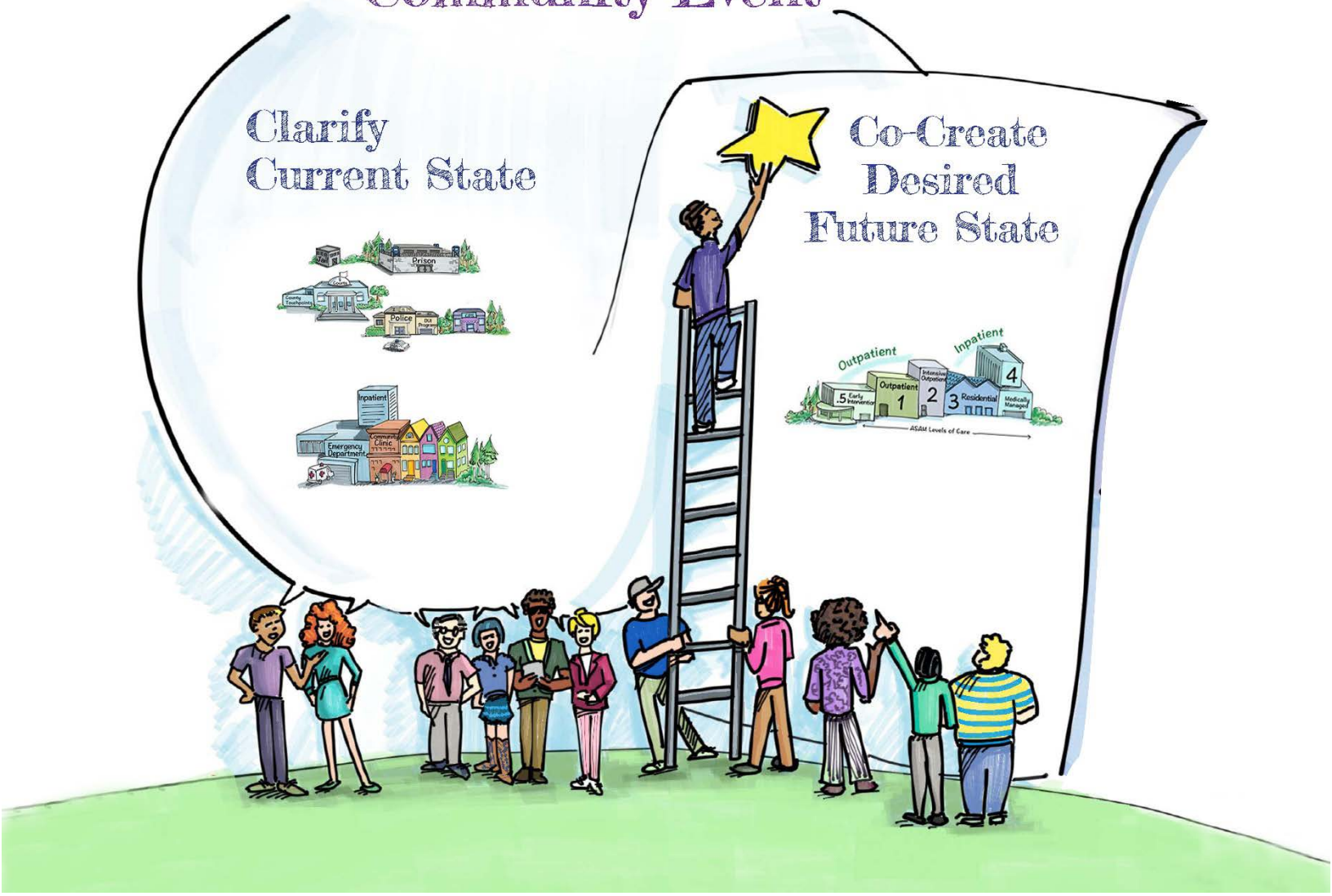
Collaborative Provider Community Event



BUILDING SUSTAINABLE TRANSITIONS OF CARE FOR PEOPLE WITH ADDICTIONS

Humboldt County Community Process Improvement Event

June 19-20, 2019

HEALTH MANAGEMENT ASSOCIATES

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Executive Summary

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

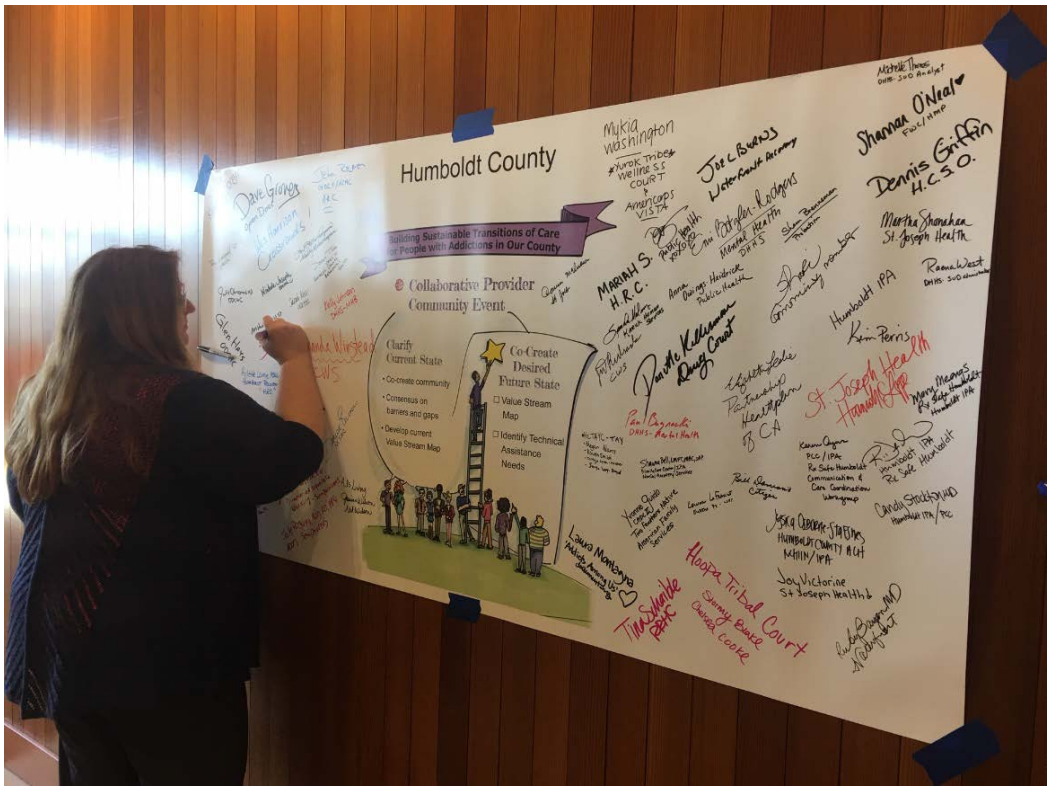
Understanding this reality, the federal government has allocated billions of dollars to states to build appropriate systems of care for patients with opioid use disorder (OUD) and other addictions; including the State Treatment Response (STR) and State Opioid Response (SOR) grants. The California Department of Health Care Services (DHCS) received STR and SOR grants which are being used for the California Medication Assisted Treatment (MAT) Expansion Project. This initiative aims to serve an estimated 290,000 individuals with Opioid Use Disorders (OUD), prevent drug overdoses, and treat OUD as a chronic disease. Health Management Associates (HMA) received SOR funding from DHCS to focus on developing predictable and consistent transitions of care to sustain addiction treatment as individuals' 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. Humboldt County, one of the 10 counties selected, participated in a large-scale process improvement event on June 19th and 20th, 2019 that included members from different aspects of government, healthcare, addiction treatment, law enforcement and those who pay for that treatment. During the event, attendees participated in intense work sessions with a focus on identifying current treatment processes, barriers and gaps in these processes and a future state treatment system to support transitions of care for Humboldt County residents in need of addiction treatment and support services.

The Humboldt County Department of Health and Human Services, Behavioral Health Services Division, the Humboldt Independent Practice Association (IPA),Rx Safe Humboldt, North Coast Health Improvement and Information Network (NCHIIN) and the Humboldt Community Health Trust partnered with HMA to convene stakeholders and examine the disease of addiction and evidence-based treatments, and to conduct an evaluation of the entire addiction treatment system in and around Humboldt County, CA.

The two-day event concluded with the development of a group-based consolidated vision of the future state that includes, use of the World Health Organization's (WHOs)

ASSIST (Alcohol, Smoking and Substance Involvement Screening Test) screening tool for all populations needing assessment. Humboldt County collaborating agencies are in agreement on the need for future development and use of a standardized countywide release of information form that satisfies 42CFR Part 2. The Humboldt Community Health Trust will conduct additional stakeholder engagement to arrive at a common form for countywide use for sharing and release of information. The participants identified three standardized universal screening forms for use countywide that vary by the populations being assessed. They include the NIDA 4 for Adult Populations in clinical settings, the CAGE-AID for Adult Populations in social care settings, the 4P's for the perinatal populations and NIDA 4 plus a Marijuana screening for adolescents while additional community conversations are held to ensure appropriateness. These screening and assessment tools d 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 California.

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 began in September 2018 and runs for two years through September 2020.

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 Humboldt 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 Humboldt 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 the Humboldt County DHHS Mental Health Services leadership including the county's Behavioral Health and Substance Use-disorder program leadership, specifically Emi Botzler--Rodgers, Paul Bugnacki, and Raena West and their respective staff. In addition, HMA also partnered with the Humboldt Independent Practice Association (IPA), RX Safe Humboldt, North Coast Health Improvement and Information Network (NCHIIN) and the Humboldt Community Health Trust, to help our team meet and understand the tremendous work already underway by the community related to Substance Use-Disorder and addiction treatment services within Humboldt County. Collectively, County and NCHIIN staff assisted our team in launching the process improvement event and subsequent ongoing technical assistance program. NCHIIN staff helped identify key stakeholders to engage, conducted outreach, arranged stakeholder meetings and distributed invitations. NCHIIN took an active role in ensuring the event included stakeholders from all areas of the addiction treatment ecosystem, and their leadership set a strong tone of collaboration for the event.

B. County Leadership/ Key Change Agents

Humboldt County Department of Health and Human Services (DHHS) - Behavioral Health and Recovery Services

- Emi Botzler-Rodgers, Behavioral Health and SUD Director
- Paul Bugnacki, Deputy Behavioral Health and SUD Director
- Raena West, SUD Program Administrator

Humboldt Independent Practice Association (IPA), RX Safe Humboldt, North Coast Health Improvement and Information Network (NCHIIN) and the Humboldt Community Health Trust

- Rosemary DenOuden, CEO Humboldt IPA
- Dr. Mary Meengs M.D., Medical Director – Humboldt IPA & RX Safe Humboldt
- Jessica Osborne-Stafsnes, ACH Project Director NCHIIN
- Patty Torres, ACH Project Manager NCHIIN
- Martin Love, CEO - NCHIIN

C. Who Was Involved

- AEGIS Treatment Centers
- AJ's Living
- City of Eureka
- Crossroads
- DHHS BHS
- DHHS MH (incl MIST & MRT)
- Eureka Police Department CNET
- The Humboldt Family Wellness Court
- First 5 Humboldt
- Fortuna Adventist Community Services (ACS) Humboldt Alcohol Recovery Treatment (HART) DUI Program
- Healthy Moms Program
- Humboldt County Child Welfare Services
- Humboldt County Drug Court
- Humboldt County Correctional Facility (HCCF)
- Humboldt County Crisis Stabilization Unit

- Humboldt County Department of Health & Human Services
- Humboldt County Probation
- Humboldt County Sheriff's Department
- Humboldt County Transition Aged Youth Collaboration (HCTAYC)
- Humboldt Independent Practice Association (IPA)
- Humboldt Recovery Center
- North Coast Health Improvement and Information Network (NCHIIN)
- NorCal Recovery Services
- Open Door Community Health Centers
- Partnership Health Plan
- Priority Care Center
- Redwood Community Action Agency
- Redwoods Rural Health Center
- St Joseph Health
- Two Feathers
- United Indian Health Services
- Waterfront Recovery Services
- Yurok Tribe BHS

D. Structure of the Intervention

In advance of the event, HMA worked with the county to electronically and directly gather high-level information on addiction treatment capacity in Humboldt. We spent an additional 3-days in preparation, meeting with a large number of the providers and programs throughout Humboldt County. After these meetings all the information gathered was collated and examined in preparation for two-days of intensive on-site value stream mapping, presentation, and discussion.

Most healthcare professionals are familiar with Lean Processing and the need to improve efficiency of an existing system. Some are familiar with the technique of agile

innovation (or Scrum) and the role it can play in developing and managing an entirely new process. However, the field of addiction medicine is neither fully built nor just being born. Given this, HMA facilitated a hybrid process to obtain the current state structure and wrap around the proposed new pathways and future state.

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

The attendees developed lists of gaps and barriers to the delivery of addiction care in Humboldt. These were then displayed around the room so that all participants could view their counterparts' struggles. In the afternoon, the group completed a current state mapping exercise that helped all programs outline their current path for persons with addiction. This included screening tools, assessments and level of care referrals. This also, began to overlay the complex barriers found throughout the system.

Participants were tasked with including all interventions and decision points. Stakeholders were also instructed to discuss both intervention-specific and global barriers and gaps. While the work produced 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 Humboldt 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.

Each program gave an oral description to the group that highlighted the flow through the value stream. This allowed for those in the room to get an idea about how others were approaching those with addiction and the struggles that are involved.

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

It is worth mentioning that the participants in attendance were an engaged group representing a wide cross-section of decision makers, doers, and people with lived experience. The future state map was developed based on the previously gathered information from in person meetings, electronic surveys and the input of the groups that had developed the current state maps. While not every treatment organization was present, the buy-in from the different groups was substantial and it was their voices that created the product.

E. Screening and Level of Care Determination

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

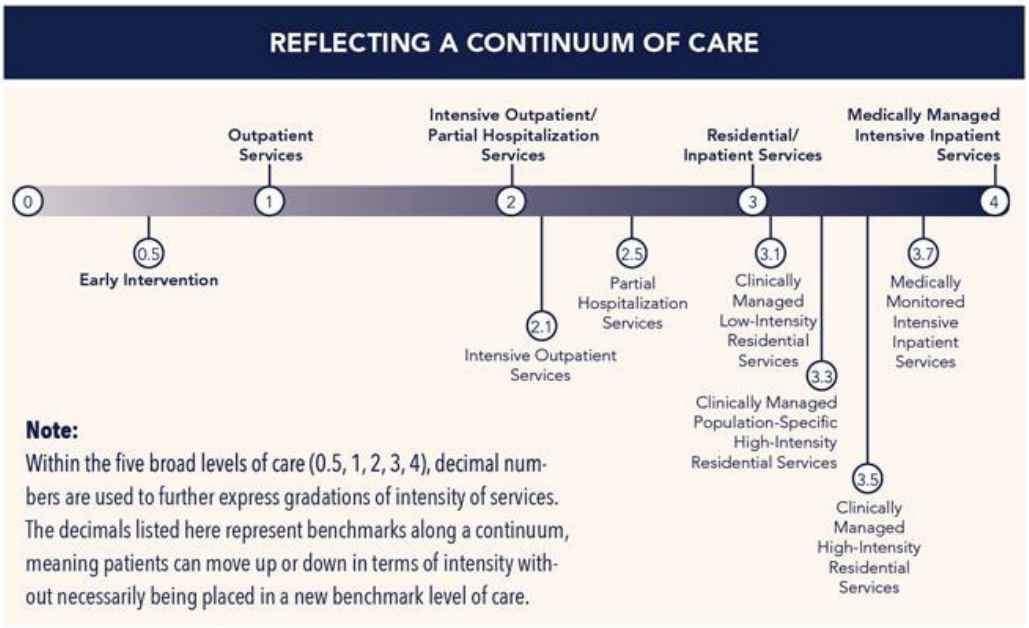
ASAM's criteria, formerly known as the ASAM patient placement criteria, is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. Today the criteria have become the most widely used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

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

Patient Placement Criteria in 1991. The coalition addresses feedback and ensures that the Criteria adequately serves and supports medical professionals, employers, purchasers and providers of care in both the public and private sectors.

The "short form" of the ASAM Criteria

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



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

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

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

**California is 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:

- More welcoming, treatment viewed as a gift rather than a punishment
- Funding
- Eliminate stigma
- Lower barriers to Treatment
- Easy access to Data
- Prevention in children
- Decrease unnecessary death
- Better transitions
- More acceptance and understanding or non-traditional treatment
- Predictably trained and knowledgeable workforce
- Increase ease of access – no wrong door
- To make sure people understand that while medication is a good start, it is not the full treatment package. Medication = shock
- MAT Youth program
- Access to services in rural areas especially among native population

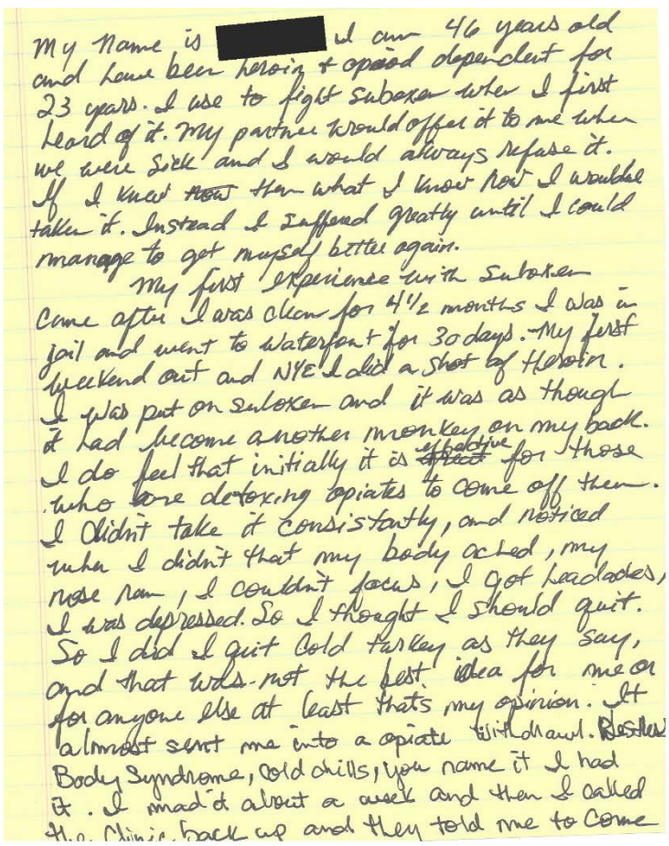
An overarching goal for Humboldt County, under which all the goals named above can be placed.

THE OVERARCHING GOAL:

ELIMINATE ADDICTION-RELATED DEATHS IN HUMBOLDT COUNTY

B. Stories of Experience with Addiction in Humboldt County

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



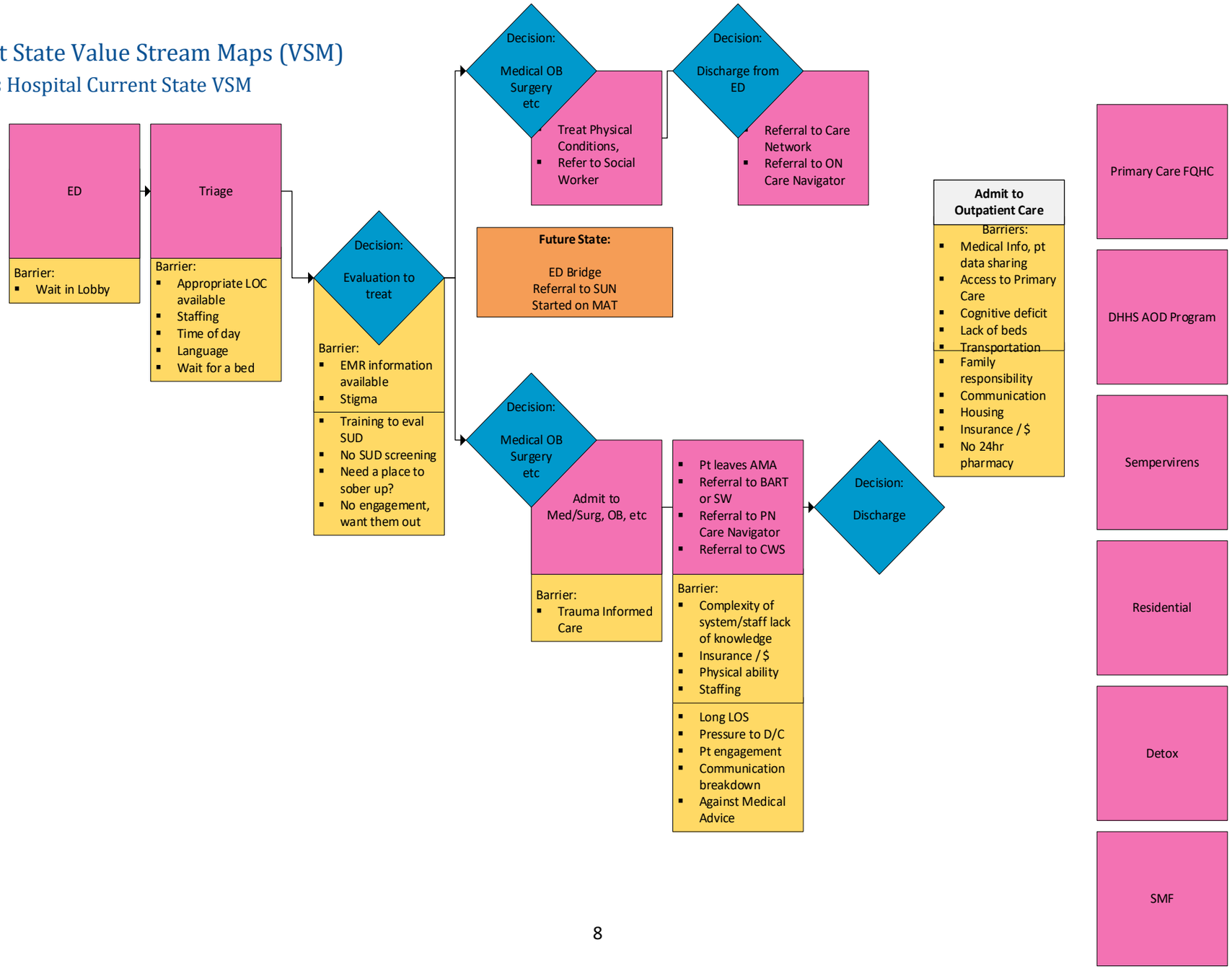
My Name is [redacted] I am 46 years old and have been heroin + opiod dependent for 23 years. I use to fight Suboxone when I first heard of it. My partner would offer it to me when we were sick and I would always refuse it. If I knew then what I know now I would have taken it. Instead I suffered greatly until I could manage to get myself better again.

My first experience with Suboxone came after I was clean for 4½ months I was in jail and went to Waterfront for 30 days. My first weekend out and NYE I did a shot of Heroin. I was put on Suboxone and it was as though it had become another monkey on my back. I do feel that initially it is effective for those who have detoxing opiates to come off them. I didn't take it consistantly, and noticed when I didn't that my body ached, my nose ran, I couldn't focus, I got headaches, I was depressed. So I thought I should quit. So I did I quit cold turkey as they say, and that was not the best idea for me or for anyone else at least that's my opinion. It almost sent me into a opiate withdrawl. Restless Body Syndrome, cold chills, you name it I had it. I made it about a week and then I called the Clinic back up and they told me to come back in the next day for another induction. They said that if I wanted to get off it, that they would wean me off slowly. 2 for 3 weeks then 1½ for 3 weeks then 1½ for 3 weeks and 1 for 1 week and so on. Taking about 3 months. During my visit they gave me 14 8mg Strips for 7 days. that was 3 weeks ago today and I still have 5 left. I never went back I feel like I don't need that much that long. I feel that I can take it when I need it and it helps immediately. I don't abuse it. The amount is so small, that the withdrawl is going to be very managable.

thank-you

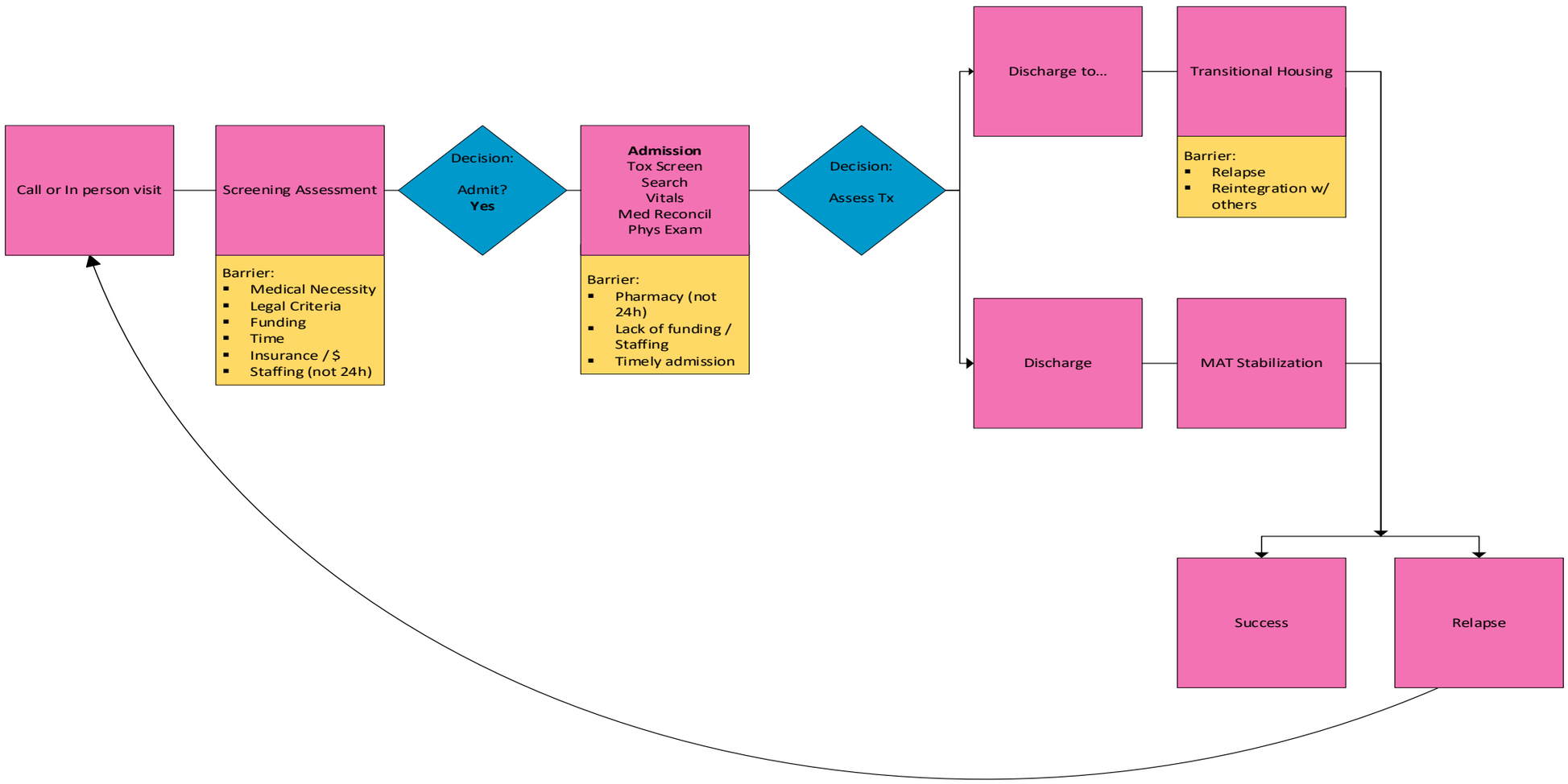
C. Current State Value Stream Maps (VSM)

St. Joseph's Hospital Current State VSM



St. Joseph's Hospital is the main general medical facility in Eureka. They are in the process of building a comprehensive approach to patients with substance use disorder, however, are still in the early stages of implementation. Currently if a patient with a substance use disorder arrives to the emergency department, they will be triaged with the possible barrier of having to wait in the lobby for extended periods of time. Depending on the time of day, the language the patient speaks and the availability of appropriate staff they may or may not be able to directly intervene for chronic substance use disorder. After triage the patient is evaluated for treatment, however little to no outside information for addiction treatment is available through the electronic medical record and there is no standardized substance use disorder screening or a place for intoxicated patients to sober up. Generally speaking, there is no direct engagement concerning their chronic substance use disorder and they are discharged without intervention. If the patient is admitted to the hospital they will be treated for their physical conditions and referred to social work for evaluation, however, the same issue of not having a standardized screening tool or pathway to move them through remains a significant barrier. Another significant barrier identified by the hospital team is a lack of consistent training surrounding substance use disorders. This includes physician staff, nurse practitioners, physician assistants, nursing and even social workers. Given the lack of access to screening, assessment or level of care determination the ability for referral and placement in the appropriate care setting is very limited.

Waterfront Recovery Services Current State VSM

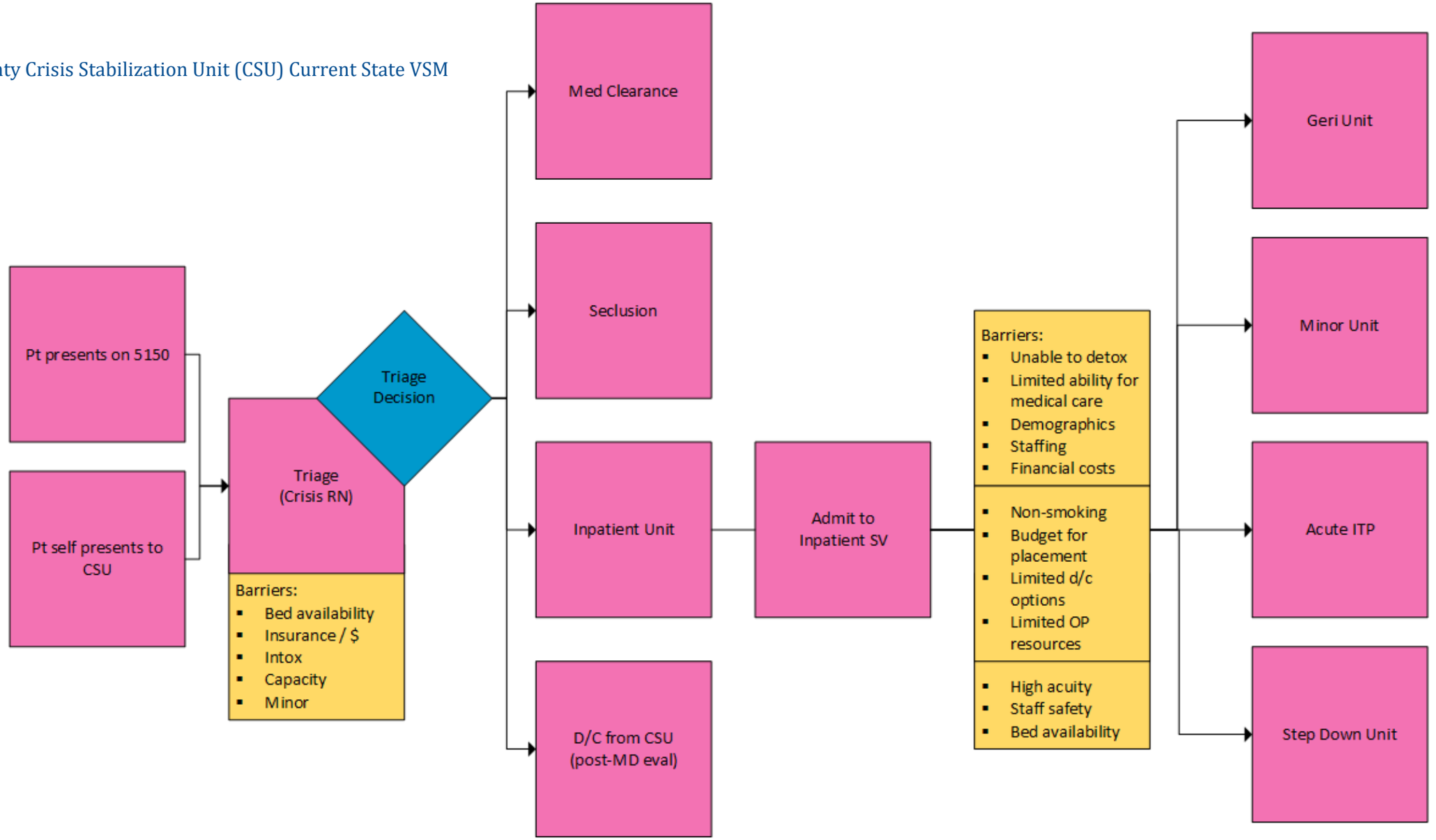


Waterfront Recovery Services - A referral is the first step to access services at Waterfront Recovery Services; this referral can come from numerous sources but is most often in the form of a call or an in-person visit. It was identified that the referral and intake process is difficult and has many delays. This occurs for both telephonic and walk-in referrals. However, once a patient is scheduled for intake a screening assessment is performed to determine if admission is appropriate. If so, the patient is admitted and numerous services, including a toxicological screen, records evaluation (if present), vital signs, medical reconciliation, and a physical exam are conducted. If the patient meets the level of care requirement and is admitted they can stay as long as the insurance allows and can then be transitioned to the next level of care. After initial assessment and treatment, the patient may be discharged to transitional housing or for Medication Assisted Treatment stabilization. Either of these paths can lead to success, but some patients relapse and require a new assessment and reentry to treatment.

Due to funding limitations, decisions must be made to the equitable distribution of funds. A policy which aims to address this is probation for patients who leave against medical advice. If a patient leaves Waterfront Recovery Services against medical advice, they are placed on "probation" for 90 days. If this occurs three times, then the patient is on "probation" for 1 year.

Throughout the Waterfront Recovery Services treatment pathway, further barriers include medical necessity, legal criteria, funding, financials and insurance, time, staffing, pharmacy hours, and reintegration with others.

Humboldt County Crisis Stabilization Unit (CSU) Current State VSM

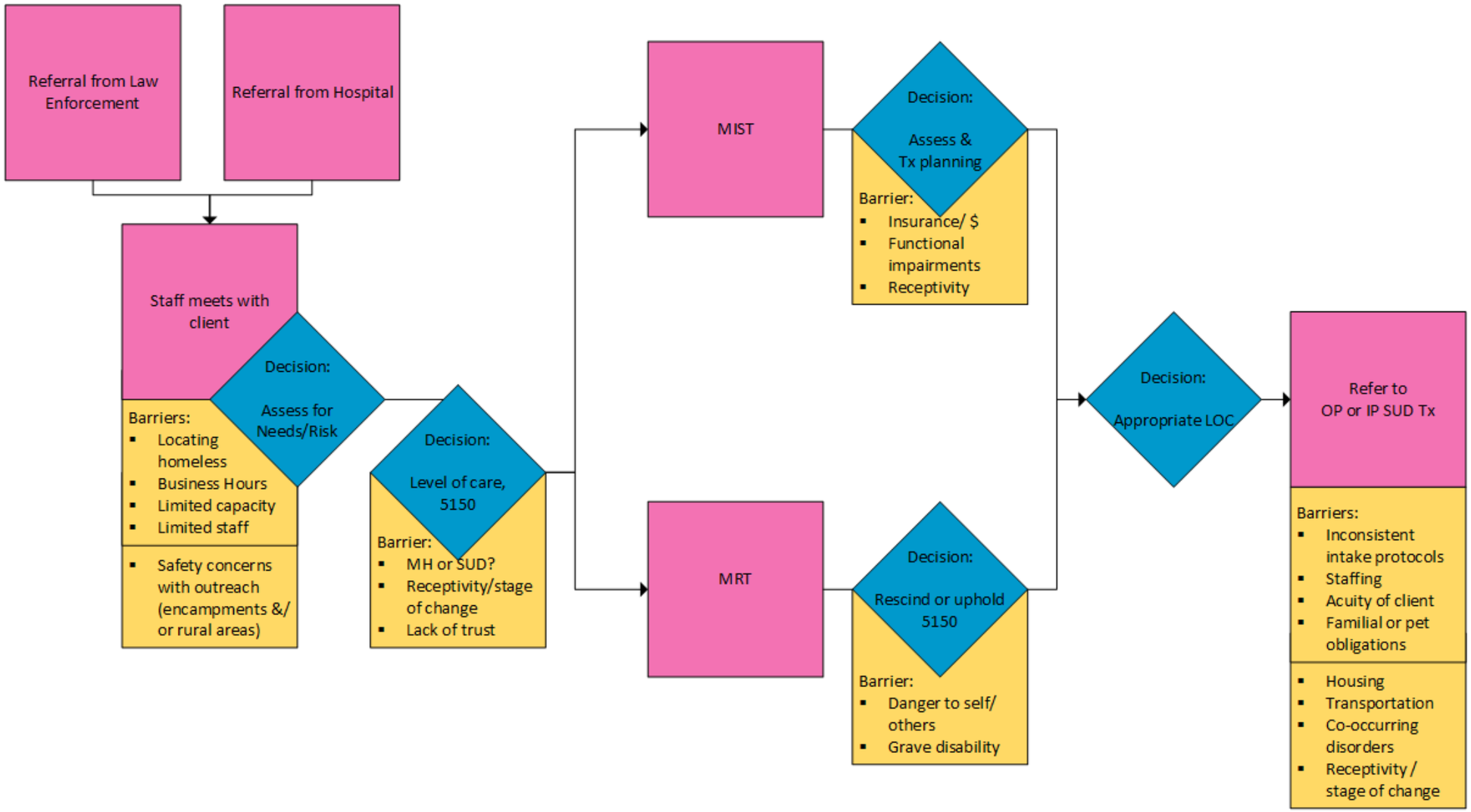


The Humboldt County Crisis Stabilization Unit (CSU) is an outpatient program that provides crisis intervention and stabilization services to individuals in need of immediate and emergency services. Services include crisis intervention services 24 hours a day, 7 days a week, 23-hour crisis stabilization to prevent the need for inpatient hospitalization, a treatment team consisting of physicians, nurses, mental health workers, and clinicians who provide care and assistance including linkage to community providers and/or outpatient services.

Individuals may encounter the Humboldt County Crisis Stabilization Unit Pathway through two entry methods: presenting on a 5150, or self-presenting to the Crisis Stabilization Unit. At presentation, a crisis RN will triage the individual and come to a triage decision. The individual may be medically cleared, placed in seclusion, continued to be stabilized, or, after medical evaluation from a physician, discharged from the Crisis Stabilization Unit. The final option at triage decision is to admit the patient to an inpatient unit, Sempervirens (SV). SV offers a locked hospital-based treatment for clients who have serious and persistent mental illness that need acute psychiatric care. Patients admitted with an opioid use disorder are not provided with medication-assisted treatment, therefore opioid use disorder clients experiencing a psychiatric emergency often endure severe withdrawal symptoms.

At triage, barriers include a need for better availability, insurance and financials, intoxication, capacity, and the patient being a minor. Hospital regulations preclude treating detox and substance use disorders. Throughout the inpatient treatment pathway, barriers include unable to offer MAT, limited availability for medical care, demographics, staffing, financial costs, non-smoking, budget for placement, limited discharge options, limited outpatient resources, high acuity, the safety of staff, and bed availability.

Department of Health and Human Services (DHHS) – Mental Health Mobile Services Current State VSM

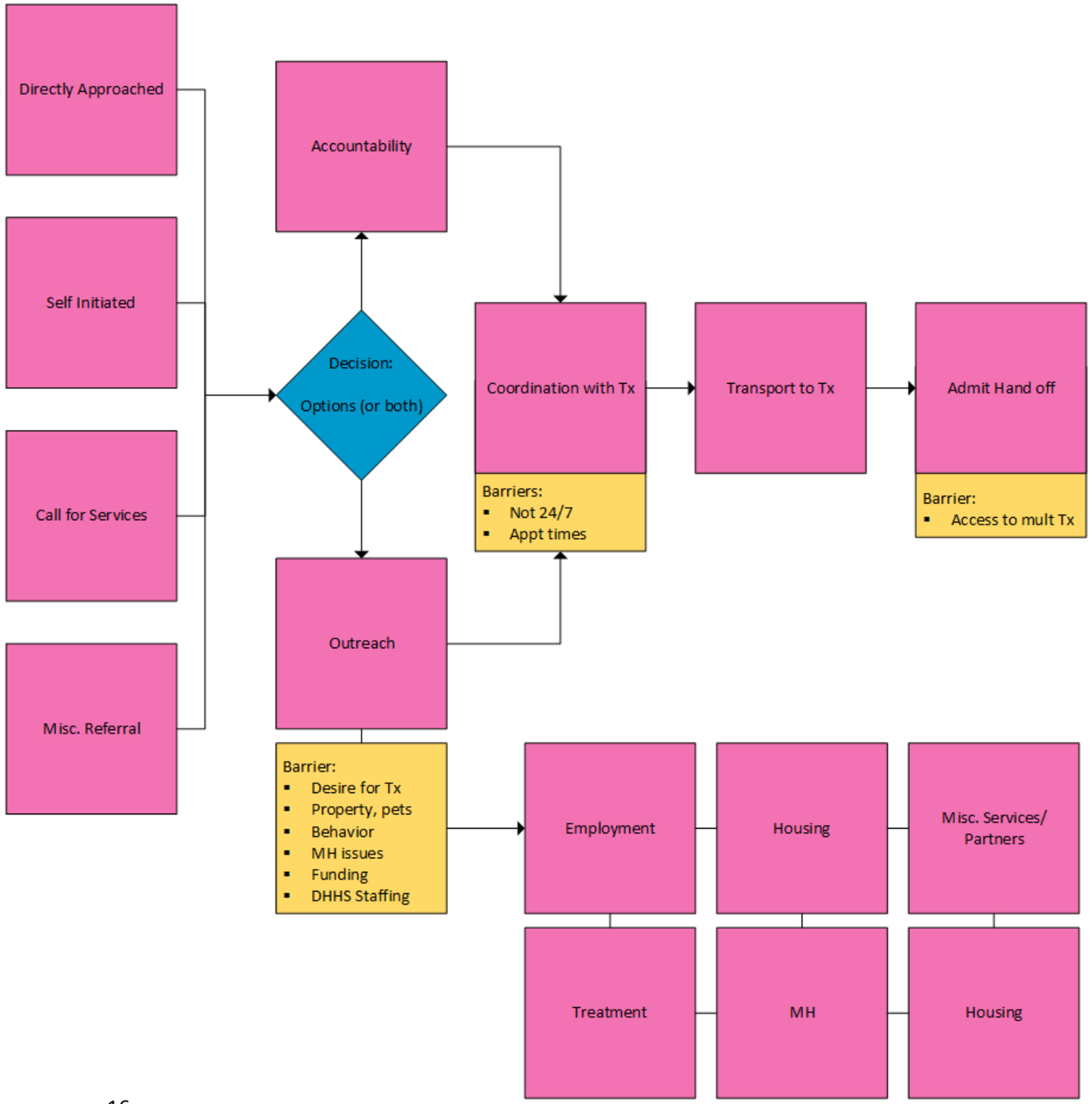


Department of Health and Human Services (DHHS) – Mental Health Mobile Services - Individuals may come into contact with the Department of Health and Human Services Mental Health division through referral by law enforcement or referral from hospitals.

Upon referral, DHHS MH staff meets with the client and a Needs and Risks Assessment is conducted. The decision is made regarding level of care, and the client is met by the Mobile Intervention and Services Team (MIST) or the Mobile Response Team (MRT). Assessment and treatment planning are conducted along the Mobile Intervention and Services Team (MIST) pathway, and the decision to rescind or uphold the 5150 is made along the Mobile Response Team (MRT) pathway. At this time, a decision is made as to the appropriate level of care for the individual. Individuals are referred to outpatient or inpatient mental health or substance use disorder treatment, as determined by their individual needs.

Throughout this treatment pathway, barriers include housing/homelessness, availability of business hours, limited capacity and staff for the department, and safety concerns with homeless outreach. Further barriers include motivation for change (Stages of Change), lack of trust, financial/insurance concerns, cognition, danger to self or others, grave disability, familial or pet obligations, transportation, co-occurring disorders and inconsistent intake protocols.

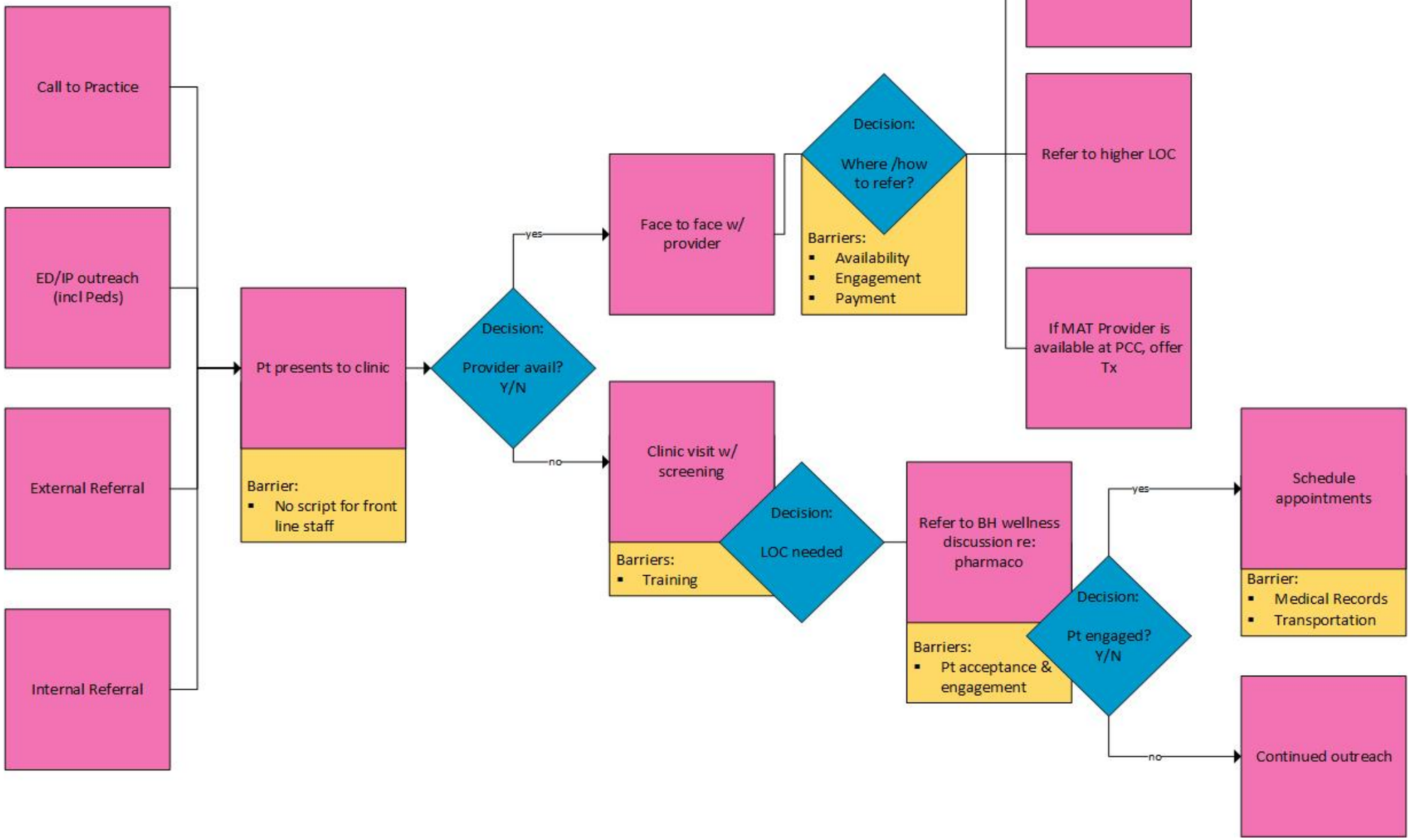
Eureka Police Department Community Safety Enhancement Team (CSET)
Current State VSM



Eureka Police Department Community Safety Enhancement Team (CSET) - Individuals in need of substance use services may encounter the Eureka Police Department by calling for services, self-initiated walk-ins, directly approach by the department, or by various referral pathways. A decision is made in regard to individual accountability or outreach, for both of these pathways, coordination retreatment will occur, the individual will be transported to the treatment facility and whenever possible, the individual will be admitted with a warm hand off. In the outreach pathway, individuals receive assistance with employment, housing, mental health, treatment and from miscellaneous services/partners.

Throughout this treatment pathway, barriers include desire for treatment (Stages of Change), property, pets, family, behavior, mental health issues, funding, DHHS staffing, time in access to multiple treatment options.

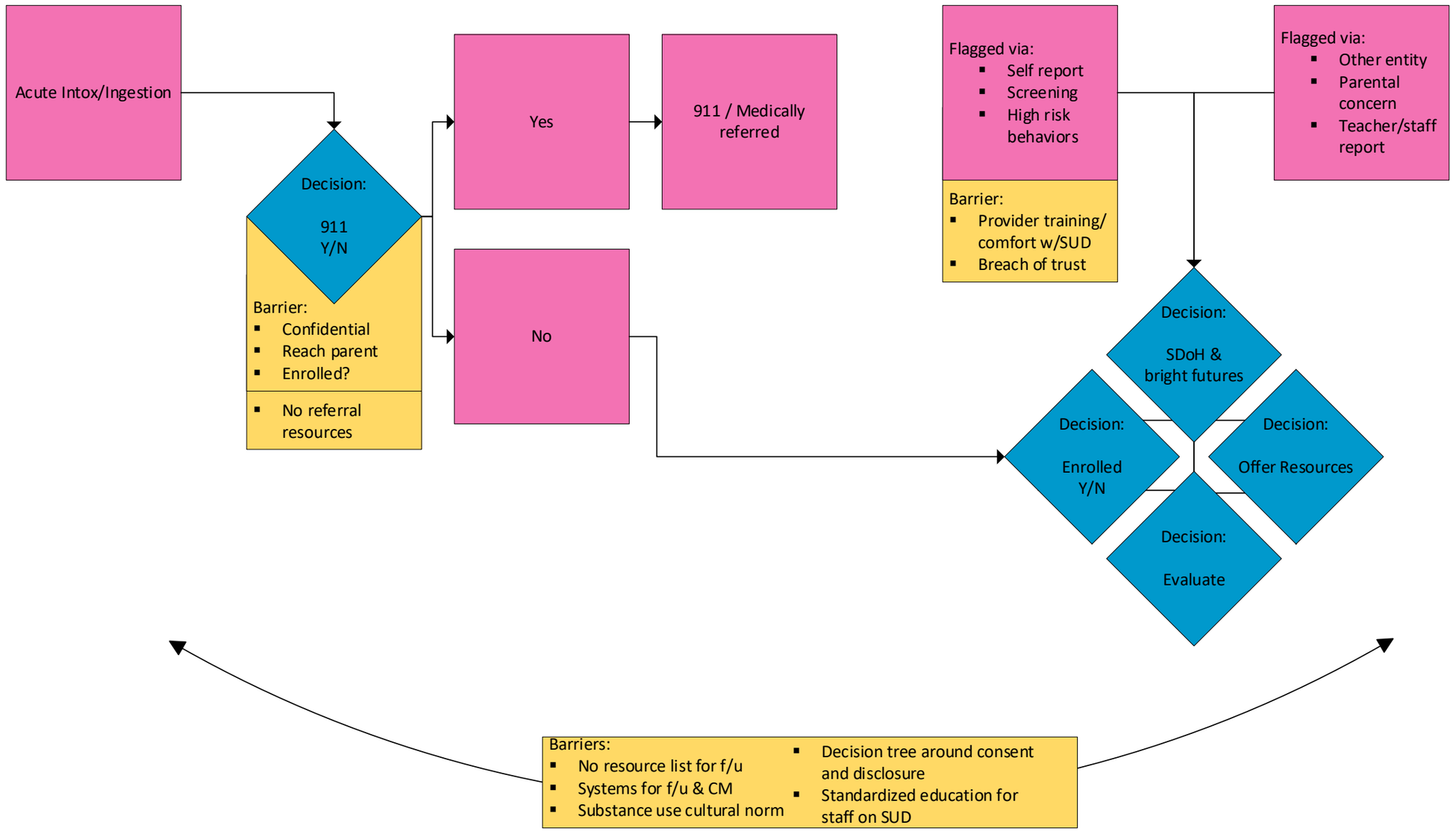
Priority Care Center Current State VSM



Priority Care Center - Individuals may access Primary Care, Wellness Coaching, Mental Health and Care Coordination services through Priority Care Center by way of personal call to the practice, emergency department or inpatient referral, as well as other internal and external referrals. Presentation to the clinic, if a provider is available the patient meets face-to-face with a provider, a decision is made if the services can be offered at the Priority Care Center or to refer the patient to a local clinic or that offers MAT or advanced to a higher level of care. If a provider is not available at Priority Care Center, clinic visit with screening is conducted. A decision is made as to the level of care needed for the patient, and a referral to behavioral health, wellness coaching or other external service is made. If the patient is engaged in receiving services at the Priority Care Center, appointments are scheduled for the future. If a patient is not engaged, outreach continues.

Throughout the Priority Care Center treatment pathway, barriers include training for frontline staffing at the clinic and lack of script for this staff, training for SUD, availability of providers, patient engagement, financial/payment concerns, medical record coordination and transportation.

School Based Health Center Current State VSM

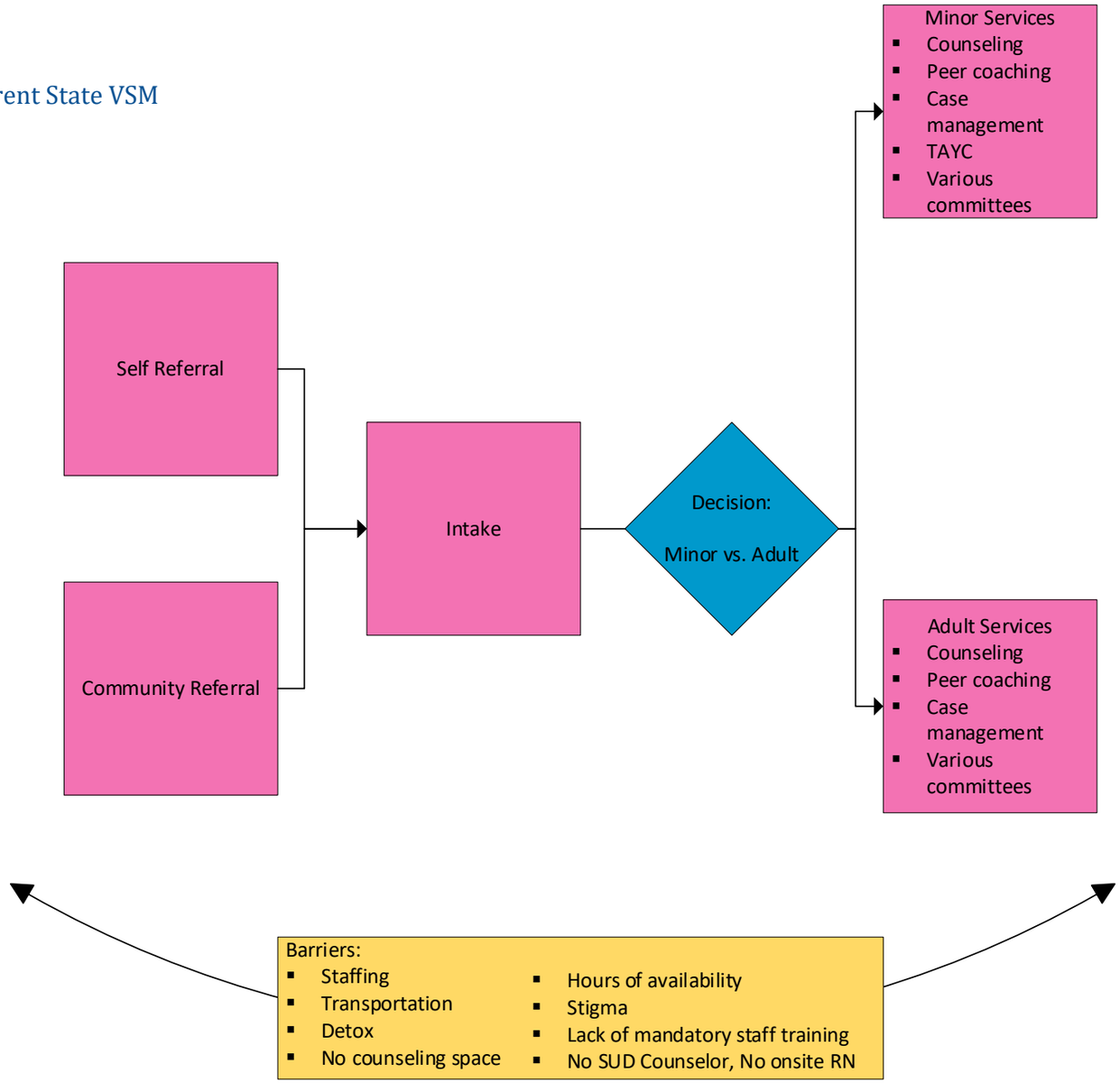


School Based Health Center - The Priority Care Center provides additional services on the campus of a local middle school. A nurse practitioner and a registered nurse typically staff this site. Services are billed to the student's health insurance however no one is turned away for lack of insurance or inability to pay.

In the School Based Health Center, points of entry to the treatment pathway include acute intoxication/ingestion, screening, self-reporting, high risk behaviors, parental concern, teacher or staff report, and other entity referral. In the event of acute intoxication/ingestion, 911 is called as appropriate. For all the other entry pathways, an evaluation including student's enrollment status is completed. The decisions surrounding the results from the social determinants of health and bright futures assessments are made and resources are offered as appropriate to the individual student.

Throughout this treatment pathway, barriers include provider/staff training and comfort with SUD treatment, breach of trust with regard to student confidentiality, lack of resources, lack of understanding regarding systems for follow up and case management, cultural norms surrounding substance use, unclear protocols around consent and disclosure.

Humboldt County Transition Aged Youth Collaboration (HCTAYC) Current State VSM

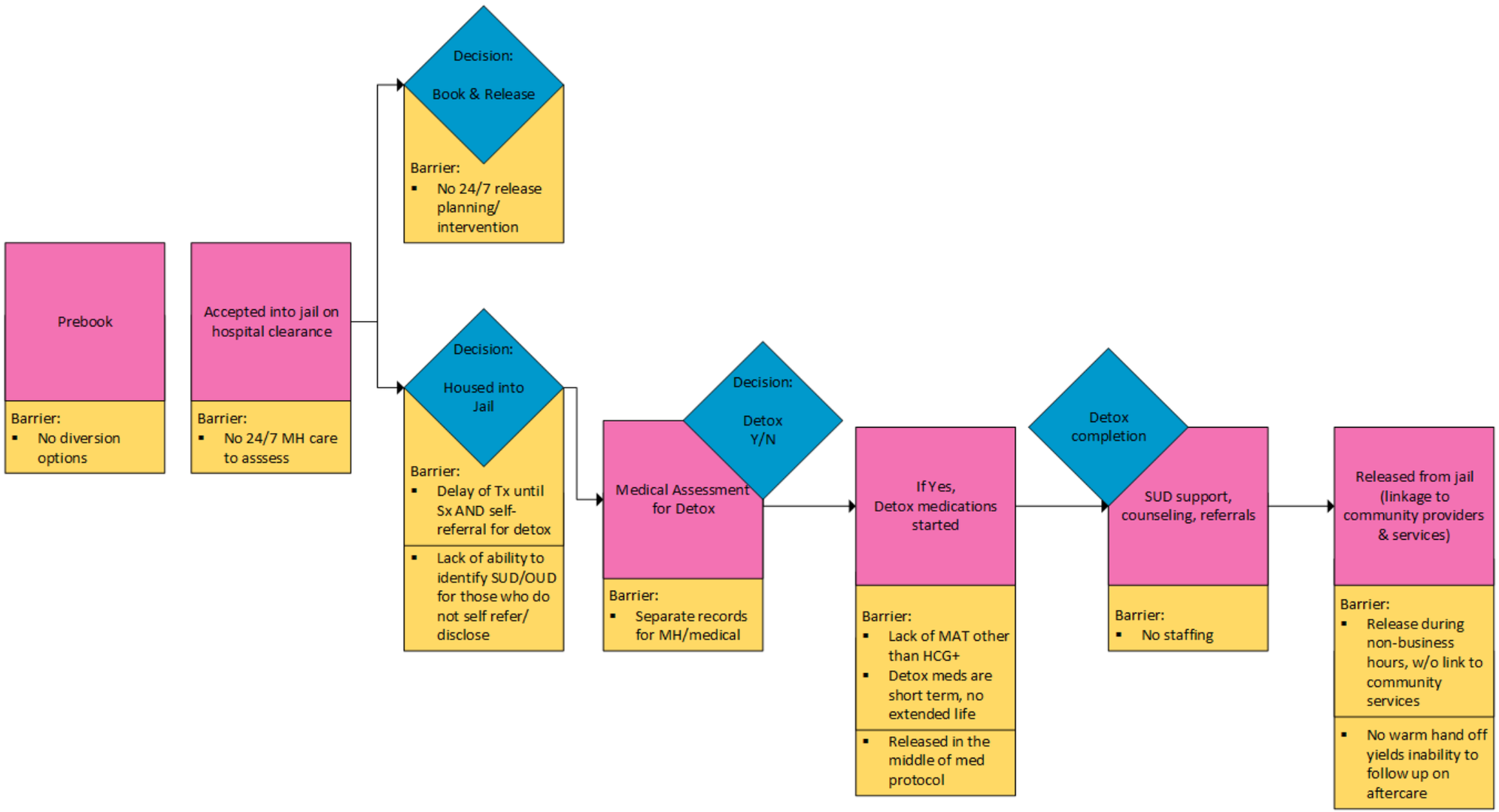


Humboldt County Transition Aged Youth Collaboration - The Humboldt County Transition-Age Youth program serves youth and young adults ages 16 to 26. Services are tailored, collaborative and based on a young person's strengths. The goal is to create an environment where young people thrive at home, school, work and in their community.

Individuals enter by way of referral, either self or from the community. An assessment is completed and is varied, dependent on the age of the individual. Programs vary dependent on age, counseling, peer coaching and case management is available to all. There are additional youth programs for those under the age of 18. Additionally, various committees are available including LGBTQ+, indigenous leadership, and Substance misuse and abuse committee.

Throughout this treatment pathway, barriers include staffing, transportation, detox, hours of availability, stigma, no confidential counseling space (lack of privacy), no substance use disorder trained counselor, no on-site RN, and a lack of mandatory staff training such as First Aid/CPR and prevention awareness. The minimum age of 16 is a further barrier to those who are younger but may benefit from the services.

Humboldt County Correctional Facility Current State VSM

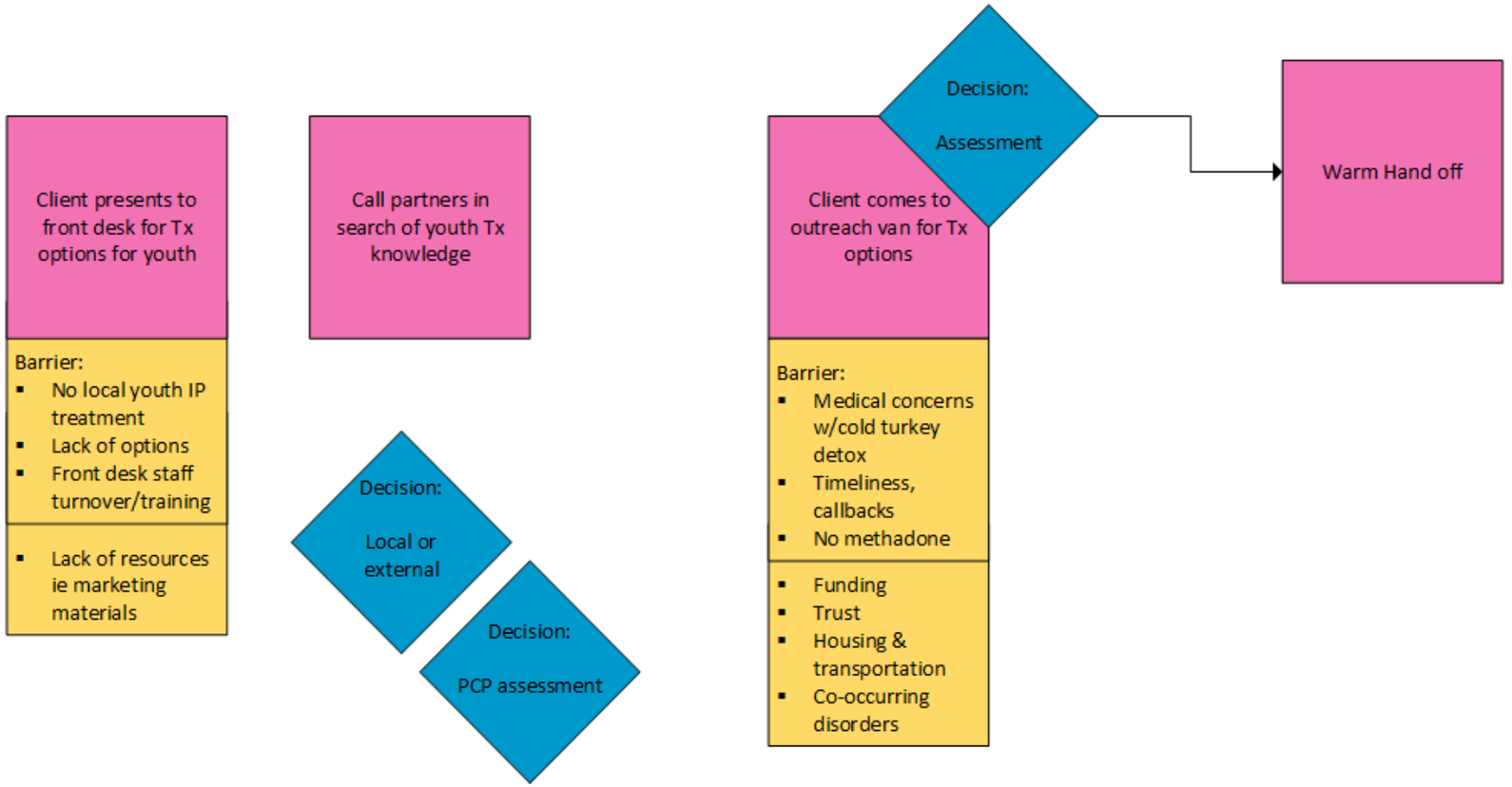


Humboldt County Correctional Facility - With a capacity of 417 beds, the Humboldt County Correctional Facility houses individuals arrested and accused of crimes within the jurisdiction of the County. Mental Health and substance abuse treatment services are provided through the Humboldt County Department of Health and Human Services.

If an individual is to be accepted into the Humboldt County Correctional Facility on hospital clearance, a pre-booking first takes place. A decision may be made to book and release. If the individual is housed in the jail, they undergo a medical assessment for detox. If they meet criteria, then detox medications are started. At the completion of detox, Substance Use Disorder support counseling and referrals are made, and the individual is released from jail with linkage to community providers and services.

Numerous barriers are present throughout the Humboldt County Correctional Facility treatment pathway, there are numerous barriers. They include: lack of diversion options, lack of round the clock mental health care, lack of round the clock release planning and intervention, treatment delays within the jail, inability to identify substance use disorder or opiate use disorder if individuals do not self-disclose, lack of map other than HCG +, no extended life detox medication availability, individuals may be released in the middle of a medication protocol, inadequate staffing for substance use disorder support counseling and referrals, releasing individuals without linkages to community services (after hours, etc.), inability to follow up on aftercare due to lack of a warm handoff.

Humboldt County Public Health Department Current State VSM

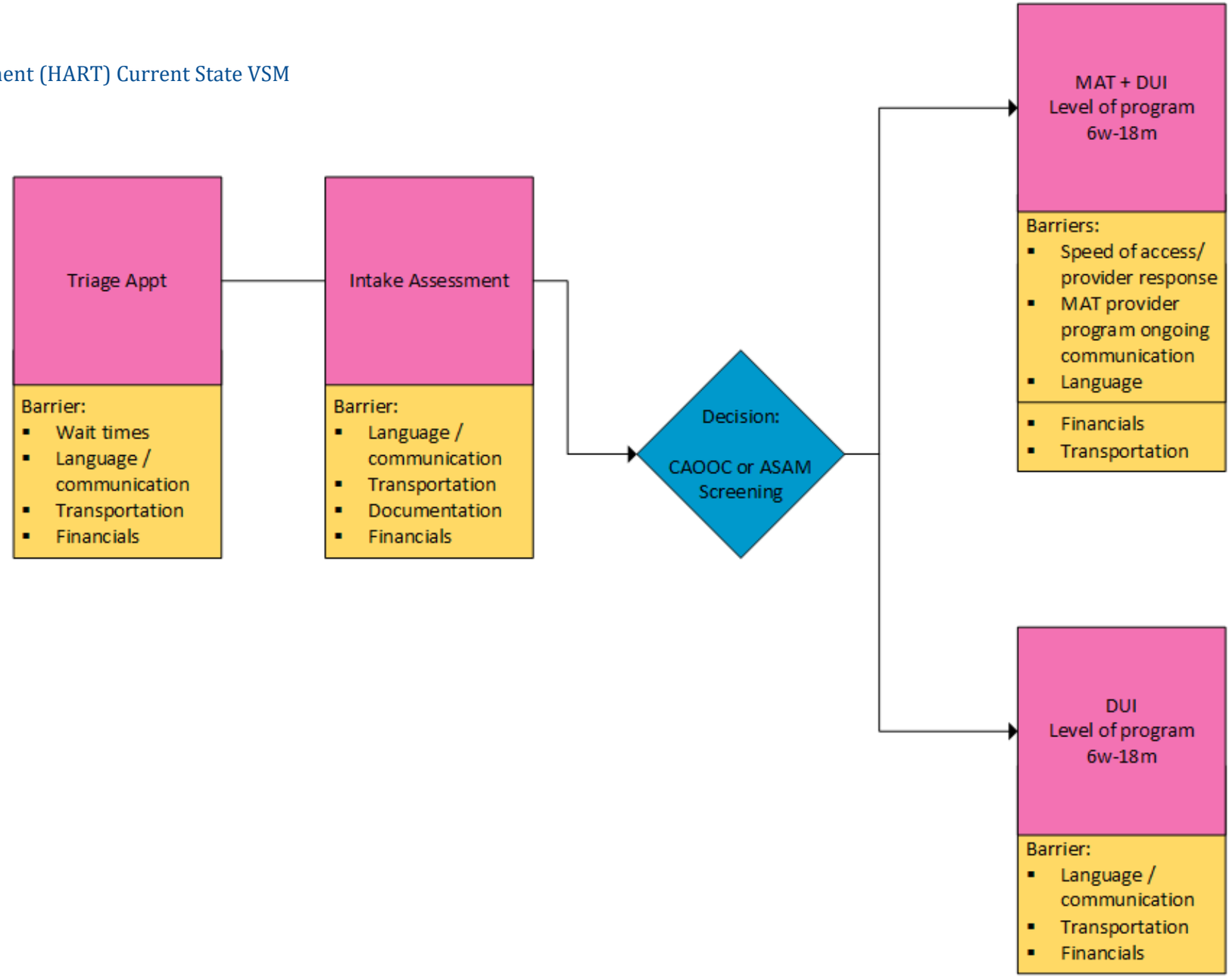


Humboldt County Public Health Department - When a client presents to the front desk for treatment options for youth, the front desk staff calls partners in search of youth treatment knowledge and resources. Decisions are then made regarding local or external treatment options, and a PCP assessment is conducted.

If a client comes to the outreach van for treatment options, an assessment is conducted, and a warm handoff is initiated.

Throughout this treatment pathway, barriers include no local impatient treatment options, lack of options for youth, staff turnover and training, lack of marketing resources, medical concerns with a cold turkey detox, timeliness, call backs, no methadone, funding / financials, trust, housing and transportation and co-occurring disorders.

Humboldt Alcohol Recovery Treatment (HART) Current State VSM

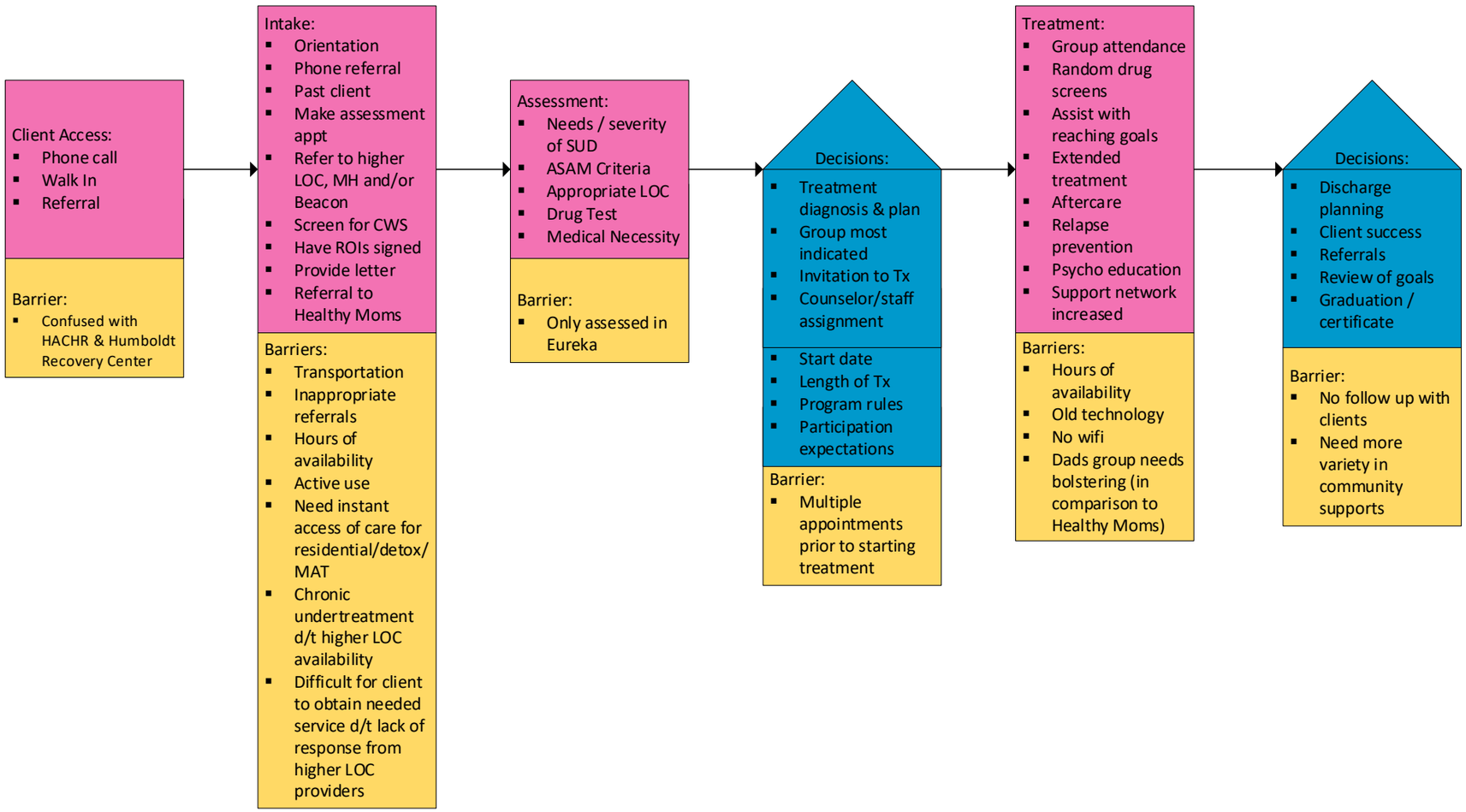


Humboldt Alcohol Recovery Treatment (HART) has provided DUI Program Services for Humboldt County since July 1991. HART provides programs for any individual who has been arrested or convicted of Driving Under the Influence of alcohol or drugs.

When an individual enrolls in the HART program, a triage appointment is first conducted. An intake assessment is then performed, and decision is made to use California Association of DUI Treatment Programs Certified Alcohol and Other Drug Counselor (CAODC) or ASAM screening. The individual then follows the Driving Under the Influence level of program or the Medication Assisted Treatment plus Driving Under the Influence level of program. Each of these programs run 6 weeks to 18 months.

Throughout this treatment pathway, barriers include language or communication barriers, wait times, transportation, finances/insurance, documentation, provider response and speed of access, and MAT provider program ongoing communication.

Humboldt County Program for Recovery – Substance Use Disorder Treatment Current State VSM



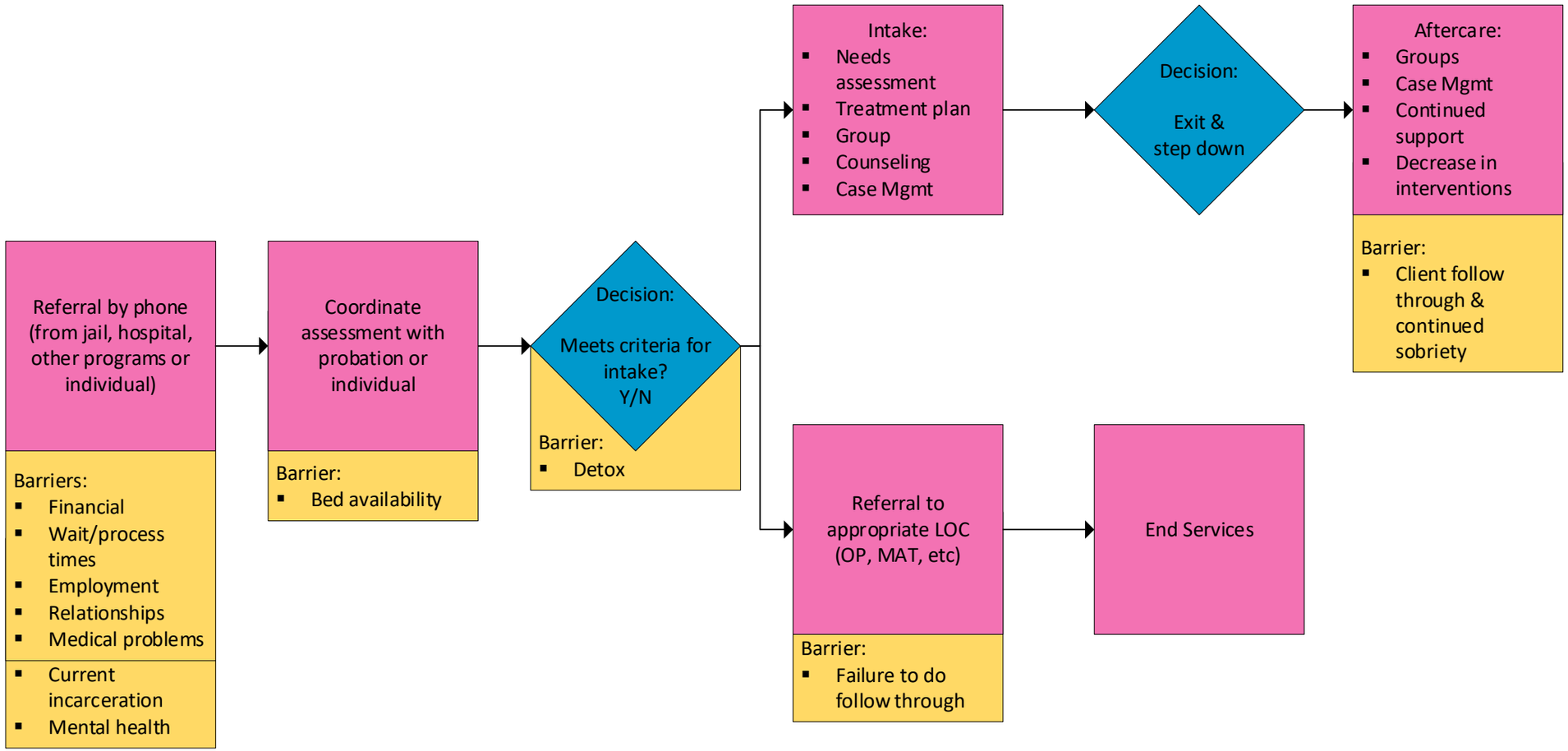
Humboldt County Programs for Recovery - Humboldt County Programs for Recovery is an adult SUD treatment program offering outpatient treatment 1-4 days per week, depending on an individual's treatment needs. Treatment is conducted in treatment groups. Admission preference is given to intravenous drug users.

Those who need services may access the program by phone call, walk-in, or referral. Clients are invited to an intake session, where an assessment appointment is made, or the individual may be referred to a higher level of care, county mental health, and/or Beacon. Counselors provide SUD screening for CWS if necessary. ROIs are signed. A referral to Healthy Moms Program may be made. Healthy Moms Program is a Drug Medi-Cal intensive outpatient treatment program, ASAM Level 2.1, serving pregnant women and women with children under the age of five. Childcare is provided on-site. At the assessment appointment, a needs and severity evaluation for substance use disorder is completed, ASAM criteria is used, appropriate LOC is assigned, a drug test is completed, and medical necessity is determined.

Further determinations include diagnosis and treatment planning, group most indicated, invitation to treatment, counselor / staff assignment, start date and length of treatment, program rules and participation expectations. Once in treatment, the individual will attend group sessions, submit to random drug screening, receive assistance reaching goals, receive extended treatment, aftercare, relapse prevention, psychological education, and there is an increase to the support network. Finally, decisions are made regarding client success, and discharge planning is underway, referrals are made, goals are reviewed, and graduation ceremony with a certificate of completion is held.

Throughout the Humboldt County Programs for Recovery treatment pathway, barriers include confusion due to a name change for the recovery center, transportation, inappropriate referrals, hours of availability, active use, need instant access of care for residential/detox/MAT, chronic under treatment due to a lack of higher level of care availability, difficulty for client to obtain needed service due to lack of response from residential and detox providers, assessment only available in Eureka, multiple appointments prior to starting treatment, old technology, lack of Wi-Fi, Dads group needs bolstering, little or no follow up with clients, and more variety in community supports is needed.

Crossroads Current State VSM

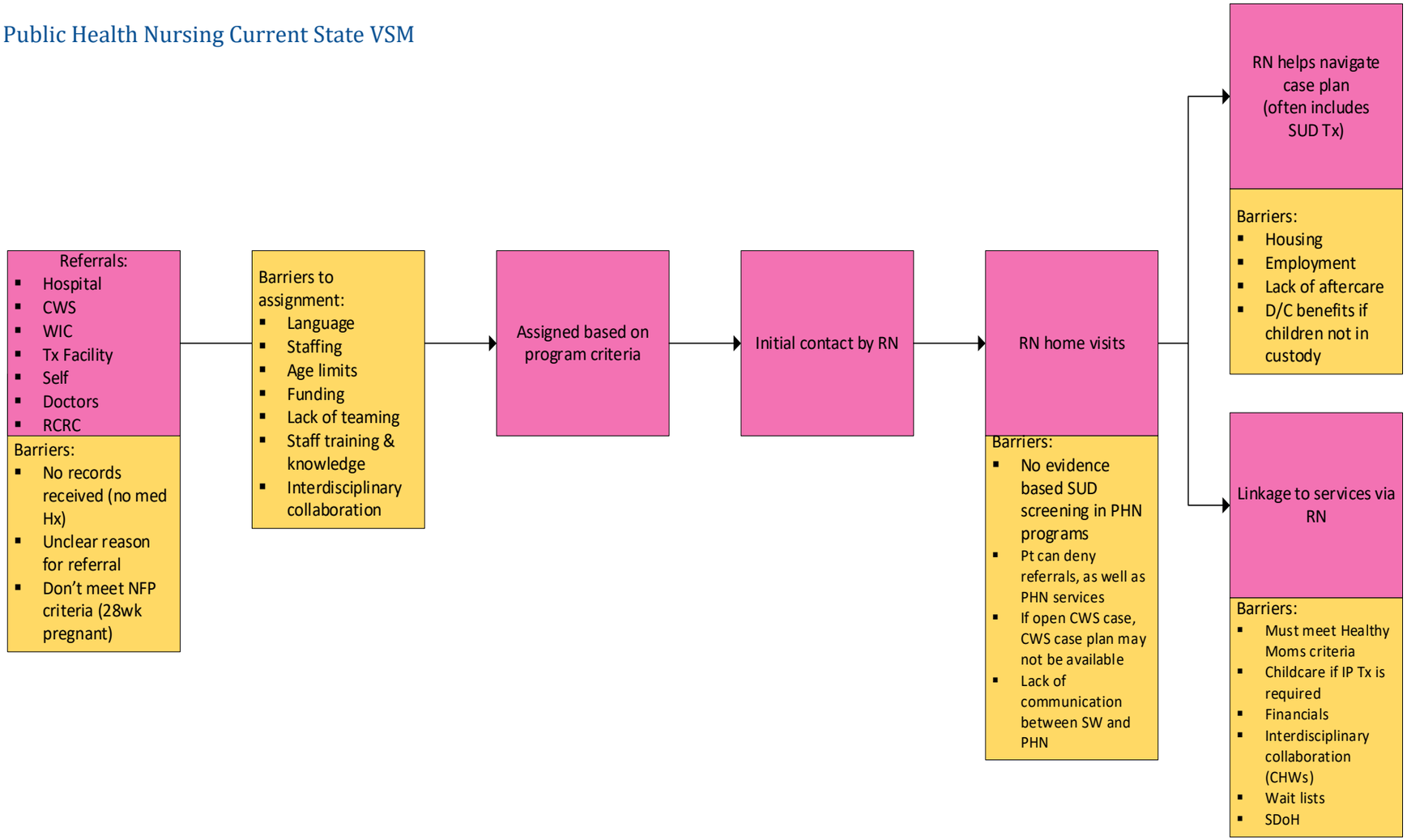


Crossroads -

At Crossroads Recovery Center patients can be referred by telephone from the jail, hospital, individually or other programs. Barriers to this initial referral or intake could be financial, wait times, employment or other medical problems. Once Crossroads counselors are able to coordinate the assessment with probation or the individual themselves than Crossroads counselors will assess if the patient meets for the appropriate level of care. If a patient meets the appropriate level of care, they may still need withdrawal management which is not provided at this location and bed availability is of a significant issue. If they do not meet for the appropriate level of care a referral is made to outpatient care, medication assisted treatment or to withdrawal management services, however some patients are unable to follow through with this pathway.

If the patient does meet criteria for their level of care, then intake is done which includes a needs assessment, treatment plan and case management plan. Patient continues through group interactions as well as individual counseling at the required number of clinical intervention hours. Once the patient is stabilized and/or met their time limitation the patient will step down to aftercare which includes continued group therapeutics, case management continued support via a peer or referral to other programs. The program is currently looking to add an intensive outpatient level of care but at this time only offers ASAM level 3.1.

DHHS Public Health Nursing Current State VSM

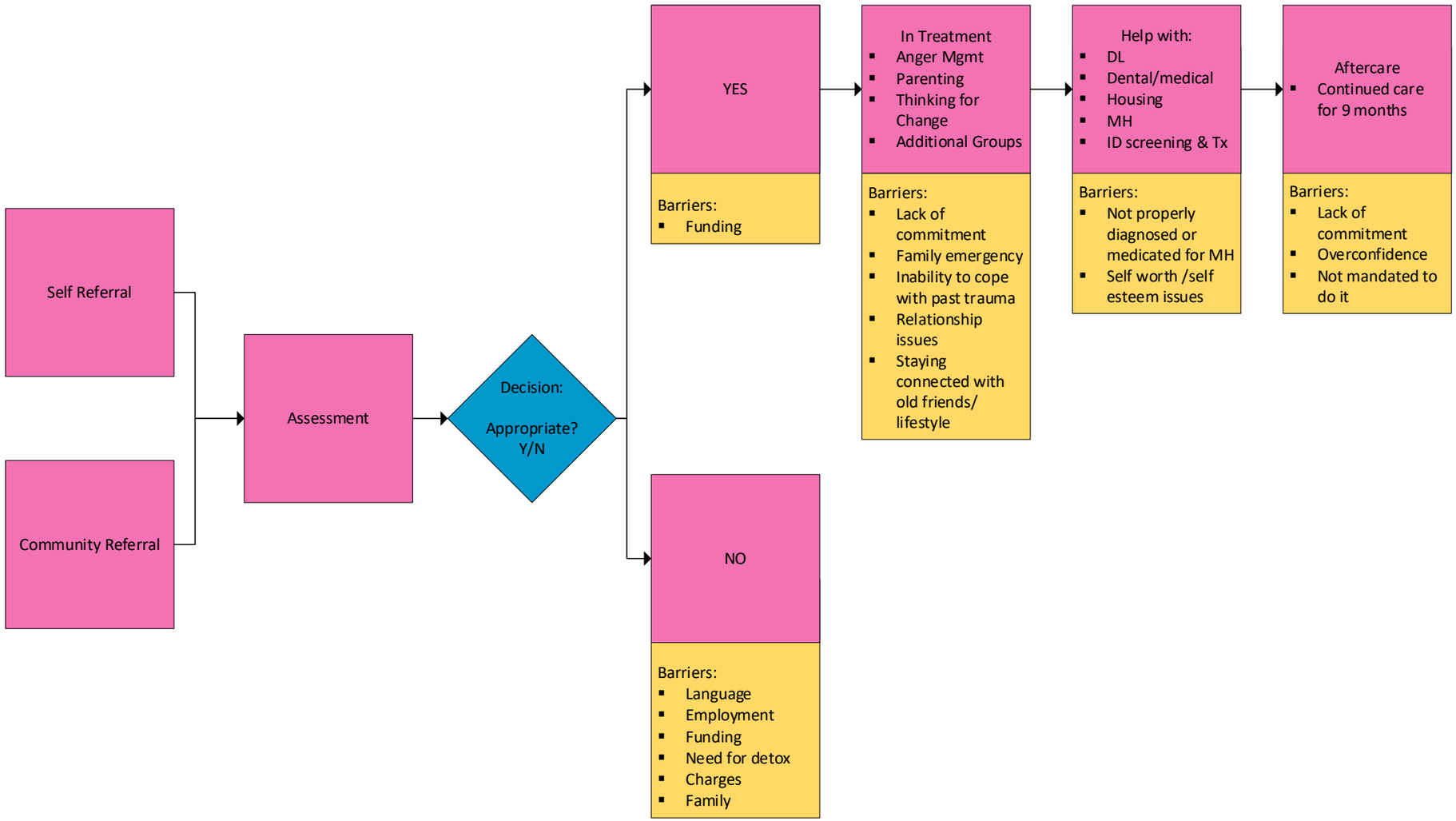


DHHS Public Health Nursing Program - The Public Health nursing program is a home visiting program with a nurse-family partnership, safe care and an assigned field nurse.

Individuals may be referred to Public Health Nursing by self-referral, the hospital, CWS, WIC, treatment facilities, their physician, or RCRC. Individuals assign based on program criteria and the public health nurse makes the initial contact with the individual. Once the home visits begin, a treatment plan is developed, and the nurse helps navigate the case plan which often includes substance use disorder treatment. Nursing also provides linkages to services, such as the Healthy Moms program.

Throughout this treatment pathway, barriers include: lack of an initial report from referring institution or not meeting pregnancy criteria, language and communication barriers, staffing, program funding, lack of teaming approach, timeliness, housing, patient engagement, staff training and awareness of updated resources, no evidence based SUD screening model to assess for SUD in this program, patient can deny referrals, social determinants of health, employment and lack of aftercare.

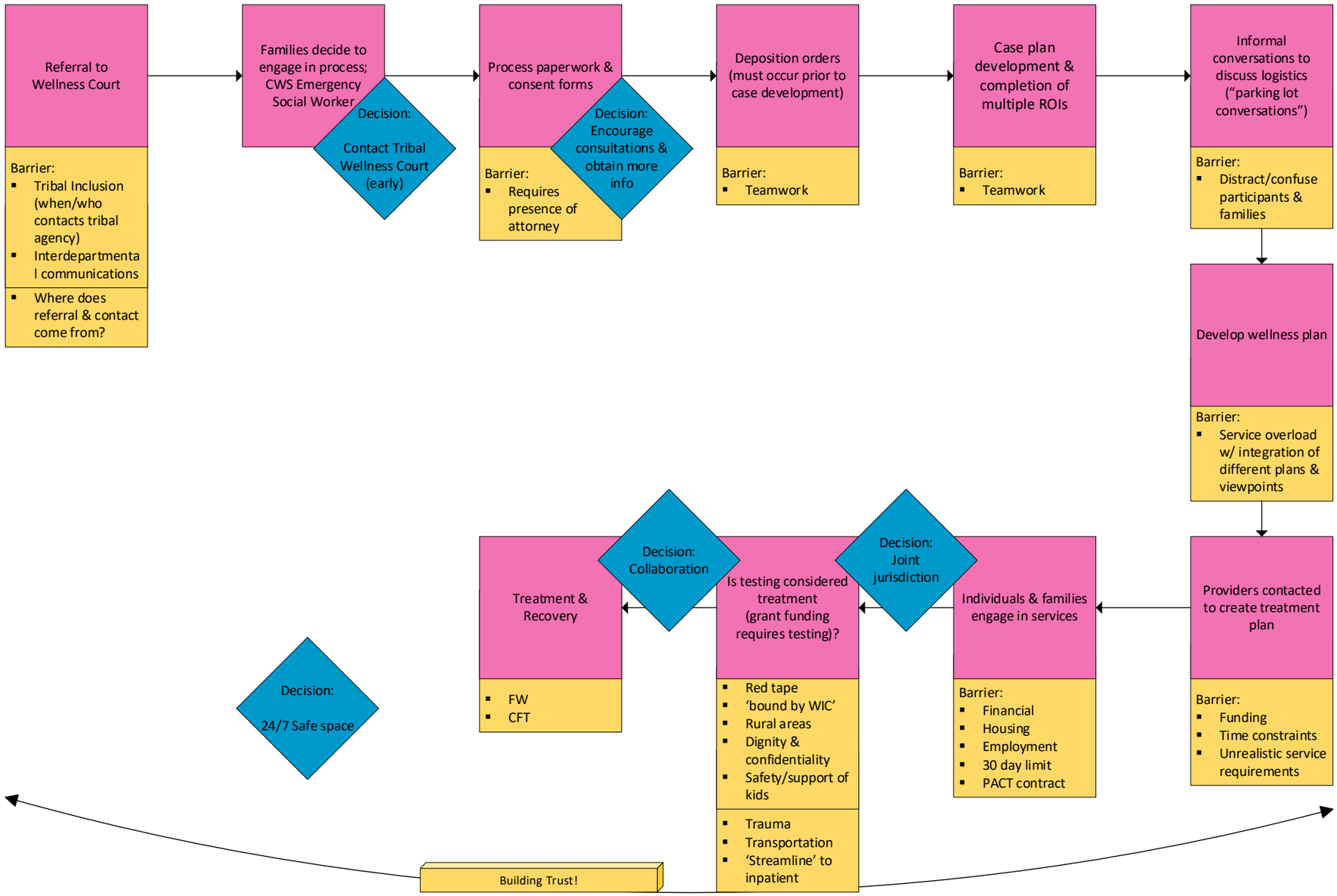
Humboldt Recovery Center (HRC) Current State VSM



Humboldt Recovery Center - Founded in 1972, Humboldt Recovery Center (HRC) is the largest and oldest licensed and certified residential substance abuse treatment facility on the California North Coast. HRC receives clients from both self-referrals of clients that come directly to the facility and through community referrals from primary care, hospital providers and other community-based organizations. Once a client presents at HRC we conduct an ASI assessment (transitioning to ASAM) to determine if the client can be served by HRC.

Barriers to serving clients who we can serve are typically funding/payment. Some potential clients that screen out that we are not able to service are often due to lack of insurance/funding, language barriers, employment, members requiring detox/withdrawal management, people with family issues, etc.

Family Wellness Court
Current State VSM



Family Wellness Court Family Wellness Court is a joint jurisdictional collaboration between the Humboldt Superior Court and Yurok Tribal Court that offers an alternative to Family Dependency Drug Court. Cases referred to Family Wellness Court require an open case with Child Welfare Services (CWS) Agency. Participation in Family Wellness Court is voluntary. Some barriers to participating include Tribal inclusion, interdepartmental communications, point of referrals and contacts.

Once a family decides to engage in the Family Wellness Court process a CWS social worker engages the Family Wellness Court Team, which includes Tribal Social Worker, Mental Health Clinician, Case Manager, Tribal Court Judge, and state court Judge. CWS works with the family to complete the paperwork and consent forms. This intake process encourages family participation and gathers additional information needed to proceed. Barriers include the presence of an attorney.

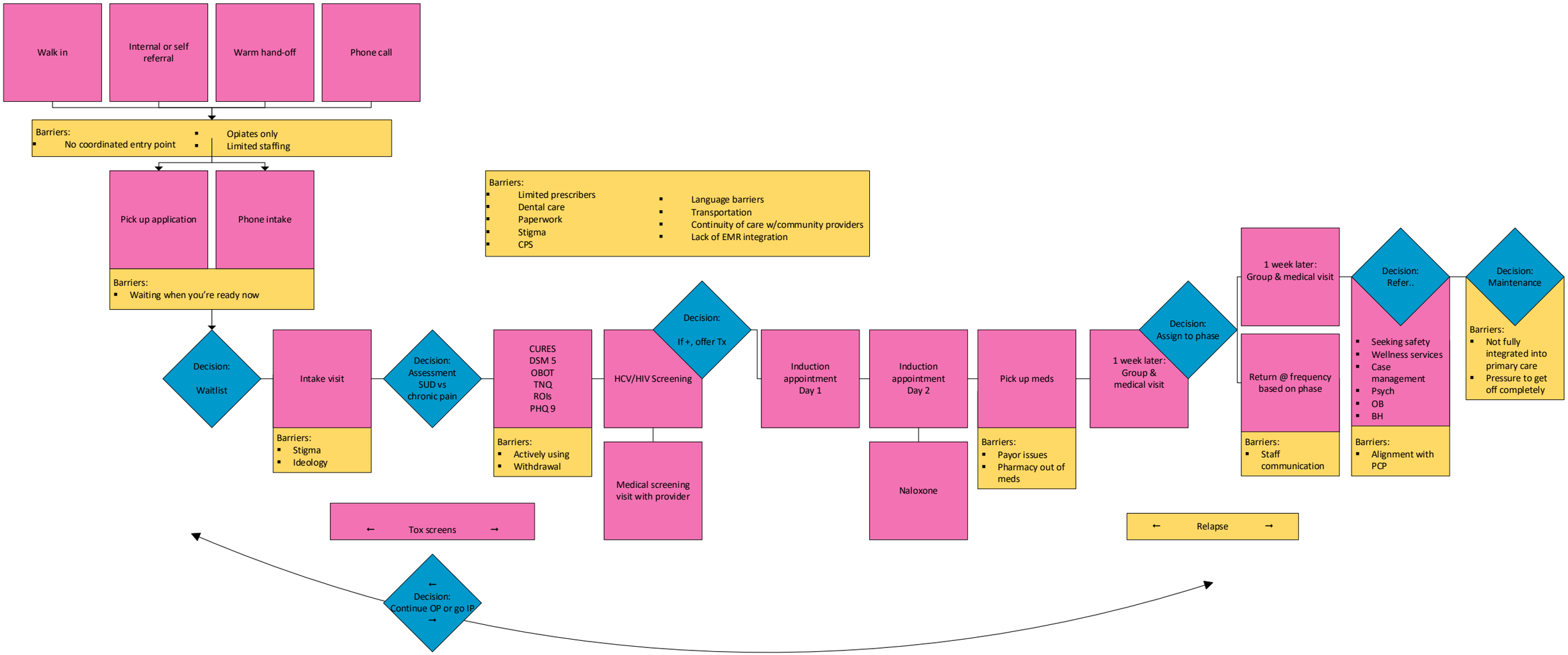
Depositions are required in order to develop the case. Teamwork of all agencies and entities can be a barrier.

A Family Wellness plan is developed with a focus on family reunification and cultural connection. Providers are contacted to help create a treatment plan. Some barriers in this area are time constraints, funding and unrealistic service requirements.

Parents and their families engage in services. Barriers to engaging in services are often financial, related to housing and employment. Parent participants are routinely drug tested throughout program participation. Barriers include program red tape, lack of privacy regarding testing, dignity and confidentiality concerns, trauma, safety and support of kids and transportation to and from services.

Successful completion results in family reunification, building trust with the family and the Family Wellness Court system and providing the family with 24/7 safe spaces for the children.

Open Door Community Health Centers Current State VSM



Open Door Community Health Center has four principal pathways to intake new clients for their Medication Assisted Treatment (MAT) services program. The program primarily connects with new patients through 1) Walk-ins at the clinic, 2) internal or self-referrals, 3) warm handoffs from other treatment professionals in the community, and 4) phone referrals. Currently the program does not have a coordinated entry point and they only provide MAT services for people with opiate addictions.

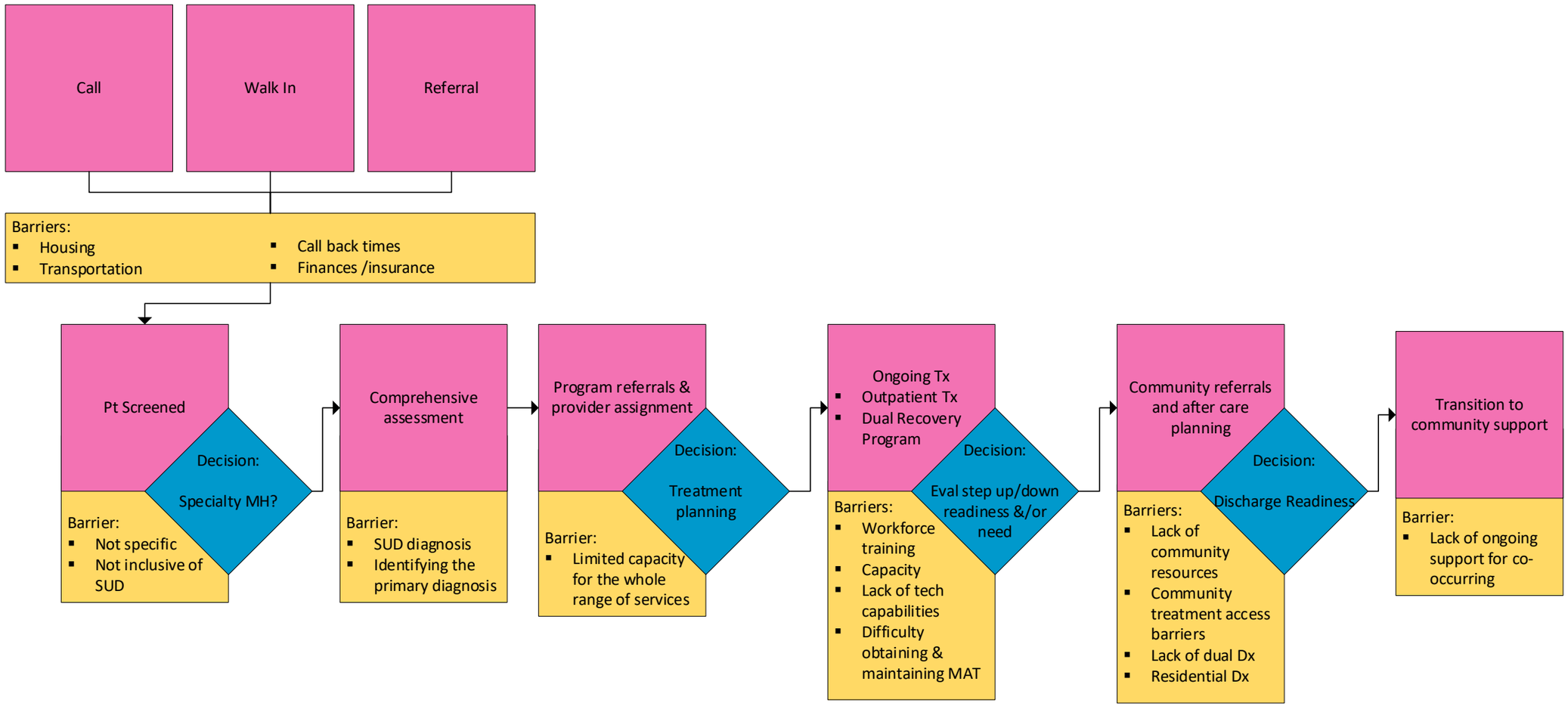
The intake process is conducted primarily by clients picking up and completing an application for services, or through a phone intake consultation with the clinic. Individuals that screen positive for services at Open Door are placed on a waitlist. The use of the waitlist does present a barrier for people who are ready to seek treatment at the time they present but not able to quickly access services. Once the clinic has openings to see new patients from the waitlist, they will schedule an intake appointment. During the intake visit the clinician will complete an assessment which will identify is treatment is for a substance use- disorder or individual with chronic pain. There are often barriers to getting clients to their intake visit, stigma places a role in getting clients to keep their appointments. Clients are often either still in active use at their intake appointment or in withdrawal as many continued to use while on the waitlist.

During the screening the clinic will complete the assessment using one of the many assessment tools based on the client's current condition. The assessment tools include the use of one or more of the following; Cures, DSM5, OBOT, TNQ, ROIs or the PHQ9. Clients are also screened for HCV and HIV during the assessment visit as well as complete a medical screening with their treatment provider. Clients that test positive for HCV or HIV are also offered appropriate treatment services for these conditions. After the intake is complete clients are set up for a MAT induction appointment.

MAT Induction appointments are the first appointment. The clients will be induced at the clinic and typically wait 20-40 minutes at the clinic to observation. Clients are sent home with enough medication for the next day. The Day Two appointment is set for the following day. Clients are then given their prescription for MAT and pick up their medicine at the pharmacy of their choice. Clients do not go to group on the day of induction, group therapy will generally begin the following day. Waiting can be a barrier. Clients are often waitlisted after screening until a formal intake, application process and program requirements. Induction appointments are generally on Mondays. The week after induction clients go into a phase one schedule which consists of a weekly visit with counseling and a provider. Clients go into group at this time. Once moved into phase two, clients come every couple of weeks and phase three is once a month. Toxicology screens are conducted at each visit and also randomly. Randoms are used with clients who are not seen at regular sessions and used as a way to outreach and engage clients. The random screenings are used as a way to provide additional support to clients who may be struggling. Some barriers for clients within the MAT program often are from payor issues and situations when the pharmacy runs out of meds. Once clients are assigned to their specific program phase they are scheduled for follow-up with their provider.

Once clients are assigned to a phase they are set into regular group and individual counseling sessions. Clients will be referred to the various courses within the program that includes the Seeking Safety group, wellness services, case management, psych services, OB, and/or behavioral health. Some barriers at this phase can include relapse, communications between staff and alignment of services with the client's PCP. Once clients are fully integrated into the program, they go into a maintenance phase. Some barriers for these clients are not having their maintenance services fully integrated into primary care and external pressures to get off of MAT treatment.

Department of Health and Human Services (DHHS) Mental Health Outpatient Current State VSM



The Department of Health and Human Services (DHHS) Mental Health Outpatient Substance-Use Disorder programs. The program treats people with serious mental illness (SMI). There are three primary pathways in which most individuals enter the program; 1) Calls, 2) walk-ins, and 3) referrals. There are often barriers to getting people into services such as homelessness, transportation, call back times and insurance and finances.

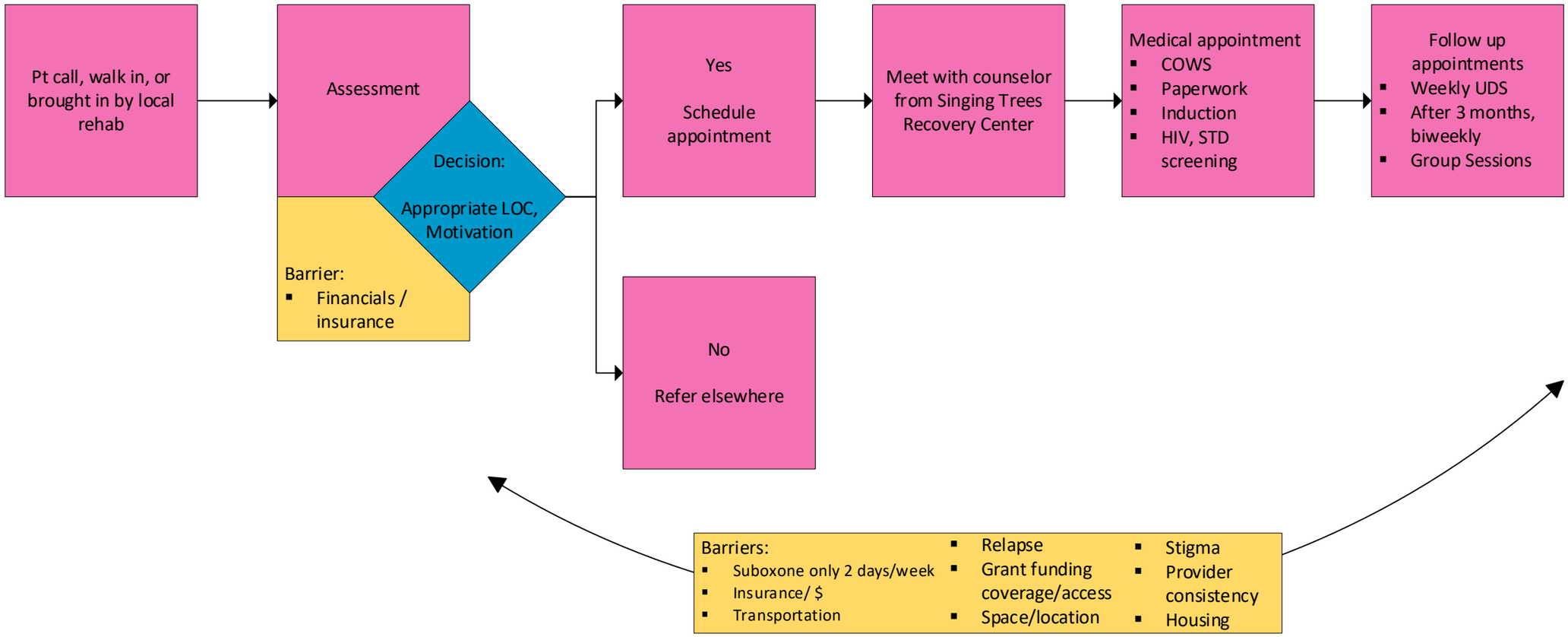
Once an individual is connected to the program they get screened to determine if they meet the criteria of level one for SMI. Part of the screening is specific for substance use disorder. Some barriers are when the determination is not specific to SMI resulting in a delay in receiving SUD services. People who have a positive screen for SMI receive a comprehensive assessment and are then referred to the specific program of need and a provider assignment. People who do not screen positive for SMI but require services are referred to Beacon for the mild to moderate mental health program. Some barriers within assessment are when there is co-occurring SMI and SUD, it is difficult to determine the primary diagnosis. Program referrals and provider assignment barriers include the limited capacity of the complete range of services. Once a program referral and provider assignment are made the client begins to receive ongoing treatment.

The treatment options are primarily in either the outpatient behavioral health clinic or dual recovery program. Some barriers to ongoing treatment are program workforce limitations, capacity, difficulty obtaining and maintaining MAT. Once clients are receiving treatment, they are monitored to evaluate whether they need stepping up or stepping down, depending on treatment progress.

Community referrals are made as clients phase out of the program nearing discharge. Barriers include lack of community resources, and lack of community treatment options for both single and dual diagnosis clients, especially for inpatient residential treatment and detox services.

Once clients are discharged from the program, they transition to community support. There is a lack of ongoing support for clients discharged from the SMI – SUD co-occurring program.

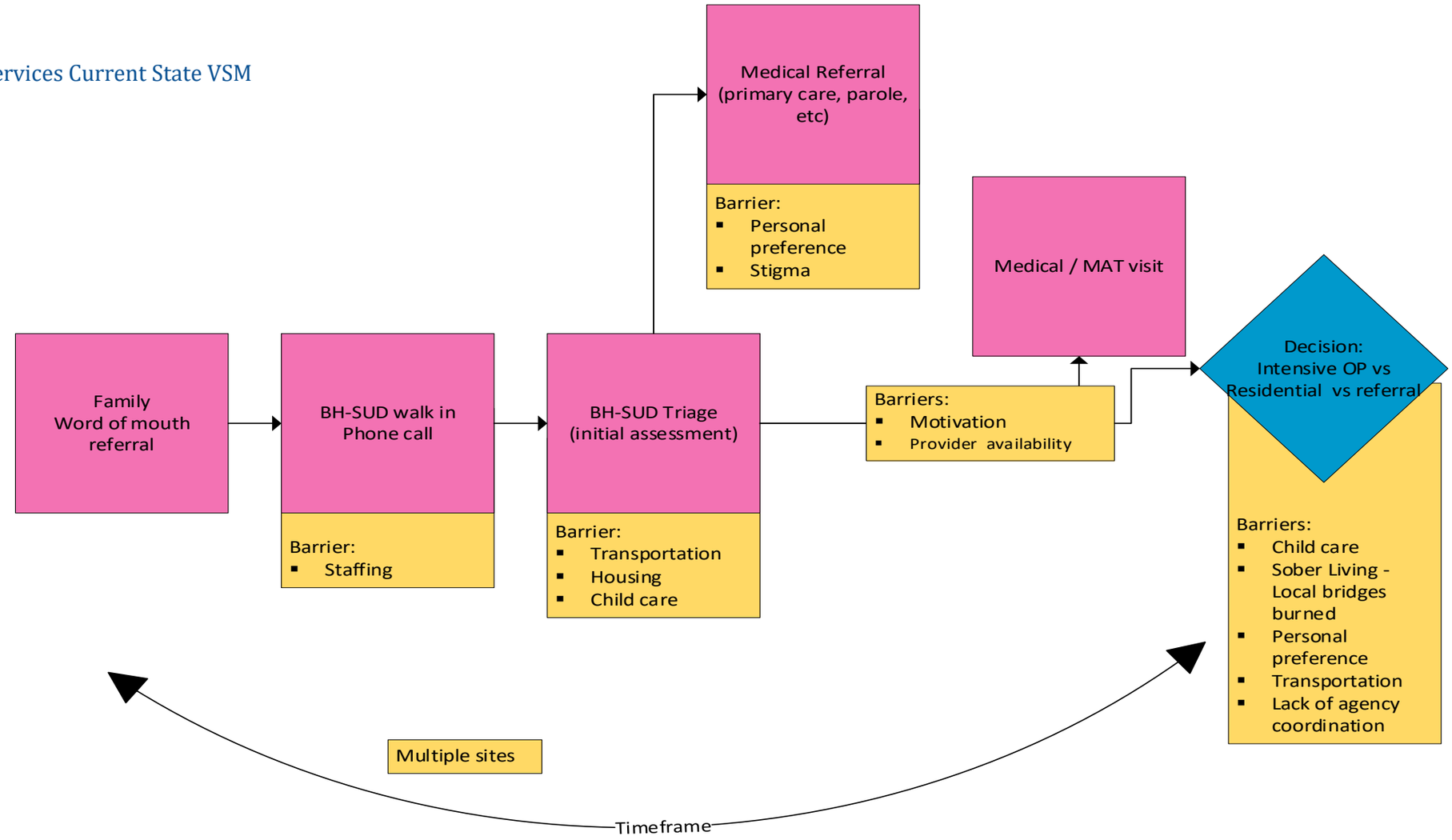
Redwood Rural Health Center (RRHS) Medication Assisted Treatment (MAT) Program Current State VSM



Redwood Rural Health Center - Individuals can access services at Redwood Rural Health Center by calling the clinic or walking in. An assessment is conducted to determine motivation and appropriate level of care; this also determines if Redwood is the appropriate fit for the individual. If not the appropriate fit for the individual, they will be referred out. If Redwood does seem to be the appropriate fit for the individual, then an appointment is scheduled. At the initial appointment the individual will meet with the counselor from Singing Trees Recovery Center, and social determinants of health such as housing and other concerns will be discussed. After this meeting, the medical appointment takes place, where the Clinical Opiate Withdrawal Scale or COWS assessment is completed. Also occurring at this appointment is paperwork, the medical induction and screening for HIV and hepatitis. Follow up appointments occur weekly for the first 3 months after which they are tapered as appropriate. During follow up appointments, a urine drug screen is completed, and group sessions are held.

Throughout this treatment pathway, barriers include housing, transportation, insurance / financial concerns, grant funding access and coverage, space within the physical location of the clinic, consistency between providers, relapse and stigma.

United Indian Health Services Current State VSM



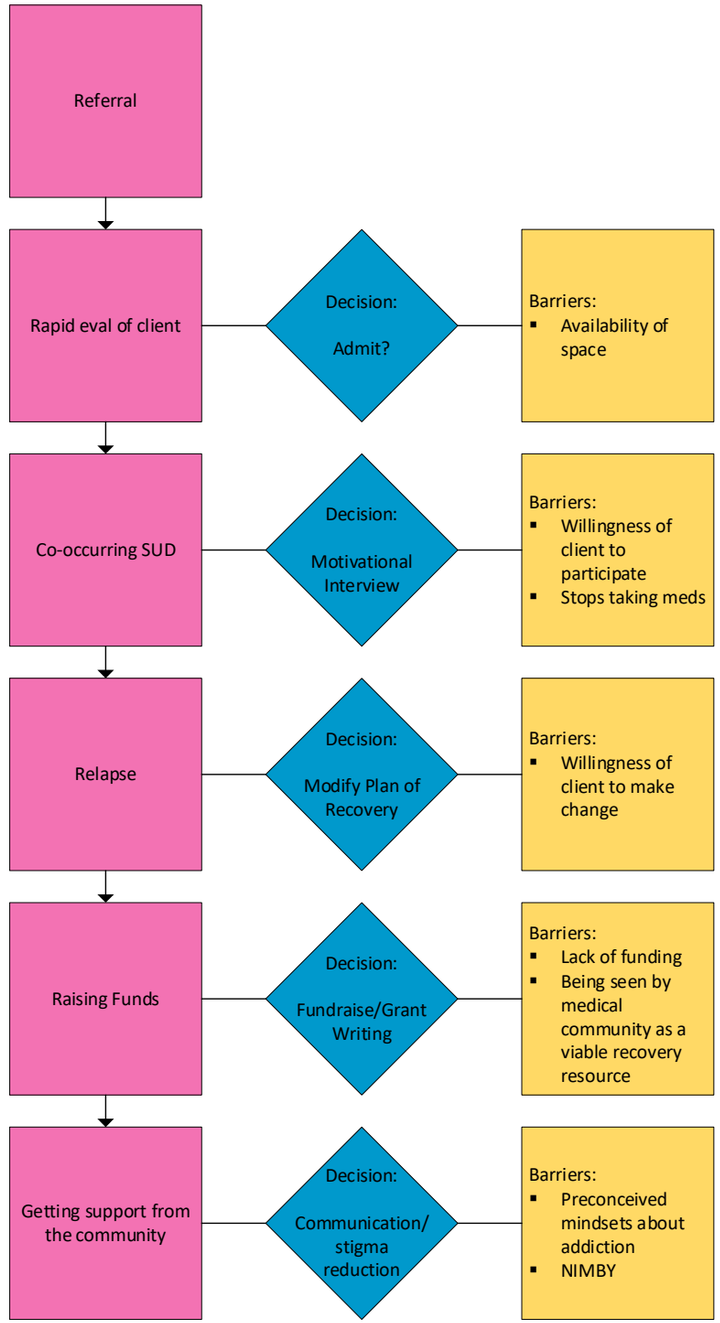
United Indian Health Services – United Indian Health Services (UIHS) receives patients from three primary referral sources; 1) Family-word of mouth referrals, 2) Behavioral Health walk-ins/phone calls, and 3) Medical referrals from primacy care, parole and other referral sources. Some barriers getting patients into services are staffing shortages, personal preferences of patients, stigma and documentation for new patients not established at UIHS. New members need to provide tribal documentation which can be a barrier to treatment.

Once a patient enters care, they meet with a counselor and receive an initial behavioral health assessment/SUD triage. Barriers for patients to get assessed include lack of transportation, housing and childcare.

Patients are assigned to either the Intensive Outpatient MAT program or the Residential Treatment program. UIHS programs focus on connecting tribal members to culturally competent care using a mindfulness approach. This approach reconnects patients with their tribal culture with a focus on the sense of belonging and identity. First group sessions consist of a beading class to help develop a sense of belonging.

Barriers effect the determination of program placement among the residential and intensive outpatient treatment program. Barriers include the availability of childcare for parents, sober living availability or lack of, fear of loss of housing, transportation, and lack of agency coordination.

AJ's Living Current State VSM



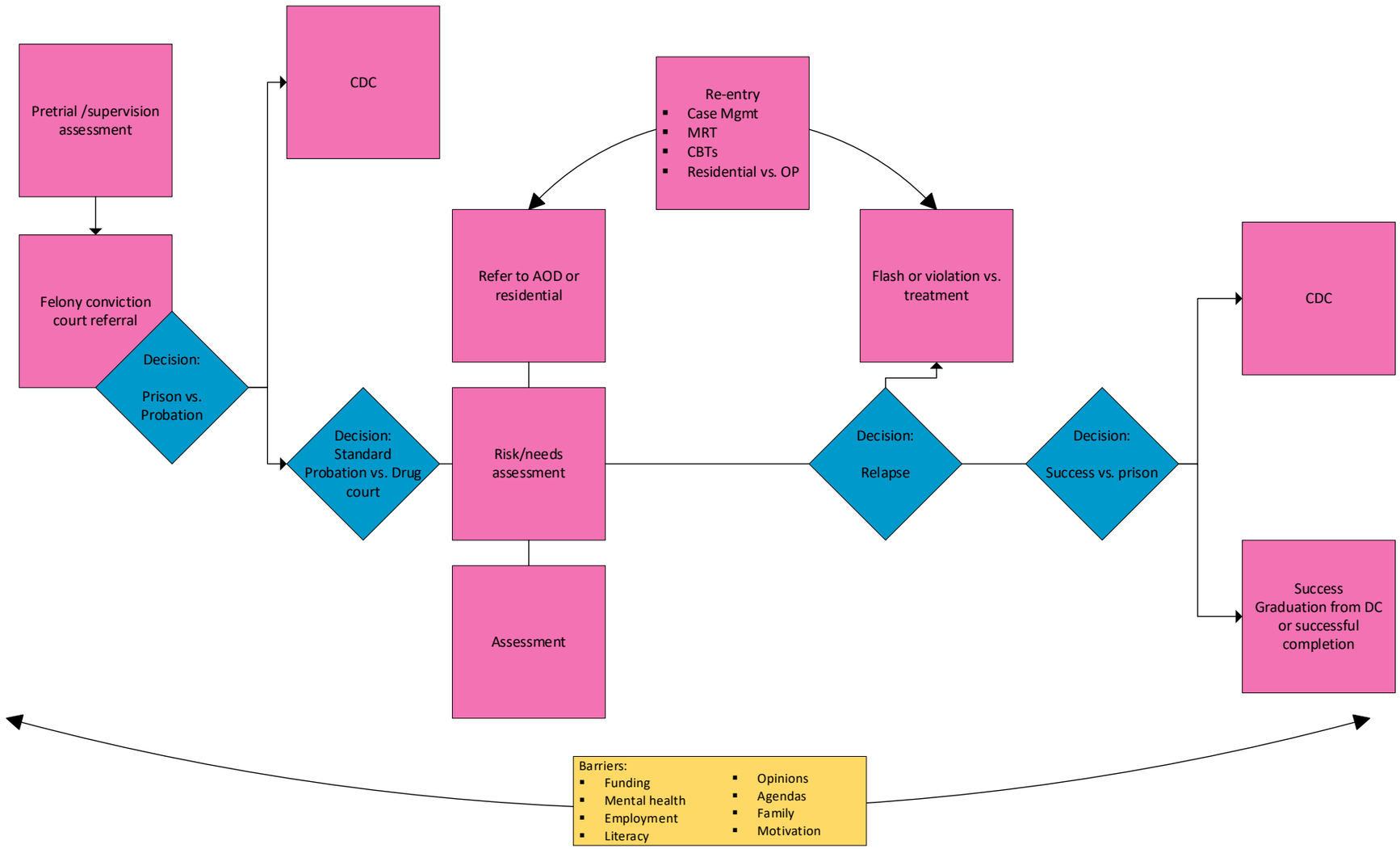
AJ's Living Program - Program referrals come from all over Humboldt County. The program focuses on rapid evaluation of clients and an admission decision is made quickly. Barriers to admission are often availability for new clients. The program uses motivational interviewing for individuals with co-occurring conditions. Barriers for people with co-occurring conditions tends to be willingness of clients to participate and adherence to medications.

The program works with its clients who relapse based on a plan of recovery. Clients have to be willing to change in order to successful remain in the program.

The program is mostly self-funded through donors. Clients pay based on their income, mostly general relief other income. The program does fundraise to help cover additional costs. Barriers include a lack of funding and being seen as a viable recovery resource by the medical community.

The program works to gain community support. Communications to reduce stigma about the program is important. Barriers include preconceived mindsets about addition and NIMBY-ism.

Humboldt County Probation and Drug Court Current State VSM



Humboldt County Probation and Drug Court – Referrals come to the Probation and Drug Court for Adults (mostly) who have a felony conviction just prior to being sentenced. The Probation and Drug Court program will conduct a risk assessment to determine likelihood to re-offend. The assessment will determine If the person is assessed as able to remain in the community on probation or if they should go to state prison. If the person is determined to reoffend, they will be remanded to the California Department of Corrections.

If assessed to remain in the community, they person is determined for either standard felony probation or drug court

Individuals are referred to Alcohol and other outpatient Drug treatment programs or Residential Treatment programs. Once referred to a treatment program, a risk/needs assessment is completed by the program. Participants that relapse of test positive on a drug screen can be flash incarcerated and then renter the program. Participants who participate in and successfully complete Drug court will have their felony conviction record vacated.

Some barriers to participating in drug court include funding, mental health needs, employment or lack of, literacy, opinions, agendas, family and motivation.

D. Barriers and Gaps – Inventory and Discussions

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

Full Group Barrier Discussion #1

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

- Access (point of contact unclear, timeliness, capacity, limited business hours, bed availability, conflicts with employment times)
- Lack of providers, staffing salaries, conflicting ideologies between providers, staff education, clinician lack of understanding about MAT screening, etc.
- Geography/Space (transportation, distance to services, rural)
- Rules and regulations as related to funding and treating dual diagnosis
- Complacency of drug culture
- Lack of effective referrals between programs
- Stigma / lack of community understanding of current SUD neuroscience, community resistance to suboxone, lack of social cohesion and empathy of folks experiencing SUD, lack of understanding of SUD/Addiction in the community
- Benzo detox w/suboxone
- Poverty/patient finances (specifically in commercially insured population), insurance/$ coverage for MAT,
- Payment models don't acknowledge MH/SUD are co-occurring, commercial payors don't cover treatment (residential and outpatient)
- Patient engagement/denial
- Difficult to connect people in pharmacotherapy with community providers willing to provide/continue services
- Limits on pharmacy supply; DEA regulation
- Lack of housing first models
- Not enough quality clean and sober housing
- Challenges connecting participants to detox within "medical necessity" window
- Screening and assessments based solely on self-disclosure – need for inclusion of info from tribe and CWS
- MOU forms not updated
- Community lacks awareness of UIHS services, Native American access to MAT, Lack of culturally appropriate services, cultural practices not always integrated; lack of cultural awareness and humility
- Laws that regulate share of information inhibit good service delivery (i.e. CWS and public health – 42 CFR part 2 and HIPAA)
- PHF will not prescribe MAT

- Pregnant moms fearful about starting treatment and still having their babies removed, reunification services not currently prioritized
- No daycare
- Underutilization of current resources
- In-patient doesn't accept Medi-Cal

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
St Joseph's Hospital	2	4	5	2	5		2	3	1	2	1
Waterfront Recovery	2	1	1	3				2	2	1	
Crisis Stabilization Unit	1		7	3				2	2	1	1
DHHS - MH	5		6	3	1	1		3		1	
EPD CSET	4		2	1				1	1		
Priority Care Center	3	2	1		1					1	
SBHC	1	1	2		4	1	1				
HCTAYC											
HCCF	1	1	6	1	2						
Public Health	2		4	1					1		1
HART	2	2	1					2	1	1	1
HC Program for Recovery	1	3	2	1		1					
Crossroads Recovery Center		1					1	2	1	1	
Public Health Nursing	1	2	2		2	1		1	1	1	1
Humboldt Recovery Center	1						1	4	2		1
Family Wellness Court	2	3		1		1		3	1		2
Open Door Community Health Centers	1	4	2	2			2	2		1	1
DHHS Mental Health Outpatient	1	2	4	2	1		1	2	1	1	
Redwood Rural Health Center MAT Program	1	1	1				1	3	1	2	
United Indian Health Services		1		2			1	3			
AJ's Living	1			1			2		1		
Probation & Drug Court					1	1		5	1		

Breakout Discussions: Solutions to Barriers

Small groups were asked to discuss barriers and brainstorm solutions, and then share their solutions with each other. The following is a consolidated list of proposed solutions to top barriers from both group discussions:

- Rules and regulations as related to funding and treating dual diagnosis
- Increase bus services in the community; express routes to improve access to services/transportation concerns
- Educate providers and the community to improve complacency of drug culture
- Educate the community to decrease resistance to suboxone, improve understanding of SUD/Addiction in the community, awareness of UIHS services
- To address stigma: Education for providers and all
- Staff, Education in nursing and medical school, PR campaign to explain they are part of us in the community, Self-esteem building by breaking down stigma in the community as well as the medical and behavioral communities; no ugly stepsisters; all approaches are valid, community pharmacy collaboration/counseling
- EBP, MET to improve patient engagement/denial
- To address poverty/patient finances (specifically in commercially insured population), allow CalWORKs even when children in foster care
- To improve connections of people in pharmacotherapy with community providers willing to provide/continue services, increase MAT providers
- Building the space and programs to improve utilization, privacy concerns
- Use DHHS grants to fund quality clean and sober housing
- Standard SUD training for all in Humboldt Co. to resolve conflicting ideologies
- Expand MIST & MRT regional services to increase 'business hours'
- Include family in screening and assessments (currently based solely on self-disclosure); provide inclusion of info from tribe and CWS
- Cultural coaches at every agency to improve cultural practice integration; lack of cultural awareness and humility
- Engage Senator Jeff Stone (Riverside, 28th district) to champion legislation funding to improve bed availability; beds available no need for detox
- UIHS provides MAT services to ensure Native American access to MAT

E. Future System Goals

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

Integration/ Coordination

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

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

Access to Care

Many groups mentioned a desire for a "no wrong door" approach to addiction treatment so clients could engage with any organization in the addiction treatment system in Humboldt County and be referred to the correct level of services. Three different groups discussed the need for a navigation platform that would help to facilitate streamlined entry and access to a comprehensive list of resources.

Evidence-Based Care

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

Resources for People Living with Addictions

Many groups mentioned the important of investing in Social Determinants of Health (SDOH), particularly permanent and transitional housing, transportation, and employment support, in order to achieve "whole person care." Group also discussed the lack of transportation as a barrier and the need to add more transportation resources to get people with addictions to and from treatment.

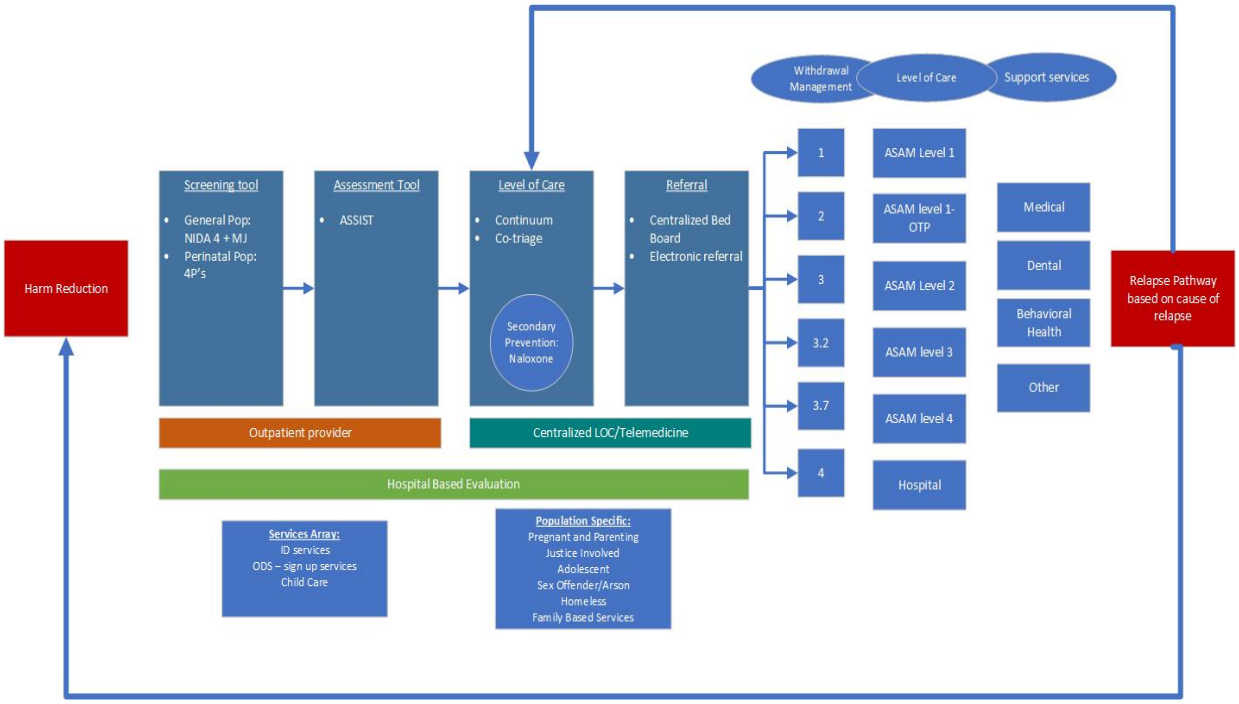
F. Triggers

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

G. The "Scaffolding" of the Future State

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 Humboldt County.



Considerable time was spent during the process improvement event considering the current state of the SUD ecosystem and barriers that exist within this system. These conversations, plus the extensive county-wide prework, informed the ultimate future state discussion of the whole group. A community wide set of Screening and Assessment tools were not identified at the PIE event. Given the community consensus on the need for additional discussion on importance of the selection of the future state Screening and Assessment tools the community tabled the selection of tools and had additional discussions at the standing July RxSafe Humboldt Opioid Coalition meeting one week following the PIE event. The RXSafe Humboldt Coalition requested a follow-up conversation to collectively identify a screening and assessment tool for community use. RxSafe Humboldt, the Humboldt Community Health Trust, and DHHS–Mental Health staff partnered to host a follow-up conversation on July 18th, 2019.

The meeting on July 18th allowed for collective participant review and evaluation of evidence-based screening and assessment tools as recommended by HMA in their June and July webinars on screening and assessment. A local physician who is board certified in addiction medicine served as the content expert to review the tools and answer question. Participants in the meeting agreed upon the value of using evidence-based screening tools and a shared assessment tool. It was recommended by the group that the following tools be used for screening in Humboldt County: CAGE-AIDE, NIDA, 4P's (Perinatal Population). The group recommended a variety of evidence-based tools given the variance in populations and settings in which tools may be administered

Screening

The group discussed and decided on the use of the following screening tools:

- NIDA 4 (plus a marijuana question) for the general population such as adults in clinical settings,
- CAGE-AID for Adults in social settings
- 4Ps plus for the pregnant population.

HMA will assist the Safe RX Humboldt coalition and community in a follow-up conversation as part of the projects technical assistance component to help identify a screening tool for use with the adolescent population. The community initially agreed to the use of NIDA 4 plus a Marijuana Screening in the interim. These screenings will both evaluate for multiple substances and are extrapolatable to all cultures in Humboldt County. Each is recognized by the payer's and provider's alike and can be performed by anyone from the patient to the provider.

Assessment

The group discussed and decided on the use of the following assessment tools:

- The ASSIST tool (World Health Organization) was chosen as the primary county-wide assessment tool.

This tool has been validated in adolescents, pregnant patients, Spanish speaking individuals and American Indian populations, just to name a few. It is also recognized by payers and providers as a valid tool to determine the presence and severity of addiction to all substances. If this tool finds the presence of a substance use disorder, then the patient should have a level of care determination done.

Level of Care Determination

The state of California's Drug Medi-Cal program (DMC) requires that the ASAM criteria be used to determine the level of care for patients with addiction. The Criteria looks at 6 dimensions of the patient's condition to determine their treatment plan and the most appropriate location for that treatment plan to be executed. This can be done through a structured interview or an on-line tool called the Continuum (the short form is the Co-triage). It is recognized by all payers as the standard of care and allows for the location of care to be based on a set of parameters, rather random chance. This is also one of the stages that naloxone can be distributed or prescribed.

Treatment Ecosystem

Within and outside of Humboldt County there are many levels of service that can be delivered for both withdrawal management and treatment of the SUD. These need to be identified and vetted to determine how many slots or beds are available at each level of care, what services are delivered, how fast the patients can have access to MAT, who treats co-occurring and all of the other aspects to complete addiction care. Once this is done, awe can overlay the support services as needed.

Dental was mentioned more than once as a significant need and should be dealt with post haste. There are many ways to do this, especially with the expansion of Medicaid. Helping with obtaining an ID, getting housing and having appropriate food should all be coordinated through a central “hub” for information and referral.

Relapse

Early relapse detection and intervention decreases the risk for accidental overdose and the risk of obtaining and infectious disease. Having centralized telephonic support, Emergency Department pathways of care and community training for post relapse intervention is of the utmost importance.

Overall the future state represents an evidence-based, pragmatic approach to addiction care that is achievable. With the technical assistance that will be provided and the continued hard work of the community partners, there is no doubt that it can be realized.

03 Section 3: Implementation Strategy

A. Next Steps

In a matter of two days stakeholders from across Humboldt 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 Humboldt 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.

B. Technical Assistance Program

Prior to the process improvement event, we collaborated with the DHHS and the Humboldt Community Health Trust to develop an attendee list and conduct outreach to invitees to encourage attendance. Also prior to the event, the DHHS completed a survey to document existing substance use disorder (SUD) capacity and resources in Humboldt 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 Northern California Team Lead (Don Novo). On the TA Application, respondents were asked to check the box or boxes that best described their TA needs. Options included: (1) Learn more about caring for people with addiction and provide more information and training to our staff; (2) Learn more about how our organization can participate in a community wide solution to the opioid epidemic; (3) Improve our role in managing the transitions of care as residents in our community move within addiction system of care; (4) Start providing MAT services at our organization; (5) Scale up our current MAT program by increasing the number of patients treated; (6) Learn how to provide or improve addiction treatment to pregnant and parenting women. Based on their selection(s) on the TA Application, organizations are put into one of two TA tracks:

1. Generalized TA: Sites that are unlikely to provide MAT but are seeking general TA
2. TA Coaching: Sites that can potentially provide MAT and are interested in learning more **or** sites that already provide MAT and want more specific TA to scale up services

Those who checked options 1, 2, 3, or 6 were put into the Generalized TA track, and those that checked options 4 or 5 were put into the TA Coaching group where there will receive more hands-on coaching to begin providing MAT services or scale up existing services. This is because the focus of the Transitions of Care Project is on the expansion of MAT services in the state.

Organizations in the TA Coaching group were asked to complete a TA Assessment that included more specific questions about TA interests and needs and will be used to match each organization with a TA coach. Once matched with a TA Coach, the Coach will reach out to the Organization Lead identified in the TA Assessment to schedule an initial coaching call. The Coach will provide individualized coaching to their organizations, or "sites", through September 2020.

Generalized TA offerings are available to both groups, and include live webinars and recorded webinars, and access to a variety of resources on the Transitions of Care project website, AddictionFreeCA.org. Anyone can submit a specific TA request through the TA request portal on the AddictionFreeCA.org website. 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 25 organizations applied for TA:

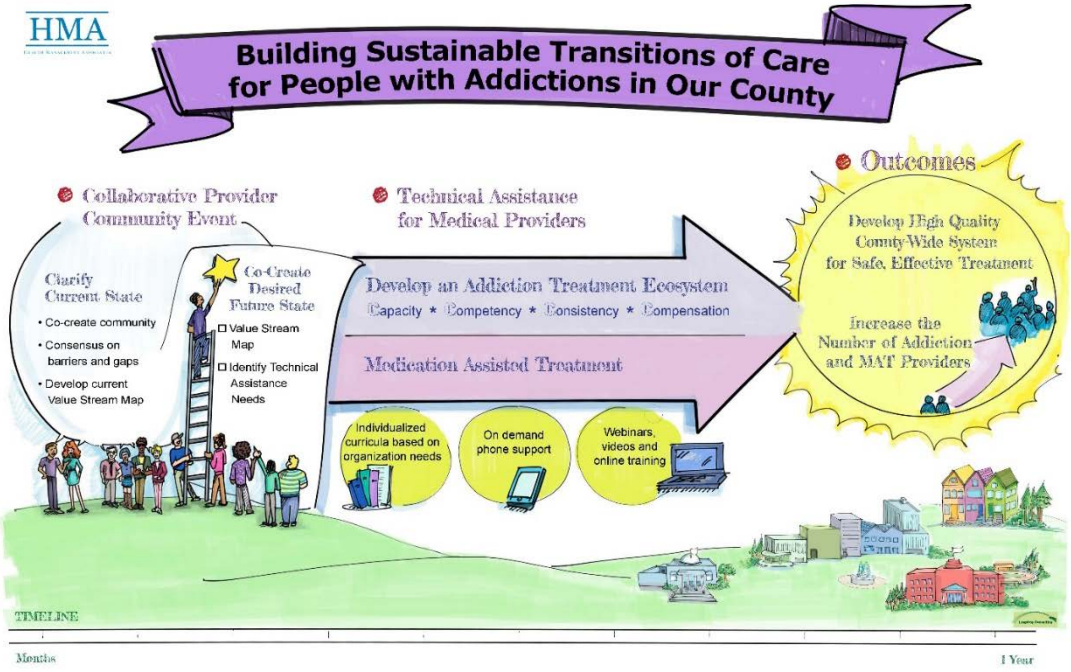
- AJ's Living
- DHHS Mental Health - Adult Crisis Services
- DHHS Mental Health - Children's Services / Transition-Age Youth (TAY)
- DHHS Public Health
- DHHS SUD & MH - Adult OP
- Family Wellness Court
- Fortuna Adventist Community Services HART Program
- Healthy Moms Program
- Hoopa Tribal Court
- Humboldt County Child Welfare Services
- Humboldt County Correctional Facility
- Humboldt County Office of Education
- Humboldt County Probation
- Humboldt Recovery Center Inc
- Karuk Tribe Human Services
- Kimaw' Medical Center
- NorCal Recovery Services
- North Coast Substance Abuse Council
- Open Door Community Health Centers
- Redwood Community Action Agency (RCAA)
- Redwoods Rural Health Center
- St Joseph Health
- United Indian Health Services
- Waterfront Recovery Services
- Well Path - HCCF

The 25 organizations/teams who requested TA requested the following specific goals:

Goal	Frequency
Learn more about caring for people with addiction and provide more information and training to our staff.	22
Learn more about how our organization can participate in a community wide solution to the opioid epidemic.	20
Improve our role in managing the transitions of care as residents in our community move within addiction system of care.	17
Learn how to provide or improve addiction treatment to pregnant and parenting women.	14
Start providing MAT services at our organization.	7
Scale up our current MAT program by increasing the number of patients treated.	5

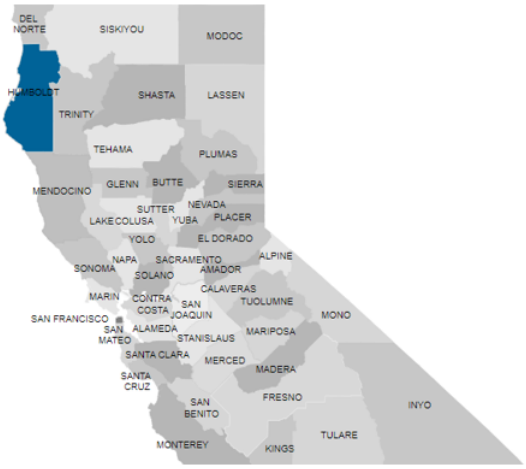
C. Conclusion

In conclusion, HMA thanks the Humboldt County community who turned out with their hearts and minds committed to this work. We hold the deep conviction that the Humboldt County community and stakeholder coalition of addiction treatment providers, medical professionals, hospitals, law enforcement and CBO 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 Humboldt Department of Health and Human Services along with Partnership Health Plan, the Humboldt Community Health Trust, RX Safe Humboldt, Humboldt Independent Practice Association and the hospital community have the vision, leadership and ability to fully implement the envisioned future state pathway 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. Humboldt County Data

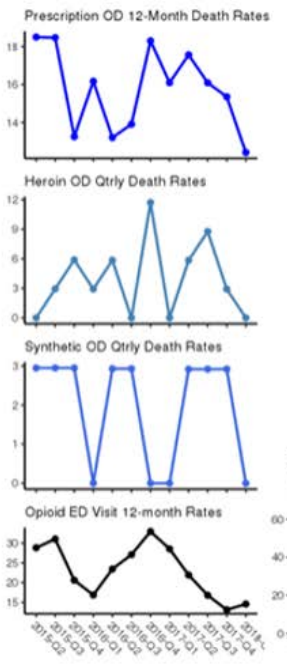


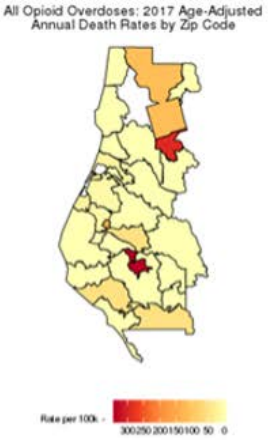
STATISTICS

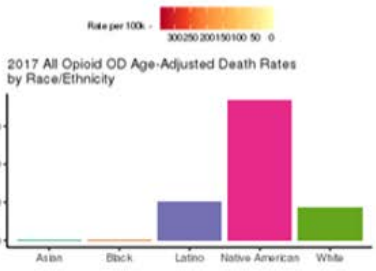
- OUD Death Rate
  - 2017: 21.0, Rank 2/41
  - 2016: 22.4, Rank 2/41
- All Drug Death Rate
  - 2017: 31.7, Rank 3/41
  - 2016: 37.8, Rank 1/41
- ED Opioid Rate
  - 2017: 41.1, Rank 7/41
  - 2016: 65.0, Rank 4/41
- 5 Hospitals
- 28 Pharmacies
- 2 FQHCs
- Methadone Pt Rate 0: Rank n/a

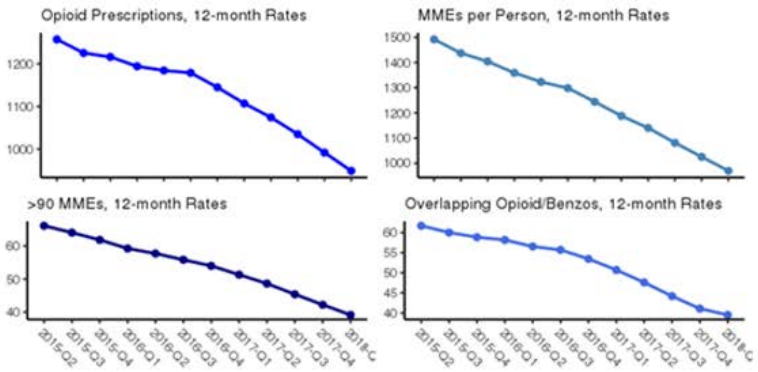
ADDITIONAL FACTORS

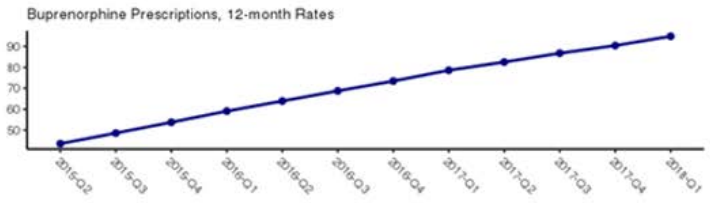
- Coalition: RxSafe Humboldt
- *PHI recommends as receptive*
- SAMHSA Funds: $328,750
- Hub with 7 Spoke Sites
- Drug Medi-Cal Organized Delivery System?: Yes
- Presence of CA Bridge: Yes











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

B. Process Improvement Event Slides

HEALTH MANAGEMENT ASSOCIATES

Building Sustainable Transitions of Care for People with Addictions in Humboldt County

June 19-20, 2019

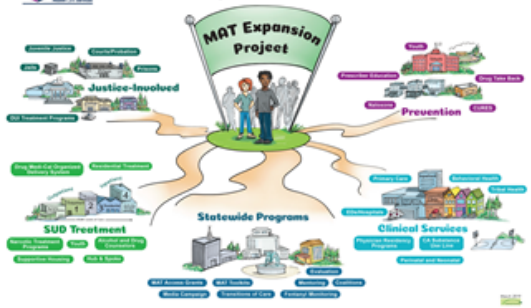
DHCS California Department of Health Care Services

Funding for this event was made possible (in part) by H79TI081808 from SAMHSA. The views, opinions and content in written event materials or publications and by facilitators and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

1

SAMHSA MAT EXPANSION GRANT

In California, Treatment Starts Here



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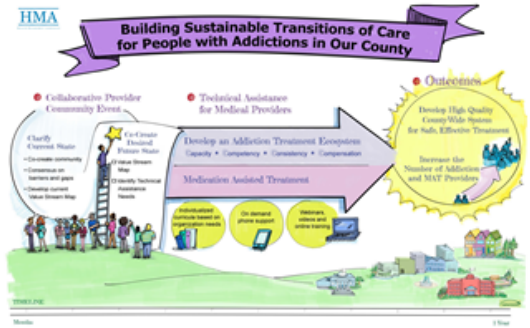
2

HMA TRANSITIONS OF CARE PROJECT



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3

AGENDA

DAY ONE	DAY TWO
Morning Session + Why are we all here? + Addiction 101 + Addiction Treatment Ecosystem + Barrier Identification and Resolution	**Morning Session** + ½ Current State Value Stream Mapping (VSM) + Current State Presentations
Afternoon Session + Current State Value Stream Mapping (VSM) + ½ Current State Presentations + Future State Set-Up	**Afternoon Session** + MAT Basics + Future State Group Session + Next Steps

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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

5

SCOPE OF TECHNICAL ASSISTANCE

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

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

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

6

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

7

HUMBOLDT COUNTY: POPULATION 134,623

STATISTICS

- OUD Death Rate
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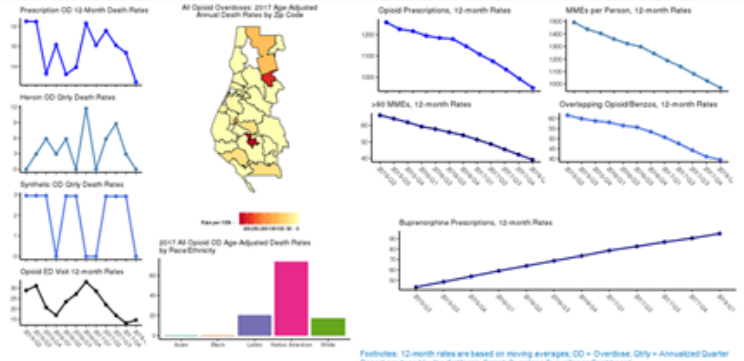
8

HUMBOLDT COUNTY: POPULATION 134,623



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RXSAFE HUMBOLDT

RX SAFE HUMBOLDT
Safer Care and Better Outcomes

Develop and implement community standards and supporting infrastructure for diagnosis and treatment for chronic pain

- Provide patients with optimum care consistent with the risks of treatment
- Support diagnosis and treatment for acute pain recognizing the risks of treatment, across providers and settings prescribing opioids
- Develop strategies for minimizing misuse and diversion of prescription pain medications

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RXSAFE HUMBOLDT: COALITION PARTNERS

- Humboldt Independent Practice Assoc.
- North Coast Health Improvement and Information Network
- Open Door Community Health Centers
- North Coast Clinics Network
- Partnership Healthplan of California
- Mad River Community Hospital
- Humboldt County Sheriff's Department
- Humboldt County Department of Health and Human Services
- Humboldt County Public Health Department
- St. Joseph Health, Humboldt County
- Humboldt Area Center for Harm Reduction
- Cloney's Pharmacy
- Aegis Treatment Centers
- Community members

RX SAFE HUMBOLDT
Safer Care and Better Outcomes

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RXSAFE HUMBOLDT: ACCOMPLISHMENTS

- 12 Medication Disposal Bins located across Humboldt County
- Over 5,000 lbs. of unwanted prescriptions disposed of in the last 3 years
- Naloxone kits distributed by the Humboldt Area Center for Harm Reduction and the County Public Health Department.
- Several hundred overdose reversals reported each year.
- Support increased MAT access through academic detailing and increasing number of waivered providers

www.RxSafeHumboldt.org

www.StopOverdoseHumboldt.org

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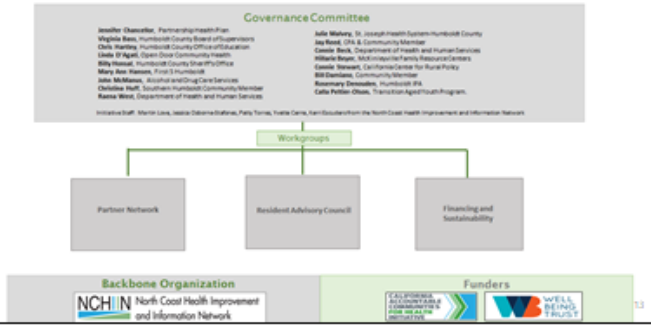
HUMBOLDT COMMUNITY HEALTH TRUST: AN ACCOUNTABLE COMMUNITY FOR HEALTH

Humboldt Community Health Trust

A cross-sector collaboration working together to holistically address substance use disorder in Humboldt County



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HUMBOLDT COMMUNITY HEALTH TRUST: DISCOVERY AND FINDINGS

Service Provider Interviews to Date: 31 Lived Experience Interviews to Date: 35 **Community Listening Sessions to Date: 6**

1. There are no local SUD treatment programs where clients can bring their families

2. Wide Variety of Assessment and Data Collection Processes Across Providers

3. Factors that Limit Service Capacity:
   - ☐ Funding (42%)
   - ☐ Lack of Coordination (26%)
   - ☐ Workforce (21%)

4. Navigating the Treatment System is Complex

5. Complexity: Polysubstance Use, Co-Occuring Mental Illness, Trauma

6. Substance Use Starts at a Young Age

7. Critical Role of Prevention
"Childhood sucked, it was horrible. Until I discovered alcohol, by the time I was 12 years old I was drinking every day...it was my medicine. I totally understood at that age, that this is what I need to do to feel normal."

HEALTH MANAGEMENT AS

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HUMBOLDT COMMUNITY HEALTH TRUST: GOALS

1. Reduce alcohol and substance use injury and overdose
2. Increase access to prevention and early intervention
3. Improve policies to better address social determinant of health needs
4. Enhance substance use disorder system access, integration, and coordination

For More Information: HCHT.NCHIIN.org

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ACH & RXSAFE HUMBOLDT: ALIGNED INITIATIVES AND PROJECTS

Adverse Childhood Experiences (ACES) Collaborative
- Led by First Five Humboldt
- Efforts focus on preventing ACES and increasing individual and community-level resilience

Allies for Substance Abuse Prevention
- Coalition staffed by DHHS- Alcohol and other Drug Prevention Program
- Primarily focused on prevention

Emergency Department Bridge Program
- Led by St. Joseph Health System
- Supports MAT in emergency departments and the development of a care navigator role

Medication Assisted Treatment in the Jail
- DHHS, Sheriff's Department, Rx Safe Humboldt and other community partners
- HMA-led learning collaborative increase to access to MAT in jail systems

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ACH & RXSAFE HUMBOLDT: ALIGNED INITIATIVES AND PROJECTS

Perinatal Substance Use Disorder Project

- Community project with a multi-agency project team: NCHIIN, St. Joseph, DHHS, CCRP
- Focused on screening women for SUD during prenatal care, referring to a Pregnancy Care Navigator, increasing access to MAT for pregnant women, and establishing consistent messaging around cannabis use during pregnancy and lactation.

Road to Resiliency

- First Five Humboldt, First Five Del Norte, and Joint Jurisdictional Court project
- Focused on supporting tribal care navigators for women and families experiencing SUD in tribal communities

Sequential Intercept Mapping

- Led by Humboldt County Probation Department
- Focused on people who are mentally ill and/or have SUD who intersect with the criminal justice system

***NOTE: Not intended to be a comprehensive list. There are numerous other programs, initiatives, and efforts that are SUD focused or SUD adjacent in Humboldt.*

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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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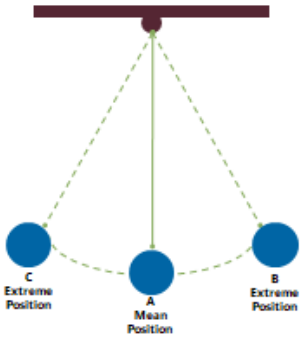
ADDICTION 101 – SAFE OPIOID PRESCRIBING



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IS ALL ADDICTION THE SAME?

Patient 1

- Early life trauma
  - Neglect
  - Sexual assault
- Isolation from friends
- Early use of marijuana
- Heavy episodic drinking in early high school
- Opioids at 19 y/o
- Heroin at 22 y/o

Patient 2

- Parents divorced and had shared custody
  - No neglect
  - No assault
- Lots of friends
- Tried MJ once in HS, used couple times per month in college
- Episodic binge drinking in college
- Finished college
- Went to medical school
- Given naloxone in the resident call room

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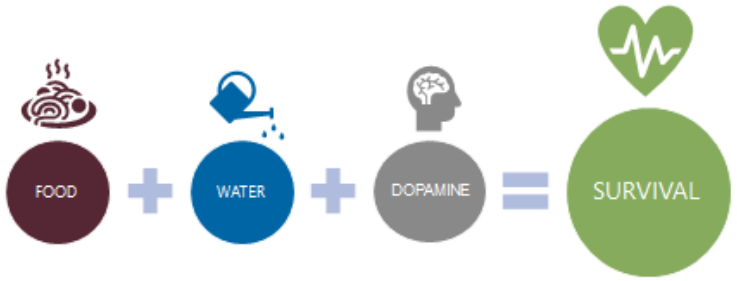
ADDICTION 101



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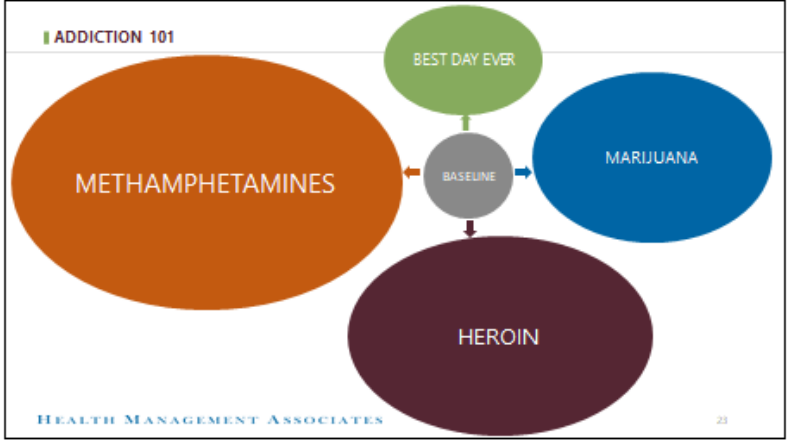
ADDICTION 101



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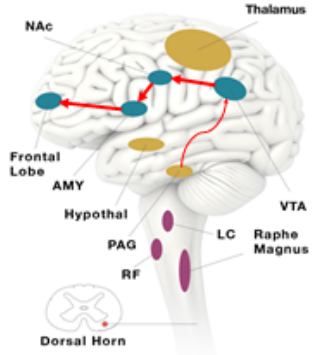

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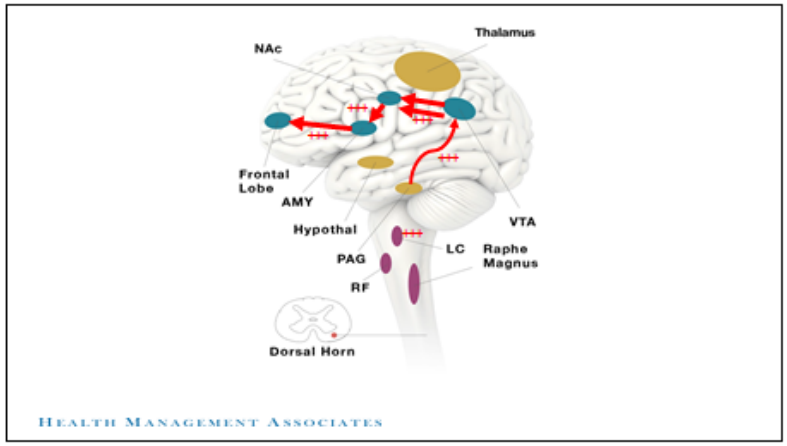
NAc
Thalamus
Frontal Lobe
AMY
Hypothal
VTA
PAG
LC
Raphe Magnus
RF
Dorsal Horn
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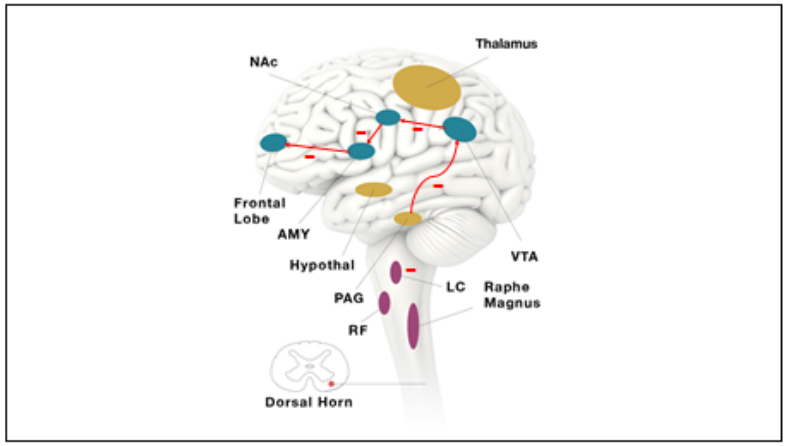
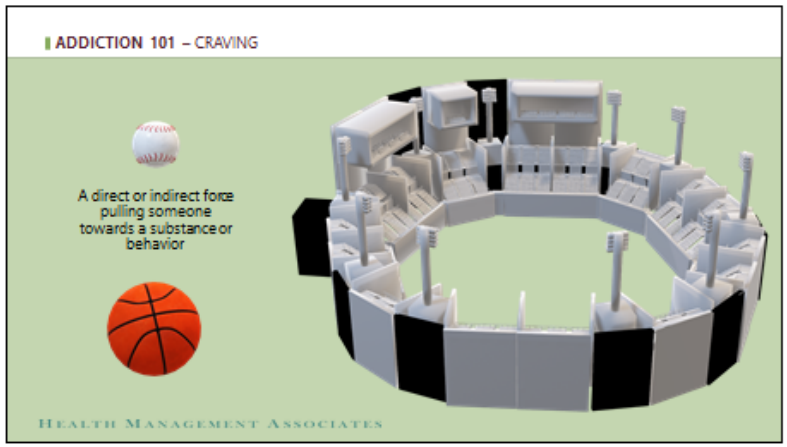

NAc
Thalamus
Frontal Lobe
AMY
Hypothal
VTA
PAG
LC
Raphe Magnus
RF
Dorsal Horn

26


ADDICTION 101 – CRAVING
A direct or indirect force pulling someone towards a substance or behavior
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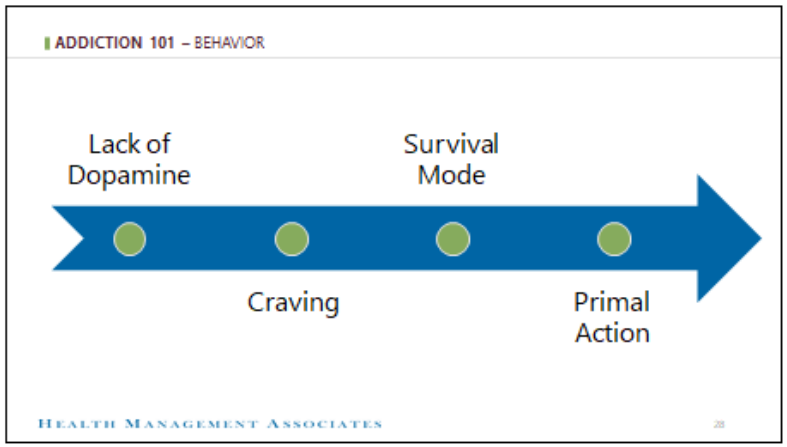
ADDICTION 101 – BEHAVIOR
Lack of Dopamine
Survival Mode
Craving
Primal Action
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DSM-V DIAGNOSIS OF OUD

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

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

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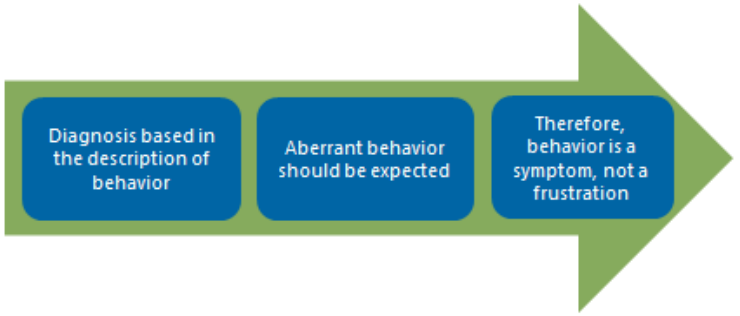
ADDICTION 101 – BEHAVIOR



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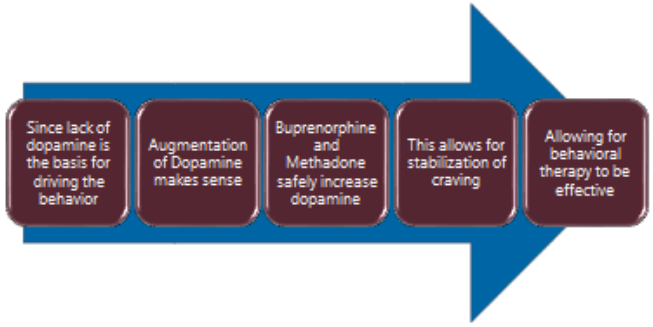
ADDICTION 101 – TREATMENTS



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ADDICTION TREATMENT ECOSYSTEM CLINIC STRUCTURES

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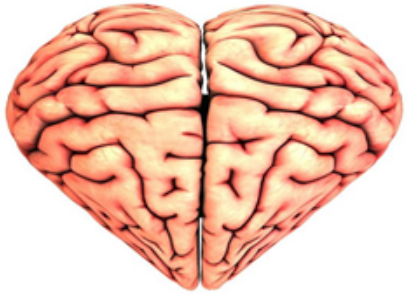
ADDICTION TREATMENT ECOSYSTEM CHANGING HEARTS AND MINDS

ADAPTIVE vs. TECHNICAL



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ADDICTION TREATMENT ECOSYSTEM IMPLEMENTATION

- **Capacity**
- **Competency**
- **Consistency**
- **Compensation**
- **Community**

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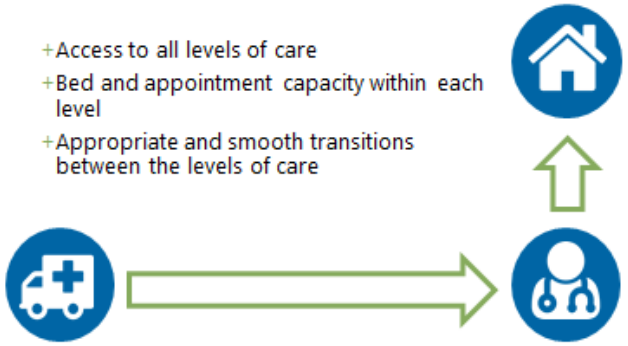
ADDICTION TREAMENT ECOSYSTEM CAPACITY

+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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SCREENING, ASSESSMENT & LEVEL OF CARE DETERMINATION

❑ **Screening:**
A rapid evaluation to determine the possible presence of a condition (high sensitivity, usually low specificity)

❑ **Assessment:**
A deep evaluation meant to solidify the presence and severity of a disease (lower sensitivity, high specificity)

❑ **Level of Care Determination:**
Using an assessment and other factors, the most appropriate level of care for the severity of the condition is identified (outpatient vs inpatient).

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IS THERE A ROLE FOR TOX SCREENING?

- Typically does not test for alcohol or tobacco use
- Potential for false positive and false negative results
- Increases risk for possible child welfare involvement
- Test results do not assess parenting capabilities
- Often applied selectively
- Lab cut-off points for sensitivity

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SCREENING TOOLS

❑ Screening is the act of identifying if someone is at risk for an illness
❑ We will discuss a few screening tools validated in the pregnant population
  ❑ National Institute for Drug Addiction 4 (NIDA 4)
  ❑ CRAFFT
  ❑ 4 p's plus

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ASSESSMENT TOOLS

- If a patient screens positive, then they need to be assessed for the presence of the disorder
- If the disorder is present, we can determine the severity
- Many validated tools exist; we will discuss the 3 most common and most validated
  - Alcohol Use Disorders Identification Test (AUDIT)
  - Drug Abuse Screening Test (DAST)
  - Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

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LEVEL OF CARE DETERMINATION

Evaluating for placement

- ☐ ASAM Criteria is the Gold Standard
  - ☐ Continuum Co-triage tool (20 questions)
- ☐ Who is screened
  - ☐ Patients positive for high/severe on assessment
- ☐ Delivery
  - ☐ On-line tool
- ☐ Who delivers
  - ☐ Can be done by MA, RN or MD/DO
- ☐ How paid for
  - ☐ Part of SBIRT payment

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EXERCISE: GAPS & BARRIERS

- Everyone has barriers, what are yours?
- With the people at your table, write down your common gaps and barriers
- After you write them down, please place them on the wall

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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?

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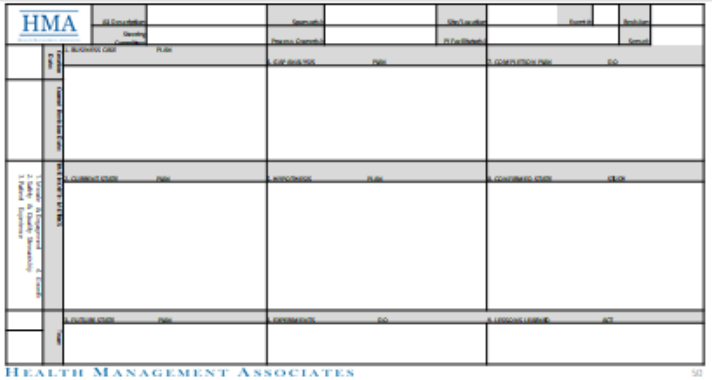
A3 BARRIER AND SCOPING



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JUNE 19:

AFTERNOON SESSION

COHORT 1

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FIELD NOTES

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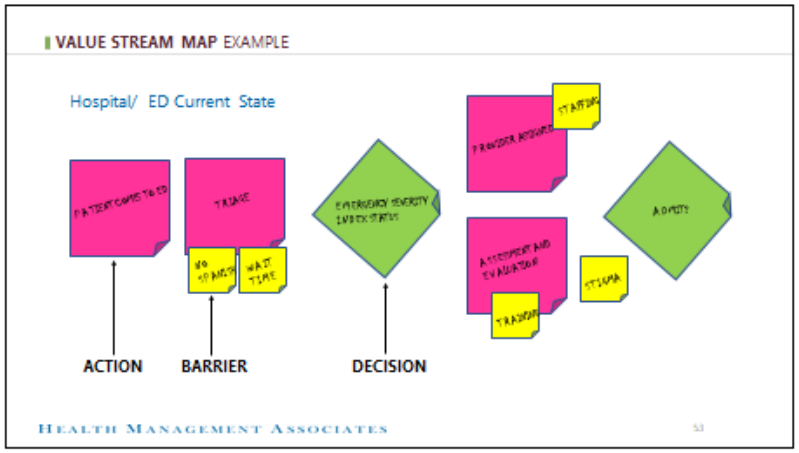
VALUE STREAM MAP EXAMPLE
Hospital/ ED Current State
ACTION
BARRIER
DECISION
HEALTH MANAGEMENT ASSOCIATES

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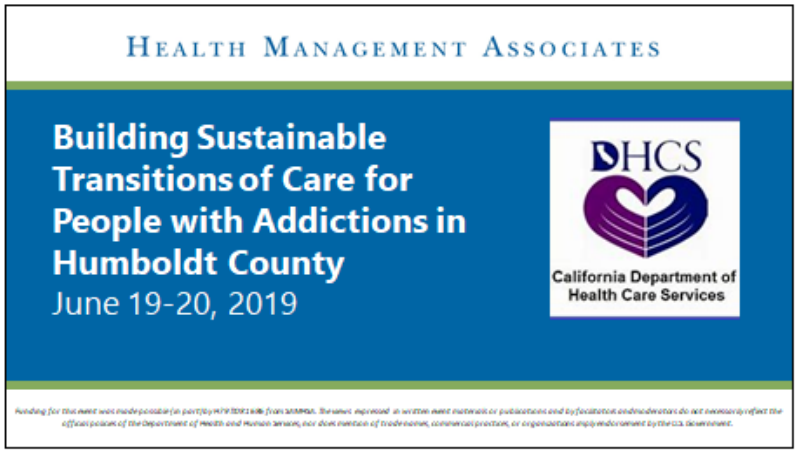
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Building Sustainable Transitions of Care for People with Addictions in Humboldt County
June 19-20, 2019
DHCS
California Department of Health Care Services

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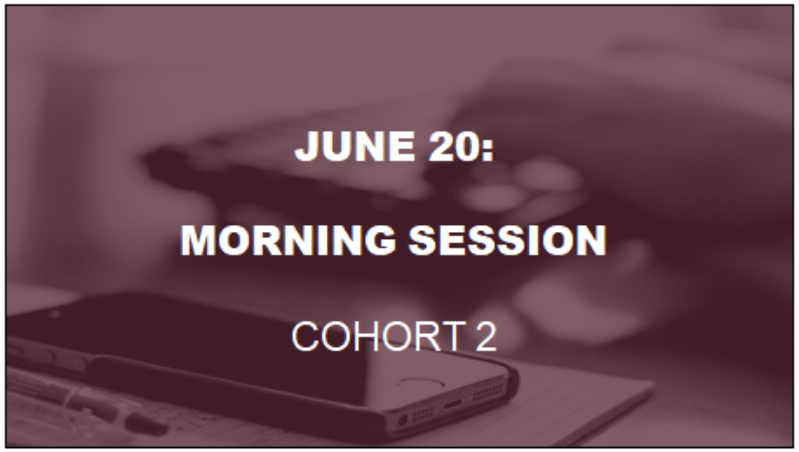
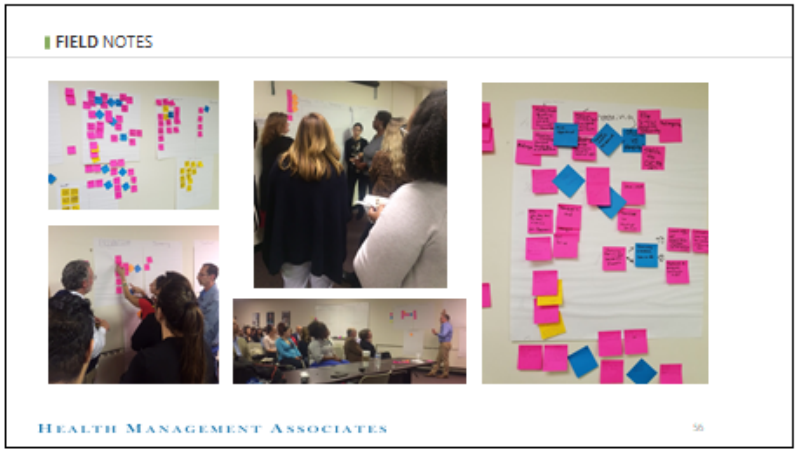

JUNE 20:
MORNING SESSION
COHORT 2

55


FIELD NOTES
HEALTH MANAGEMENT ASSOCIATES

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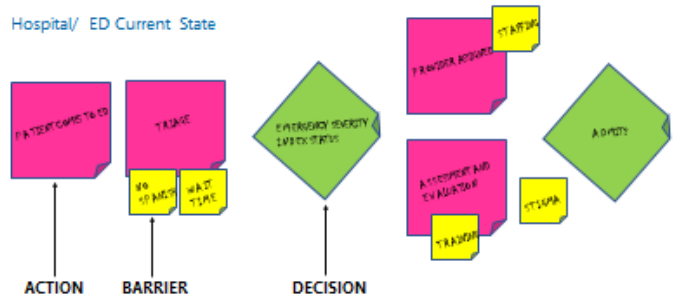
VALUE STREAM MAP EXAMPLE

Hospital/ ED Current State



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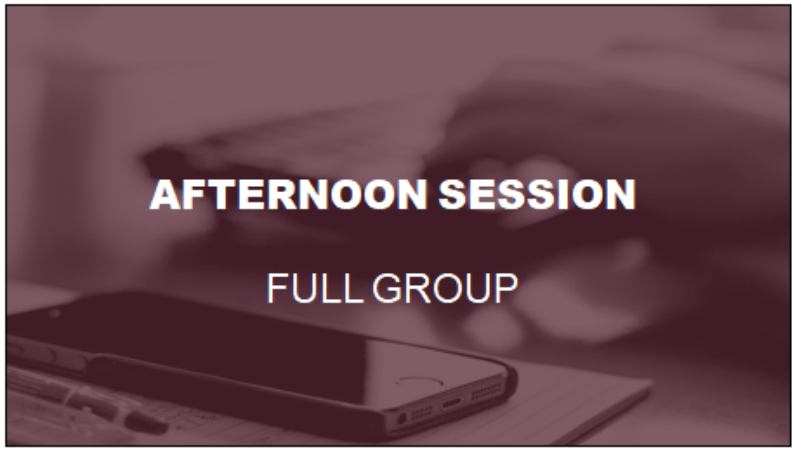

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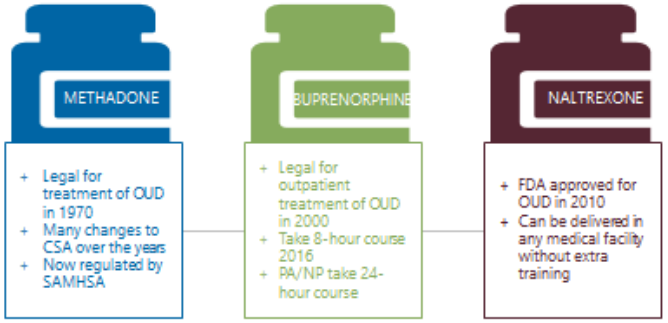
MEDICATION-ASSISTED TREATMENT (MAT) INTRODUCTION



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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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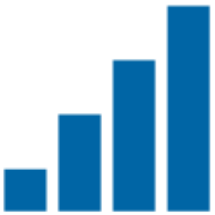
METHADONE OUTCOMES

+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 90s 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 FOMS

- Pills at 25mg and 50mg
- 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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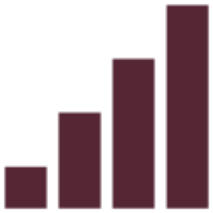
NALTREXONE OUTCOMES

- 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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SH7

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 abstinence

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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 an opioid treatment system.

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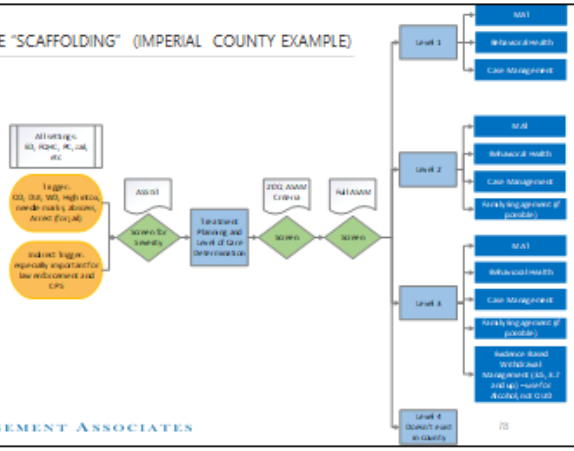
FUTURE STATE THE "SCAFFOLDING" (IMPERIAL COUNTY EXAMPLE)



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Substance Abuse and Mental Health Services Administration. Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63, Full Document. HHS Publication No. (SMA) 18-5063FULLDOC. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Spotlight on Opioids. Washington, DC: HHS, September 2018.

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1

GAPS & BARRIERS LIST

Most common gaps/barriers (themes):

- Funding
- Transportation
- Housing
- MH
- Family Care
- Age
- Lack of youth substance programs
- Lack of culturally appropriate services
- Access to medication

Most surprising barrier:

- Pets – taking care of
- Lack of dental care
- Facilities that take care of family too
- No care available in the evening
- Access to evaluation after hours not available

Most annoying:

- 42 CFR part 2
- Paid family leave only covers birth, adoptive or foster parents but not reunifying parents.
- Lack of bed space availability - there are beds, but not enough funding

Missing

- Addiction in Humboldt isn't as prominent of an issue as it needs to be
- Access to appropriately trained workforce

Easiest things to fix

- Communication between services providers (lots of woo's from audience)
- Working as a team, not individuals or as silos
- Create more interdisciplinary training opportunities

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CURRENT STATE VSMS

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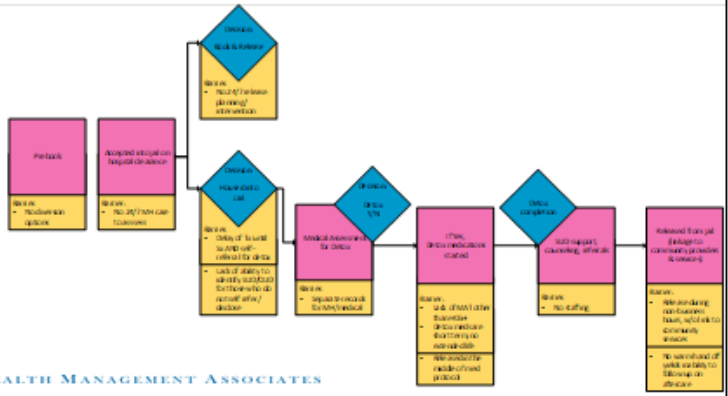
3

CURRENT STATE VALUE STREAM MAP CORRECTIONAL



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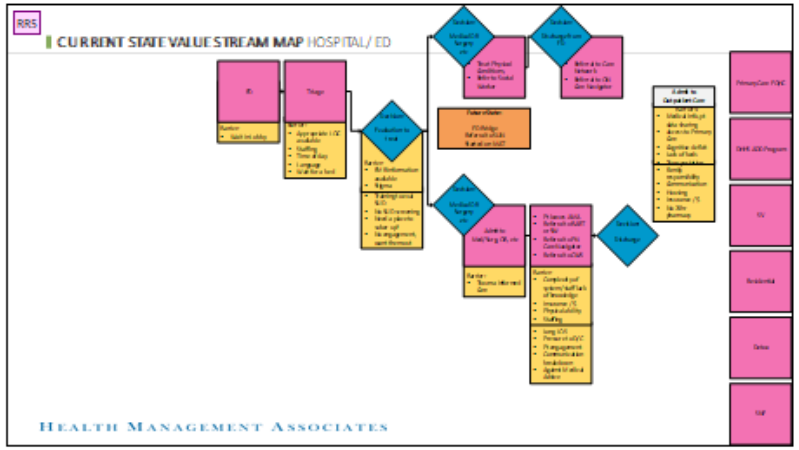
RR5
CURRENT STATE VALUE STREAM MAP HOSPITAL/ ED
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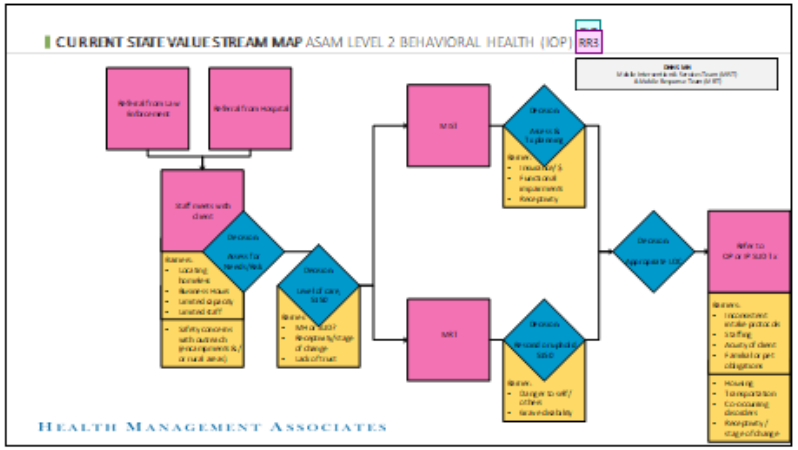
CURRENT STATE VALUE STREAM MAP ASAM LEVEL 2 BEHAVIORAL HEALTH (IOP)
RR3
HEALTH MANAGEMENT ASSOCIATES

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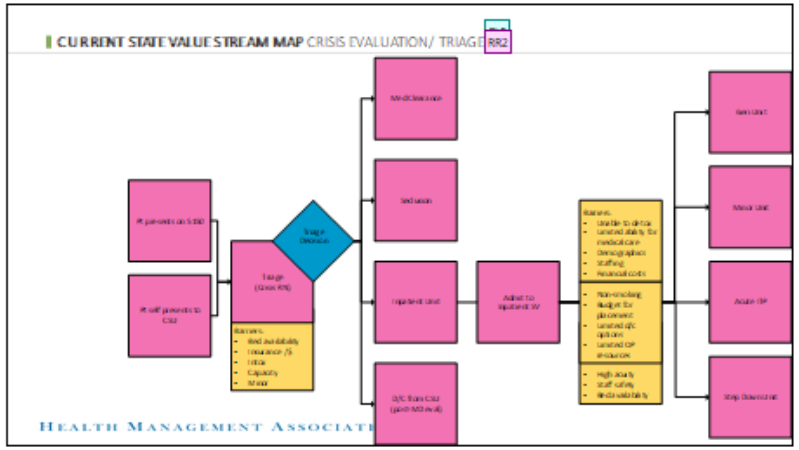
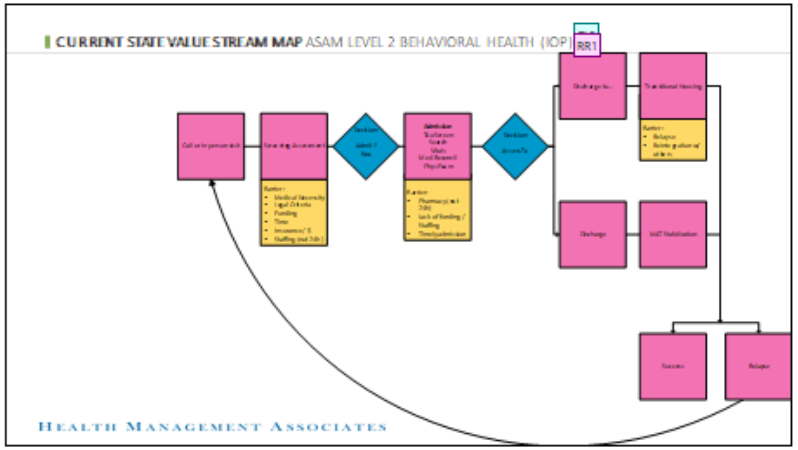

CURRENT STATE VALUE STREAM MAP CRISIS EVALUATION/ TRIAGE
RR2

6


CURRENT STATE VALUE STREAM MAP ASAM LEVEL 2 BEHAVIORAL HEALTH (IOP)
RR1
HEALTH MANAGEMENT ASSOCIATES

8

FUTURE STATE VSM

HEALTH MANAGEMENT ASSOCIATES

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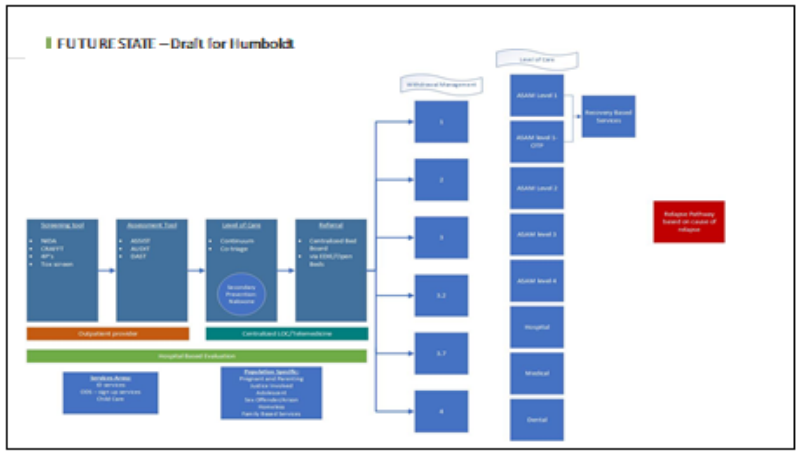

14

OVERCOMING GAPS & BARRIERS

HEALTH MANAGEMENT ASSOCIATES

15

PROCESS IMPROVEMENTS

HEALTH MANAGEMENT ASSOCIATES

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17

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

D. Citations

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