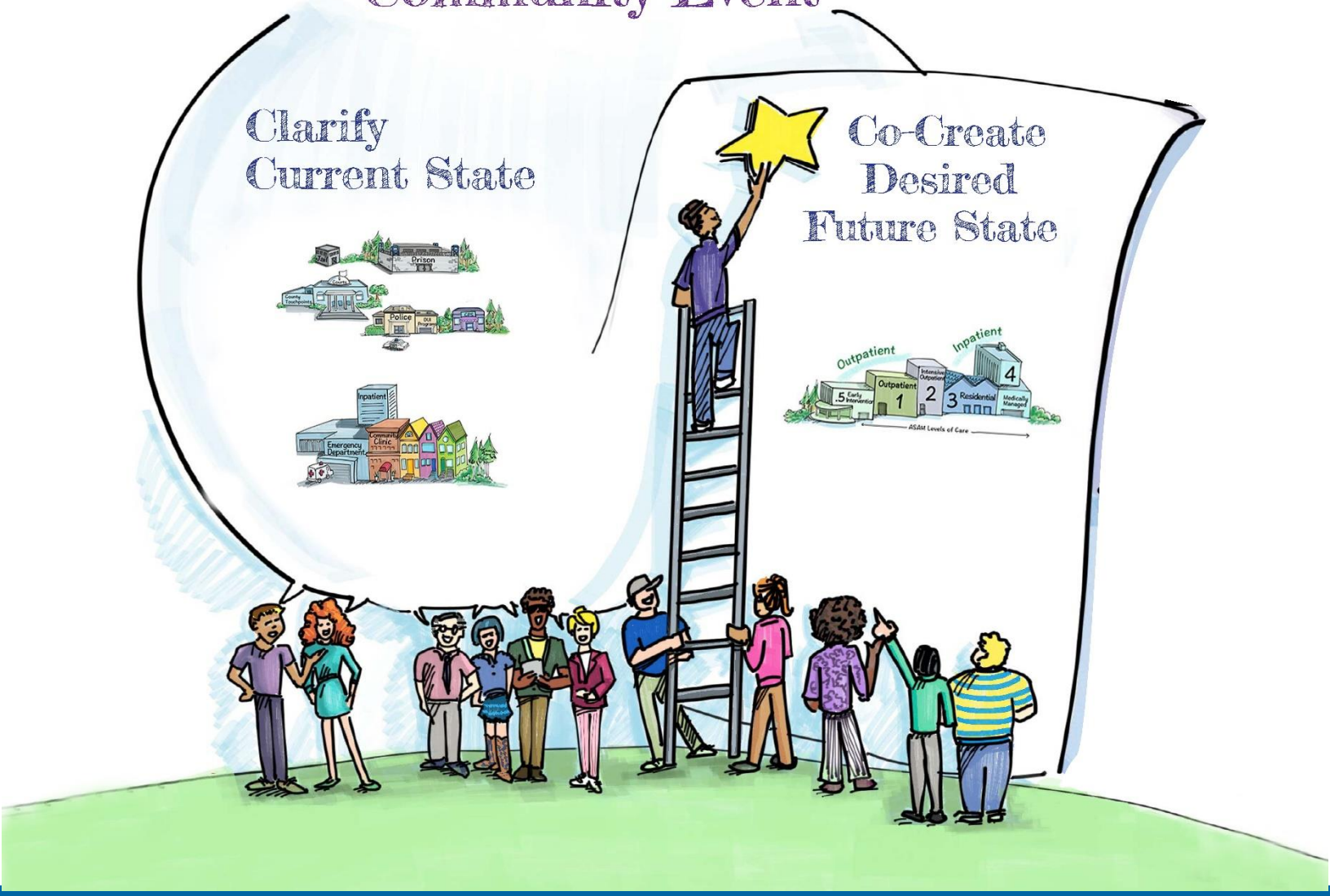
Collaborative Provider Community Event



BUILDING SUSTAINABLE TRANSITIONS OF CARE FOR PEOPLE WITH ADDICTIONS

Fresno County Community Process Improvement Event

June 20-21, 2019

HEALTH MANAGEMENT ASSOCIATES

BUILDING SUSTAINABLE TRANSITIONS OF CARE FOR PEOPLE WITH ADDICTIONS

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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. Although the rates of use and overdose are lower than in many states, opioid use and overdose have been steadily increasing in California.

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 Targeted 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 County-wide 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. Fresno County, one of the 10 counties selected, participated in a large-scale process improvement event on June 20-21, 2019 that included members from different aspects of government, healthcare, addiction treatment, and those who pay for that treatment. During the event, attendees participated in intense work sessions with a focus on identifying current treatment processes, barriers and gaps in these processes and a future state treatment system to support transitions of care for Fresno County residents in need of addiction treatment and support services.

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

The two-day event concluded with the development of a group-based consolidated vision of the future that includes, but is not limited to, early prevention efforts aimed at pre-teens and teens, ubiquitous and standardized screening for OUD/SUD establishing every contact across all systems and sectors as points of identification and potential entry into the treatment and recovery system. The group

contemplated a referral system that is enabled by technology to simplify the assessment process by providing access to the online ASAM Assessment tools (both the Co-triage, short form, and the Continuum, long form), secure, simplified data sharing to facilitate better coordination and continuity of and retention in treatment, and an online locator service for both beds and spaces to facilitate access and forecasts of treatment supply and demand. The Fresno system would proactively deliver other services at the front end aimed at identified social determinants of health while patients are in the queue for treatment, and smooth transition into aftercare services with adequate capacity at the back end to address the ongoing treatment and recovery needs of clients. The ideal treatment in Fresno is of high quality (i.e., well-trained providers), of sufficient capacity, portable across County lines and available at all ASAM levels of care. This coupled with the didactic training of all parties involved will yield one of the most comprehensive and easy-to-use addiction treatment ecosystems in the country.

To implement the future state as envisioned by this group, there will need to be ongoing collaborative interaction and a bevy of systems developed to receive and track patients as they flow through the system. However, given the collective buy-in by the County, this should be achievable 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 Targeted Response (STR) and State Opioid Response (SOR) dollars to fund the California MAT Expansion Project which aims to serve an estimated 290,000 individuals with Opioid Use Disorders (OUD), prevent drug overdoses, and treat OUD as a chronic disease. The first phase of the project, California MAT Expansion Project 1.0, is funded by STR and focuses on populations with limited MAT access (including rural areas, American Indian and Alaskan Native tribal communities) and increasing statewide access to buprenorphine. The California MAT Expansion Project 2.0 project is funded by SOR and builds upon the existing STR funded work. California MAT Expansion Project 2.0 runs for two years beginning in September 2018.

HMA received SOR funding from DHCS to focus on developing predictable and consistent transitions of care to sustain addiction treatment as individual transition from locations such as emergency departments, jails, primary care clinics, the community at large and/or inpatient hospital settings. Through rigorous assessment of all 58 counties in California, HMA identified Fresno 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 Fresno 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 County-wide 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 Fresno County Department of Behavioral Health, specifically Loretta Brandon, Staff Analyst, Katherine Anderson, Principal Analyst, Susan Holt, Deputy Director, Clinical Operations, and Dawan Utecht, Director, to launch the process improvement event and subsequent ongoing technical assistance program. Fresno County Department of Behavioral Health identified key stakeholders to engage, conducted outreach, and distributed invitations. Fresno County Department of Behavioral Health 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

Fresno County Department of Behavioral Health

- Dawan Utecht, Director
- Susan Holt, Deputy Director, Clinical Operations
- Katherine Anderson, Principal Analyst
- Loretta Brandon, Staff Analyst
- Jolie Gordon-Browar, Division Manager
- Stacy VanBruggen, Division Manager

C. Who Was Involved

- Fresno County Department of Behavioral Health
- Fresno County Department of Social Services
- California Health Sciences University
- Comprehensive Addiction Programs, Inc.
- Fresno County Probation
- Aegis Treatment Centers
- Lags Medical Centers
- Clinica Sierra Vista
- Transitions Children's Services
- WestCare
- Fresno New Connections, Inc.
- Turning Point of Central California, Inc.
- Fresno County Department of Public Health
- Anthem
- Community Regional Medical Center
- Medmark
- Valley Recovery Center
- Promesa
- Wellpath
- Central California Recovery
- US Attorney's Office
- Kings View Behavioral Health Services
- Fresno County Superintendent of Schools
- Fresno County Needle Exchange Program
- Fresno County Public Defender
- BAART Programs
- Fresno Police Department
- Sierra View Medical Center
- Saint Agnes Medical Center
- Kaweah Delta District Hospital

D. Structure of the Intervention

In advance of the event, HMA worked with the County to electronically gather high-level information on addiction treatment capacity in Fresno 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.

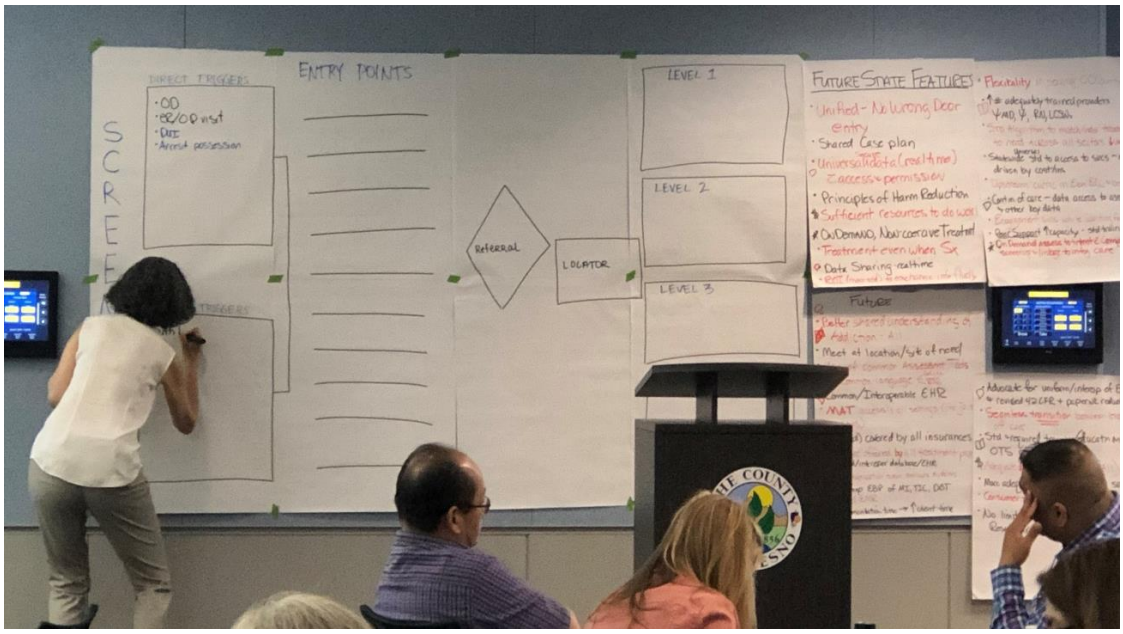
This event included a variety of stakeholders who represent different aspects of the addiction space in Fresno County: SUD treatment, hospitals, probation, education, behavioral health, public health, people with lived experience, and many others. HMA

used the morning of day one to facilitate group discussion about the barriers and gaps in the current addiction treatment system, including the identification of ideas for addressing the barriers and gaps. The group also identified desired outcomes from any intervention/future state plan.

In the afternoon, attendees completed current state value stream maps for their part of the addiction treatment system. For this exercise, the larger group was divided into smaller groups by organization/addiction treatment area to develop a current state value stream map that depicted exactly how a community member moves through their system. Participants were tasked with including all interventions and decision points, who performs them, and how long they take. They were also instructed to discuss both intervention-specific and global barriers and gaps. While the work product had some variation in depth, scope, and structure, we were able to get a good sense of the current state of addiction screening, placement and treatment in Fresno 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.

On the afternoon of day one and the morning of day two, each provider group presented their map to the whole group.

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



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

E. Screening and Level of Care Determination

The Fresno County Substance Use Disorder Assessment

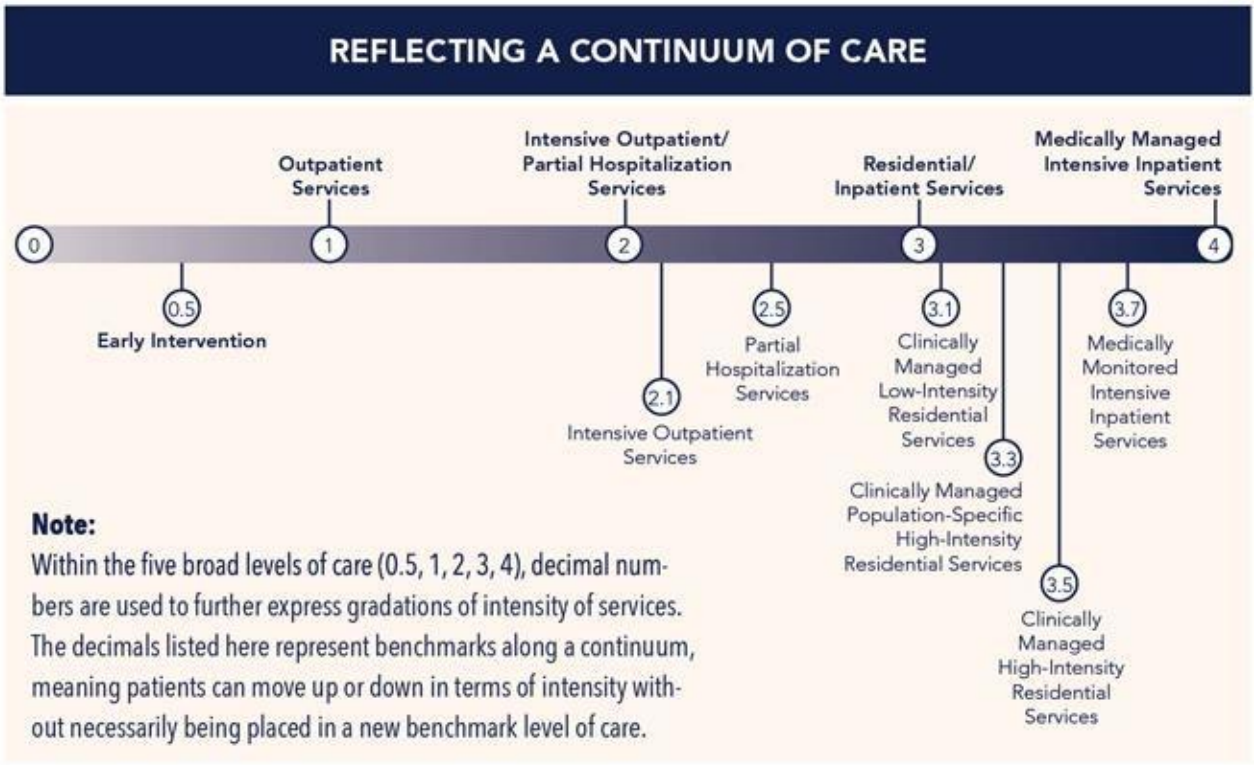
Fresno County is contracted with the state Department of Healthcare Services (DHCS) as a Drug Medi-Cal, Organized Delivery System (DMC-ODS). That contract began in January 2019 and is still evolving. DHCS requires ODS counties to utilize the ASAM criteria for making level of care and placement determinations. Fresno developed the Fresno County Substance Use Disorder Assessment to meet that need. Although some commercial drug treatment providers in Fresno previously used the ASAM CONTINUUM and Co-Triage, all providers in the Fresno ODS are now required to use the Fresno County Substance Use Disorder Assessment. The section that follows describes the

ASAM criteria in the context of the copyrighted ASAM assessment tools (CONTINUUM and Co-Triage). While the criteria descriptions are pertinent to this report and to the ODS waiver counties in general, the County does not use the copyrighted ASAM assessment tools.

CONTINUUM™, 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 serve and support medical professionals, employers, purchasers and providers of care in both the public and private sectors.



The "short form" of the ASAM Criteria

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

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

- Make provisional ASAM Level of Care treatment recommendations
- Easily identify ASAM dimensional needs that require immediate attention including any withdrawal management, co-occurring, or bio-medical enhanced services
- Increase the likelihood that patients are referred to the correct ASAM Level of Care

- Build from and easily synchronize with the research-validated CONTINUUM™ ASAM Criteria comprehensive assessment tool

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

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

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Section 2: Event Results

A. Goals of the Participants

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

- Coordinated entry, single point of entry
- Shared database of information that everyone from health plans to providers can access; Health Information Exchange
- Shared understanding of health care and treatment
- Shared scientific approach to treating addictions across all partnering agencies
- Reduction in paperwork and documentation requirements, specifically for Medi-Cal
- More telemedicine, especially for juveniles
- Bundling procedures under one service code
- Shared screening and assessment tools
- Treatment on demand
- 24/7 access to medications in Emergency Departments
- Pharmacies that stock and dispense Suboxone
- Standard Electronic Health Records system

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

THE OVERARCHING GOAL:

ELIMINATE ADDICTION-RELATED DEATHS IN FRESNO COUNTY

B. Stories of Experience with Addiction in Fresno County

Building a person-centered system of addiction treatment in Fresno 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 Fresno to share their stories with us if they were willing. Below is a response we received:

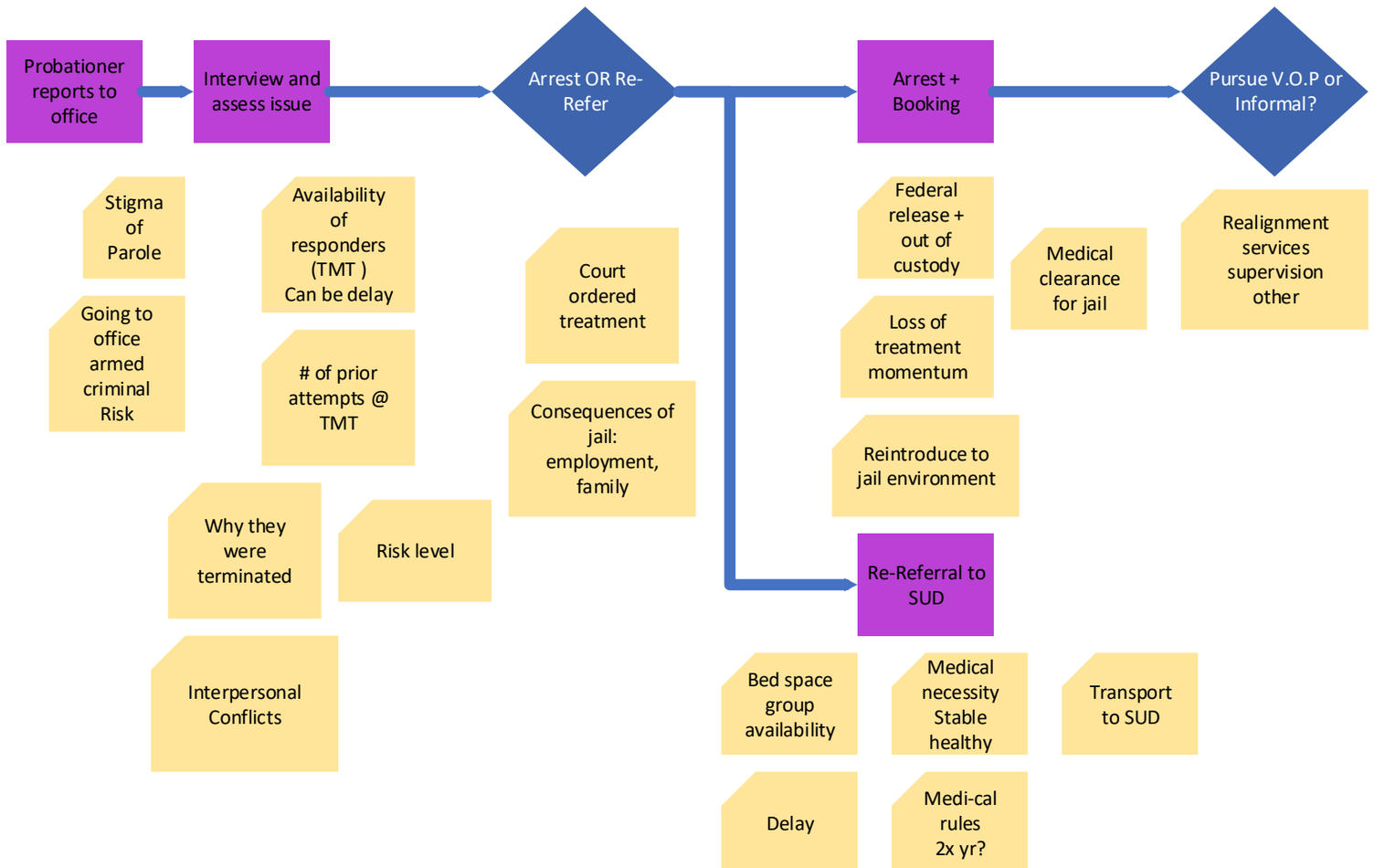
Lived Experience

At the age of 15y/o I was prescribed diet pill Amphetamines due to obesity. This began a long progressive addiction to legal & illegal amphetamines. In 2008 I began using meth nasally due to the inability to obtain legal amphetamines. As my addiction progressed I began to use daily. As a result I lost my career as a hair stylist & business. Further, my life began to spiral out of control. I lost my home, my vehicles, & many friends. Family began to notice the issues & losses in my life. I started having MH issues & psychosis due to staying up for days at a time. My parents felt it necessary to protect my children from me. My husband and I ended up using together. This caused us to be turnt away from family. We were living in a Camper w/ no running water or toilet facilities. We had no means of income or transportation. Our life hit bottom very quickly & very hard. It was in those moments that my life was in danger due to living on properties of those who were manufacturing & dealing meth. When it was evident that those individuals wanted me dead as they had beat me beyond recognition I cried out to my Lord & Savior Jesus Christ. In those moment I met a Substance Abuse Counselor who began to work with me & my husband. We committed to sobriety & slowly got our lives on track. The SA counselor was a professor & encouraged my husband & I to go to college to become SUD counselors. In 9 years we regained our life, attended & graduated college, became licensed SUD counselors, obtained new home & vehicles, had our children back & had gainful employment in our profession. We started several SUD programs in juvenile facilities & community MH. We are now 11 years clean & have continued our education. We are currently in our Masters Programs & continue to share our experience, strength, & hope.

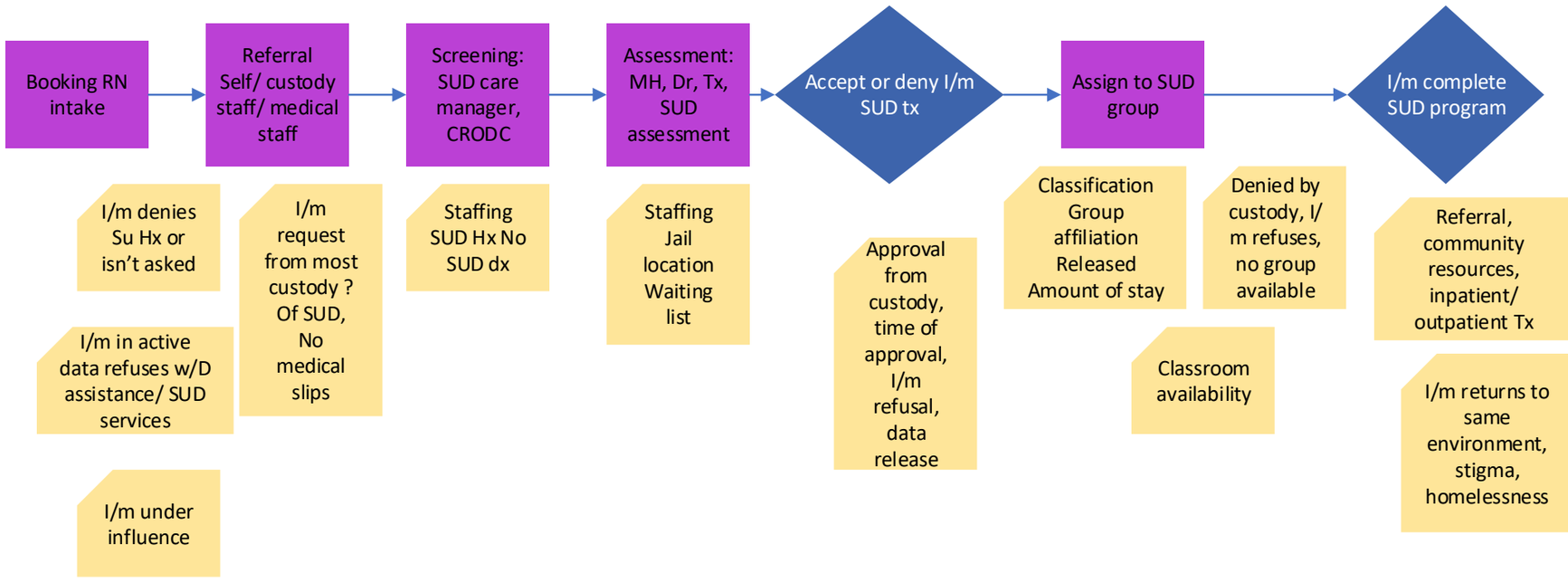
C. Fresno County's Current State Value Stream Maps (VSM)

Justice Current State VSMs

Probationer Terminated from Treatment



Inmate Enters Jail for Probation Violation



Probationer Terminated from Treatment

For a probationer terminated from treatment, the very first act of reporting to the probation office and stating that they have been terminated from a treatment program requires overcoming a number of challenges: transportation to get to the office, long wait times, and reluctance to disclose the information due to stigma of failure and fear of re-arrest and related repercussions. If a probationer chooses not to report to the office, the provider sends a progress report, and the probation staff will contact the probationer. There are often delays with this due to difficulty getting in contact with the probationer.

Once the probationer is able to meet with staff, they are interviewed to assess the situation and investigate why they were terminated from treatment. Rather than assuming the defendant is wholly to blame for termination (as was the previous protocol), the probation office is moving toward a more comprehensive view and taking into account issues with cost, homelessness, other survival issues that may have taken priority, transportation, and interpersonal conflicts with peers or treatment staff. This complete picture of termination is necessary to determine whether the defendant should be arrested for violation or re-referred to treatment.

When making the decision to arrest or re-refer, the probation office relies on the risk level determination from the STRONG (Static Risk and Offender Needs Guide) tool, which is done before the defendant is sentenced. Staff considers numerous factors including whether the instance was a violation of court-ordered treatment, whether arrest is necessary/ worth putting employment at risk, whether the defendant is the sole family provider, and what the other consequences of arrest might be. Barriers include stigma, overcrowding, loss to follow up due to early release, and general risk of being in a jail environment. However, there are also many barriers to making a re-referral: availability of bed space, availability of appropriate programs, delay in service delivery, medical necessity of receiving treatment, co-occurring health issues, transportation, and Medi-Cal rules of providers relating to termination. A substance use specialist will assess the probationer to determine the level of care for an OUD or SUD person, and may use criminal justice assessments for certain individuals (such as those with DUI offenses).

Inmate Enters Jail for Probation Violation

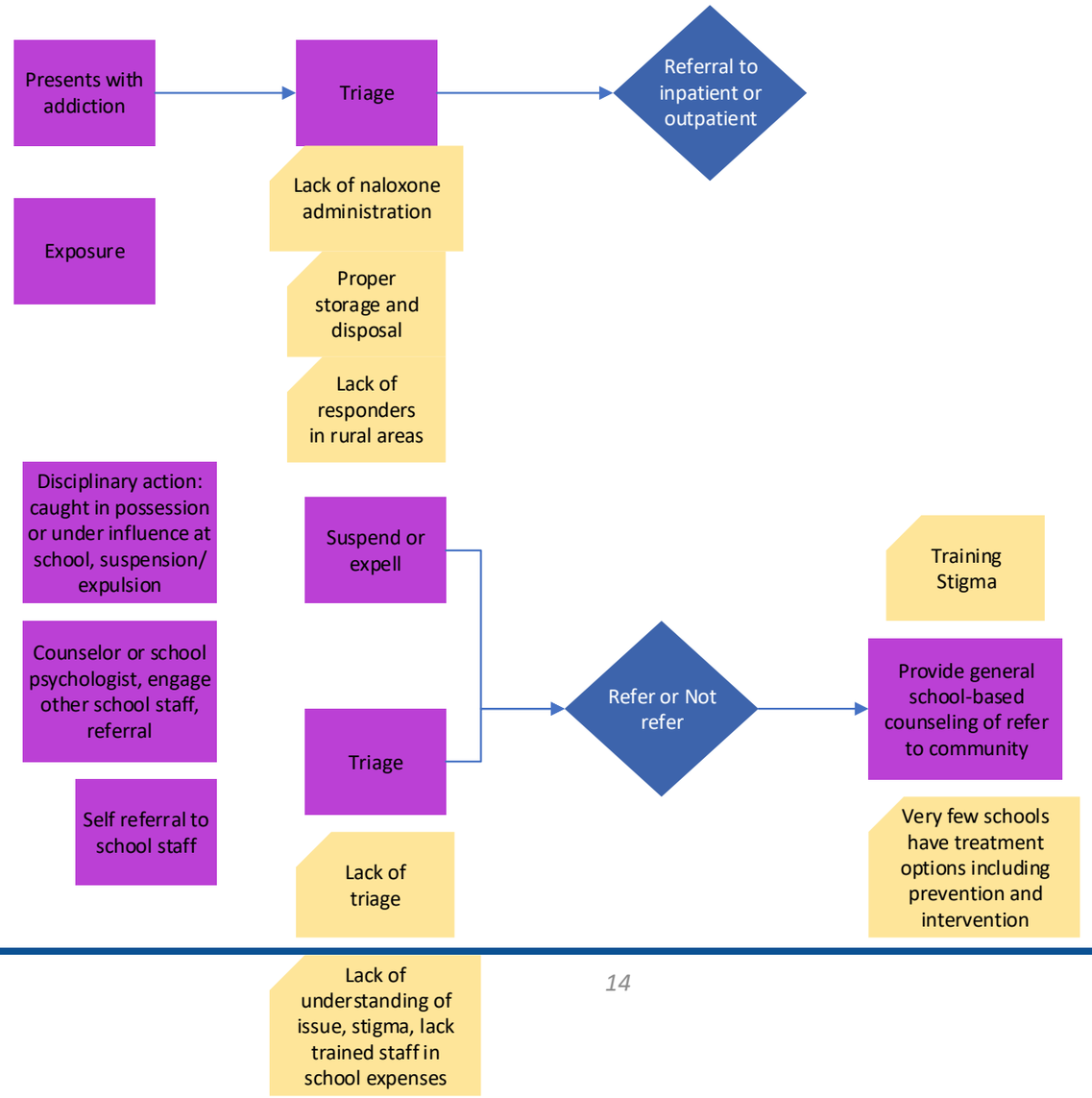
Inmates entering jail begin their process by seeing an RN in booking or intake. The RN may ask about history with substance use, but this is not asked consistently and often not asked at all. If an inmate is put into a "pod" or expresses that they want services, medical staff will put in a referral or the inmate can self-refer. Inmate request forms often get lost, however, and there is limited capacity to accommodate requests from over 3,000 inmates. There is also limited awareness of programming among staff, including custody, medical personnel, and night staff.

After a referral, a substance use disorder (SUD) nurse, care manager, or counselor will conduct a screening to review the inmate's profile, diagnosis, and past assessments. During the assessment process, staff uses motivational interviewing and cognitive behavioral therapy (CBT) to determine stage of change and engage inmates in their recovery. However, the process of putting in assessments is bottlenecked—typically two staff members must process 40 referrals in three days. During the SUD and mental health assessment, staff determines a diagnosis and treatment plan. There is limited staffing capacity at this step of the process as well, in addition to lack of space to conduct interviews.

Acceptance into treatment is based on approval from custody, and this is sometimes denied due to an inmate's history of violence or gang affiliation. Other reasons for denial/ refusal include early release, classroom availability, and lack of available groups that meet specific inmate needs (e.g., inmates who must be separated). If an inmate is accepted, they are assigned to SUD group to complete a program. Programs are purely focused on SUD counseling, and do not currently provide MAT.

Upon completion, discharge becomes a challenge both for those going to prison and those re-entering society: inmates are stigmatized for addiction, and re-entry populations face challenges with homelessness and accessing services in the community.

Fresno County Education Current State VSM



The K-12 education staff in Fresno County become aware of students having a substance use or abuse issue in two main ways: a student is caught in possession or under the influence of a substance at school, or the issue comes to light through the student working with a school counselor or social worker.

While there are opportunities for identification and treatment of SUD in schools, there are many barriers in the current process. Schools lack screeners, education, and training capacity, and currently students who are identified with a substance use issue are referred to a new school for one or two semesters. For students who are expelled due to substance use or possession, the expulsion order recommends drug or alcohol counseling, but this is not a mechanism for referring to a specific treatment provider, and the responsibility of finding a provider falls to the family. However, accessing treatment is used as criteria for readmission to school after expulsion.

Within the school itself, there is a lack of capacity for counseling and treatment for drugs and alcohol. Without trained staff, the school must refer students to community-based services, but this is not always available in rural areas of the County. There is a need for more school-based providers to improve access to treatment, as well as stigma reduction and psychoeducation for students.

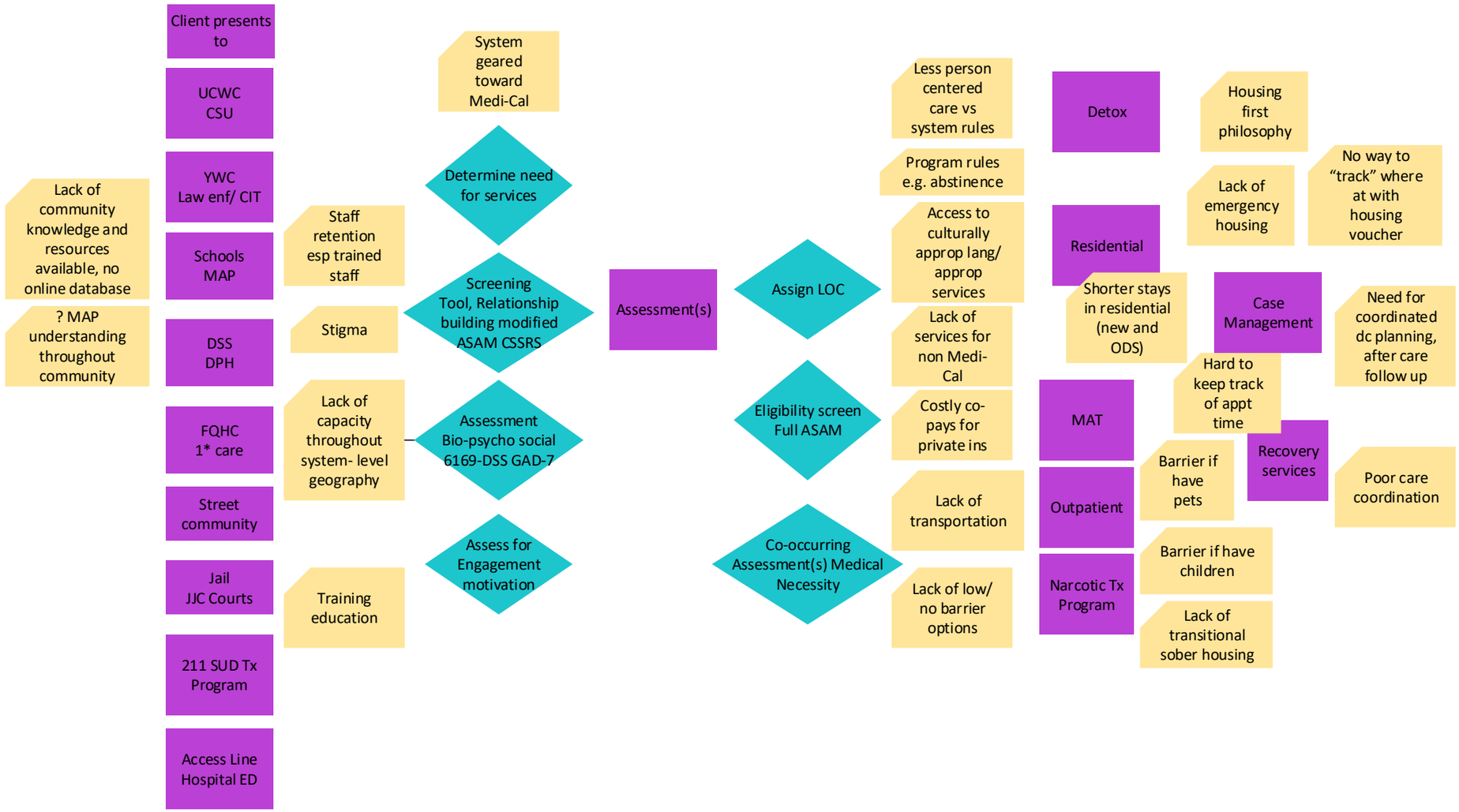
AEGIS, BAART, Medmark, and Lags Current State VSM

AEGIS, BAART, MedMark, and Lags are SUD treatment providers that offer MAT in Fresno County. When a patient comes to one of these organizations, either as a walk-in or through a referral, they undergo an initial screening from staff to ensure they meet treatment requirements. This screening is not an ASAM assessment, but rather a general set of questions that identify whether the person is in the appropriate place and meets the criteria to be seen by a doctor that day. Staff will obtain a urine sample from the person to determine if opioids are present in their system and depending on when/what substance they last used, staff will determine when and if it is appropriate to start medication. Medication options include Methadone, Buprenorphine (Suboxone), and Vivitrol.

After screening, the person meets with a program physician to make the diagnosis of Opioid Use Disorder (OUD) and to be admitted to the treatment program. The physician determines which medication to start, which is dependent on history, frequency, intensity and duration of use. However, there are a number of challenges that often preclude starting treatment: insufficient insurance coverage or ability to pay for medication, transportation, wait times, wait lists, time from last use, and availability of physicians able to admit.

Patients undergo an ASAM assessment within six days after being admitted and attend a series of appointments during which staff use the assessment to determine other levels of care (NB: Title 9 standards allow up to 28 days for this assessment). For patients with co-occurring medical or mental health needs, it can be difficult to coordinate care. It can also be a challenge for patients to stay engaged in treatment for as long as is necessary to be effective. Within these organizations, there is significant opportunity to implement best practices regarding mechanisms for temporizing treatment and bridge to MAT.

Fresno County Behavioral Health Current State VSM



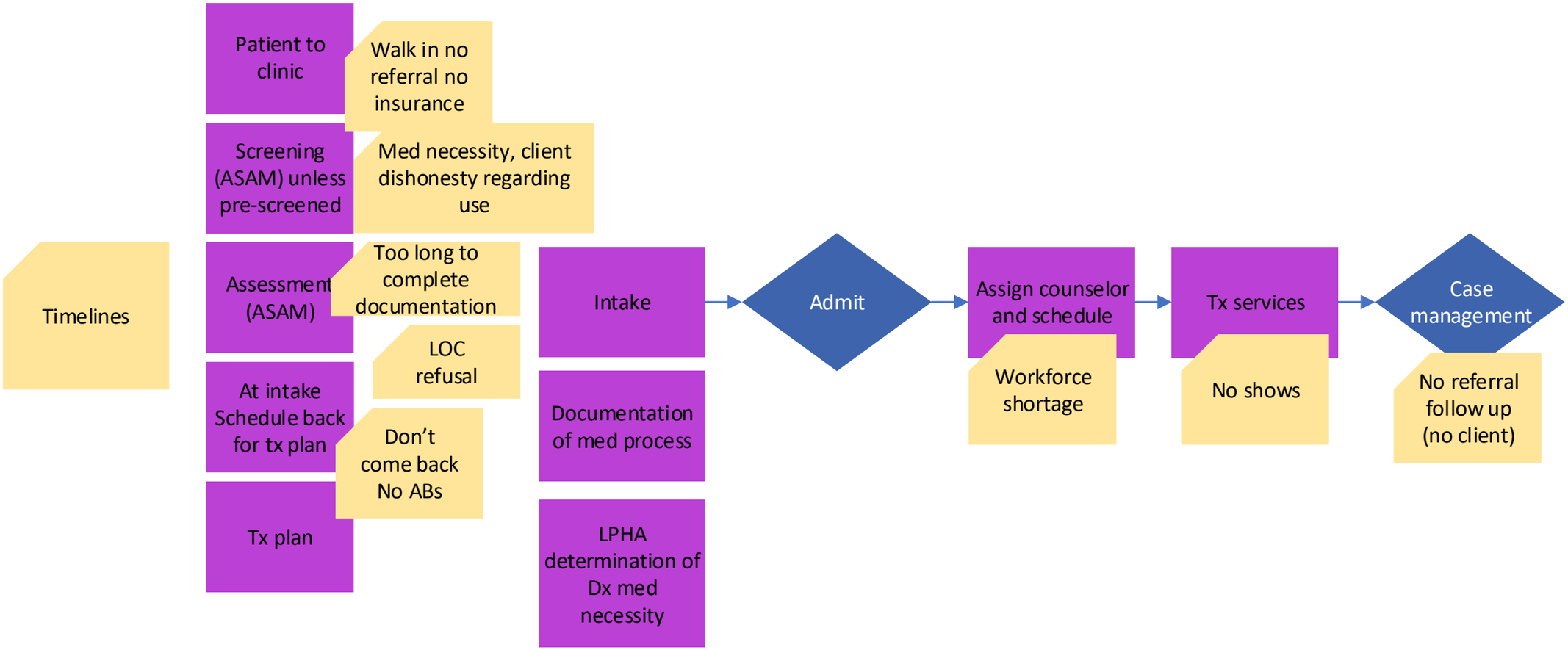
The Fresno County Behavioral Health system has multiple points of entry, including the urgent care wellness center, crisis stabilization units, youth wellness centers, law enforcement, FQHCs, primary care and other clinicians in the field, street outreach, 211, and Multi-Agency Access Program (MAP).[1] In terms of addiction treatment, staff determine a need for services through relationships, screening tools (e.g., GAD-7, etc.), the Columbia Suicide Severity Rating Scale (C-SSRS), bio-psycho-social assessments in the community, 6169 and motivational interviewing. An assessment is then performed to assign the patient to the appropriate level of care (modified ASAM), and patients undergo an eligibility assessment (full ASAM). Those with co-occurring mental health needs must be assessed by a medical doctor and/or psychiatrist to determine medical necessity.

Based on the assessment results, patients are connected with withdrawal management, MAT, outpatient treatment, narcotic treatment, case management, and other services.

The process of moving through the behavioral health systems and being connected with the appropriate level of care for addiction treatment is rife with barriers. There is a general lack of awareness of resources in the community, and though there are multiple entry points to the system, people are not aware of many of them. Community members also do not have a clear understanding of what MAT is and how to access it. In terms of treatment capacity, there are issues with staff retention and turnover, and a need for well-trained professionals. There is also a disparity in terms of urban versus rural capacity, a lack of culturally and linguistically appropriate services, and a lack of resources to address social determinants of health such as housing and transportation. Care coordination and coordinated discharge planning is a challenge, as well as coordination with social service agencies. There also is a need to overcome stigma and structural/ policy challenges in order to provide care that is person-centered.

[1] The MAP program is a free service to all persons living in Fresno County that is a collaboration between the Fresno County Department of Behavioral Health and several community based organizations (CBO) to link individuals and families to “the right care, at the right place, the first time,” Collaborating CBOs utilize appropriate screening., provide navigation support, create care/service plans and provide linkages to a spectrum of mental and physical health, substance use, housing , employment readiness and other social services.

Fresno County Outpatient Services Current State VSM



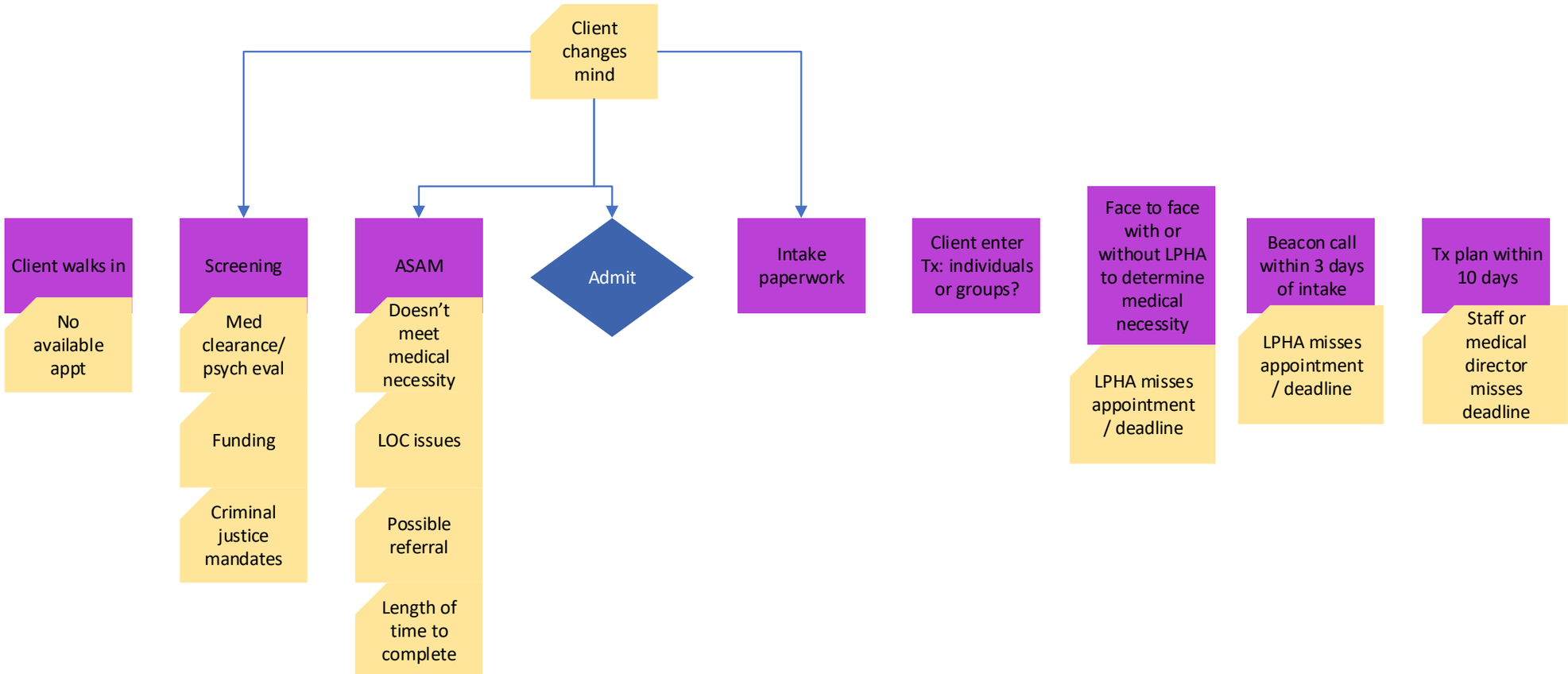
Outpatient services are contracted by Fresno County Behavioral Health. The outpatient care process begins with a person arriving at the clinic, which can pose issues if the person arrives without an appointment, a referral, or insurance coverage. During the appointment, the majority of patients will undergo ASAM screening, except for a small number that have a pre-screen. Separate from the ASAM assessment, it can be difficult to establish medical necessity, particularly if patients do not disclose the event that prompted them to seek treatment.

The ASAM assessment process is very lengthy and often extends the intake process to several hours, making it difficult to maintain patient engagement. Consequently, there is a need for staff with strong motivational interviewing skills to avoid losing clients. Patient may also experience withdrawal or cravings during this process, particularly if they have not been forthcoming about their most recent use of substances. Based on the level of care determination, clients may also show some resistance at this stage, particularly for clients who meet the criteria for residential treatment and fear losing employment.

After the assessment is performed, the client must return, often at a separate visit, to get a treatment plan. Some clients are lost to follow up because of a 10-day window allowable to enroll the client in services before they have to start the intake process over.

After intake, medical necessity is established through a meeting with a counselor, and the client is admitted and assigned to a counselor and a schedule of group therapy meeting. Barriers include lack of workforce capacity, and lack of treatment adherence which can result in a client being dropped from the program if they miss a certain number of days. Clients receive case management during treatment, which includes medical referrals. When it comes time for clients to be discharged, some clients feel that they did not have enough time in treatment and would benefit from more services.

Fresno County Residential Services Current State VSM

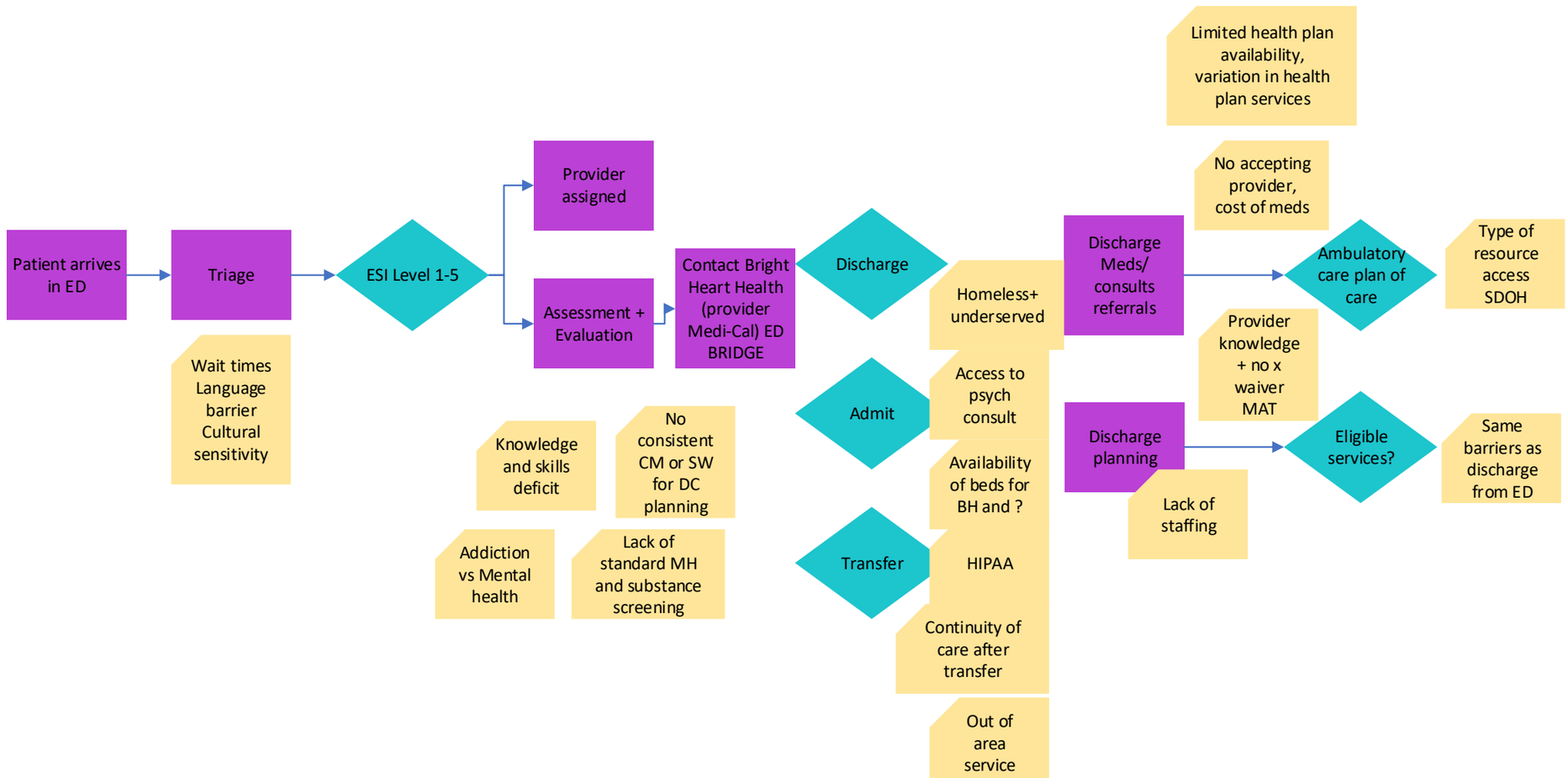


The process for receiving treatment in a residential facility begins with a client arriving for treatment, either by walk-in or appointment. During the appointment, staff perform screening and ASAM assessment to determine eligibility for the residential modality of care. Barriers to eligibility include timely and successful medical and psychiatric clearance, having medication, funding, bed availability, and criminal justice mandates such as 30-day limits despite a need for longer term care. [2]Additionally, clients may meet ASAM criteria but not meet medical necessity criteria according to DMC-ODS. After the ASAM assessment, if the decision is made to admit the client into treatment, the client completes intake paperwork.

After entering treatment, the client will receive both group and individual counseling. More than treatment capacity, residential providers face issues with medical necessity justification and Medi-Cal authorizations. Providers also face an overarching issue with clients changing their mind at any point during the treatment process about whether they want to continue.

[2] Currently there are no 30-day limits. Residential services are for a maximum of 90 days per treatment episode or two treatment episodes per 365-day period. Client can receive one (1) thirty (30)-day extension annually if the 90-day episode is not sufficient. Treatment is approved in 30-day increments and extensions of each 30-day period must be requested by the treating provider in advance of the end of the current 30-day period.

Fresno County Hospital/ Health Plan Current State VSM

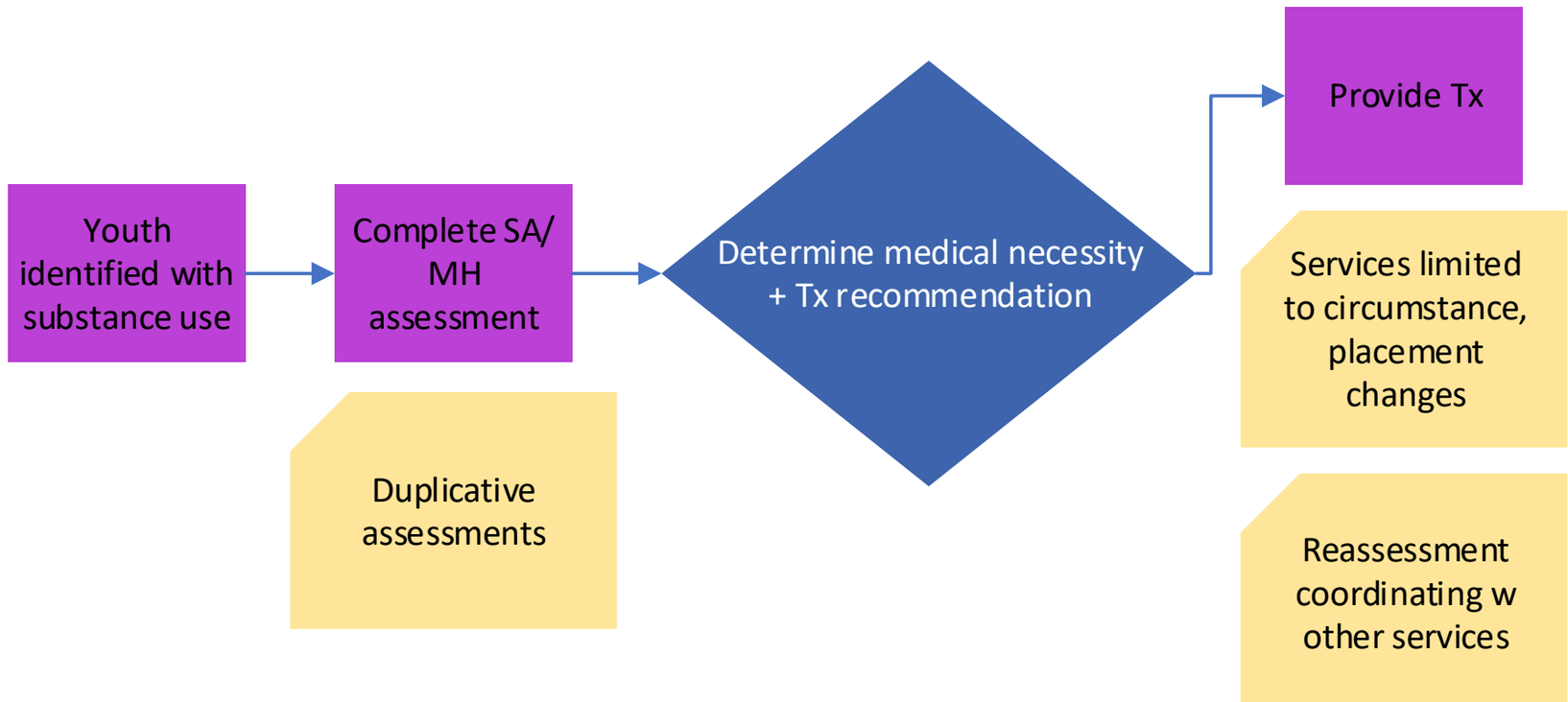


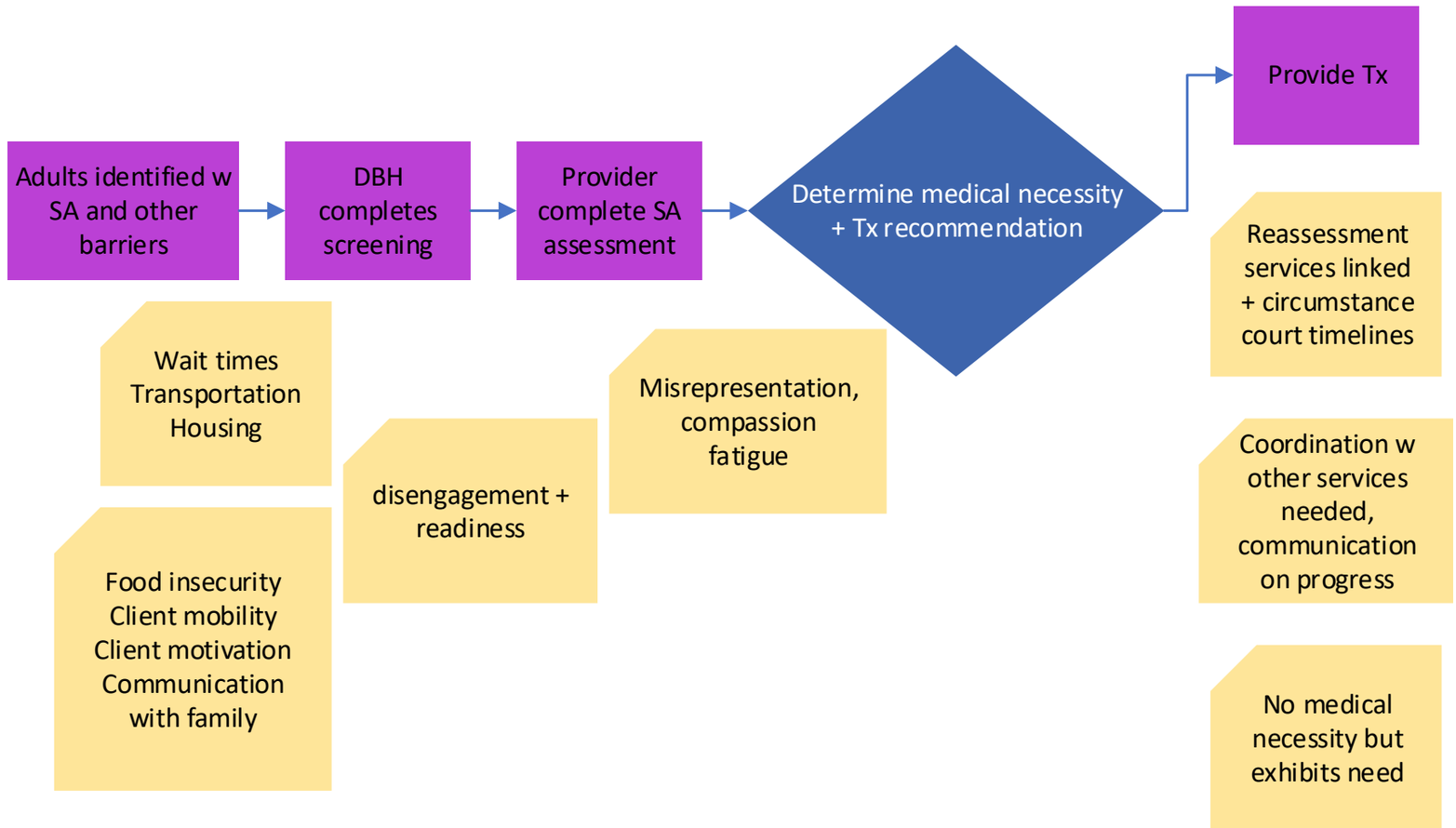
This group was comprised of both hospital and health plan stakeholders and identified the beginning of their process with a patient arriving in the emergency department. The patient first undergoes medical screening (as required by law) and triage, and because the ED is used for both emergent and nonemergent care, patients face long wait times. Due to language barriers and cultural sensitivity issues, patients may not disclose all information in triage. After the patient is assigned a triage level, a provider is assigned to them to complete a medical assessment and evaluation. However, once this assessment and evaluation is completed, determining next steps becomes a challenge. With a shortage of physicians, newer PAs and NPs may be placed in this environment to extend the care team but experience a learning curve within emergency services. There is a lack of consistent discharge planning, and lack of standardized processes for mental health and substance use screening to properly identify addiction issues versus mental health needs. The County does have an ED Bridge presence which collaborates with Bright Heart Health, a telemedicine MAT provider that extends MAT access through telehealth physician support for induction, treatment and related issues. Even deploying telehealth resources does not reach everyone, as capacity is limited within the hospital. Additionally, there are limited office based opioid treatment (OBOT) MAT options in Fresno.

After assessment and evaluation, a decision is made either to admit the patient to the hospital, discharge him from the ED, or transfer her out to another setting, such as an inpatient behavioral health setting. There is a lack of treatment capacity in terms of both bed and provider availability, and continuity of care post-transfer is a significant challenge at a most critical transition point. A patient who is discharged after initiation of MAT faces myriad barriers including limitations in health plan benefits to cover MAT, and consequent cost barriers for MAT continuation; as well as a dearth of providers trained and willing to accept patients on MAT or for other treatment services. Providers generally lack training and knowledge about SUD treatment. If the assessment determines the patient requires inpatient psychiatric care, patients are often transferred out of the County. Finally, it is particularly challenging to meet treatment and or psychiatric needs for adolescents.

Fresno County Social Services Current State VSMs

Foster Youth




Adults identified w SA and other barriers
DBH completes screening
Provider complete SA assessment
Determine medical necessity + Tx recommendation
Provide Tx
Reassessment services linked + circumstance court timelines
Coordination w other services needed, communication on progress
No medical necessity but exhibits need
Misrepresentation, compassion fatigue
disengagement + readiness
Wait times
Transportation
Housing
Food insecurity
Client mobility
Client motivation
Communication with family

Foster Youth

When foster youth are identified with substance use issues, perhaps associated with a runaway episode or an event prior to child welfare system involvement, social service staff make a referral to a specialist to complete a mental health or SUD assessment. Afterwards, they are referred to treatment to complete the ASAM assessment and to determine if they meet criteria for medical necessity.

Foster youth are sent to a variety of providers, but services are usually linked to circumstances. There is continual reassessment of progress and needs. Additionally, it can be especially challenging to coordinate with other services, given the array of challenges faced by many youth in the foster system.

Currently, there are no MAT services available for youth, and no residential treatment options specific to youth with SUD. Care continuity can be difficult for youth on psychotropic meds if they run away from their placement, and there is no way to track medication adherence.

Adults

Adults with social challenges include adults who have touched the child welfare system, welfare to work, and adults experiencing homelessness. Persons identified with a set of challenges undergo assessments that vary depending on individual and population needs and can include the VI-SPDAT and the ASAM.

If substance use is identified as an issue, the client receives a referral to Behavioral Health to do a screening, but this can be challenging due to wait times, transportation, competing basic needs, mobility, and readiness factor. If Behavioral Health sends the client to a provider for an assessment, a client may disclose different information to the provider than they did to social services, creating issues with establishing medical necessity.

In terms of accessing treatment services, adults face barriers with constant reassessment, services being linked to circumstance, court timelines, family reunification timelines, coordination with other services, communication on progress, and difficulty establishing medical necessity despite evident challenges related to substance use.

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 Fresno County to address addiction, stakeholders agreed there were many challenges, particularly around available services, system integration and coordination, workforce capacity and stigma.

In small groups, participants identified barriers and gaps within the Fresno County addiction treatment ecosystem, as well as potential solutions. Below is a summary of the discussion organized by types of gaps and barriers. Solutions are summarized in groups of similar solutions.

Barriers/Gaps

Lack of needed services

- Little to no access to care-full capacity, waitlists, few options, financial status, insurance, rural areas, limited hours of operation, language barriers
- Waiver but shorter stay in residential care, better discharge planning to assure step down programing or longer length of care in-patient
- Loss of client/family due to few sober living beds
- Waiting list for community housing means client returns to community where they lived
- MAT Outpatient services
- Capacity-# of providers for families, recovery residences, eligibility and length of treatment allowed/ Limited hours for services/ Limited staff on site/ Not enough providers (i.e., 2.1 level)/ Lack of MAT and residential, outpatient, intensive outpatient and DT
- Lack of preventative or early intervention services, lack of access to services for co-occurring disorders
- Lack of training including curriculum or mandate to educate students in the education system; Lack of training for teachers and administration; Lack of SUD education in the school systems elementary to college; Highschool education
- Lack of services for youth including: 3.0 level of care for youth, Psychiatric care for youth, adolescent residential services, Youth psychiatric inpatient
- Minimal inpatient treatment for population/Long-term residential treatment/ Amount of treatment episodes (residential)
- Dual diagnosis treatment
- Medication Management
- Lack of mental health care, care coordination and holistic care

- Lack of recovery residence
- Medical detox
- Sobering center
- Supportive education/employment
- On demand treatment
- Access to wrap around services
- Access to treatment facilities accepting children and families
- Street services-innovative ideas
- Telehealth
- MAT in jails

Workforce development/capacity

- Competency for Co-Occurring Disorders (COD) -capable services
- Inconsistent screening/assessments/ Inaccurate completion of assessment leading to misdiagnosis/wrong diagnosis
- Burnout and high turnover
- Staffing-qualified and committed
- Workforce shortage-not enough providers/ Lack of workforce and workforce education
- No capacity to treat for substance issues- counseling and therapy services
- Hours of service to connect for care-ED service hours
- Chronic pain management providers versus ED recommendations for safe prescribing
- Non-profit relationships with County arrangements for funding-loss of trained people and turnover leads to inefficiencies
- Lack of experience with peer support services
- Lack of experience with MAT services
- Lack of understanding about harm reduction
- Cultural understanding (i.e., native and tribal populations)
- Lack of clinical knowledge-build systems using old information-interventions lag behind

System linkages/system issues

- Integration between systems/ Collaboration-systems linkages, how to respect where the client is/ Coordination between agencies/ Lack of warm handoff/ Lack of seamless system of care/Collaboration with everyone/ Lack of care coordination
- Lack of communication between agencies and staff/Information sharing-complicated and bureaucratic/ Data sharing/HIPAA/42 CFR

- Inconsistent law-state. Federal (e.g., MJ)
- Intake process is too long
- Duration requirement of dependence to enter treatment
- Insurance barriers/Insurance to cover treatment/ Insurance is a barrier/ Increased medical costs and variation in each plan's reimbursement structures/ Reimbursement for services to sustain work of the agency-payroll dependent on reimbursement
- Different goals, benchmarks, responsibilities at each agency
- Misuse of resources
- Drug Medi Cal/ODS waiver not prepared; lack of communication/ ODS Waiver and new system requiring managed care and providers struggling with new rules
- Waiting lists-outreach funding
- Medical necessity=legal system-court ordered
- Definition of treatment is different with different entities
- Jail to community SUD services-handoff/referral to community SUD/MH resources
- Prescriber/provider on hand for private addiction program (outpatient program)
- Jail environment is a barrier due to safety and security issues/protocols (not conducive for MHSUD treatment)
- Jail-barrier don't know release date
- Alumni services and support
- Lack of support from DSS for MAT services
- Providers or family dictating how long or what type of treatment a patient receives
- Lack of follow-up on referrals given by providers-follow up or follow through
- Positive drug test makes client they will be kicked out so they leave-transitional housing voluntary-referred out to treatment
- "Violations"-guidelines for people trying to stabilize/recover
- Lenience in laws that allow people to work the system
- Mental health versus addiction versus criminal issues-clear diagnosis
- Billing system
- Timeliness of access for non-DMC clients
- Disconnect between housing services and AOD services
- Lack of communication between hospitals and criminal justice
- Funding stream restrictions
- Lack of access for certain populations due to funding restrictions
- Gap between what treatment providers and criminal justice believe is the standard of care

- Lack of coordination of Welfare to Work money for MH, SUD and domestic violence
- Reimbursement-MAT-OV health plan-medication state, money, supportive services-FQHCs
- Lack of integration of MH and SU services
- Non-pharmacological response to pain

Stigma

- Stigma, fear of government
- Stigma from staff and doctors/Stigma among providers/Client stigmas/ Provider bias/stigma
- Denial of disease
- Stigma from other providers, community, family and friends-culture/religion, criminal justice system
- Lack of education, personal bias, pregnancy-fear of CPS
- Culture of custody staff to remove stigma of MH/SUD diagnosis
- Political will/interest-values driven/Politics-fear/risk of losing Medi Cal/Fear of losing employment
- Lack of education regarding nature of addiction-physiological underpinnings of addiction
- Lack of understanding/knowledge of MAT
- Understanding need for services (i.e., homeless population)

Social Determinants of Health

- Homelessness
- Lack of transportation/ Rural public transportation
- Client doesn't want resources
- Lack of support systems
- Lack of housing for those who are symptomatic

Solutions

Training for professionals

- Co-occurring Disorders (COD) training-better linkage/coordination/ Make all COD capable and harm reduction oriented/ Co-Occurring capable training and monitored implementation
- Increase training and education on SUD/ More training and supervision/Training/ More education for stigma-doctors, judges, police/ More training in diagnostic criteria and medical necessity/Educate SUD providers/MAT

on how to outreach to MH system/ Understanding who your patients are/ Train to wellness and other business models for staff engagement (Gallup Organization)/Team building activities/ Education to increase understanding/Training and supervision/ Oversight and accountability/Clear expectations/ Human resources/Increase capacities/ Inservice trainings/education/ Trainings SUD professionals/ Including stigma reduction and addiction training to DSS and justice/Required courses in education system/Cultural competency training for state and County providers/Revise medical school and other health professional curricula to include reducing stigma

+ Develop County-wide standardized training on how to complete forms/assessments/ Streamline intake and collaborative documentation/ ASAM criteria-standardized forms/ Assessment -provider training versus peers

Community outreach/education

+ Community outreach/education about available resources/ Community outreach/education of other providers in community/ Education and outreach to faith groups and religious community/ Education/ More outreach/ Community outreach/coordination of care/ Increase outreach and form relationships/ Understanding resources available/ Collaboration between programs/ Release of Information Forms/ Business Association Agreements/ Open house/ Programs/processes systematized to link to needed programs/services after release/ Establish community relationships/SOAR Training/SUD First Aid training-like MH First Aid training/Curriculum-National Council?/Case management/Liaisons of point within each agency/organization/ Education about available resources/Training on addiction and harm reduction/Gabor Mate-addiction expert/Education about addiction/Education in the community at churches and ethnic/social settings (Rotary, Lions, Immigrant groups, philanthropic agencies) about neurobiology of addiction/More outreach and early intervention/Community resource directory specifically with SUD providers/programs/SUD provider network-membership/participation regardless of agency/Collaborate with FMCOC (Fresno-Madera Continuum of Care)
+ Early prevention-starting at school age/ Early intervention, education and outreach/ Try to partner with the new superintendent of schools-contract for clinicians in schools-use as an in road since they are already there/ SUD education for school personnel/ Ongoing educator training/ Start in grade school-assemblies on drug free zones

- More collaboration with schools/Funding for MH in education system/Work with universities and high schools

Service Delivery

- Comprehensive services and understanding/Increased staff and money/ Resources available/ More money/Medical transportation/Self-care/More engagement with services/Merit-based incentives/Stages of change/Denial management/ Family System Work/Therapy/ Partner MAT providers/ Youth diversion program/ Motivational interviewing/ Drugfreeworld.org/ MAP point/ Case Western-dual diagnosis treatment from Ohio-look at website/Cal Viva Logistic Care/Lock boxes/Cal Viva Lock in program/ Connecting with medical insurance for transportation/ Transportation/Assistance with application process/ Recovery services-life after treatment/ Bilingual staff/Logistic care/ Care coordination/Harm reduction/ Medi-Cal transportation-member services/ Anthem, Medi Cal, Bright Hearts Health/ Use/require harm reduction/What can HMIS use to coordinate care/Support MDS for X waiver/Utilize CURES system/Remove barriers to state and County funding/ Hub and Spoke Model-medication units/ Referrals for covered transportation services/Effective/reflective project "abstinence"/On demand treatment (Bright Hearts, Anthem Medical)
- Telehealth Outpatient Alcohol and Drug Services (T.O.A.D.S.)/Avatar access/ Collaborate with NIDA and other online resources for youth intervention/ Telehealth
- Initiate treatment in jails/Build roles in the criminal justice system that are well trained and appropriately paid/Medication in jail/Improve community-care coordination with jail services/Training of custody staff/Employing PSS in justice/Education to law enforcement and justice
- Work with DHCS on residential restrictions/Increase solo living capacity/Housing plan and "community approach"
- Maximize what we can in the HIE/EMR system for history validation/ Centralized database accessible to all

Advocacy

- Show up at hill days-vote/ Advocacy for youth services/Vote/ Host bi-annual event for staffers and elected officials on hot topics/More advocacy for outreach funding

Consolidated Barriers and Gaps

The discussions 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 and the number of times the barrier/gap was mentioned.

	Structural Barriers	Structural Inefficiencies	Structural Gaps	Capacity	Knowledge/ Training	Inconsistency	Stigma/ Decriminalization	Social Correlates	Funding	Insurance	Cultural Competency
Justice	1	4	2	5	1	1	3	5		2	
Education			2	3	1						
AEGIS, BAART, Medmark and Lags	4		5	5	2			2		1	
Fresno County Behavioral Health	4		7	3	2		1	4		2	1
Outpatient Services	2		1	1				3		2	
Residential Services	2	2		1				1	2	2	
Hospital/Health Plan	2	2	4	3	2			2		1	2
Fresno County DSS		3	2	1	1			6		1	

What is Working Well in Fresno County

Following the small group discussions about barriers, gaps and potential solutions, the larger group talked about what is working well regarding Fresno County's addiction treatment system. Participants agreed that there are many strengths to build off of in the County including:

+ SUD program in Fresno County jail now. Working in jail, 240 voluntary inmates going to cognitive behavioral therapy with an additional 150 on a waitlist. MAT in jails.

- AB109 –Collaboration of providers with adult probation is very good.
- Clinical supervisor for rural co-responder team, co-located with police stations. Fresno County currently, in that model and new metro model, are regularly intervening with SUD. Ensuring safety and building relationships to support episodic and long-term care.
- Instead of saying relapse, saying "decompensated and was unable to manage their illness". I would never tell anyone with major depressive disorder to get out. It's okay to see them while they're symptomatic. That's what we do for all other psychiatric illnesses.
- Early 2017 -enhanced harm reduction by law enforcement agencies. Increased the number carrying Naloxone. Embraced harm reduction efforts. Increased efforts by first responders in central valley.
- Turning Point – integrated model of care; SUD co-occurring and mental health

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, HMA 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 Fresno County community. Below is a summary of what participants identified as their most desired features of a future system.

- Unified entry-Coordinated single point of entry/no wrong door
- Shared case plan
- Universal, real-time, secure data with access and permissions
- Shared police principles of harm reduction
- Sufficient resources to do the work
- On-demand, non-coercive treatment
- Treatment, even when symptomatic
- Real-time, universal data sharing
- More fluid exchange of info, standardized Release of Information
- Better and shared understanding of addiction for everyone serving the population
- Meet client at their point of need-homeless, at-risk of homelessness, incarcerated, etc.
- Use of common language, common assessment tools between agencies and services-everybody speaking uniform language across levels of care
- Electronic health record that's common and amongst agencies
- MAT access in all health settings, including jails and prisons-especially in rural areas
- All MAT covered by all insurances-all types of care, all medications
- Aftercare offered by all treatment programs
- Shared database, common EHR system
- Increased communication between collaborative partners-across entire human services system
- Increased training of evidence-based practices and supervision
- Shared EMR
- Reduction in documentation time = more time to spend with clients

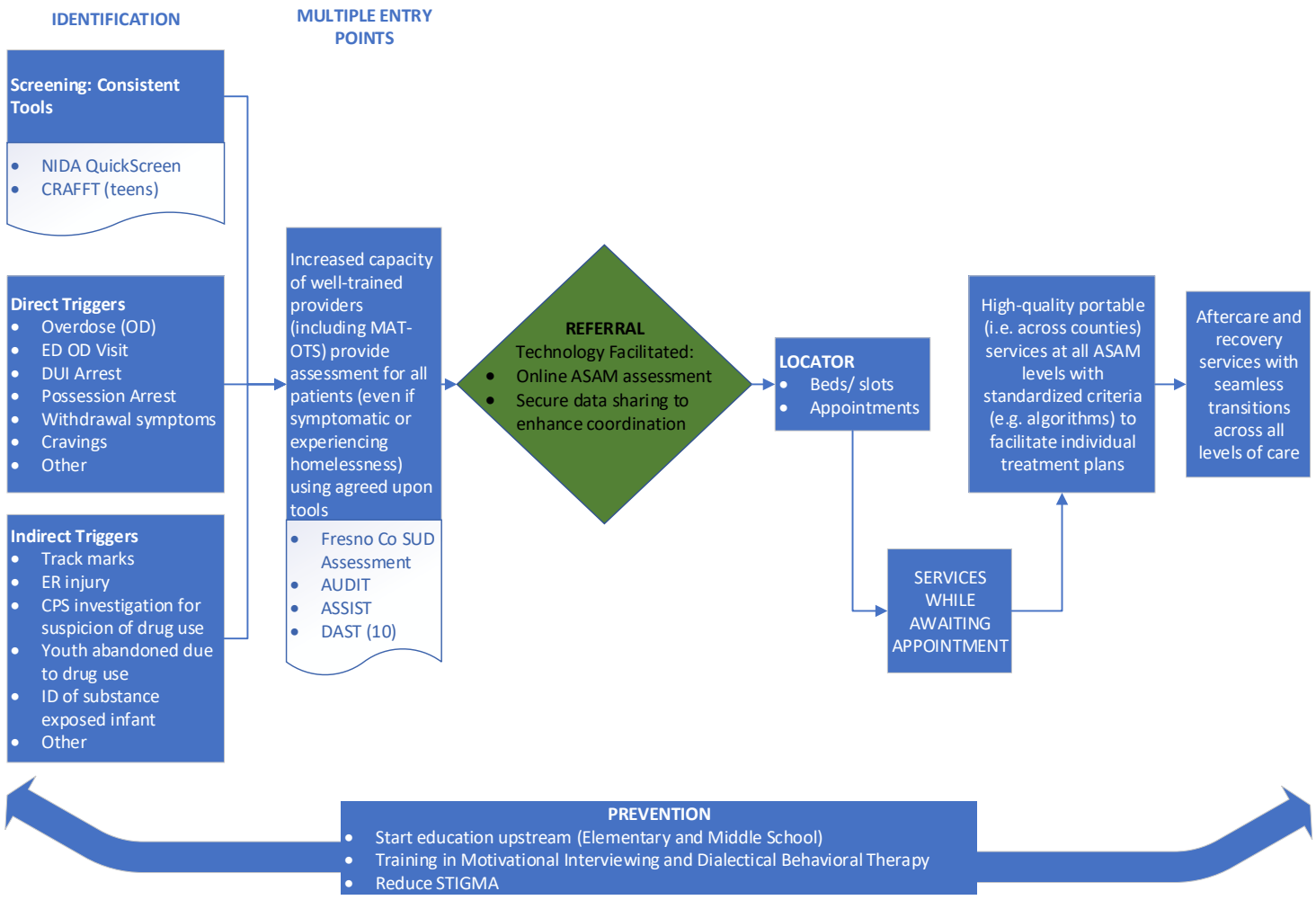
- Being able to serve clients with out-of-county Medi-Cal without entering agreement with outlying county-flexibility in serving out-of-county
- Enough adequately trained providers to meet demand
- Standard algorithm of how treatment plan is individualized to the need, across all sectors
- Statewide standard for access to service
- Start younger, in school systems, educating about this health need-upstream curriculum
- Continuity of care, providing hub of online resources you can access ASAM or any assessment tools you might need (screenings, diagnosis data, etc.)
- Engagement services while individuals are on a wait list, so they're not just waiting and continuing to use
- More peer coaching-training peers at a level to provide more peer support to help with the lack of workforce, provider burnout, etc.-standardized training
- On-demand access to treatment with comprehensive screening and linkage to integrated care
- Advocate for uniform or interoperability of EHR system and for revised CFR-42 and paperwork reduction
- Seamless transitions in care between levels of care/effective care coordination
- Standardized, required training/education on OTS services among providers
- Adequate and trained staff
- More adequate aftercare and recovery services
- Assessments that are consumer driven
- No limitations on number of episodes/admits to residential care

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"



The "Scaffolding" is the structural representation of services, processes and decision points which are consistent across all locations that a patient with addiction may encounter. It represents the culmination of the process improvement event: an agreed-upon future state for Fresno County.

Considerable time was spent during the process improvement event contemplating the current state of the SUD ecosystem and the many barriers that exist within this system. These conversations, along with the determination of the most desired features of the future system informed the whole group discussion of the ultimate future state map. Once the most desired features were determined within small groups. these features were shared and ultimately mapped into an ideal future state treatment and recovery ecosystem.

Undergirding the entire system is a prevention orientation that addresses both drug use as well as building a compassionate, caring system that engages those with OUD/SUD regardless of their state. That begins early in life with prevention activities aimed at informing individuals about the neurobiology and risk of OUD/SUD must begin early, perhaps as early as elementary school or middle school. There is also a need for a systemic approach to building knowledge, skills attitudes and behaviors that willingly engage those with OUD/SUD in facilitating readiness through strategies such as motivation interviewing techniques and trauma informed care principles. Additionally, efforts must be made to recognize, and eliminate the stigma that keeps people from seeking help and drives off-putting behaviors that lead to discrimination resulting in reluctance to seek and accept services.

When the prevention principles and activities fail, a system must be in place to address the entire continuum of care, which begins with screening and identification. The active mechanisms for identification involve the use of validated, evidence-based screening tools that identify risk for SUD to be utilized in both likely (e.g., drug treatment programs and hotlines, primary care provider offices, etc.) and unlikely (e.g., public health services and offices, schools, faith-based groups, etc.). There are a wide variety of screening tools being utilized across Fresno County. It may be useful to narrow the number of tools, so that more providers are trained in their utilization, and more importantly, there is more common knowledge about the interpretations of scores for the screening tools (resulting in more referrals and assessments). In addition to active screening and given the difficulty in establishing ubiquitous screening for addiction, there should be protocols in all or most nodes of entry that establish criteria that constitute "triggers" for assessment and referral, even in the absence of a formal screening tool or process. Collectively the group identified both direct and indirect triggers. The former are events or symptoms defined by drug use. The latter are a step removed from, but highly associated with drug use. Below is a list of direct and indirect triggers identified by the group.

DIRECT TRIGGERS	INDIRECT TRIGGERS
Overdose (OD)	Track marks
DUI arrest	CPS investigation for drug use
High Intoxication	Youth abandoned due to drug use

Emergency Department OD visit	Infants of substance abusing mother (e.g., with NAS symptoms)
Positive screen via NIDA 4	Emergency Department injury
Cravings	
Withdrawal symptoms	

While referral is a central component of the future state, there is the expectation that those referrals could be improved in significant ways and streamlined to facilitate entry into treatment. In particular, Fresno participants are seeking technology enabled referrals that simplify the process by providing access to the online ASAM Assessment tools (both the Co-triage, short form, and the Continuum, long form). Secure, simplified data sharing would enable quicker placement and better coordination of care for patients entering treatment and increase the likelihood of retention in treatment. Similarly, having an online locator service for both beds and spaces would facilitate access, while allowing the County to monitor capacity and better forecast the need for building the supply of treatment providers.

Once in treatment, or at least in the queue for treatment, Fresno County envisions several key features including the provision of other services that address the other social determinants of health identified during the assessment. The provision of those services is seen both as good faith efforts from the County and meeting crucial needs that may just keep those with OUD engaged while awaiting the next treatment option. The ideal treatment in Fresno is of high quality (i.e., well-trained providers), of sufficient capacity, portable across County lines and available at all ASAM levels of care. Finally, participants see a huge need for aftercare services to facilitate the ongoing treatment and recovery needs of clients, and further, that care transitions are made efficiently and smoothly.

03 Section 3: Implementation Strategy

A. Next Steps

In a matter of two days stakeholders from across Fresno 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 technology enabled, secure, 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, portability of services across County lines, 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 Fresno 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 Fresno County Department of Behavioral Health to develop an attendee list and conduct outreach to invitees to encourage attendance. Fresno County Department of Behavioral Health completed a survey to document existing SUD capacity and resources in Fresno County, as well as understand barriers to coordinated care for SUD. At the event, one "champion" per organization/team completed a paper technical assistance (TA) application with guidance from the Central California Team Lead (Shannon Breitzman). Following the process improvement event, information collected through the TA application was entered into Qualtrics, an online survey and data collection platform. Each organization/team interested in starting or expanding MAT services will receive an individualized link to a Provider Assessment, which will be pre-populated with information from the TA application. The Central California Team Lead will work with each organization/team to facilitate completion as necessary. Following completion of the assessment, the Team Lead and Subject Matter Expert(s) will review the information provided through the TA application and Provider Assessment, to determine the appropriate TA track and curriculum for each organization/team. Once the TA needs and goals are reaffirmed by the coach and SME, the organization/team is assigned to a track and TA can begin and will continue for 12 months. For those stakeholders not interested

in starting or expanding MAT, but are interested in general information and TA, they will be assigned a track that provides for this level of need.

The three TA Tracks are as follows:

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

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

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

The following 23 organizations applied for TA:

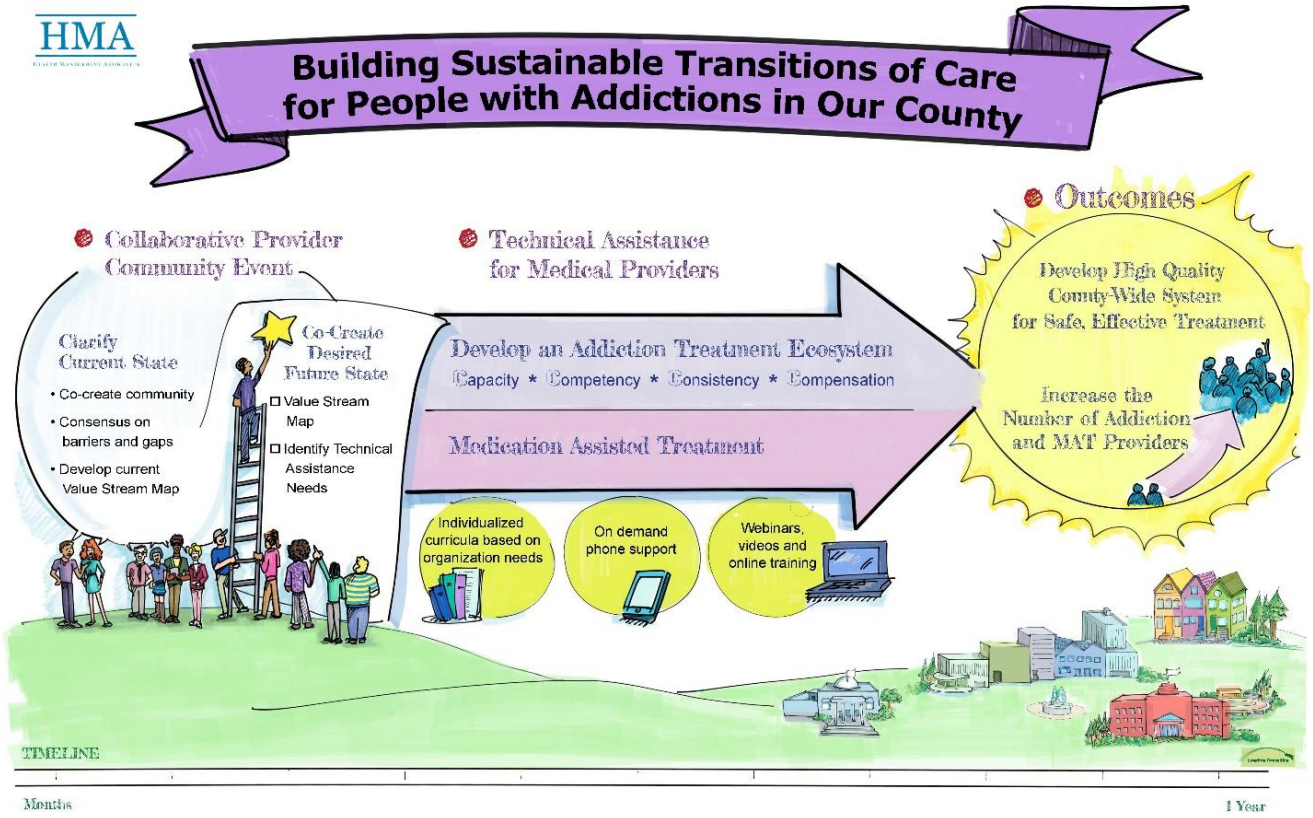
+ Promesa Behavioral Health
+ Fresno New Connections, Inc.
+ WestCare California, Inc.
+ Fresno County Department of Public Health
+ AEGIS Treatment Centers
+ Fresno County Department of Behavioral Health
+ Fresno Needle Exchange Program
+ Community Regional Medical Center-ED Bridge
+ Med Mark Treatment Center
+ Comprehensive Addiction Programs, Inc.
+ Fresno County Probation
+ Turning Point of Central California
+ BAART Programs
+ Wellpath FC Jails SUD Program
+ Kings View Mental Health Systems
+ Sierra View Medical Center
+ Fresno Police Department
+ Saint Agnes Medical Center
+ Lags Medical Centers
+ Kaweah Delta District Hospital
+ Fresno County Public Defender
+ Clinica Sierra Vista Behavioral Health
+ Fresno County Street Outreach

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

Goal	Frequency
Learn more about how our organization can participate in a community wide solution to the opioid epidemic.	21
Improve our role in managing the transitions of care as residents in our community move within addiction system of care.	20
Learn more about caring for people with addiction and provide more information and training to our staff.	21
Scale up our current MAT program by increasing the number of patients treated.	12
Learn how to provide or improve addiction treatment to pregnant and parenting women.	15
Start providing MAT services at our organization.	11

C. Conclusion

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



Appendix

A. Fresno County Data

Fresno County: Population 930,450

STATISTICS

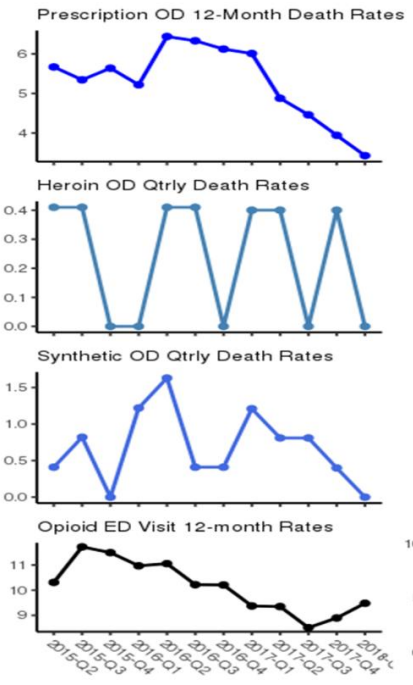
- **Opioid Use Disorder Death Rate**
  - 2017: Rank 29/58
- **All Drug Death Rate**
  - 2017: Rank 29/58
- **Emergency Dept. Opioid Rate**
  - 2017: Rank 15/58
- 10 Hospitals
- 6 Pharmacies
- 32 Federally Qualified Health Centers (FQHC)
- Methadone Patients: Rank 5/58

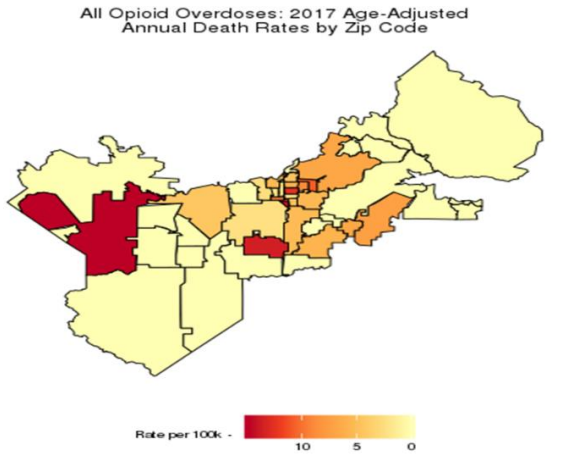
SOURCES: California Opioid Overdose Surveillance Dashboard maintained by California Department of Public Health (CDPH); California's Office of Statewide Health Planning and Development: Facility Finder (Hospital selection); California Primary Care Association

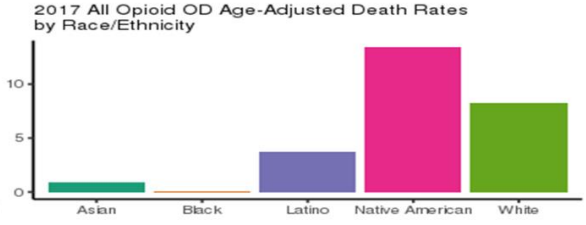
ADDITIONAL FACTORS

- Coalition: Central Valley
- SAMHSA Funds: $328,750
- Drug Medi-Cal Organized Delivery System? Yes
- Presence of CA Bridge: Yes

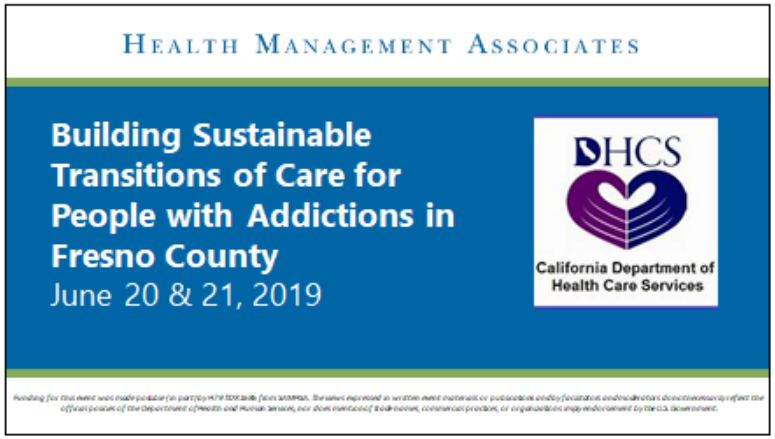
SOURCES: California Department of Health Care Services; Individual sites and the California Opioid Safety Network; ED Bridge

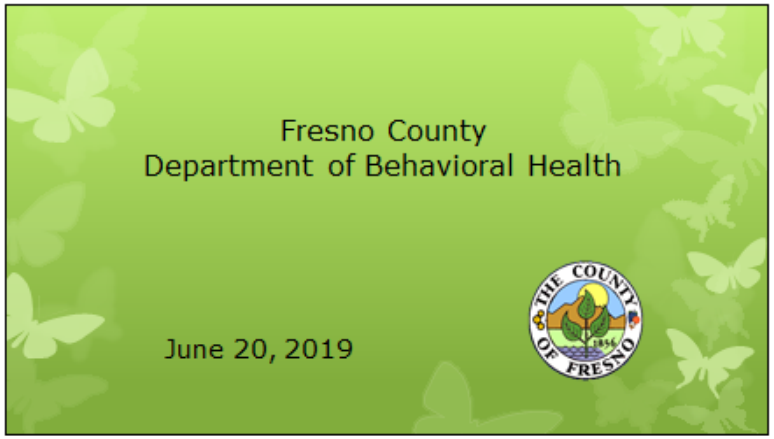


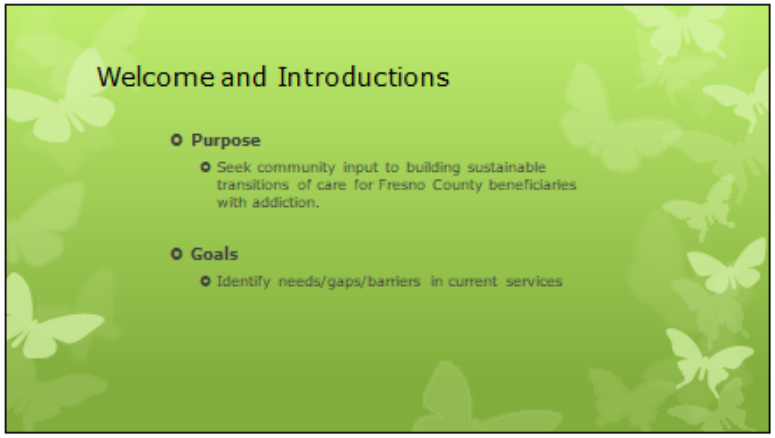




B. Process Improvement Event Slides







Our Vision

Health and well-being for our community

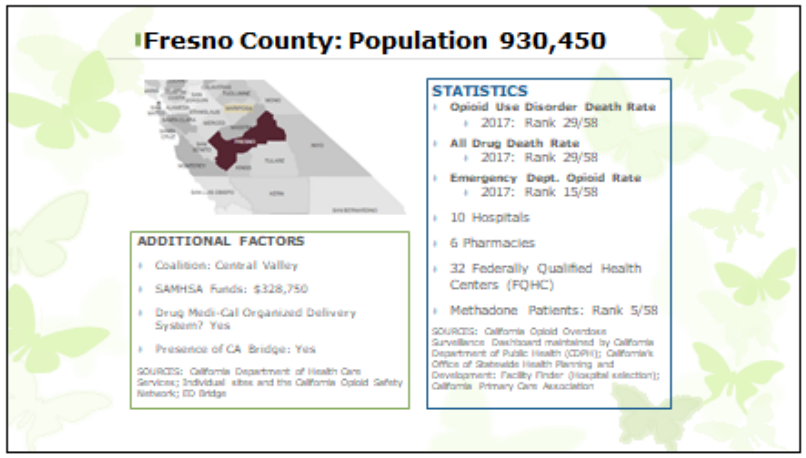
DBH Guiding Principles of Care Delivery

1. Timely Access and Integrated Services
2. Strength-Based
3. Person-Driven and Family-Driven
4. Inclusive of Natural Supports
5. Clinical Significance and Evidence-Based Practices
6. Culturally Responsive

DBH Guiding Principles of Care Delivery

7. Trauma-Informed and Trauma-Responsive
8. Co-Occurring Capable
9. Stages of Change, Motivation, and Harm Reduction
10. Continuous Quality Improvement and Outcomes-Driven
11. Health and Wellness Promotion, Illness and Harm Prevention, and Stigma Reduction

Fresno County Department of Behavioral Health Substance Use Disorder Services Trends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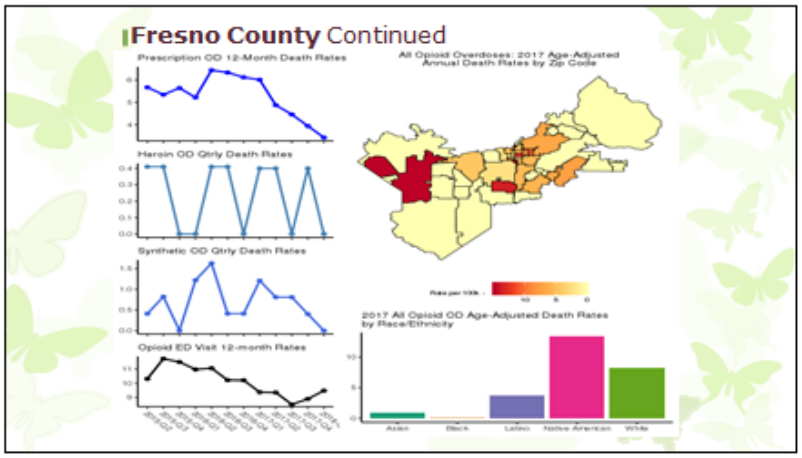
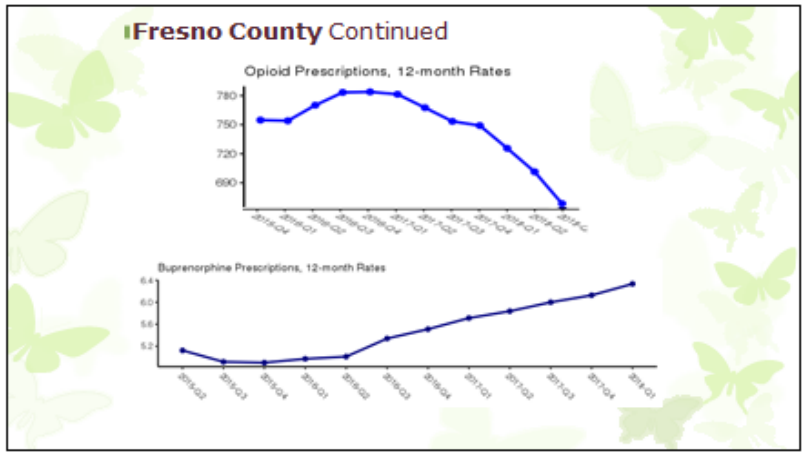
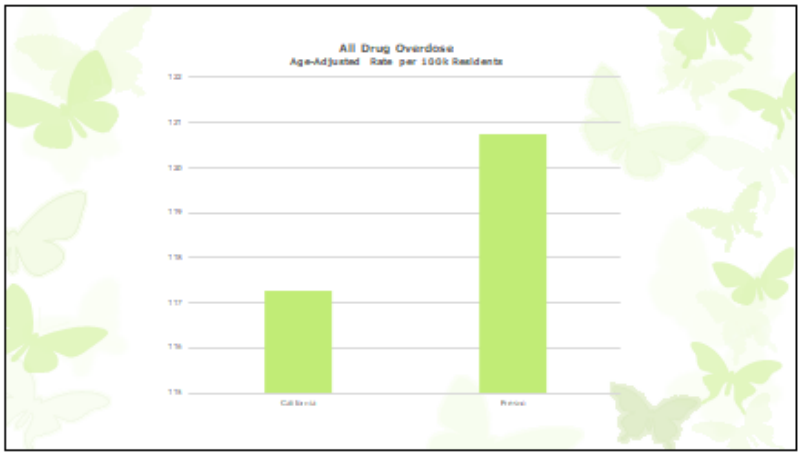
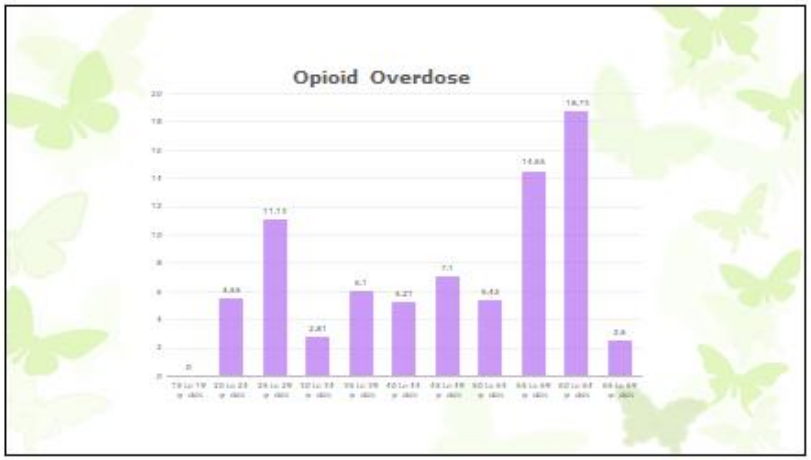
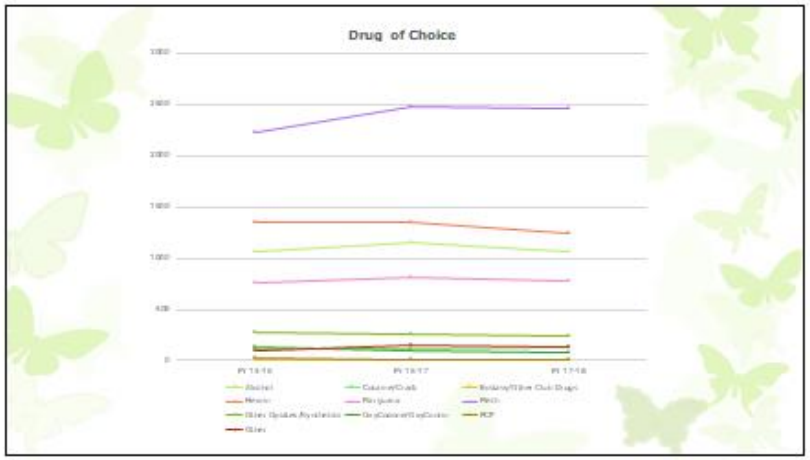
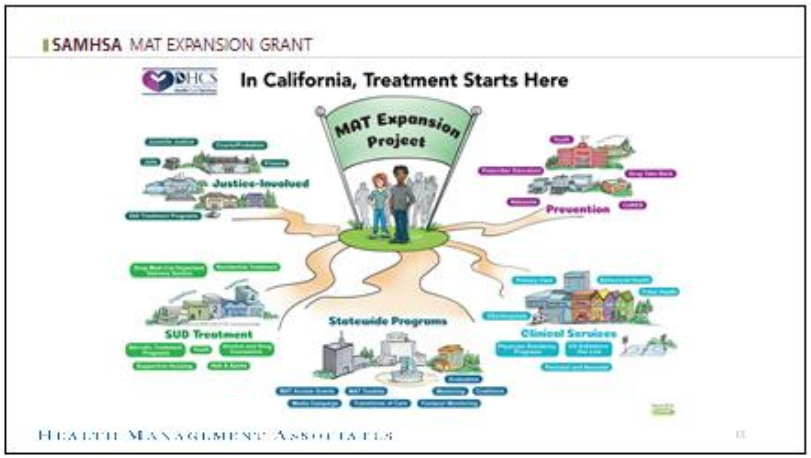

Fresno County Continued
Prescription OD 12-Month Death Rates
Heroin OD Qtrly Death Rates
Synthetic OD Qtrly Death Rates
Opioid ED Visit 12-month Rates
All Opioid Overdoses: 2017 Age-Adjusted Annual Death Rates by Zip Code
2017 All Opioid OD Age-Adjusted Death Rates by Race/Ethnicity
Asian
Black
Latino
Native American
White

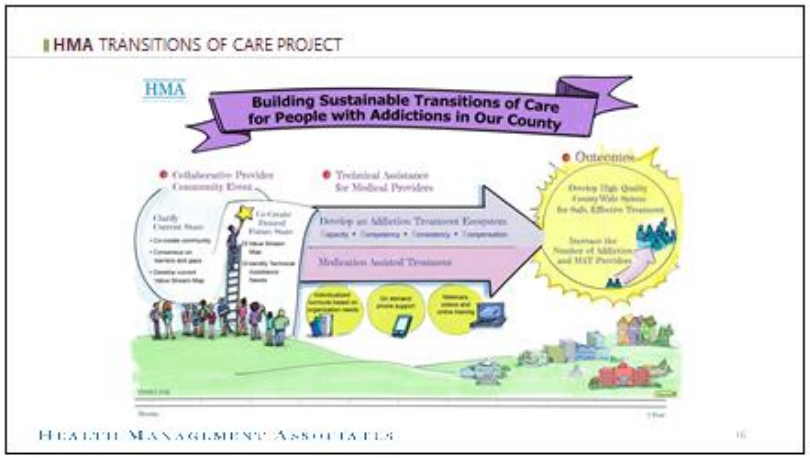

Fresno County Continued
Opioid Prescriptions, 12-month Rates
780
750
720
690
Buprenorphine Prescriptions, 12-month Rates
6.4
6.0
5.6
5.2


All Drug Overdose
Age-Adjusted Rate per 100k Residents


Opioid Overdose


Drug of Choice


SAMHSA MAT EXPANSION GRANT
In California, Treatment Starts Here
MAT Expansion Project
Justice-Involved
Prevention
Statewide Programs
SUD Treatment
Clinical Services
HEALTH MANAGEMENT ASSOCIATES


HMA TRANSITIONS OF CARE PROJECT
HMA
Building Sustainable Transitions of Care for People with Addictions in Our County
Collaborative Provider Community Event
Technical Assistance for Medical Providers
Outcomes
Develop an Addiction Treatment Ecosystem
Medication Assisted Treatment
HEALTH MANAGEMENT ASSOCIATES

AGENDA

DAY ONE

Morning Session

- Why are we all here?
- Addiction 101
- Addiction Treatment Ecosystem
- Barriers/ Goals Conversation

Afternoon Session

- Current State Value Stream Mapping (VSM)
- Current State Presentations

DAY TWO

Morning Session

- Current State Presentations
- MAT Basics and Levels of Care
- Future State Table Discussion

Afternoon Session

- Future State Mapping
- 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

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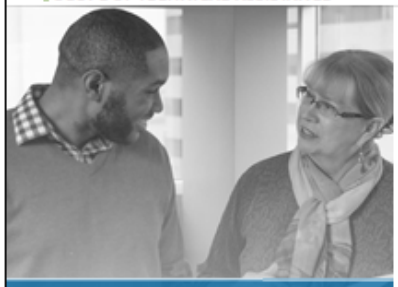
SCOPE OF TECHNICAL ASSISTANCE



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

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

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

19

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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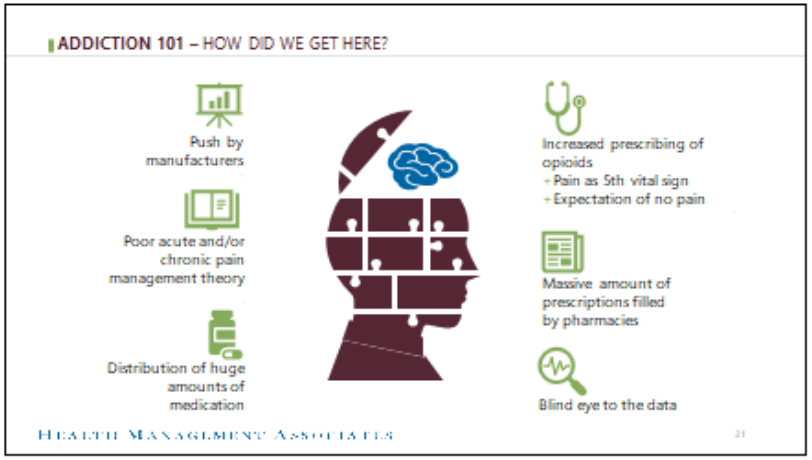
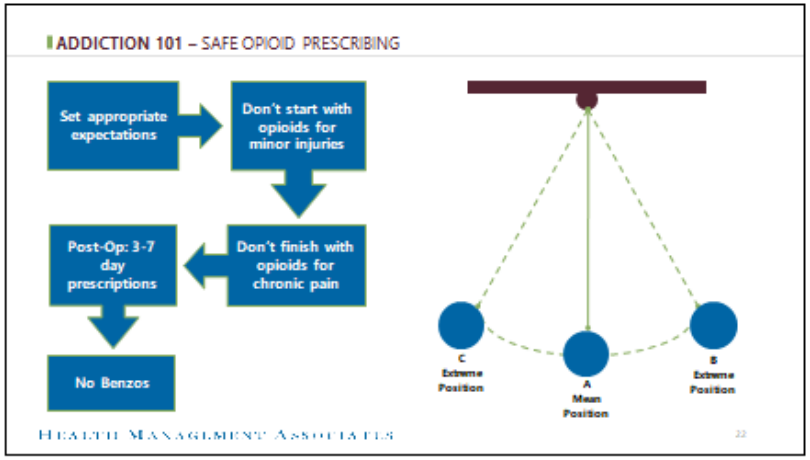
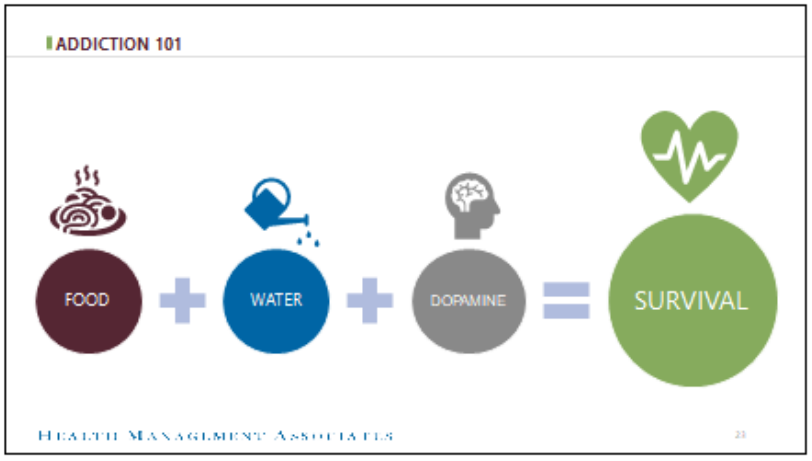
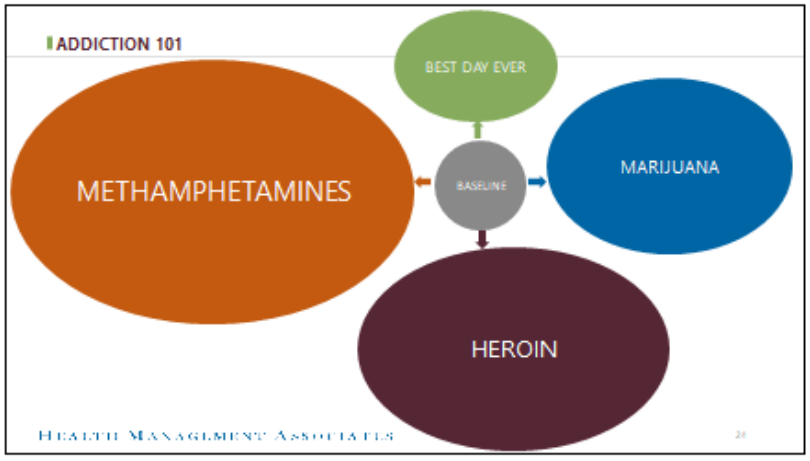
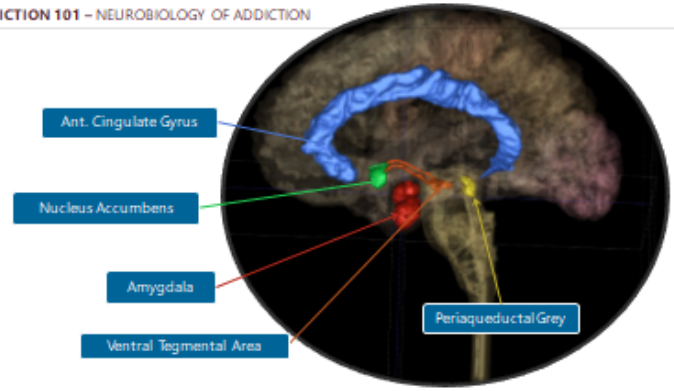

ADDICTION 101 – HOW DID WE GET HERE?
Push by manufacturers
Poor acute and/or chronic pain management theory
Distribution of huge amounts of medication
Increased prescribing of opioids
+ Pain as 5th vital sign
+ Expectation of no pain
Massive amount of prescriptions filled by pharmacies
Blind eye to the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


ADDICTION 101 – SAFE OPIOID PRESCRIBING
Set appropriate expectations
Don't start with opioids for minor injuries
Don't finish with opioids for chronic pain
Post-Op: 3-7 day prescriptions
No Benzos
C
Extreme Position
A
Mean Position
B
Extreme Position
HEALTH MANAGEMENT ASSOCIATES


ADDICTION 101
FOOD
WATER
DOPAMINE
SURVIVAL
HEALTH MANAGEMENT ASSOCIATES


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

ADDICTION 101 – NEUROBIOLOGY OF ADDICTION



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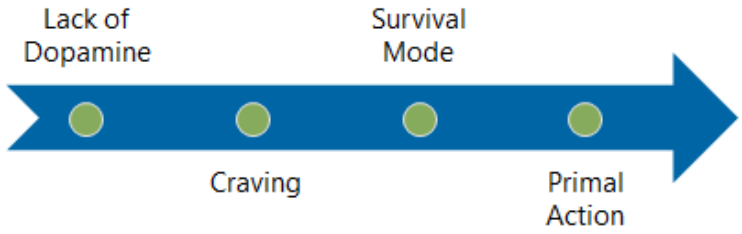
ADDICTION 101 – BEHAVIOR



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DSM-V DIAGNOSIS OF OUD

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

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

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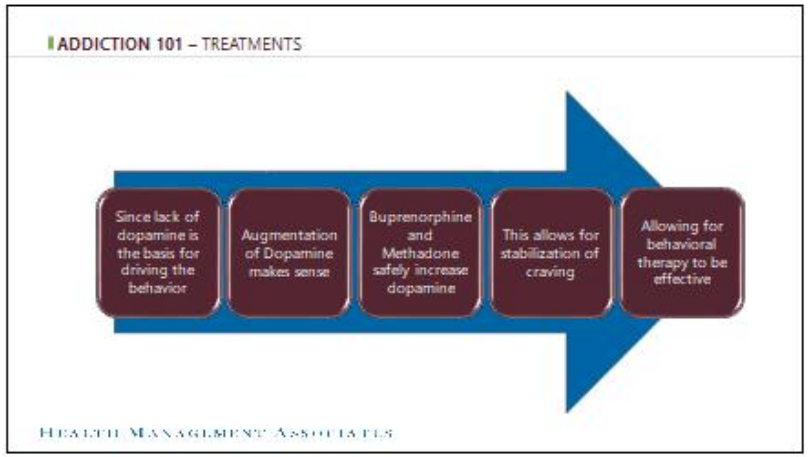
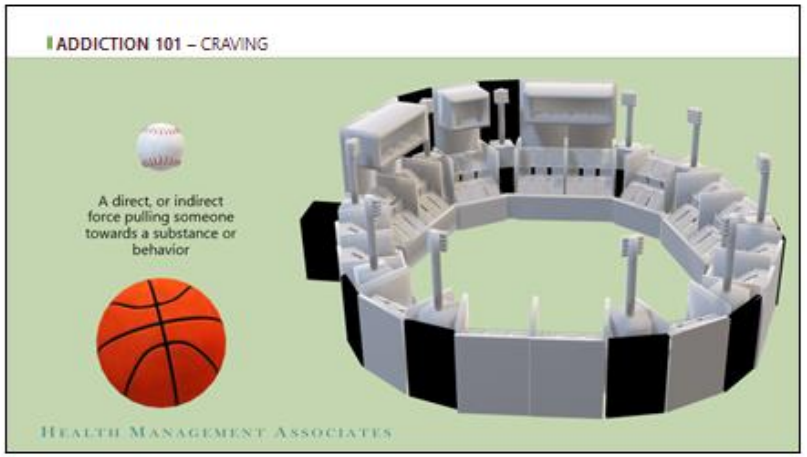
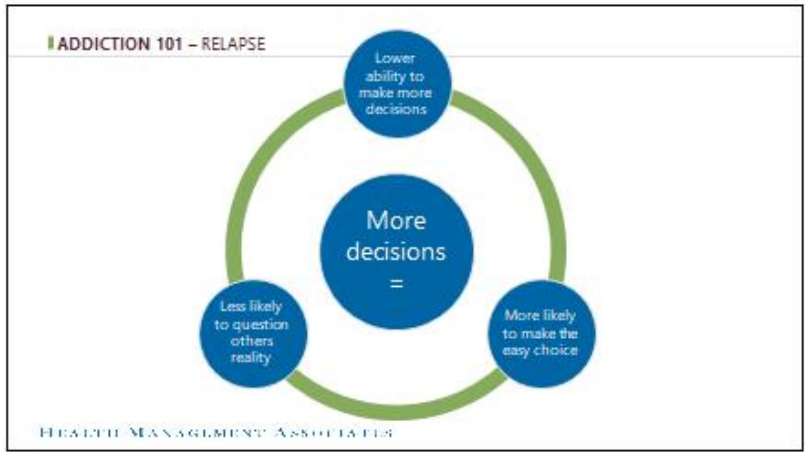
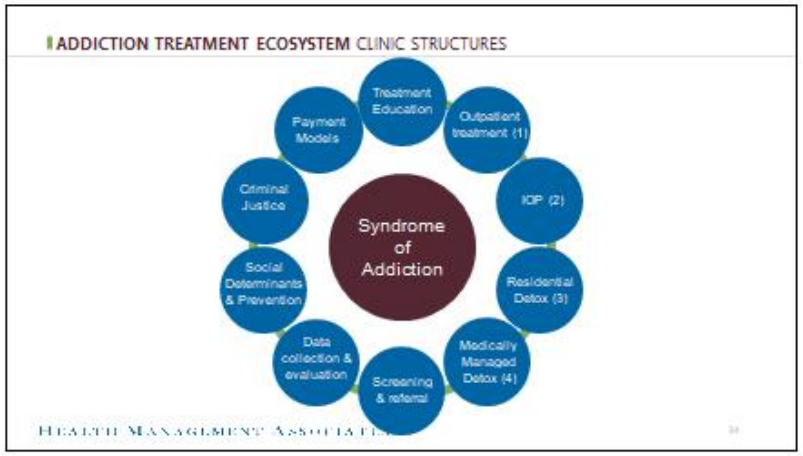
ADDICTION 101 – BEHAVIOR

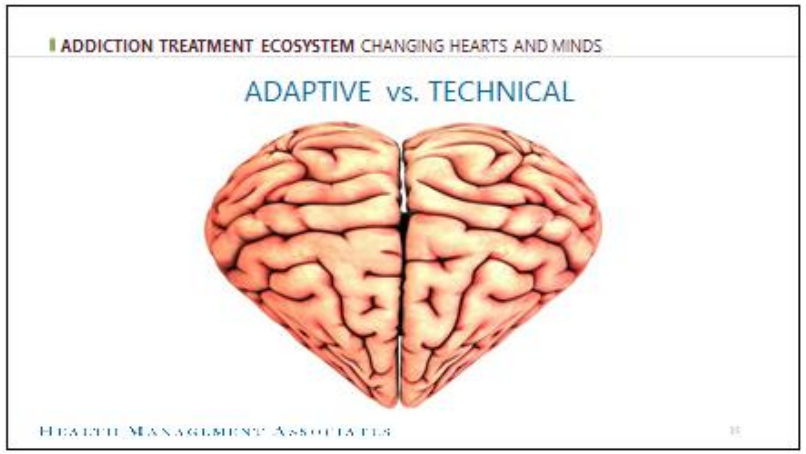
HEALTH MANAGEMENT ASSOCIATES

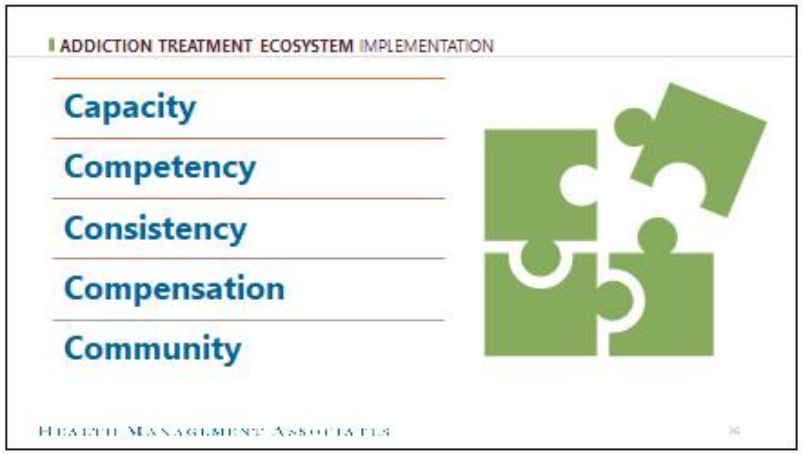

ADDICTION 101 – TREATMENTS
Since lack of dopamine is the basis for driving the behavior
Augmentation of Dopamine makes sense
Buprenorphine and Methadone safely increase dopamine
This allows for stabilization of craving
Allowing for behavioral therapy to be effective
HEALTH MANAGEMENT ASSOCIATES


ADDICTION 101 – CRAVING
A direct, or indirect force pulling someone towards a substance or behavior
HEALTH MANAGEMENT ASSOCIATES


ADDICTION 101 – RELAPSE
Lower ability to make more decisions
More decisions =
Less likely to question others reality
More likely to make the easy choice
HEALTH MANAGEMENT ASSOCIATES

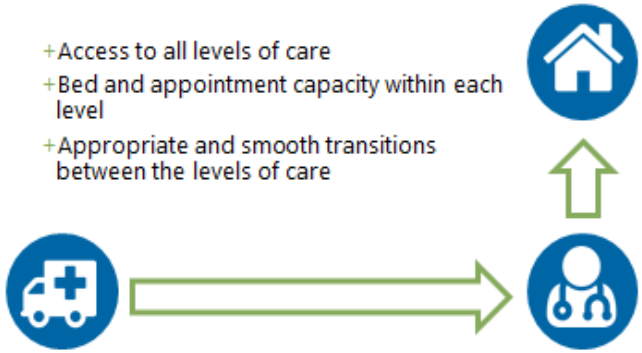

ADDICTION TREATMENT ECOSYSTEM CLINIC STRUCTURES
Syndrome of Addiction
Treatment Education
Outpatient treatment (1)
IOP (2)
Residential Detox (3)
Medically Managed Detox (4)
Screening & referral
Data collection & evaluation
Social Determinants & Prevention
Criminal Justice
Payment Models
HEALTH MANAGEMENT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


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


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

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

HEALTH MANAGEMENT ASSOCIATES

ADDICTION TREAMENT ECOSYSTEM COMPENSATION

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

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ADDICTION TREAMENT ECOSYSTEM COMMUNITY

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

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ADDICTION TREAMENT ECOSYSTEM PHASES OF PROCESS

PHASE 1

Observation/Evaluation Phase

- ID current cultural state of Institution or community
- Identify patients/clients/ members receiving care in that Institution or Community
- Deep dive evaluation of current state
- Determine alignment

Leadership Alignment

(corporate and local)

- C-suite of Institution
- Informal Community Leaders
- Community Leaders
- Business Leaders

HEALTH MANAGEMENT ASSOCIATES

ADDICTION TREAMENT ECOSYSTEM PHASES OF PROCESS

Phase 2

Cultural Alignment

- Listen to all sides
- Teaming
- Direct patient input

Goals & Scope

- Utilization
- Cost
- Expansion of Service
- Develop new service line
- Population

Data

- Payer
- Hospital
- HIE
- PDMP

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ADDICTION TREAMENT ECOSYSTEM PHASES OF PROCESS

Phase 3

Structure

- Hospital-based intervention
- Outpatient-based intervention
- Community intervention
- ASAM levels of care

Tools

- Guidelines
- Site Dashboard
- Site plans
- PM granular tools
- Patient facing tools

Knowledge

- Didactics
- Guidelines
- Asynchronous content
- Coaching calls
- Echo

HEALTH MANAGEMENT ASSOCIATES

TABLE DISCUSSION

WHAT ARE THE BARRIERS AND GAPS IN YOUR CURRENT SYSTEM?

ROVING BRAINSTORM

DISCUSS WITH YOUR GROUP POTENTIAL IDEAS/SOLUTIONS TO THE BARRIERS AND GAPS-

CAPTURE THESE IDEAS ON STICKY NOTES AND ADD THEM TO THE BARRIERS AND GAPS

GALLERY WALK

WITH YOUR GROUP-REVIEW WHAT HAS BEEN CAPTURED FOR BARRIERS AND GAPS AND

SOLUTIONS

GROUP DISCUSSION: BARRIERS AND SOLUTIONS

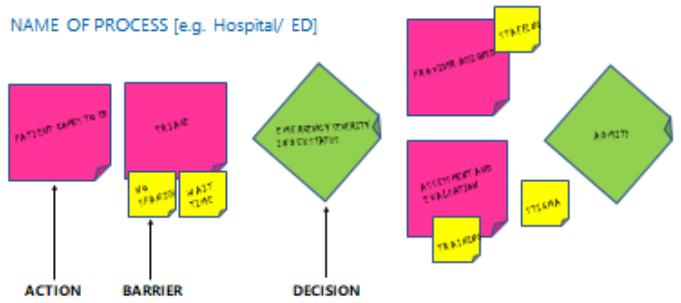
GOALS

IN A PERFECT WORLD…

HEALTH MANAGEMENT ASSOCIATES

CURRENT STATE VALUE STREAM MAP EXAMPLE

NAME OF PROCESS [e.g. Hospital/ ED]

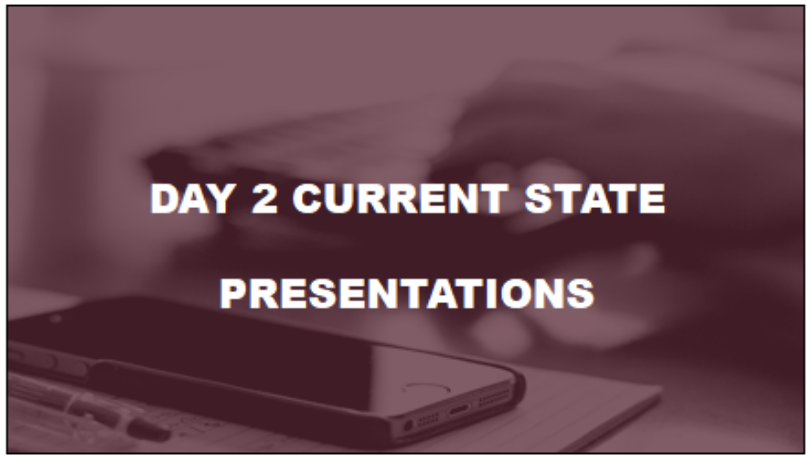


HEALTH MANAGEMENT ASSOCIATES

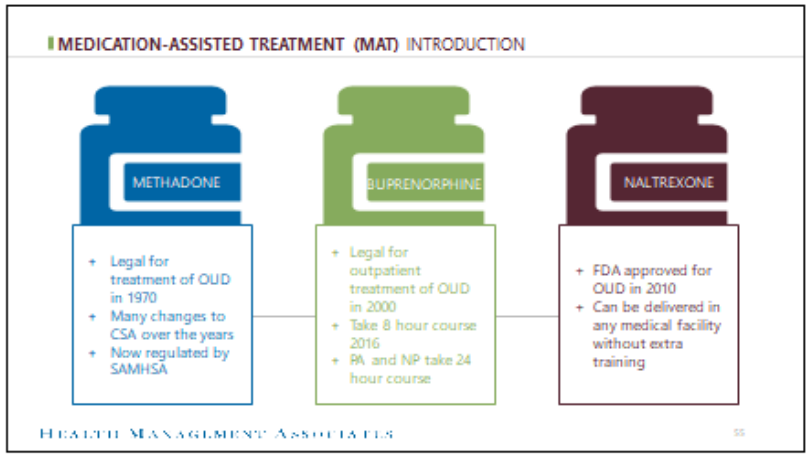
DAY 1 CURRENT STATE PRESENTATIONS

REMINDERS FOR DAY 2

- SIGN THE FRESNO PIE BANNER
- COMPLETE AND TURN IN TA REQUEST FORMS
- SUBMIT LIVED EXPERIENCE STORIES
- ENJOY BREAKFAST!


DAY 2 CURRENT STATE
PRESENTATIONS

MAT BASICS


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

MAT ASSOCIATED WITH...
+ Reduction in the use of illicit drugs
+ Reduction in criminal activity
+ Reduction in needle sharing
+ Reduction in HIV infection rates and transmission
+ Cost-effectiveness
+ Reduction in commercial sex work
+ Reduction in the number of reports of multiple sex partners
+ Improvements in social health and productivity
+ Improvements in health conditions
+ Retention in addiction treatment
+ Reduction in suicide
+ Reduction in lethal overdose
HEALTH MANAGEMENT ASSOCIATES

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

HEALTH MANAGEMENT ASSOCIATES

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

HEALTH MANAGEMENT ASSOCIATES

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

HEALTH MANAGEMENT ASSOCIATES

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

HEALTH MANAGEMENT ASSOCIATES

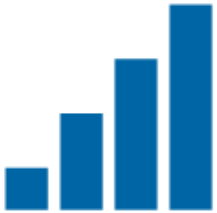
METHADONE OUTCOMES

+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



HEALTH MANAGEMENT ASSOCIATES

METHADONE CAVEATS

+Not really available in Rural areas

+Despite having the best outcomes, it has the highest level of stigma

+Requires good geographic association to patients

+Hard to get patients off after a few years of treatment

HEALTH MANAGEMENT ASSOCIATES

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

HEALTH MANAGEMENT ASSOCIATES

BUPRENORPHINE GENERAL REGULATIONS

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

Approved in 2000 for use in maintenance treatment for OUD

Now multiple forms:

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

HEALTH MANAGEMENT ASSOCIATES

BUPRENORPHINE TRAINING REQUIRED

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

HEALTH MANAGEMENT ASSOCIATES

BUPRENORPHINE OUTCOMES

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

HEALTH MANAGEMENT ASSOCIATES

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

HEALTH MANAGEMENT ASSOCIATES

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

HEALTH MANAGEMENT ASSOCIATES

NALTREXONE GENERAL REGULATIONS

No Federal regulations inhibit the use

Newer implants not FDA approved

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

HEALTH MANAGEMENT ASSOCIATES

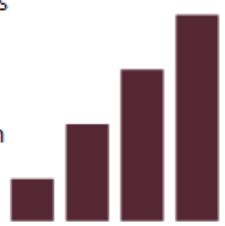
NALTREXONE MEDICATION FOMS

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

HEALTH MANAGEMENT ASSOCIATES

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



HEALTH MANAGEMENT ASSOCIATES

NALTREXONE CAVEATS

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

HEALTH MANAGEMENT ASSOCIATES

MAT CONCLUSIONS

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

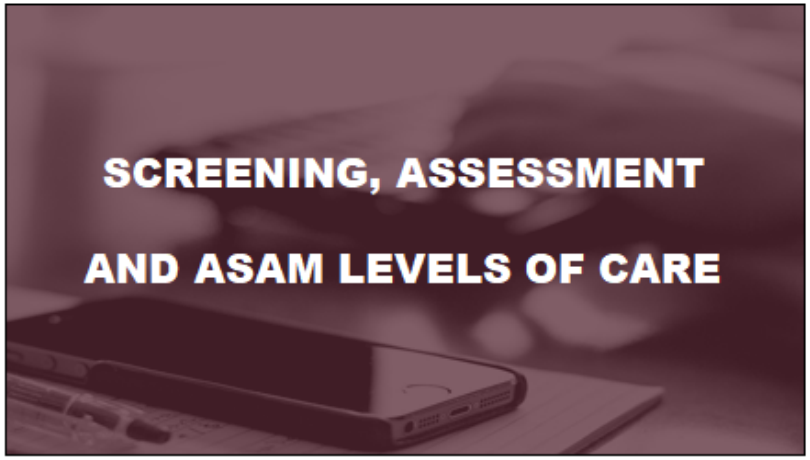
+Using medications is the standard of care

+There is no perfect answer!

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

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

HEALTH MANAGEMENT ASSOCIATES



Screening, Assessment and 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:** Use of an assessment and other factors to decide the most appropriate level of care for the severity of the condition identified. (outpatient vs inpatient)

HEALTH MANAGEMENT ASSOCIATES

What is a Brief Intervention?

- Brief interventions are evidence-based practices designed to motivate individuals at risk of substance abuse and related health problems to change their behavior by helping them understand how their substance use puts them at risk and to reduce or eliminate their substance use.
  - Build a rapport
  - Cover the pros and cons of use
  - Ask permission and give feedback
  - Assess readiness to change
  - Write down an action plan for change

HEALTH MANAGEMENT ASSOCIATES

Urine Toxicology: Biological Screening

Urine drug testing has been used to detect or confirm suspected opioid use, but should be preformed only with the patient's consent and in compliance with state laws.

Limitations of urine toxicology:

- Typically does not test for alcohol or tobacco use
- Potential for false positive and false negative results
- Test results do not assess functional capabilities
- Often applied selectively
- Standard "tox screen" may not be screening for what you need
- Lab cut-off points for sensitivity

HEALTH MANAGEMENT ASSOCIATES

Best Start to the Conversation: Screening Questionnaires

- "An important part of primary care/prenatal care is screening for any risky conditions. Some of these conditions can be scary to talk about, but are pretty common. Also, no matter the issue we have the ability to help work through it."
- Is it ok if I ask you some questions about those risks?

HEALTH MANAGEMENT ASSOCIATES

Screening Tools

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

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The NIDA 4 +1 (MJ for CA)

- ❑In the last 1 year have you...
  - ❑Smoked tobacco or vaped?
  - ❑Had more than 4(women)/5(men) drinks of alcohol in one day or more than 10 in one week
  - ❑Used a prescription for something other than prescribed
  - ❑Used an illegal or illicit drug
  - ❑Used marijuana*
- ❑If the answer is yes to any of the above questions then the screen is positive and an assessment should be done

*Added due to legalization of MJ in CA

HEALTH MANAGEMENT ASSOCIATES

Screening Tools

CRAFFT – Substance Abuse Screen for Adolescents & Young Adults

- ❑ **C** Have you ever ridden in a **CAR** driven by someone (including self) who was high or had been using alcohol or drugs?
- ❑ **R** Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?
- ❑ **A** Do you ever use alcohol or drugs while you are by yourself or **ALONE?**
- ❑ **F** Do you ever **FORGET** things you did while using alcohol or drugs?
- ❑ **F** Do your **FAMILY** or friends ever tell you that you should cut down on your drinking our drug use?
- ❑ **T** Have you ever gotten in **TROUBLE** while you were using alcohol or drugs?

Scoring: Two or more positive items indicates the need for further assessment

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Content of 4 p's plus

- ❑ Parents
  - ❑ Did either of your parents ever have a problem with alcohol or drugs?
- ❑ Partner
  - ❑ Does your partner have a problem with alcohol or drugs?
- ❑ Past
  - ❑ Have you ever drunk beer, wine, or liquor?
- ❑ Pregnancy
  - ❑ In the month before you knew you were pregnant, how many cigarettes did you smoke?
  - ❑ In the month before you knew you were pregnant, how many beers/how much wine/how much liquor did you drink?
  - ❑ In the past year, how many times did you take illicit drugs or drugs not prescribed for you?

HEALTH MANAGEMENT ASSOCIATES

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. The 3 most common and most validated tools:
  - Alcohol Use Disorders Identification Test (AUDIT)
  - Drug Abuse Screening Test (DAST)
  - Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

HEALTH MANAGEMENT ASSOCIATES

Domains and Item Content of the Full AUDIT*

Domains	Question Number	Item Content
Hazardous Alcohol Use	1	Frequency of drinking
	2	Typical quantity
	3	Frequency of heavy drinking
Dependence Symptoms	4	Impaired control over drinking
	5	Increased salience of drinking
	6	Morning drinking
Harmful Alcohol Use	7	Guilt after drinking
	8	Blackouts
	9	Alcohol-related injuries
	10	Others concerned about drinking

*Alcohol Use Disorder ID Test

HEALTH MANAGEMENT ASSOCIATES

Interpretation of AUDIT

Score	Degree of Problems
0-7	No Problems at this time
8-15	Hazardous & Harmful Alcohol Use
16-19	High Level of Alcohol Problems and Possible AUD
20-40	Probable AUD

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Content of the DAST

DAST 10	No	Yes
Have you used drugs other than those required for medical reasons?	0	1
Do you abuse more than one drug at a time?	0	1
Are you always able to stop using drugs when you want to? (in never used drugs, answer yes)	0	1
Have you had blackouts or flashbacks as a result of drug use?	0	1
Do you ever feel bad or guilty about your drug use?	0	1
Does your spouse ever complain about your involvement with drugs?	0	1
Have you ever engaged in illegal activities in order to obtain drugs?	0	1
Have you ever experienced withdrawal symptoms when you stop taking drugs?	0	1
Have you had medical problems as a result of your drug use?	0	1

HEALTH

Interpretation of DAST

Score	Degree of Problems
0	No Problems Currently
1-2	Hazardous & Harmful Drug Use
3-5	High Level of Alcohol Problems and Possible SUD
6-10	Probable SUD

HEALTH MANAGEMENT ASSOCIATES

WHOs - The Alcohol, Smoking, Substance Involvement Screening Test (ASSIST)

- ❑ Consists of 8 questions
- ❑ Evaluates individual drugs
- ❑ Is the most comprehensive
- ❑ Has been validated in many cultures and languages

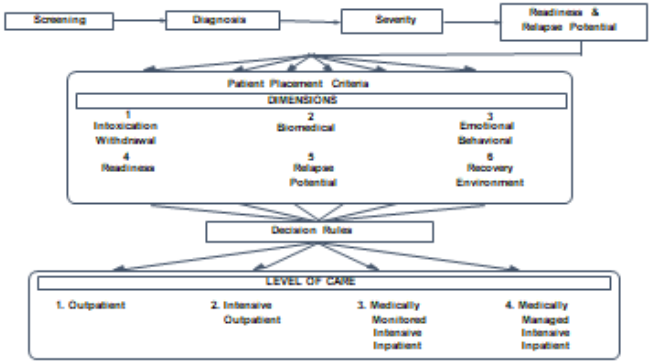
HEALTH MANAGEMENT ASSOCIATES

The ASAM Criteria Dimensions of Assessment

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical conditions and complications
3. Emotional/Behavioral/Cognitive conditions and complications
4. Readiness to change
5. Relapse/Continued Use/Continued Problem potential
6. Recovery Environment

HEALTH MANAGEMENT ASSOCIATES

The ASAM Criteria Decision Process



Level of Care Determination

Evaluating for placement

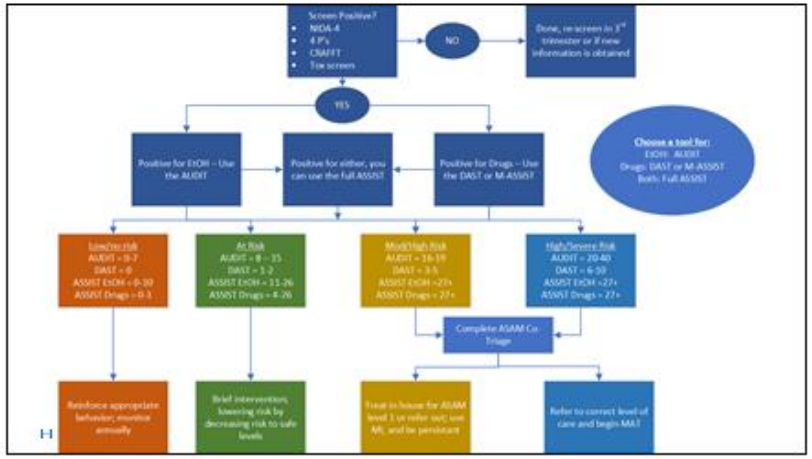
- ☐ASAM Criteria is the Gold Standard
  - ☐Continuum Co-triage tool (20 questions)
- ☐Who is screened
  - ☐Patients positive for high/severe on assessment
- ☐Delivery
  - ☐On-line tool
- ☐Who delivers
  - ☐Can be done by MA, RN or MD/DO
- ☐How paid for
  - ☐Part of SBIRT payment

HEALTH MANAGEMENT ASSOCIATES

ASAM Criteria Methods of Delivery

- Structured interview
  - High variability
  - Not always accepted
  - Write-up's vary in sophistication
- On-line Continuum
  - Asymmetrical Branching
  - Improves interrater reliability
  - Has a dashboard
  - Information is transmittable
- Co-triage
  - 20 questions (about 10-15 min)
  - Provisional level of care

HEALTH MANAGEMENT ASSOCIATES



Resources: Reimbursement for SBIRT

Payer	Code	Description
Commercial Insurance, Medicaid	99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min
Commercial Insurance, Medicaid	99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min
Medicare	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min
Medicare	G0442	Prevention: Screening for alcohol misuse in adults including pregnant women once per year. No coinsurance; no deductible for patient http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Reduce-Alcohol-Misuse-ICN907798.pdf

Resources: Reimbursement for SBIRT

Medicare	G0443	Prevention: Up to four, 15 minute, brief face-to-face behavioral counseling interventions per year for individuals, including pregnant women, who screen positive for alcohol misuse; No coinsurance; no deductible for patient http://www.cms.hhs.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=249
Medicaid	H0049	Alcohol and/or drug screening (code not widely used)
Medicaid	H0050	Alcohol and/or drug service, brief intervention, per 15 min (code not widely used)

Take-aways about Screening, Assessment and Levels of Care

- Addiction is no different than any other chronic disease
- Screening is just step 1
- Using validated tools is required
- Where someone gets care really matters

HEALTH MANAGEMENT ASSOCIATES

References

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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.

HEALTH MANAGEMENT ASSOCIATES

97

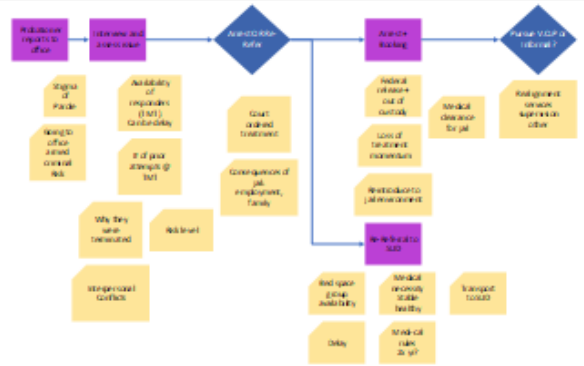
AFTERNOON SESSION

FULL GROUP

CURRENT STATE VSMS

HEALTH MANAGEMENT ASSOCIATES

CURRENT STATE VALUE STREAM MAP PROBATIONER TERMINATED FROM TREATMENT



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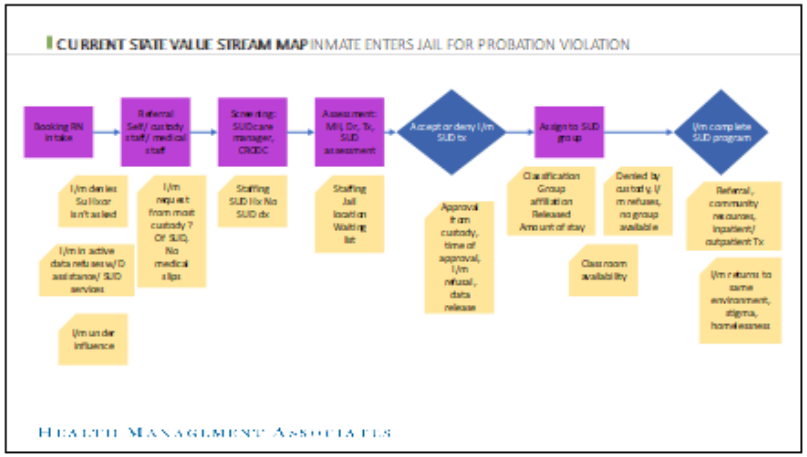
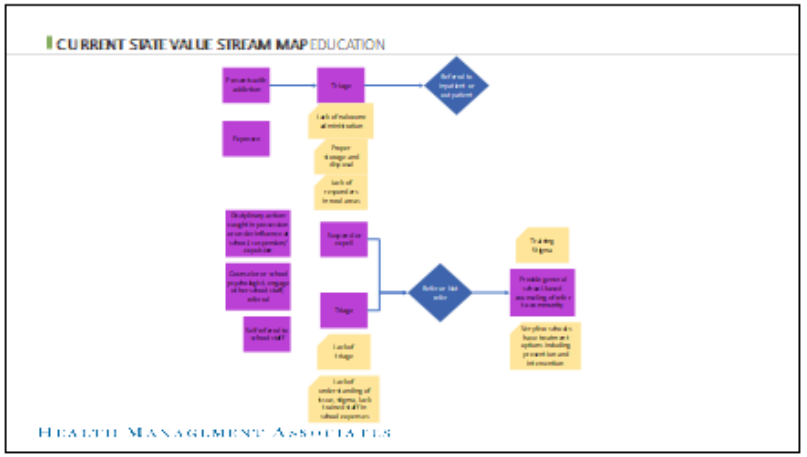
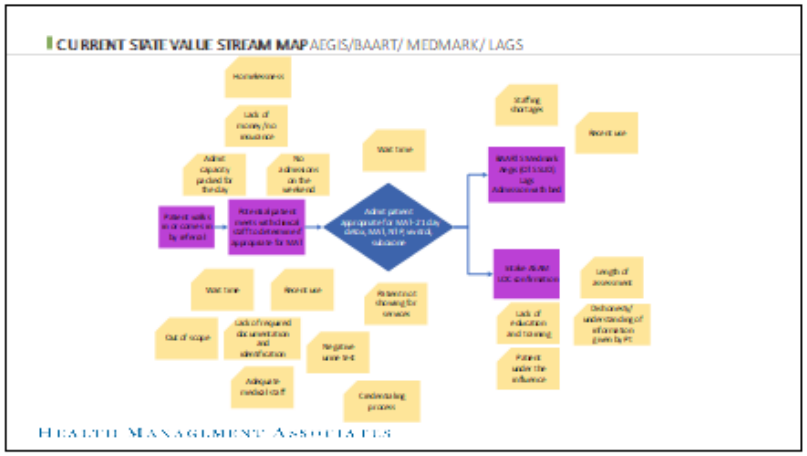
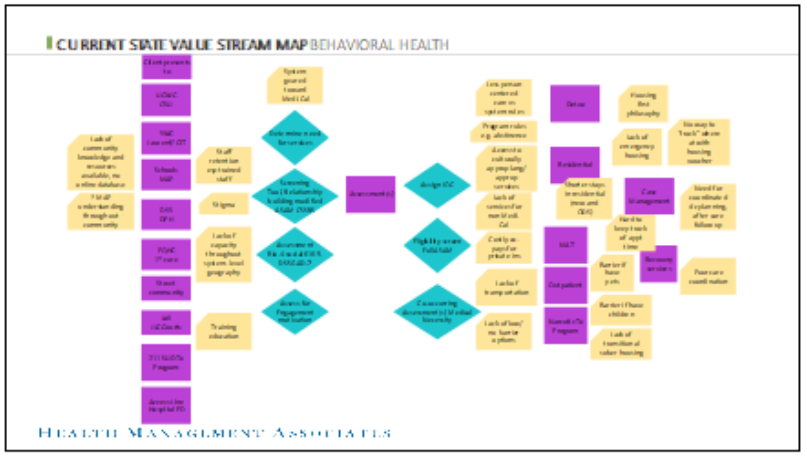
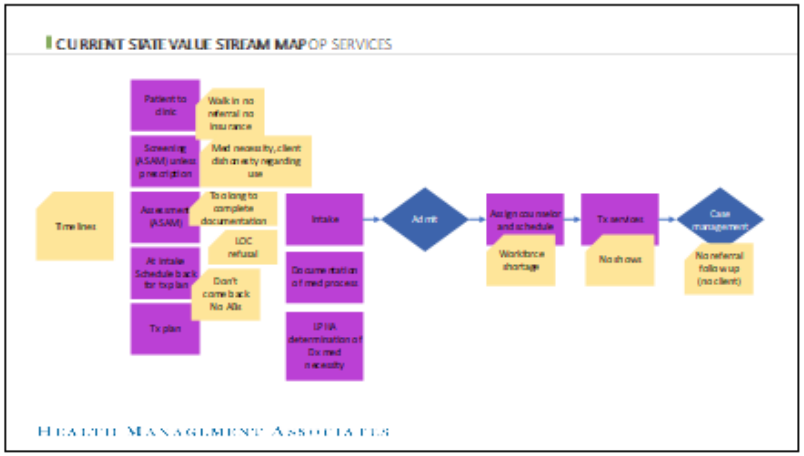
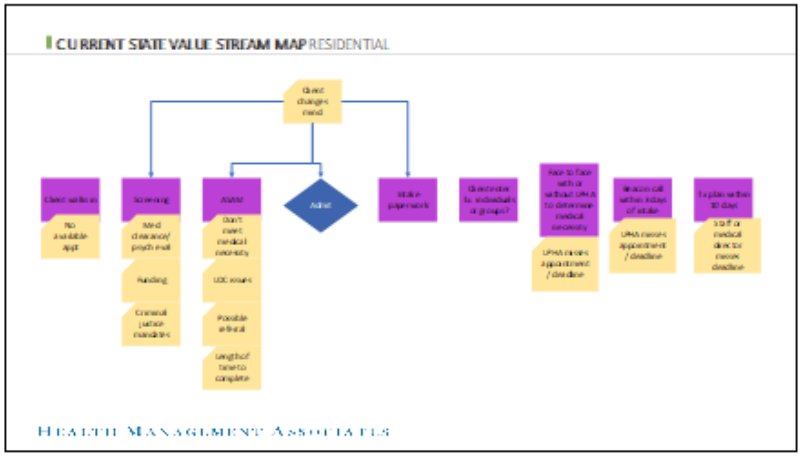

CURRENT STATE VALUE STREAM MAP INMATE ENTERS JAIL FOR PROBATION VIOLATION
Booking RN in take
Referral Self/ custody staff/ medical staff
Screening: SUD case manager, CRCDC
Assessment: MH, Dr, Tx, SUD assessment
Accept or deny I/m SUD tx
Assign to SUD group
I/m complete SUD program
I/m denies Su Hx or isn't asked
I/m in active data retrieve w/ ID assistance/ SUD services
I/m under influence
I/m request from most custody ? Or SUD, No medical slips
Staffing SUD Hx No SUD dx
Staffing Jail location Waiting list
Approval from custody, time of approval, I/m refusal, data release
Classification Group affiliation Released Amount of stay
Denied by custody I/ m refuses, no group available
Classroom availability
Referral, community resources, inpatient/ outpatient Tx
I/m returns to same environment, stigma, homelessness
HEALTH MANAGEMENT ASSOCIATES

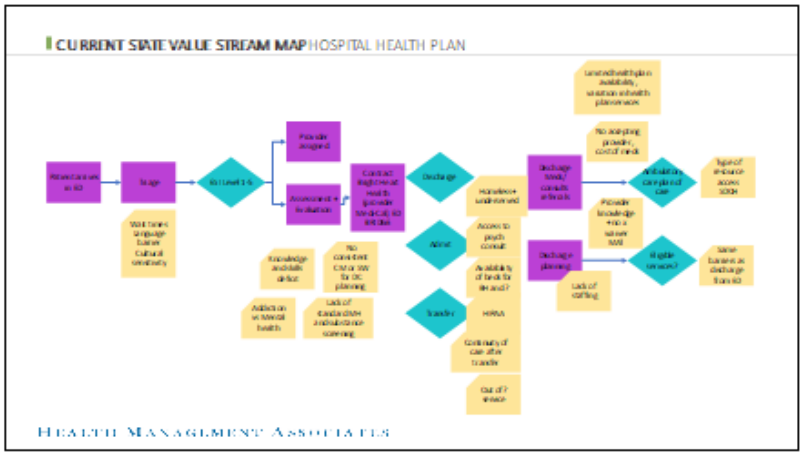

CURRENT STATE VALUE STREAM MAP EDUCATION
Triage
Lack of substance abuse treatment
Lack of resources in rural areas
Triage
Lack of triage
HEALTH MANAGEMENT ASSOCIATES

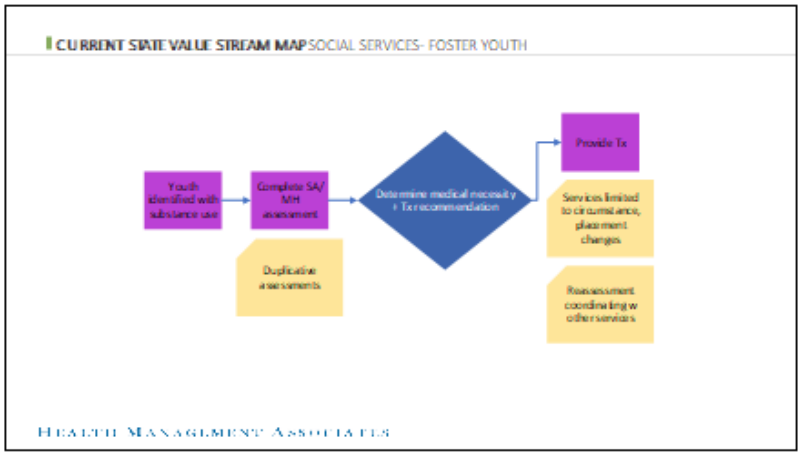

CURRENT STATE VALUE STREAM MAP AEGIS/BAART/ MEDMARK/ LAGS
Homelessness
Lack of income/ no insurance
Admit capacity packed for the day
No admissions on the weekend
Wait time
Staffing shortages
Recent use
Admit patient appropriate for MAT: 21 Dx, detox, MAT, RTC w/ MAT, substance
Wait time
Recent use
Out of scope
Lack of required documentation and identification
Negative urine test
Adequate medical staff
Condensing process
Length of assessment
Deficiency/ understanding of information given by PT
Lack of education and training
Patient under the influence
HEALTH MANAGEMENT ASSOCIATES

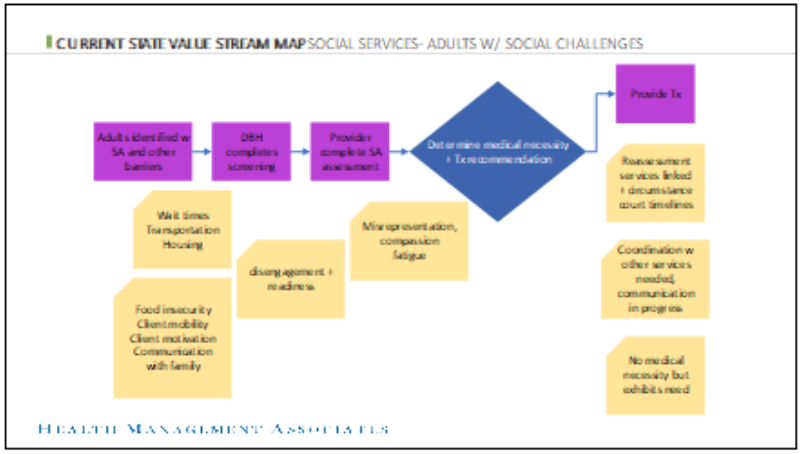

CURRENT STATE VALUE STREAM MAP BEHAVIORAL HEALTH
Assessment
Assign LOC
Detox
Training education
HEALTH MANAGEMENT ASSOCIATES


CURRENT STATE VALUE STREAM MAP OP SERVICES
Patient to clinic
Walk in no referral no insurance
Screening (ASAM) unless prescription
Med necessity, client dishonesty regarding use
Assessment (ASAM)
Too long to complete documentation
Timelines
LOC refusal
Intake
Admit
Assign counselor and schedule
Tx services
Case management
At intake Schedule back for tx plan
Don't come back No Alls
Documentation of med process
Workforce shortage
No shows
No referral follow up (no client)
Tx plan
UPHA determination of Dx med necessity
HEALTH MANAGEMENT ASSOCIATES


CURRENT STATE VALUE STREAM MAP RESIDENTIAL
Client changes need
Client walks in
Screening
ASAM
Admit
Intake paperwork
Coordinate to schedule a group?
Face to face with or without UPHA to determine medical necessity
Referral call within 10 days of intake
Tx plan within 30 days
No available Appt
Med clearance/ psych eval
Don't meet medical necessity
UPHA issues Appointment / deadline
UPHA issues Appointment / deadline
Staff or medical director issues deadline
Funding
LOC issues
Criminal justice mandates
Possible referral
Length of time to complete
HEALTH MANAGEMENT ASSOCIATES

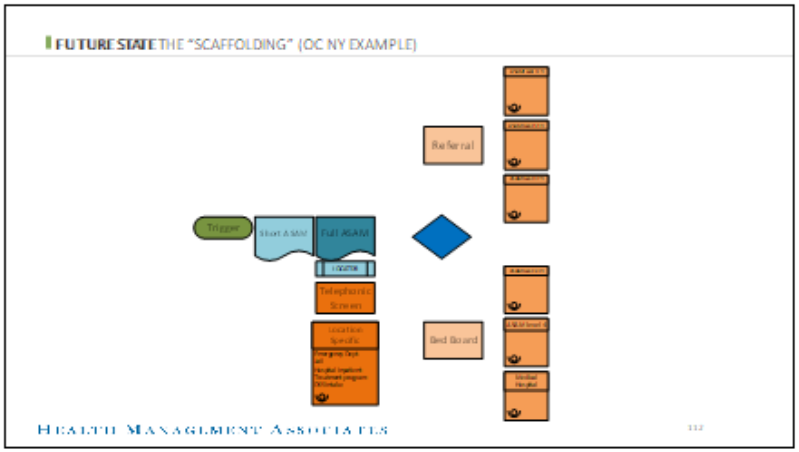

CURRENT STATE VALUE STREAM MAP HOSPITAL HEALTH PLAN
Referral to see an MD
Triage
Wait times Language barrier Cultural sensitivity
Refused Tx
Provide assigned
Assessment + Evaluation
Contact Psychiatrist with (provide SAMSHA ID and DOB)
Discharge
Admit
Transfer
Homeless+ addiction and
Access to psych consult
Availability of beds for Dx and T
HIPAA
Continuity of care after transfer
Out of? Inmate
Knowledge available about
No consistent CM or SW for DC planning
Addiction w/ Mental health
Lack of coordination and collaboration
Limited health plan availability, vacation w/ health plan issues
No accepting provider, COST/ need
Discharge SAMI/ consult, referrals
Ambulation care plan of care
Type of insurance access SOCH
Provide knowledge med + abuse w/ MH
Discharge planning
Eligible services?
Same barriers as discharge from MD
Lack of staffing
HEALTH MANAGEMENT ASSOCIATES


CURRENT STATE VALUE STREAM MAP SOCIAL SERVICES- FOSTER YOUTH
Youth identified with substance use
Complete SA/ MH assessment
Determine medical necessity + Tx recommendation
Provide Tx
Duplicative assessments
Services limited to circumstance, placement changes
Reassessment coordinating w other services
HEALTH MANAGEMENT ASSOCIATES


CURRENT STATE VALUE STREAM MAP SOCIAL SERVICES- ADULTS W/ SOCIAL CHALLENGES
Adult is identified w SA and other barriers
DBH completes screening
Provider complete SA assessment
Determine medical necessity + Tx recommendation
Provide Tx
Reassessment services linked + circumstance court timelines
Coordination w other services needed, communication in progress
No medical necessity but exhibits need
Misrepresentation, compassion fatigue
disengagement + readiness
Wait times Transportation Housing
Food insecurity Client mobility Client motivation Communication with family
HEALTH MANAGEMENT ASSOCIATES

FUTURE STATE OF
ADDICITION TREATMENT
IN FRESNO COUNTY

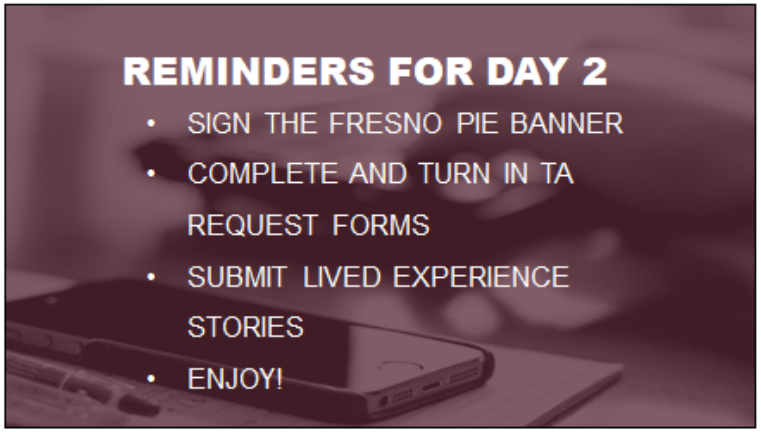
FUTURE STATE VSM
HEALTH MANAGEMENT ASSOCIATES


FUTURE STATE THE "SCAFFOLDING" (OC NY EXAMPLE)
Referral
Trigger
Short ASAM
Full ASAM
Bed Board
HEALTH MANAGEMENT ASSOCIATES

IN A PERFECT WORLD…

- Coordinated single point of entry
- Shared database
- Shared understanding across sectors-evidence based, scientific approach to treatment options
- Common language-consumer driven and strengths based
- Reduced paperwork
- Telemedicine for juveniles
- Bundling procedures under a single code
  - Treatment visit templates
  - Quick start language, click smart phrases
- Align with the client
- Treat even when symptomatic-on demand
- Standardized, ubiquitous screening and assessment
- 24/7 Access to MAT
- Standardized, interoperable EMR (reproduce complex care)
- Sufficient workforce across all roles to meet the needs
- Move upstream with prevention/intervention-address SDoH
- Trauma responsive systems of care-integrate ACES in care

HEALTH MANAGEMENT ASSOCIATES



C. Summary of Evaluation Results

1. **What did you like MOST about this forum?**
    - Neurobiology of addiction
    - Better understanding of MAT and treatment options
    - Didactics mixed with exercises
    - Lots of engagement and information that is needed
    - Hearing other service providers speak about their perspectives, barriers, challenges, and problem solving
    - Collaboration amongst participants
    - Learning more about SUD and OUD
    - Learning about addiction as a medical issue versus a personal choice/weakness
    - Mapping the current system
    - Working in groups, small group discussions
    - Great examples provided that I can take back to my program and patients
    - Networking and interaction with other providers
    - The key speaker

2. **What did you like LEAST? What changes would you recommend?**
    - Too long
    - Focus on negatives
    - More discussion about what we can expect after in regard to change after this training
    - I would have liked more education from the speaker and less time filling out post-its and posters
    - Would have liked a printout of the PowerPoint to take notes on
    - Would have liked to receive PowerPoint to do a training for colleagues

3. **Give an example of something new you learned about addiction.**
    - Amplified awareness about methadone and associate regulations
    - Better understanding of the big picture
    - No MAT services available for youth
    - MAT in Fresno
    - Buprenorphine use and the ways of administration
    - Neurobiology of addiction
    - Methadone is not about replacing one addiction for another
    - Screening and assessment tools being used in Fresno County

4. **What topics would you like to learn more about?**
    - Mental health versus addiction
    - Facilities that would accept patients with SUD and mental illness
    - What local providers offer in Fresno
    - Transitions of care for all drugs not just opioids

- Requirements for agencies to begin administering MAT
- Training on screening tools and assessments
- Diagnosis and treatment of co-occurring disorders
- Stigma reduction
- Building linkages in our community
- How other non-opioid substances impact MAT, recovery, success, and the brain
- Trauma-informed care
- ACES role in addiction
- What TA actually looks like
- Process of how jail, probation, and CPS entities are trained with SUD

5. **Other comments/questions.**
    - *"Hopeful this is the start of better care management for our community"*
    - *"Awesome training. Can't wait to see changes and willingness to help SUD patients in the community"*
    - *"We need training for mental health professionals on engaging at the point of entry to collect accurate information in order to provide appropriate care"*
    - *"I appreciated hearing and having others hear about MAT in a positive light! There is still so much stigma for MAT even with, or maybe even especially with, other treatment providers and criminal justice"*
    - *"Excellent education and engagement"*
    - *"I enjoyed the speaker and her knowledge. So enlightening and refreshing"*

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