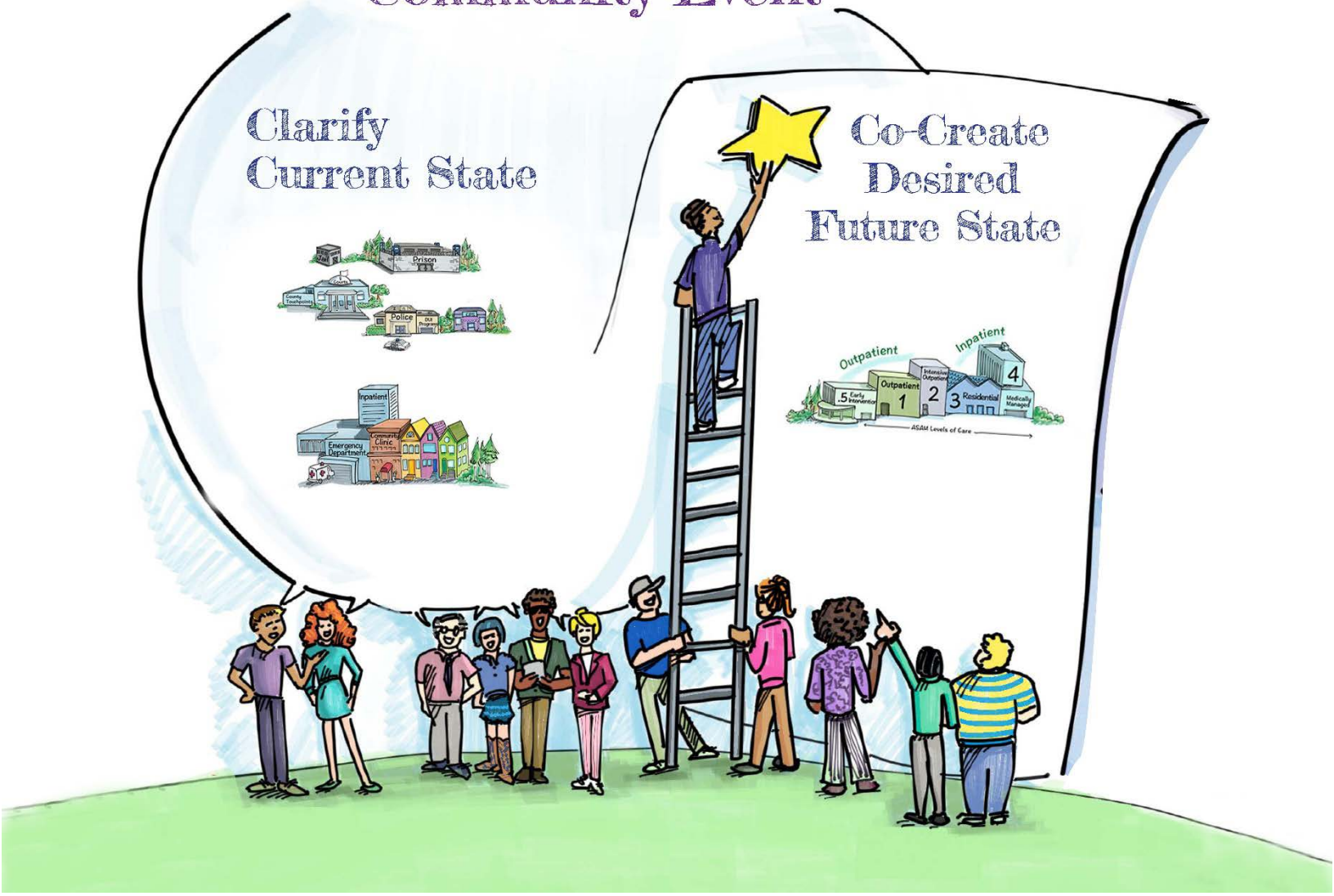
Collaborative Provider Community Event



BUILDING SUSTAINABLE TRANSITIONS OF CARE FOR PEOPLE WITH ADDICTIONS

Lake County Community Process Improvement Event

August 7th - 8th , 2019

HEALTH MANAGEMENT ASSOCIATES

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HMA

HEALTH MANAGEMENT ASSOCIATES

Funding for this event was made possible (in part) by H79TI081686 from SAMHSA.

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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 ten years, we have reached a point where the treatment system, in its current state, can no longer handle the volume of patients needing care. Opioid use and overdose have been increasing in California, though the rates of use and overdose are lower than in many states.

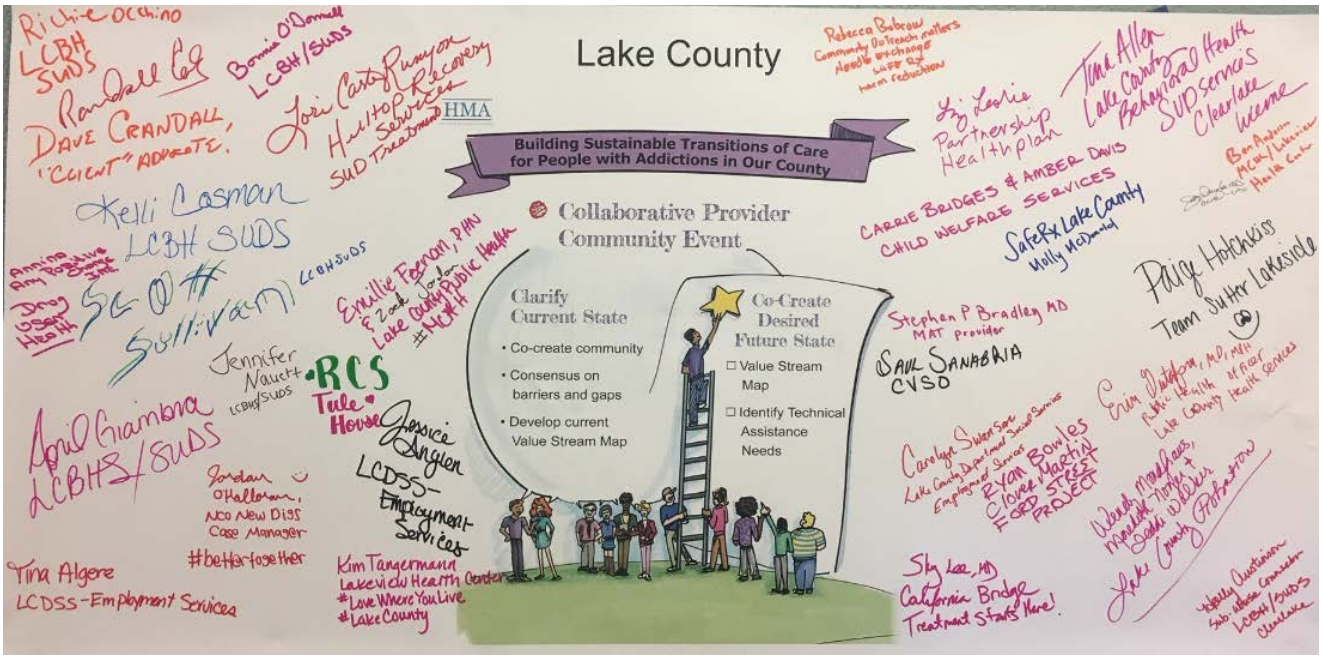
Understanding this reality, the federal government has allocated billions of dollars to states to build appropriate systems of care for patients with opioid use disorder (OUD) and other addictions; including the State Treatment Response (STR) and State Opioid Response (SOR) grants. The California Department of Health Care Services (DHCS) received STR and SOR grants which support project funding 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 countrywide 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. Lake County, one of the ten counties selected, participated in a large-scale process improvement event on August 7th and 8th, 2019 that included members from different aspects of government, healthcare, addiction treatment, law enforcement and those who pay for that treatment. During the event, attendees participated in intense work sessions with a focus on identifying current treatment processes, barriers, and gaps in these processes and a future state treatment system to support transitions of care for Lake County residents in need of addiction treatment and support services.

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

The two-day event set the stage for adopting universal evidence-based tools for screening, assessment, and level of care determination. This coupled with the didactic

training of all parties involved, will yield a more comprehensive and easy-to-use addiction treatment ecosystem.

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 strong buy-in by the participants, we should be able to achieve significant progress over the next year.



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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 in support from the federal government to build appropriate systems of care for patients with opioid use disorder and other addictions, such as methamphetamine or alcohol use disorders. California is utilizing State Treatment Response (STR) and State Opioid Response (SOR) dollars to fund the California Medication Assisted Treatment (MAT) Expansion Project which aims to serve an estimated 290,000 individuals with Opioid Use Disorders (OUD), prevent drug overdoses and treat OUD as a chronic disease. The first phase of the project, California MAT Expansion Project 1.0, is funded by STR and focuses on populations with limited MAT access (including rural areas, American Indian and Alaskan Native tribal communities) and increasing statewide access to buprenorphine. The California MAT Expansion Project 2.0 project is federally funded by the State Opioid Response (SOR) project and builds upon the existing State Treatment Response (STR) funded work. California MAT Expansion Project 2.0 began on September 2018 and runs for two years through September 2020.

HMA received SOR funding from DHCS to focus on developing predictable and consistent transitions of care to sustain addiction treatment as an 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 Lake 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 Lake County, nine other counties were identified as key locations on which to focus these efforts. Specifically, four Northern California Counties including Humboldt, Lake, Mendocino and Shasta Counties. These four rural counties are all served by Partnership Health Plan. Partnership Health Plan is contracted by DHCS to serve eligible Medi-Cal members through this unique COHS regional model.

The Transitions of Care project engages stakeholders in each selected county in a two-day countrywide 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 with Dr. Erin Gustafson, Lake County's Public Health Officer, and the Lake County Behavioral Health Services Division program leadership. Specifically, we held planning meetings with Lake County Behavioral Health Administrator Todd Metcalf; Clinical Deputy Administrator of Behavioral Health James Isherwood; Denise Pomeroy, the Health Services Director; and April Giambra, the county's Substance Use-Disorder Administrator, along with their respective staff.

Also, HMA partnered with the Mendocino Community Health Center's Lakeview Health Center to help our team understand the work already underway by the community related to Substance Use-Disorder and addiction treatment services within Lake County. Collectively, the County and Lakeview staff assisted our team in launching the process improvement event and subsequent ongoing technical assistance program. Collectively, both the County and Lakeview staff helped identify key stakeholders to engage, conducted outreach, arranged stakeholder discussions and distributed invitations. All organization 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

Lake County Health Department

- Dr. Erin Gustafson M.D.,MPH, Lake County Health Officer
- Denise Pomeroy, Lake County Health Services Director

Lake County Behavioral Health Services Division Services

- Todd Metcalf, Behavioral Health Administrator
- James Isherwood, Clinical Deputy Administrator, Behavioral Health Services
- April Giambra, SUD Program Administrator

Mendocino Community Health Center – Lakeview Health Center

- Ben Anderson, Director, MCHC Behavioral Health Services

Who Was Involved:

- AmeriCorps VISTA
- Any Positive Change
- Bridge to Treatment
- Consumers
- Ford Street Project-Ukiah Recovery Services
- Hilltop Recovery Services
- Lake County Behavioral Health Services
- Lake County Department of Public Health
- Lake County Department of Social Services, Child Welfare Services
- Lake County Health Services
- Lake County Probation Department
- Lakeview Health Center - Mendocino Community Health Clinic
- North Coast Opportunities
- Dr. Stephen Bradley
- Partnership Health Plan
- Redwood Community Services - Tule House
- Safe RX Lake County
- Sutter Health

D. Structure of the Intervention

In advance of the event, HMA worked with the county to electronically and directly gather high-level information on addiction treatment resources and capacity in Lake County. All of the gathered information was collated and reviewed 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 the 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 Lake County: SUD treatment, residential providers, hospital, probation department, behavioral health, public health, people with lived experience, and many others. HMA used the morning of day one to provide an overview of the project as well as taking time to provide a common knowledge base on the neurobiological basis of addiction. The group also spent time discussing the role of screening, assessment, and Level of Care determination and the evidence-based tools available for each of these steps.

The group completed a current state mapping exercise that helped all programs outline their current path for persons with addiction. Each program was encouraged to document as fully as possible the path an individual would follow when engaging with their agency.

Participants were tasked with including all interventions and decision points. Stakeholders were also instructed to discuss both intervention-specific and global barriers and gaps. While the work produced had some variation in depth, scope, and structure, we were able to get a good sense of the current state of addiction screening, placement, and treatment in Lake County. In a standard process improvement event, any one of the providers would take a full week to develop the same amount of work produced in only a few hours during this event. After each provider group developed a current state map, they presented their map to the rest of the participants.

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

During each agency specific current state presentation gaps and barriers experienced within the program were discussed. Following these presentations, participants were encouraged to split into four groups which tried to mix members of all agencies into each group to discuss how barriers were experienced between agencies. This exercise to allow a discussion of how barriers are experienced within the larger system of care resulted in useful dialogue as well as many ideas for potential solutions going forward.

On the morning of day two, the group returned to review the science of MAT as well as details of information release and 42 CFR. These presentations resulted in lively discussions and a consensus that both of these topics are often misunderstood in the community. Following this we held a brainstorming session on desired features in a future state and creation of 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. Several participants needed to leave the meeting at this point due to a fire in the community. Further discussions with stakeholders in Lake County will be held to finalize a unified scaffolding and consensus on tools for screening, assessment, and level of care determination.

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

E. Screening and Level of Care Determination

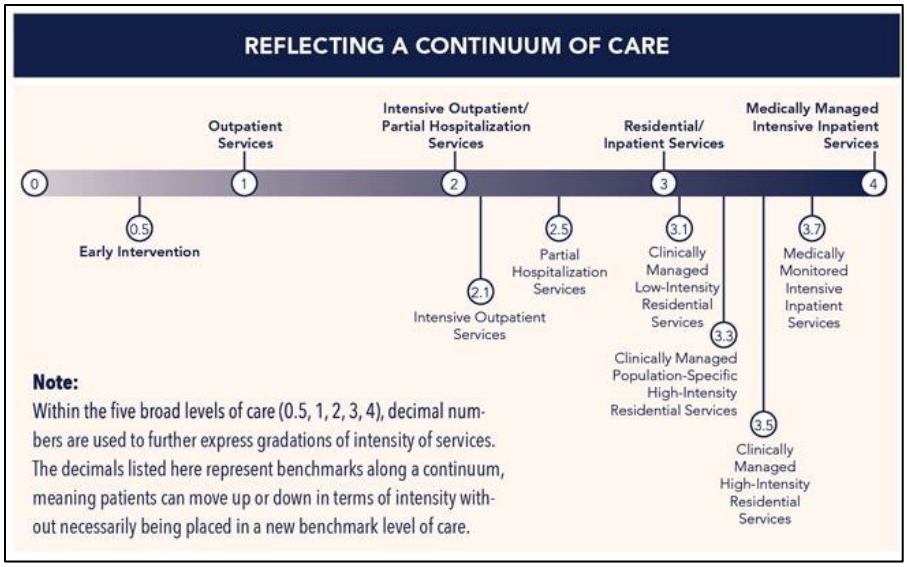
The "long-form" of the American Society of Addiction Medicine (ASAM) Criteria

ASAM's criteria, formerly known as the ASAM patient placement criteria, is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. Today the criteria have become the most widely used and comprehensive set of guidelines for placement, continued to 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 regularly been meeting since the development of the first ASAM Patient Placement Criteria in 1991. The coalition addresses feedback and ensures that the Criteria adequately serves and supports medical professionals, employers, purchasers, and providers of care in both the public and private sectors.

The "short form" of the ASAM Criteria

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



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

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

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

**California will be required to adopt the American Society of Addiction Medicine(ASAM) treatment criteria as the minimum standard of care for licensed adult alcoholism or drug abuse recovery or treatment facilities (RTFs) by 2023.*

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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:

- Create a comprehensive list of gaps in services, and a framework for how to address them
- Learn how to serve clients in an unbiased, non-stigmatizing way
- Gain a better understanding of who the partners are in the community who serve people with addiction, or are working to address addiction-related issues

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

THE OVERARCHING GOAL:

ELIMINATE ADDICTION-RELATED DEATHS IN LAKE COUNTY

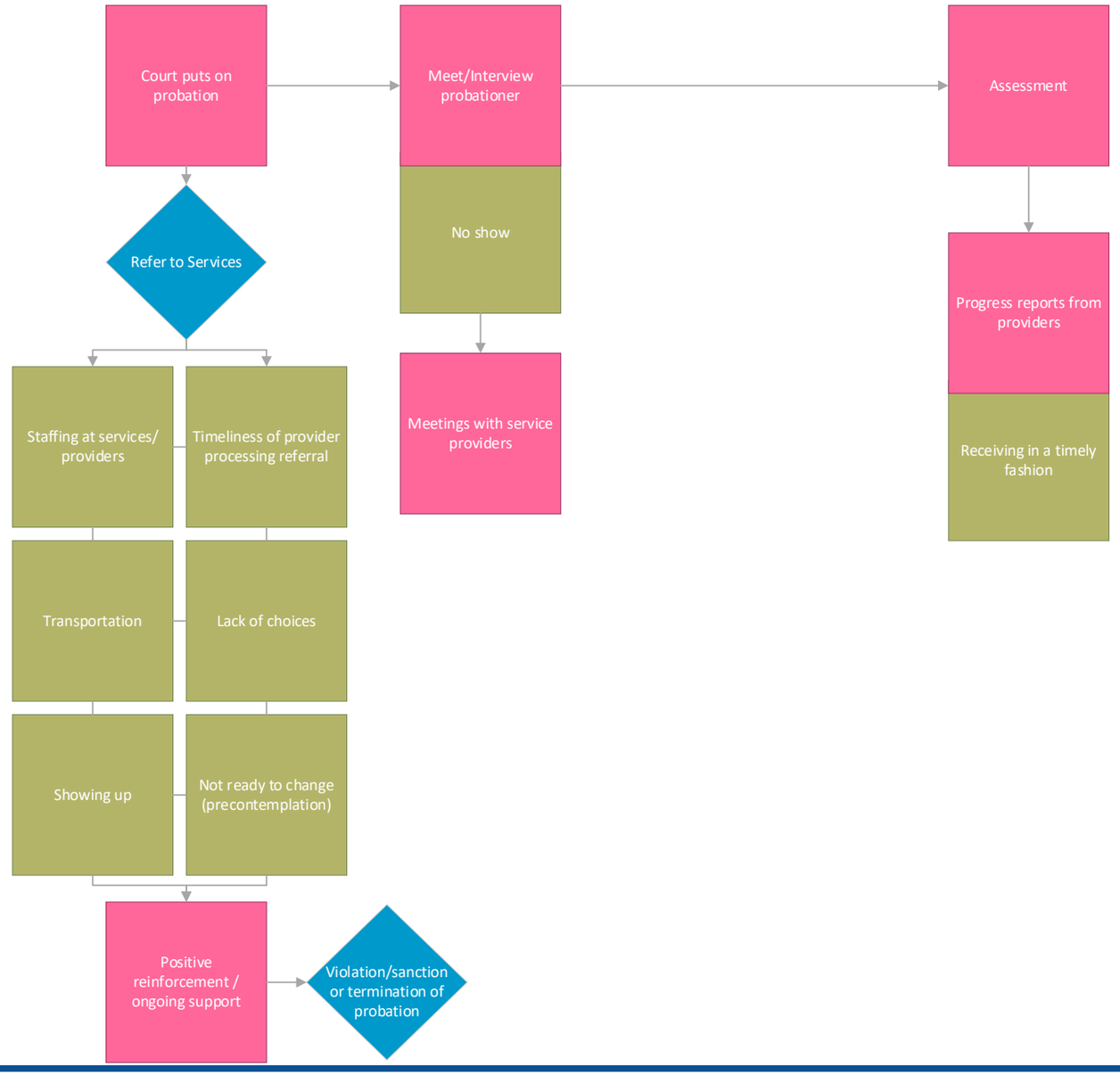
B. Stories of Experience with Addiction in Lake County

Building a person-centered system of addiction treatment in Lake County must be driven by the voices of those with lived experience. During and following 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 Lake to share their stories with us if they were willing. Below are the responses we received. These responses are the personal experiences of clients, and some descriptions may not be consistent with the evidence on this topic.

- ***"To begin, my 64 years on this planet has been a trauma filled one. Ninety percent body burn, auto accident, colon surgery, hernia mesh failure, and a list of less traumatic incidents that are less on the scale. By 1990 I was an addict. Mostly, believe it or not Darvon N was the original culprit after leaving burn center in 1988. My first attempt at recovery was at a rehabilitation facility for 30 days. Abstinence and meetings were not working. The program was easy enough to attend, but in-house procedures were not working. Any comment regarding drug use was a faux pas. Leaving the bubble of a rehabilitation center was also threatening. Remember after gaining sobriety the world still exists. Some barriers here existed from the opening of the center (my feeling). Never a mention of any controlled medication that would have taken the addict from withdrawal symptoms to a near "normal" state would never have been considered then. For ten years I floated in a state of addiction as prescribed by my doctor. Enter suboxone in 2000. Actually, it was quite easy to receive help for opiate use. Local clinic. Contract. Off you go. For the better part of this century, I have been on suboxone. I ventured off with methadone…bad move…almost died, this time from the pill that was to help me. Make no mistake I feel methadone is all right for a very short time. Long term 10 plus years would not keep patient clean as methadone has to be increased regularly. I was at 300 mg daily. Toxic levels. I believe today's recovery wholly lies on the client. The tools offered today makes that possible with the introduction of MAT program. My station in life made it easy to get help really, and because of that I feel terrible. I am an addict. Whether I have more than another person should never had been allowed. What I'm saying is the addicted soul can and will maintain a life that can be full and purposeful if allowed to immediately begin a program under the current guidelines."***

C. Current State Value Stream Maps (VSM)

Lake County Probation Current State VSM



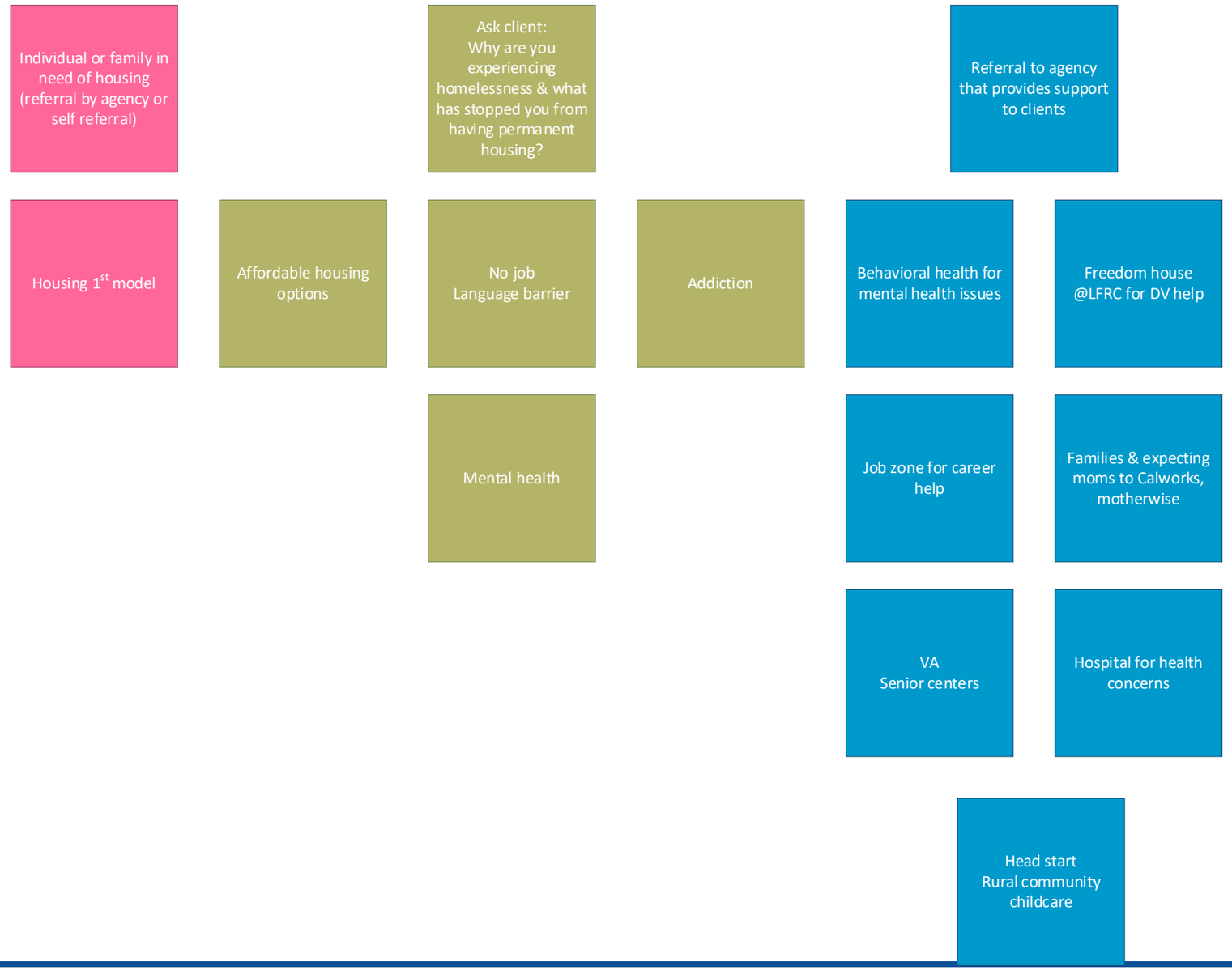
Lake County Probation

After an individual is placed in the probation program, they meet with a Probation Officer for a performance assessment interview. After this assessment, the determination is made to refer and to which services. The Probation program meets with service providers regularly, usually monthly or bimonthly, and the goal is to keep start services streamlined.

Progress reports are received from service providers, and as appropriate, positive reinforcement or ongoing supports are provided to the individual. If a progress report indicates the individual is not attending, then the decision must be made to give a sanction or violate the person, at which point they return to jail.

Barriers throughout the Probation pathway include timeliness of referrals, motivation or individuals not showing up, lack of choices, transportation, and access to services, follow up with MAT after discharge from jail, timeliness of the provider reports and lack of Sheriff's staffing.

New Digs Current State VSM



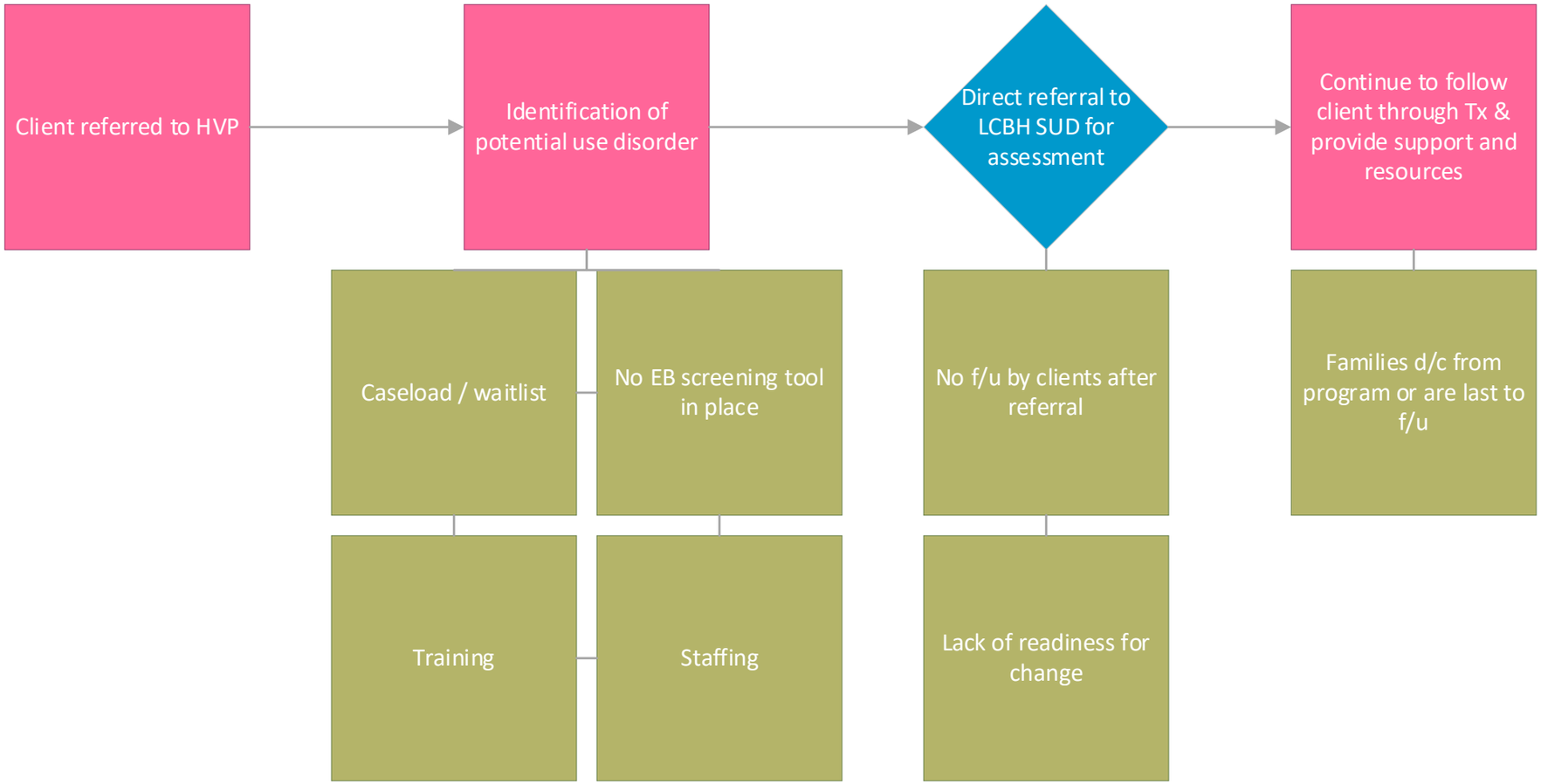
New Digs

Referrals to the New Digs Program usually come through CalWORKS or in the form of self-referral. New Digs is a housing first model, which means that the primary issue to address is housing itself. If a person who is experiencing homelessness comes into New Digs, the question asked is, 'What prevented you from finding stable housing?' Motivational interviewing is used to ascertain the needs of the individual. New Digs will not find a home for their clients but will assist them in accessing resources and housing lists to be able to find a home on their own, and the program assists with payments for a few months.

Decisions are made to refer to Freedom House, behavioral health, job zone for career help, Mother-Wise for pregnancy support, the VA hospital, or head start and rural community childcare.

Barriers encountered along the NCO New Digs Program Pathway include finding affordable housing, mental health, employment, language barriers, and substance use.

Lake County Public Health Strong Families Program Current State VSM



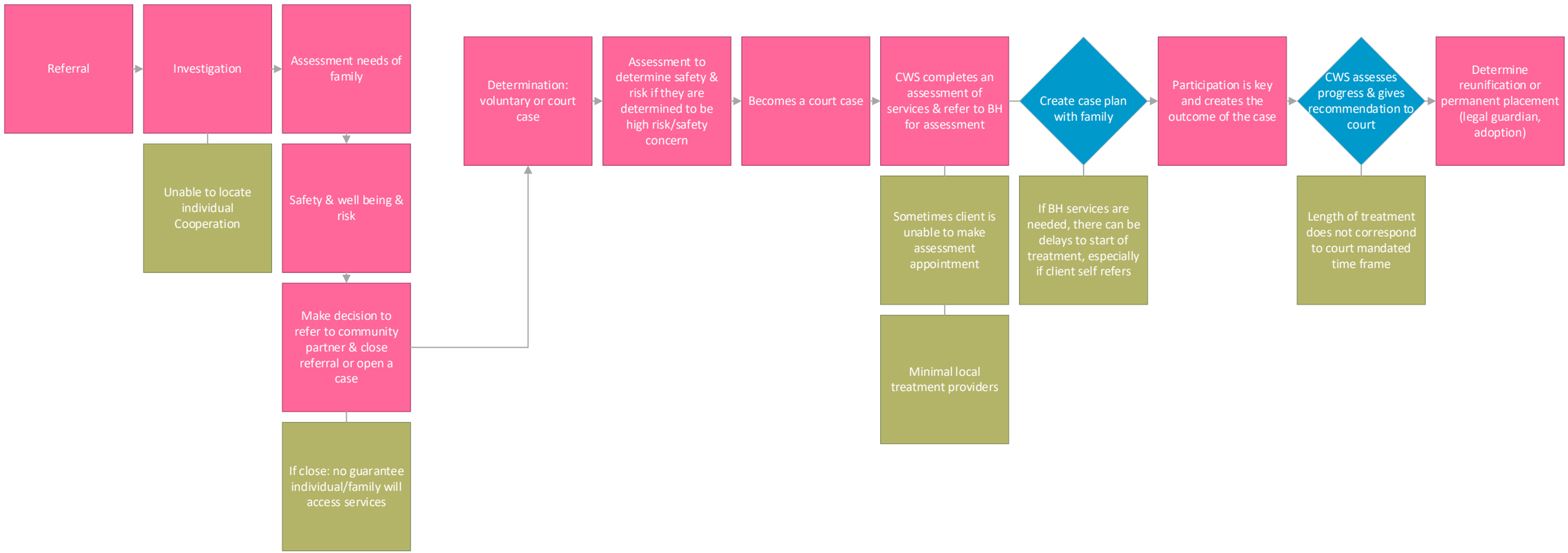
Lake County Public Health Strong Families Program

Clients may be referred to Lake County Public Health's Nurse Home Visitation Program (LCPH HVP, also called Strong Families Lake County), either by a medical provider, an outside community agency, or they may be identified at an outreach event. At intake, an intake questionnaire is performed which may identify potential for substance use disorders.

If a potential substance use disorder is identified, direct referral and warm handoff can be made to Lake County Behavioral Health SUD Program for assessment. If this occurs, clients may still be followed and receive resources and services through the Strong Families Program.

Barriers encountered throughout this pathway include large caseloads and/or waitlists, staffing issues, lack of training, and no evidence-based screening tool is currently being used. Additionally, clients may not follow up after a referral or may not be ready to change. Finally, families may discharge from the program or be last on the call list for follow up.

Lake County Social Services, Child Welfare Services Current State VSM



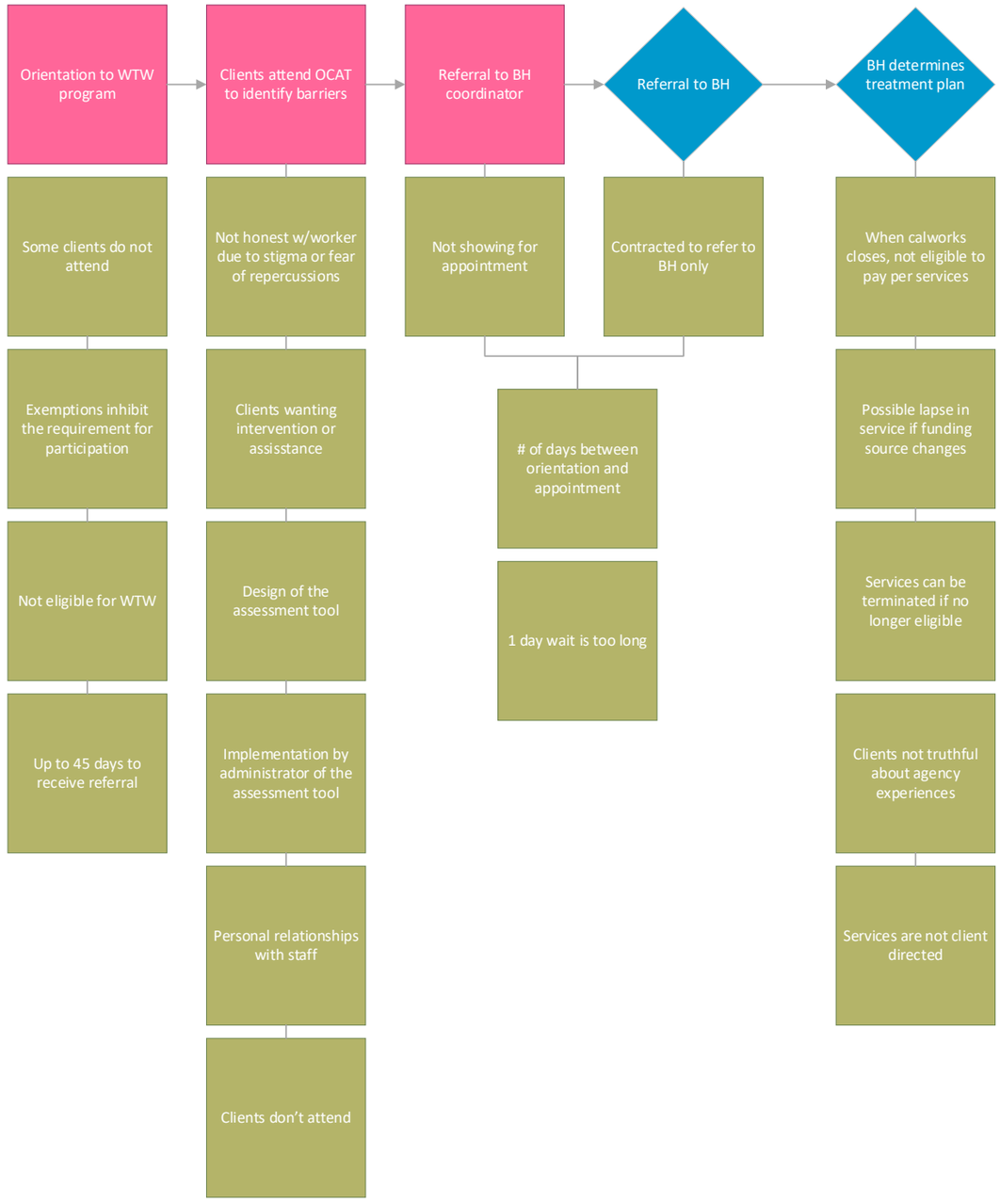
Lake County Child Welfare Services

The Child Welfare Services (CWS) treatment pathway begins with investigation and assessment of needs for the family involved. The safety, well-being and other risk factors are considered when a decision is made whether to refer the family to a community partner and close the referral or open a CWS case. If a case is opened, a determination is made as to the type of case: voluntary or court ordered. An assessment is conducted to determine possible safety and risk factors; if they are determined to be high-risk or a safety concern, then it becomes a court case. Traveler for services completes an assessment of services and refers to behavioral health for assessment. A decision is made; a case plan is created with the family. Participation is key; this informs the outcome of the case. Child Welfare Services assesses any progress and gives its recommendation to the court. At this point, the determination is made to reunify the family or find permanent placement such as a legal guardian or pursue adoption services.

Barriers along this treatment pathway include the following:

- The ability to locate an individual
- The cooperation of the individual
- No guarantee that a family or individual will access services (if referral is made)
- The inability of the client to make appointments
- The shortage of local treatment providers
- Delays in receiving Behavioral Health services as needed
- Delays to the start of treatment, especially if the client self-refers and length of treatment does not correspond to court-mandated time frame.

Lake County Social Services, Employment Current State VSM



Lake County Social Services, Employment

The Employment Services pathway begins with an orientation to the CalWORKs Welfare-to-Work (WTW) program. Then clients attend Online CalWORKs Appraisal Tool (OCAT) to identify any potential barriers. A referral to the Behavioral Health coordinator is completed, and referral of the need for Behavioral Health services is made. The Behavioral Health Services team will determine the treatment plan from there.

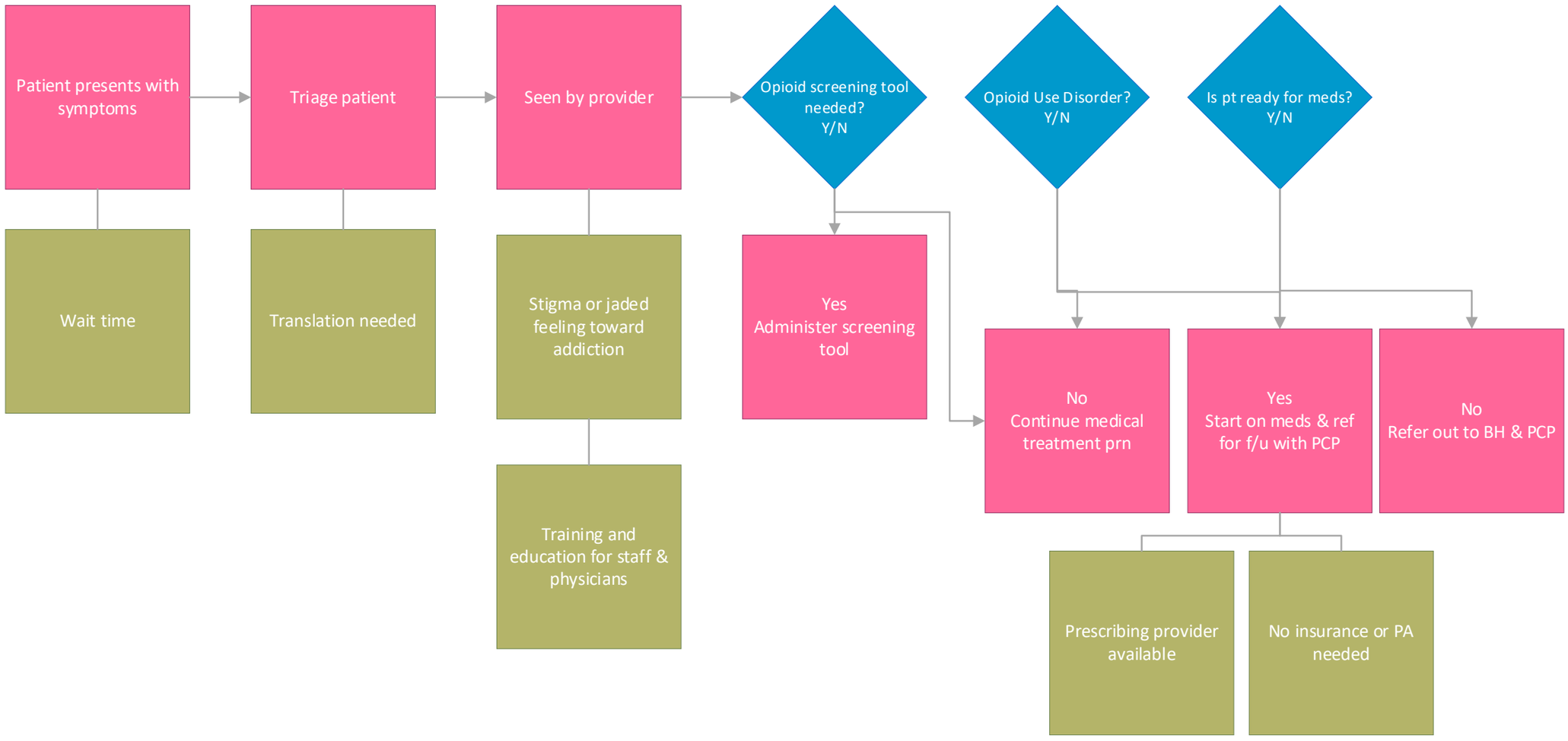
Barriers to orientation to the WTW program include clients not attending, exemptions which inhibit requirements for participation, ineligibility for WTW, and up to 45 days to receive the referral.

Barriers to client's attendance of OCAT include dishonesty with the worker due to stigma or fear of repercussions; the clients want intervention or assistance, design of the assessment tool, the implementation by administrator of the assessment tool, personal relationships with staff, and clients not attending.

Barriers throughout the referral to behavioral health through a treatment plan include the following:

- The client not showing up for an appointment
- Long waits between the orientation and appointment (1 day is too long)
- Contracted to refer to behavioral health only, when the CalWORKS office is closed,
- Not eligible to pay per service. This occurs when lapse in services due to funding source changes and the services being terminated if the client is no longer eligible
- The clients are not truthful about their employment search experiences
- The services are not client-directed.

Sutter Lakeside Hospital Emergency Department Current State VSM

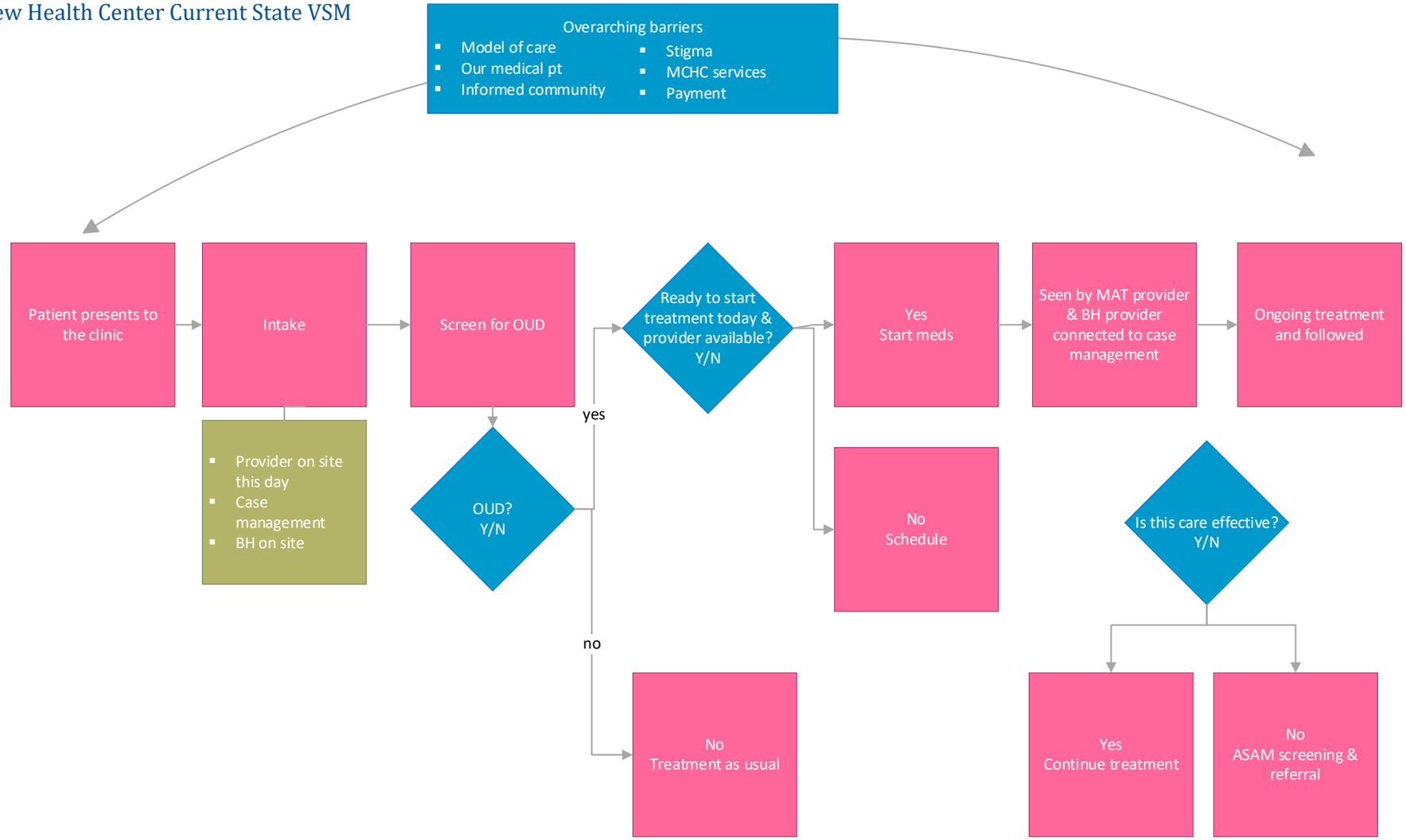


Sutter Lakeside Hospital Emergency Department

When a patient presents to Sutter Hospital Emergency Department, they are triaged for medical severity, then seen by a provider. If the opioid screening tool is not necessary, medical treatment is continued as necessary. However, if the opioid screening tool is administered, decisions are then made about if the patient has a substance use disorder or opioid use disorder, and if the patient is ready for medication. If the patient is ready for medication-assisted treatment, it is initiated, and they are referred to their Primary Care Physician (PCP) for follow up care and management. If the patient is not ready for medication-assisted treatment, they are referred out to Behavioral Health and their PCP.

Throughout a patients visit to the Emergency Department and through this treatment pathway, barriers encountered include wait times, language barriers such as translation services, stigma or jaded perceptions toward addiction, training and education for staff and physicians, prescribing provider availability (with regard to type of medication needed) and insurance may require prior authorization or the patient may not have insurance.

MCHC Lakeview Health Center Current State VSM

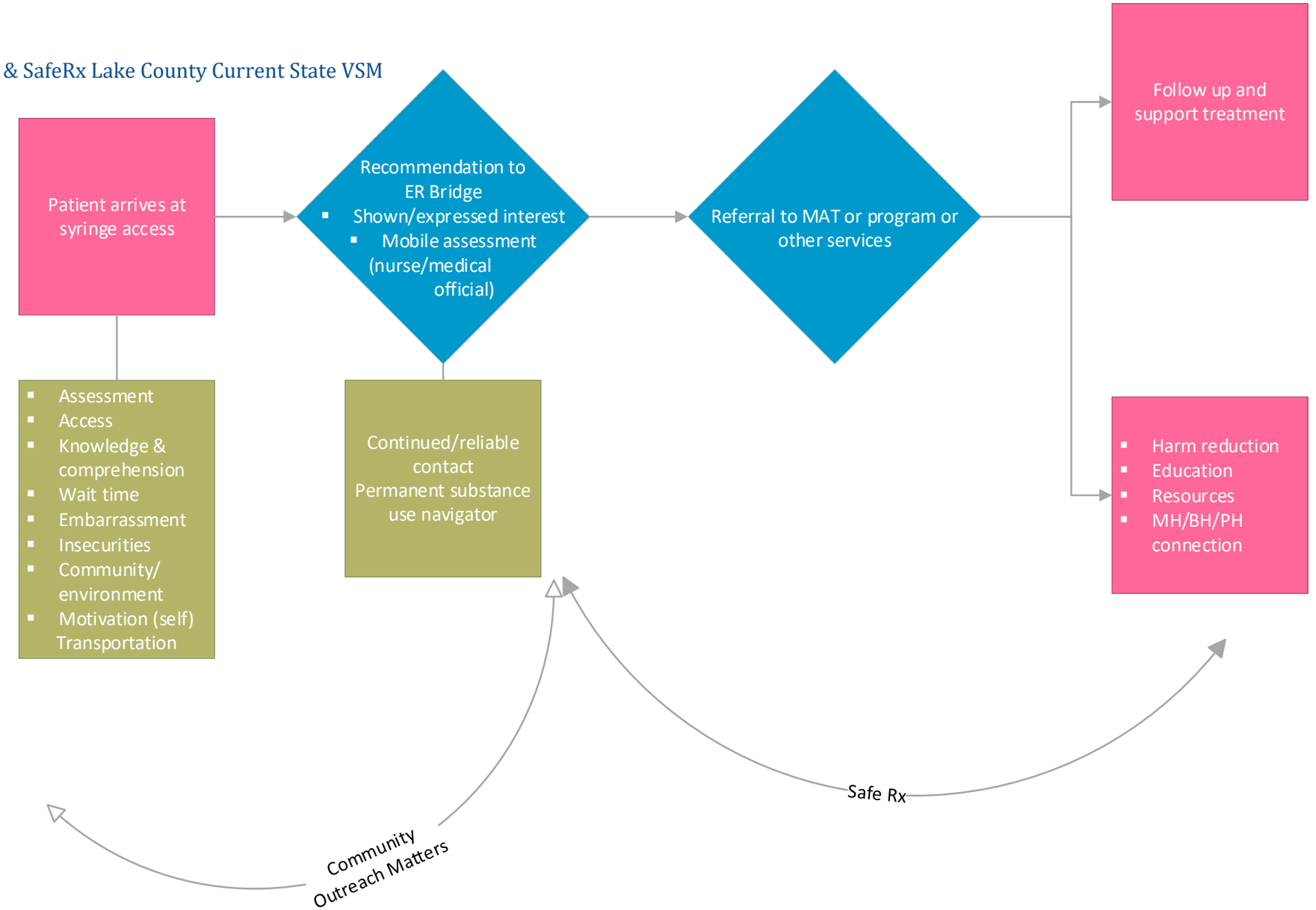


MCHC Lakeview Health Center

In this treatment pathway, the patient presents to the clinic. An intake assessment is performed, as well as a screening for Opioid Use Disorder. If the patient does not meet criteria for OUD, then treatment continues as necessary. If the patient does meet the criteria, then readiness for change is assessed, and provider availability is considered. If a provider is not available, an appointment is scheduled. If a provider is available, then the patient can be seen by the MAT provider, medications can be initiated, and referred to a Behavioral Health Provider where the patient can be connected to case management. Ongoing treatment continues, and the patient is followed through their care.

Overarching barriers for Lakeview Health Center include stigma, payment/financials, MCHC services, provider availability, the model of care, and eligibility for services.

Community Outreach Matters & SafeRx Lake County Current State VSM

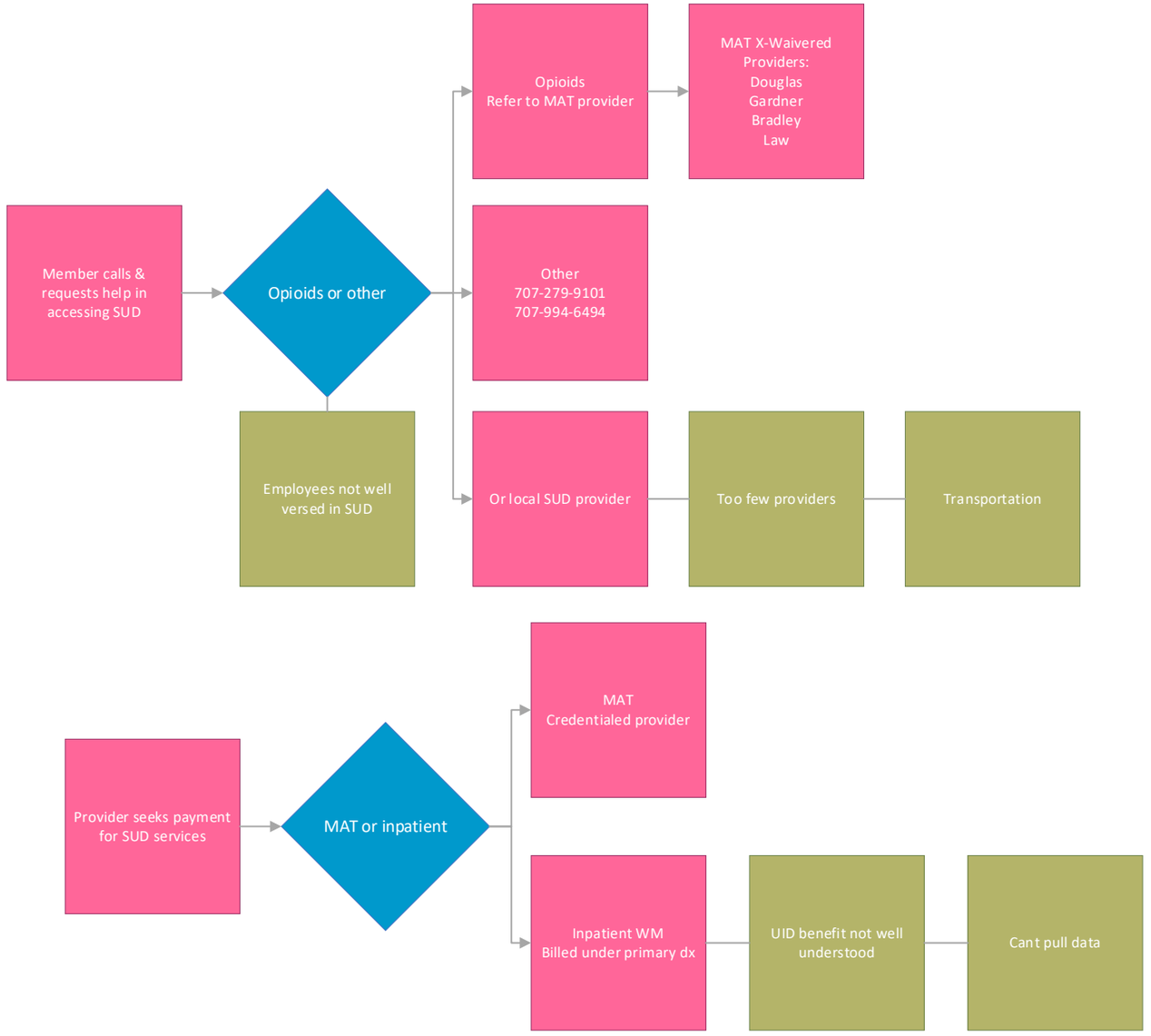


Community Outreach Matters & SafeRx Lake County

An individual may access the treatment pathways of Community Outreach Matters & Safe Rx Lake County at their arrival syringe access. At syringe access, a recommendation to ER Bridge may be warranted if the individual expresses an interest in it, or with mobile assessment by a nurse or medical officer. At this point, the referral to a MAT program or other services is completed, and the individual will be followed up with and receive support treatment or harm reduction, education, resources, and a connection to Mental Health, Behavioral Health or Public Health will be provided.

Barriers throughout the Community Outreach Matters and Safe Rx Lake County treatment pathway include assessment, access, knowledge/comprehension, wait times, embarrassment or insecurities, community/environment, self-motivation, transportation, ability to contact the individual and the lack of a permanent substance use navigator.

Partnership Health Plan Current State VSM



Partnership Health Plan

Partnership Health Plan may receive inquiries for Substance Use Disorder services by two pathways: via member or provider contact.

When a member calls into request help in accessing substance use disorder treatment, a decision is made whether the treatment is specific to opiates or other substances. If relating to Opioid Use Disorder, treatment is required, the member is referred to a MAT provider. There are four credentialed X-waivered providers (Douglas, Gardner, Bradley, and Law). If a local Substance Use Disorder provider is required, the member is referred appropriately. If other services are required, contact information for county services (in the form of phone numbers) is provided to the member.

Partnership Health Plan does cover transportation for any medical benefit that somebody is trying to access, as well as transportation to substance use benefits, even though it is not strictly medical.

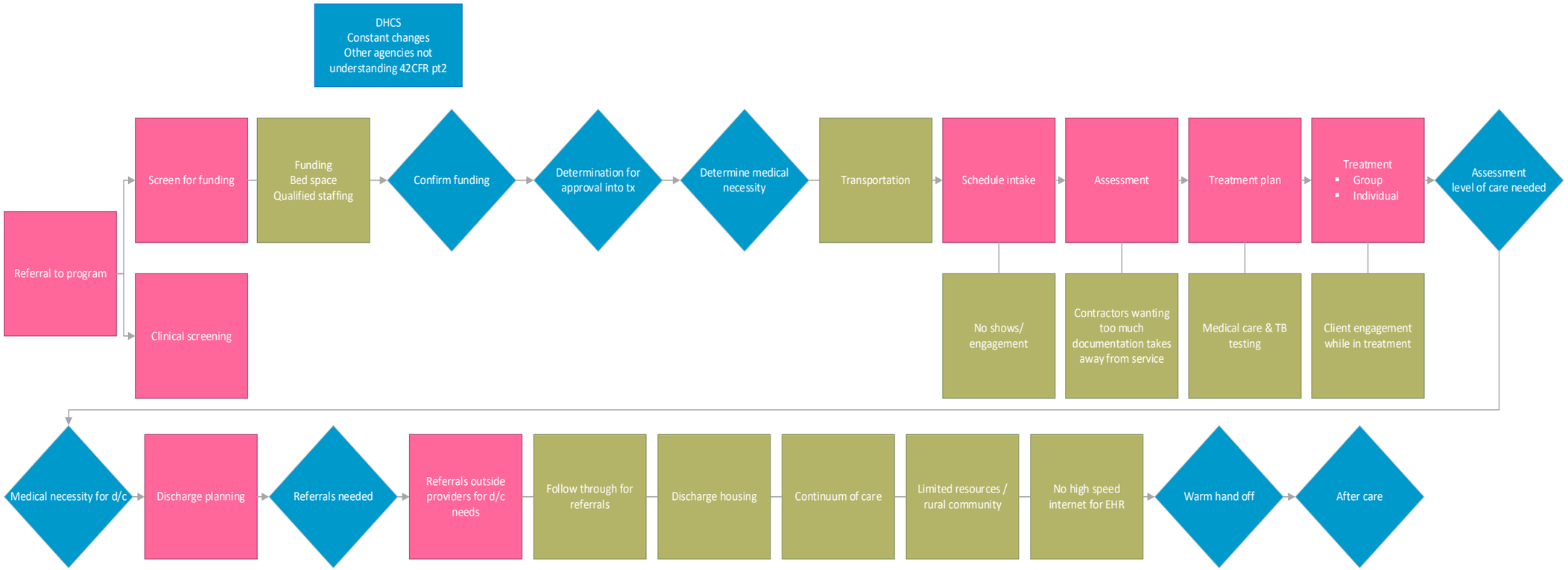
Barriers in the member pathway include employees not being well-versed in Substance Use Disorder, too few local providers, and transportation barriers for the member.

When a provider calls seeking payment for substances disorder services, a decision is made whether the services are Medication Assisted Treatment or inpatient. If inquiring about MAT services, it is dependent on their status as a credentialed provider. If inpatient withdrawal management (WM), such as in the case of an individual hospitalized for a broken pelvis secondary to a drunk driving/Driving Under the Influence (DUI) accident, then it is billed under primary diagnosis (fractured pelvis).

Barriers in the provider pathway include the OUD benefit not being well understood, and the inability to pull data if substance use is not the primary diagnosis.

Additionally, a voluntary inpatient detox benefit is available for hospitals, however, it is still not used often.

Ford Street Project, Hilltop & Tule Current State VSM



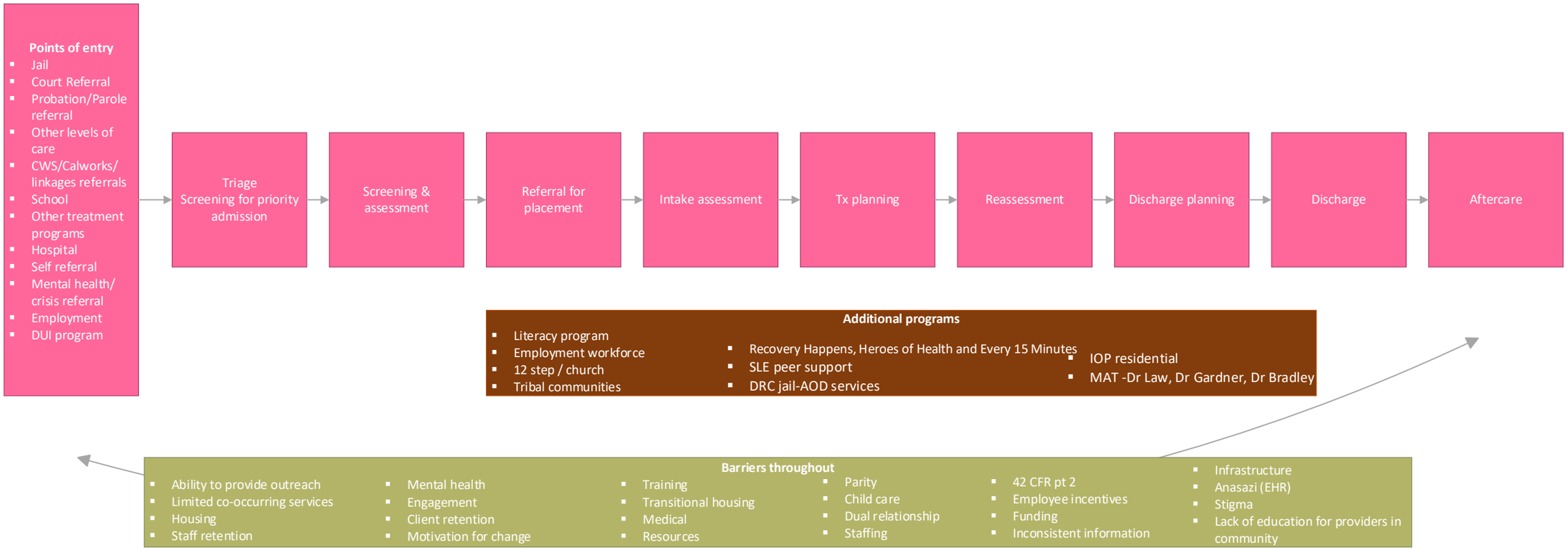
Ford Street Project, Hilltop & Tule

The beginning of the Ford Street Project, Hilltop, and Tule pathway is a basic referral to the program. This referral may come via self-referral or from a provider or an agency. Next, a funding and clinical screen are conducted to ensure the individual is appropriate for services.

Funding is confirmed, as well as determination for approval into treatment. Medical necessity is the final determination by medical directors, and intake is scheduled. Upon intake, an assessment is performed, the treatment plan is initiated, and the individual begins treatment, either group or individual. After the appropriate treatment time has been completed, an assessment is conducted to determine the continued level of care required versus discharge. If discharge planning is conducted, medical necessity for discharge is decided upon, referrals needed are decided upon and completed, and the individual is discharged with a warm handoff. Otherwise, it may be determined that the individual requires more treatment or a step down from residential to outpatient may be warranted.

Barriers throughout this treatment pathway include funding, bed space, qualified staffing, language or communication barriers, transportation, engagement, contractor requests for copious amounts of documentation, medical care/TB testing, client follow through for referrals, agency follow through on referrals, housing, and limited resources in a rural community such as high-speed internet as a barrier to accessing electronic health records. Additionally, for drug treatment, there are challenges with other agencies understanding the level of confidentiality in these programs. Finally, the Department of Healthcare Services is a big barrier.

Lake County Behavioral Health SUD Current State VSM



Lake County Behavioral Health SUD Program

Lake County Behavioral Health SUD Program receives individuals from jail, court referral, probation/parole referral, other levels of care within the community, CWS/CalWORKS/linkages referrals, school, other treatment programs, hospital, self-referrals, mental health or crisis referrals, employment, and DUI program crossover/referrals.

The client will be triaged and screened for priority admission. If the client is an IV user or pregnant SUD, they will receive priority admission and access services within 72 hours. If not meeting requirements for priority admission, they will meet with a counselor and wrap-around services will be determined. A follow-up appointment for screening and assessment will be scheduled.

At the screening and assessment appointment, the ASAM assessment tool is utilized to objectively determine the level of care appropriate to the severity of substance use disorder. Once the level of care is determined, the individual is referred to placement, whether it be out in the community, to IP or residential treatment, or to outpatient treatment, which Lake County Behavioral Health provides.

For people who meet the level of outpatient care, an intake appointment is performed. Assessment, treatment planning, and placement into groups then take place.

Upon completion of the program, reassessment occurs to assess readiness for discharge. Discharge planning ensures a safe discharge. After discharge, aftercare programs are available, which include the literacy program, employment workforce, 12-step/church, tribal communities, SLE peer support, DRC jail-AOD services, IOP residential and MAT services.

Barriers throughout the Behavioral Health SUD Program pathway include the ability to provide outreach, limited co-occurring services, housing, staff retention, mental health, engagement, client retention, motivation for change, training, transitional housing, medical, resources, parody, childcare, dual relationship, staffing, 42 CFR part 2, employee incentives, funding, inconsistent information, infrastructure, electronic health records, stigma, and lack of education for providers in the community.

D. Gaps and Barriers – 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 Lake County to address addiction, stakeholders agreed there were many challenges, particularly around stigma, staffing, and funding.

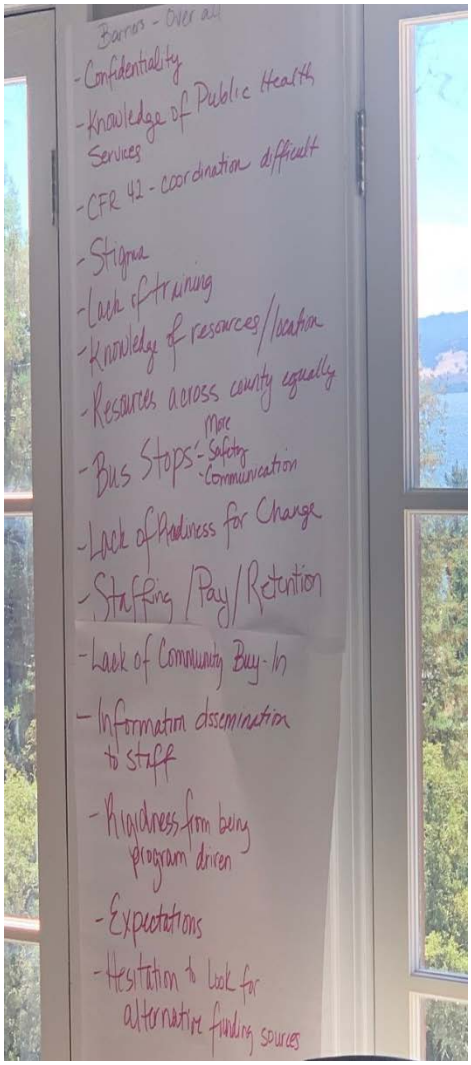
Agency-Specific Gaps and Barriers

During the current state value stream mapping session described in the previous section of this report, Lake County Stakeholders were asked to identify the barriers they encounter in their current workstream. A summary of the gaps and barriers identified during that session are summarized in the table below.

	Structural Barriers	Structural Inefficiencies	Structural Gaps	Capacity	Knowledge/ Training	Inconsistency	Stigma/ Criminalization	Social Correlates	Funding	Insurance	Cultural Competency
Probation	1	2	1	1				3			
NCO New Digs Program	4										1
Lake County Public Health, Strong Families Home Visitation Program	3		1	2	1						
Lake County Social Services, Child Welfare Services	3	1		1							
Lake County Social Services, Employment Services	7	3	4			1	1	1	1		1
Sutter Hospital Emergency Department		1		1	1		1			1	1
MCHC Lakeview Health Center (FQHC)				3							
Community Outreach Matters and SafeRx Lake County	5	1		1			2	2			
Partnership Health Plan	1		1	2	1						
Residential Treatment	5	1	5		1				1		
Lake County Behavioral Health, Substance Use Disorder Services	10		3	2	3		1		2		

Group Barrier Discussion Summary

The Lake County Stakeholders in attendance were asked to stand up from their tables and find a seat at one of four tables. The stakeholders in each of these four groups represented a mix of stakeholders, rather than just one agency. In these small groups, the stakeholders brainstormed the following as top barriers within the treatment ecosystem at-large. They were asked to come up with barriers that they perceived to be system-wide, to contrast or compare to the barriers identified during the current state value stream mapping session.



- Funding – big issues for Lake as a rural county; hesitation to seek alternative funding sources because there has been some difficulty managing funding in the past
- Referrals – completing referrals properly
- Follow up and aftercare plans
- Long wait times to see medical providers
- Billing and payment – delayed billing and payment; lengthy process to process payment
- Communication – ineffective communication between agencies; difficulty staying connected to resources available; lack of understanding of 42 CFR part 2
- Law enforcement – overall, the law enforcement community in Lake County is very supportive and collaborative. Among the barriers identified related to law enforcement include criminalization and a lack of knowledge about how MAT and treatment works
- Staffing – lack of proper staffing, lack proper training, lack of cultural competency, turnover rates are high, insufficient number of staff who speak Spanish, low pay across county
- Housing limited – in part due to fires
- Transportation – sometimes buses do not stop in front or near treatment locations because of fear that those spaces are unsafe
- Stigma – lack of awareness and understanding in community of services provided; lack of community buy-in; family members who do not understand and therefore do not support MAT; recurring clients feeling as though they burned bridges and do not want to return to services; small community causes fear about seeking necessary services; expectations on selves and providers to “fix” people.

E. Future System Goals

During the afternoon of day 2, the participating organizations began to think about moving from their current states to an improved future system of addiction treatment; we asked them to participate in two distinct table activity to 1), identify gaps and barriers that may hinder movement to the future state. Each table discussed their barriers and how to overcome them. Next, we asked each group to discuss their most desired feature in a future system, and the positive impact it would have on the Lake County community. As each table shared what they would most like to see, some clear consensus emerged:

Integration/ Coordination

Almost every group mentioned that they would like to see more integration and care coordination across the system of addiction treatment. This approach includes the integration of physical health, mental health, SUD treatment, and community resources and systems. Participants expressed a desire for better communication and information sharing across systems, alignment between public and private insurance. The participants did acknowledge the improvement that the Lake County Behavioral Health Services department has done to centralize the sharing of information, the creation of a 24-hour phone access line and the additional ramp-up of services that has occurred over the past couple of years. Lake County is not currently participating in the DHCS Drug Medi-Cal-Organized Delivery System (DMC-ODS), so they currently do not have all ASAM levels of care available within their treatment system. Lake County operates its SUD services under the Medi-Cal State Plan program. Residential treatment is offered to all clients, however, not all clients are funded under the DMC program. These services are funded through other avenues but are covered when having been identified as needing that level of care. Under the State Plan SUD program, residential services are offered to the Perinatal population. This population includes pregnant and postpartum women and EPSDT (the Early Periodic Screening and Diagnostic Treatment program) eligible children under 21-years of age. Many groups discussed co-locating services to be able to meet all needs in one place at one time. Additional residential services are occasionally available and reimbursed from SAPT funds. These services include some outpatient treatment services and limited withdrawal management services. Lake County has expressed an interest in furthering their DMC program and the potential future expansion to opt into the Partnership[Health Plan's Organized Delivery System DMC regional model.

Access to Care

Many groups mentioned the difficulties in getting clients to treatment. There are lots of barriers that impact access to care. The rural nature of the county and limited public transportation to get to and from treatment services and appointments to be assessed for appropriate level of services. Stigma was also identified as a barrier. The treatment community mentioned that patients with relapses often feel that they have burned their bridges to treatment. Both the treating providers and patients say there is a perceived

perception that can prevent this population from accessing future care. Participants mentioned the importance of addressing this stigma. Lake County also has some additional limitations with limited levels of services within its DMC State Plan program. The county has limited MAT treatment options with a limited number of X waivered physicians that can offer MAT services and no methadone treatment program operating within Lake County. Methadone treatment is most frequently accessed in Santa Rosa, Sonoma County. The distance to a methadone treatment provider can be in excess of more than an hour plus drive time.

Evidence-Based Care

Groups stated that they would like to see more MAT resources in the county, more training for providers, and more data and evaluation to drive strategic capacity building at the appropriate levels of care. In order to accomplish more appropriate, thirteen applications for ongoing technical assistance (TA) were received from participating participants. Both the Lakeview Health Center and the Lake County Veteran's Services expressed interest in MAT developing or starting MAT capabilities. HMA has assigned TA coaches to assist both organizations with their expansion goals.

Resources for People Living with Addictions

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

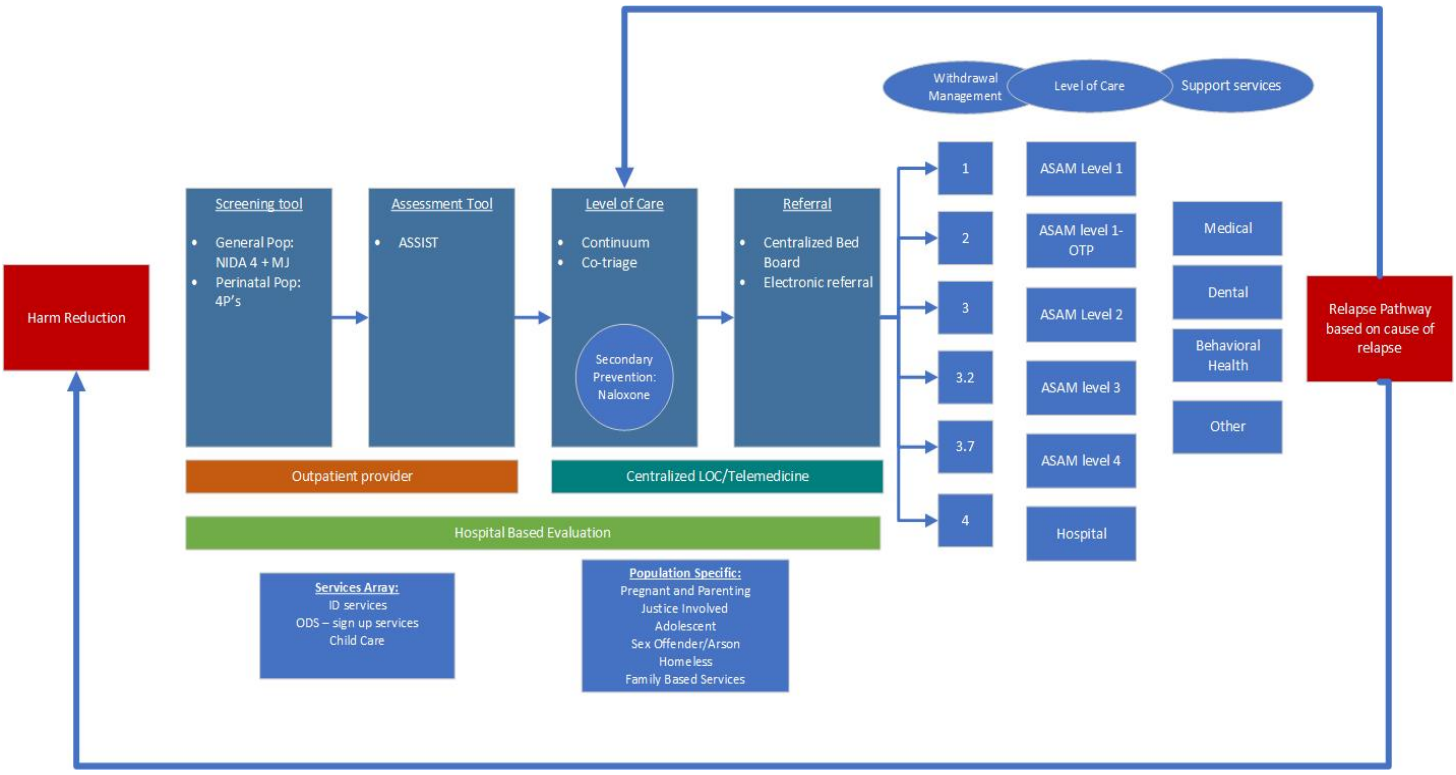
F. Triggers

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

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

G. The "Scaffolding of the Future State"

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



Considerable time was spent during the process improvement event considering the current state of the SUD ecosystem and barriers that exist within this system. These conversations informed the future state discussion of the whole group. The participants did not identify a community-wide set of Screening tools at the event, and a follow-up discussion was set with the county SUD Administrator to identify the county's preferences. The county discussed their use of the Substance Abuse Subtle Screening Inventory or SASSI assessment. There was a discussion on the county's future use of the DAPPER 3, identified as the desired assessment tool that the County will use for a one-year interim period while preparing to transition to the ASAM Continuum.

Partnership Health Plan, the Medi-Cal health plan that is standing up the Regional DMC-ODS program in the Northern Counties, will be making the final identification of screening and assessment tools required as the payer of DMC-ODS services. While Lake County is not a Regional ODS Model opt-in county, it makes sense to align with the same approach that Partnership has outlined for use in the Regional Model. Given the need for additional discussion on importance of the selection of the future state Screening and Assessment tools, a follow-up discussion was scheduled to include April Giambra, Lake County's Substance Used Disorder Administrator, and the HMA project team.

A follow-up meeting was held on Thursday, August 29, 2019, with April Giambra, Lake County's Substance Use Disorder Administrator, and the HMA project team that included, Scott Haga, MPAS, PA-C, Don Novo, and Caitlin Loyd. Along with April, they discussed all of the available tools along with the history and use of screening and assessment tools in Lake County. Scott Haga led a detailed discussion on all of the

industry-standard screening and assessment tools and a pros and cons discussion was had to help the county identify tools for future use that meet their data and reporting needs.

Screening

The county agreed on the use of the NIDA-4 -National Institute on Drug Abuse's Quick Screen tool.

Assessment

Considerable discussion surrounded an appropriate tool for assessment for Lake County. There is not a unique assessment tool currently in use by providers. A modified version of an ASAM assessment developed by LA County is currently used for both assessment and level of care determination. A decision was made to examine the ASSIST as a probable county-wide assessment tool as it is validated in multiple languages, is available without cost, and has a large number of resources to support its use in primary care.

Level of Care Determination

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

The county is transitioning away from the use of the LA County Modified ASAM form and will adopt the DAPPER 3 as an interim step as the county works to secure funding and resources needed to attain the goal of implementing the ASAM Continuum as their long-term level of care determination tool. The adaption to the ASAM Continuum will require a financial commitment from the county to ascertain necessary funding, training, and licensing tools. This transition to the ASAM Continuum is necessary to ensure compliance with state requirements and best practices. The long-term use of the ASAM Continuum will ensure that the county is developing a robust data reporting archive on the required need for all ASAM levels of care needed to meet the county's long-term planning and strategic reporting needs.

Treatment Ecosystem

Within and outside of Lake County there are many levels of service that can be delivered for both withdrawal management and treatment of the SUD. Lake County's DMC system has a more limited array of levels of care than the neighboring DMC-ODS Counties that

offer the full array of ASAM levels of care for all individuals. These levels of care need to be identified and vetted to determine how many slots or beds are available at each level of care, what services are delivered, how fast the patients can have access to MAT, who treats co-occurring and all of the other aspects to complete addiction care. Once this is done, we can overlay the support services as needed.

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

Relapse

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

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

03 Section 3: Implementation Strategy

A. Next Steps

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

All the information above in this report was pulled from the generous participation of individuals and institutions who deliver care or are otherwise vested in addiction treatment in Lake 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 Lake County Health Officer and the Behavioral Health Services department, and the MCHC-Lakeview Health Center to develop an attendee list and conduct outreach to invitees to encourage attendance. Also prior to the event, the Behavioral health Services department completed a survey to document existing substance use disorder (SUD) capacity and resources in Lake County, as well as understand barriers to coordinated care for SUD. At the event, one "champion" per organization/team completed a paper technical assistance (TA) application with guidance from the Northern California Team Lead (Don Novo). On the TA Application, respondents were asked to check the box or boxes that best described their TA needs. Options included: (1) Learn more about caring for people with addiction and provide more information and training to our staff; (2) Learn more about how our organization can participate in a community wide solution to the opioid epidemic; (3) Improve our role in managing the transitions of care as residents in our community move within addiction system of care; (4) Start providing MAT services at our organization; (5) Scale up our current MAT program by increasing the number of patients treated; (6) Learn how to provide or improve addiction treatment to pregnant and parenting women. Based on their selection(s) on the TA Application, organizations are put into one of two TA tracks:

1. Generalized TA: Sites that are unlikely to provide MAT but are seeking general TA

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

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

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

Generalized TA offerings are available to both groups, and include live webinars and recorded webinars, and access to a variety of resources on the Transitions of Care project website, AddictionFreeCA.org. Anyone can submit a specific TA request through the TA request portal on the AddictionFreeCA.org website. Organization/teams can move to different tracks as their goals change.

Organizations/teams were asked to sign up for TA during the process improvement event and provided initial goals for the TA program. The following 11 organizations applied for TA:

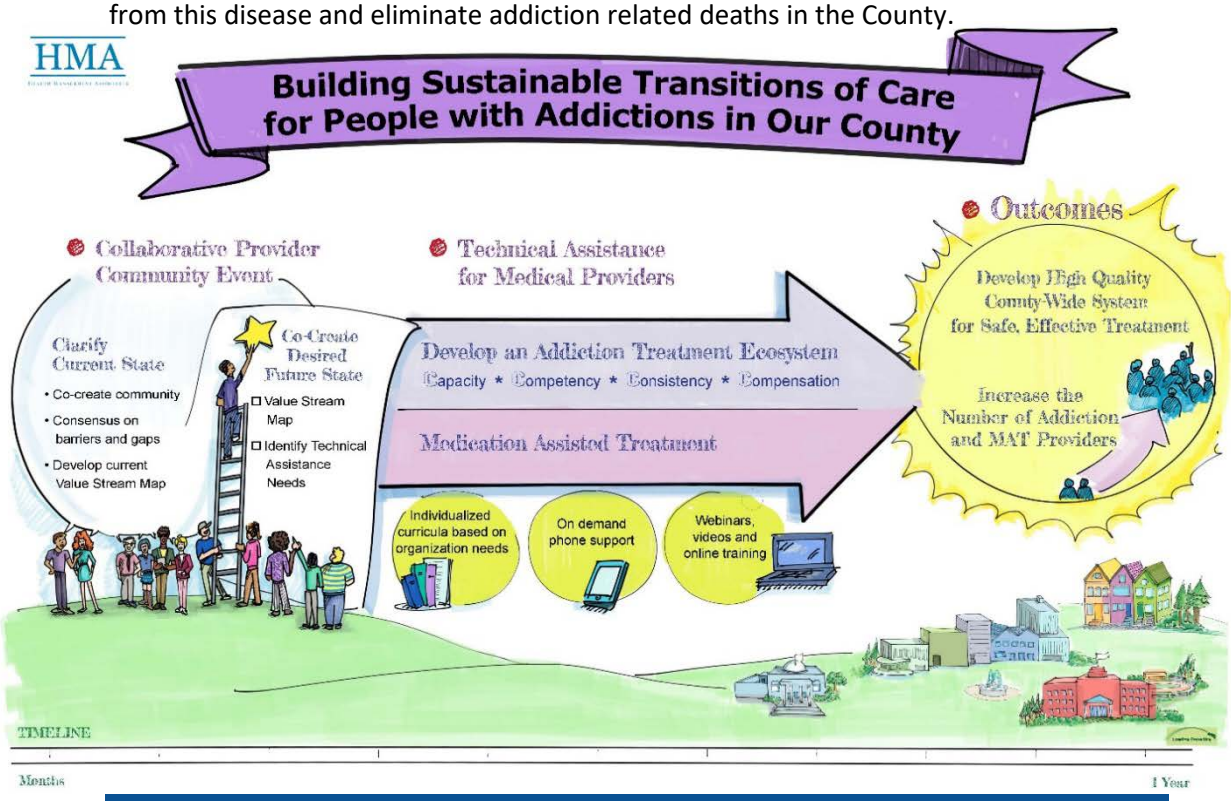
- Any Positive Change Inc.
- Hilltop Recovery Services
- Lake County Veterans Services
- Lake County Behavioral Health Services - Substance Use Disorder Services
- Lake County Department of Social Services - Employment Services (2)
- Lake County Probation
- MCHC Lakeview Health Center
- North Coast Opportunities
- Redwood Community Services
- SafeRx Lake County
- Sutter Lakeside Hospital

The 11 organizations/teams who requested TA requested the following specific goals:

Goal	Frequency
Learn more about caring for people with addiction and provide more information and training to our staff.	9
Learn more about how our organization can participate in a community wide solution to the opioid epidemic.	11
Improve our role in managing the transitions of care as residents in our community move within addiction system of care.	10
Learn how to provide or improve addiction treatment to pregnant and parenting women.	1
Start providing MAT services at our organization.	2
Scale up our current MAT program by increasing the number of patients treated.	6

C. Conclusion

In conclusion, HMA thanks the Lake County community, who turned out with their hearts and minds committed to this work. We hold the deep conviction that the Lake County community and stakeholder coalition of addiction treatment providers, medical professionals, hospitals, law enforcement and CBO community has what it takes to rethink one of the most complex medical conundrums in modern history. With resources mobilizing throughout the state and within the county, the strong leadership of Lake County Public Health Department and Lake County Behavioral Health Services, along with Partnership Health Plan, MCHC-Lakeview Health Center and the hospital community have the vision, leadership and ability to fully implement the envisioned future state pathway within the next two to three years. Together, we have the power to normalize the disease of addiction, better care for the community members suffering from this disease and eliminate addiction related deaths in the County.



Appendix

A. Lake County Data

LAKE COUNTY: POPULATION 64,665

STATISTICS

- OUD Death Rate
  - 2017: 17.0, Rank 4/41
  - 2016: 11.5, Rank 10/41
- All Drug Death Rate
  - 2017: 35.4, Rank 2/41
  - 2016: 23.3, Rank 13/41
- ED Opioid Rate
  - 2017: 48.8, Rank 3/41
  - 2016: 59.6, Rank 6/41
- 2 Hospitals
- 6 Pharmacies
- 1 FQHCs
- Methadone Pt Rate 0: Rank n/a

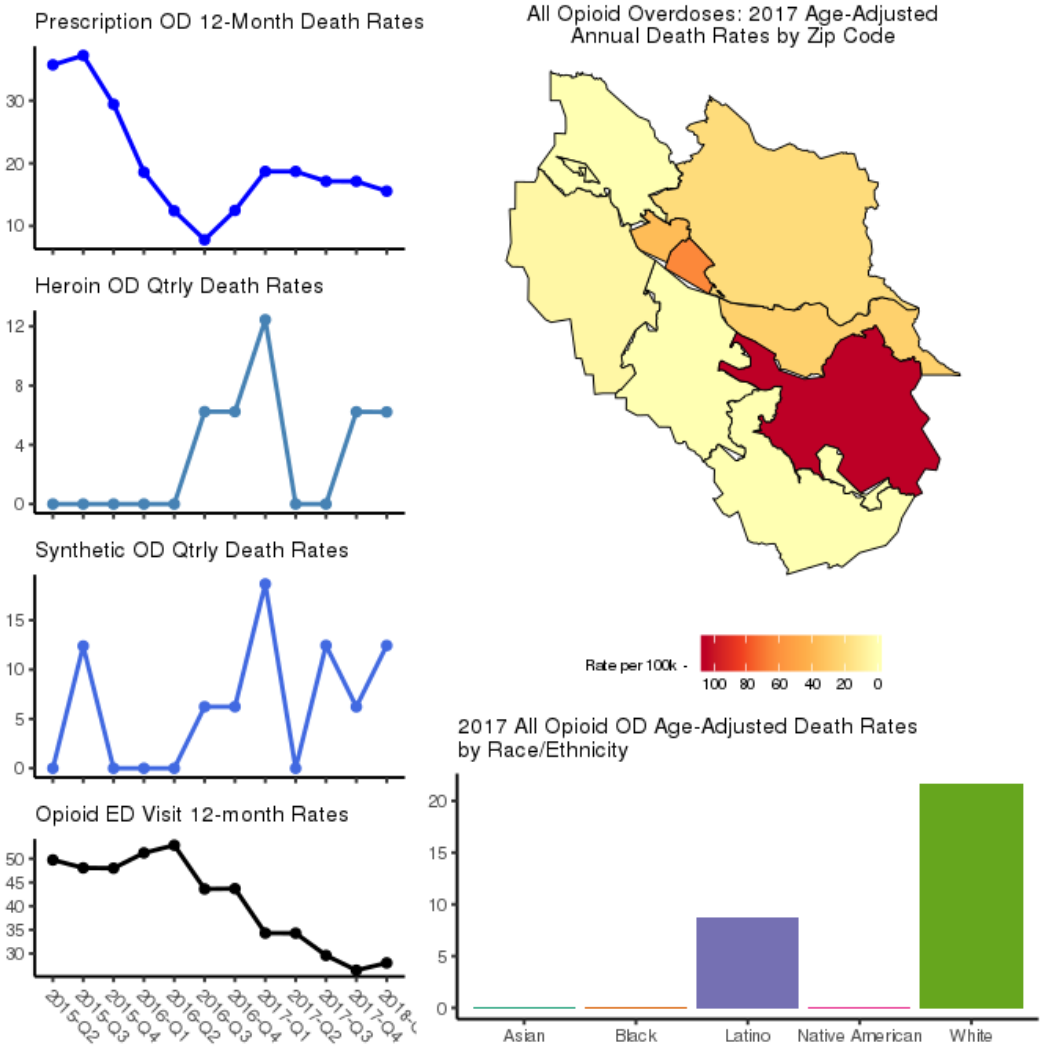
ADDITIONAL FACTORS

- Coalition: SafeRx Lake County
- SAMHSA Funds: $**0**
- Drug Medi-Cal Organized Delivery System? No
- Presence of CA Bridge: Yes
- *PHI recommends as receptive*
- *"Lake is very organized, impressive; making use of 4 vistas, very receptive*"

Lake Opioid Overdose Snapshot: 2015-Q2 to 2018-Q1

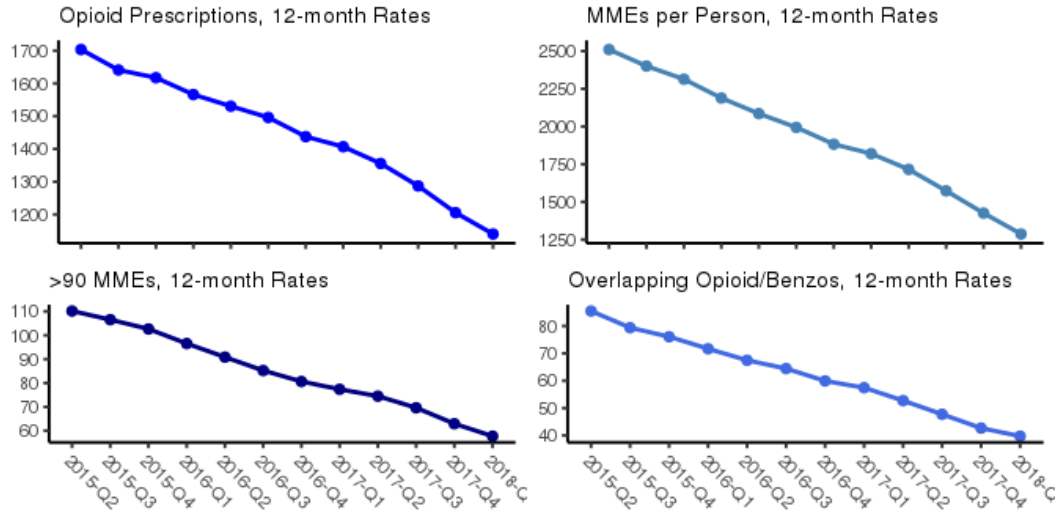
Report downloaded 10-12-2018

Lake experienced 13 deaths due to all opioid-related overdoses in 2017, the most recent calendar year of data available. The annual crude mortality rate during that period was 20.2 per 100k residents. This represents a 9% increase from 2015. The following charts present 12-month moving averages and annualized quarterly rates for selected opioid indicators. The map displays the annual zip code level rates for all opioid-related overdoses. Synthetic opioid overdose deaths may be largely represented by fentanyl.



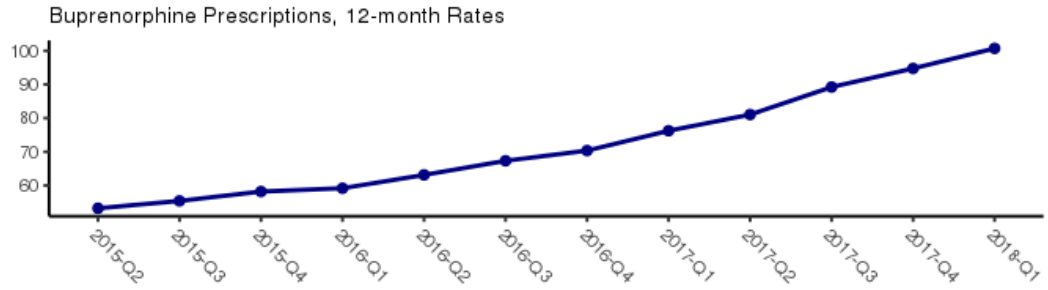
Prescribing

There were 77,437 prescriptions for opioids in Lake in 2017, excluding buprenorphine. The annual prescribing rate during that period was 1205.3 per 1,000 residents. This represents a 23% decrease in prescribing from 2015. The following charts present the annualized quarterly prescribing rates, MMEs (morphine milligram equivalents) per person per year, high dosage rate (i.e. greater than 90 Daily MMEs in the quarter), and the opioid/benzodiazepine overlap rate during 2017.



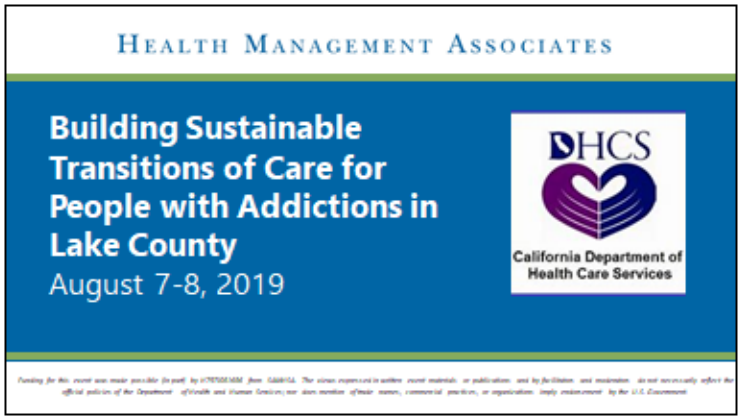
Treatment

Buprenorphine prescriptions in the county are used to gauge the expansion of medication-assisted treatment (MAT). The annual buprenorphine prescribing rate in 2017 was 94.8 per 1,000 residents. This represents a 60% increase in buprenorphine prescribing from 2015.



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

B. Process Improvement Event Slides



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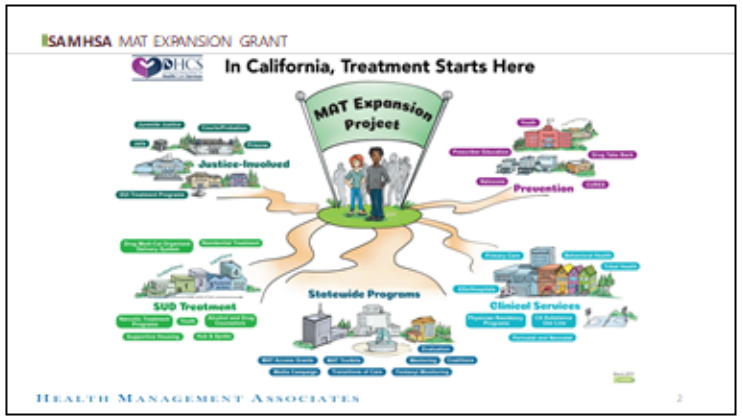

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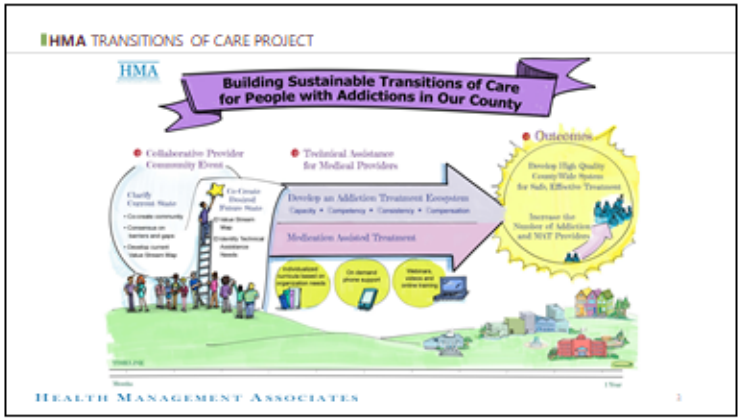

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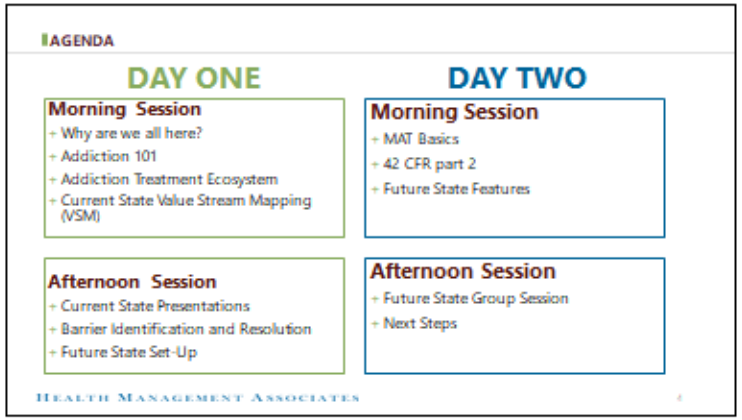

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TECHNICAL ASSISTANCE PROGRAM PLANNING GOALS

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

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

This work will be accomplished through:

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

HEALTH MANAGEMENT ASSOCIATES 5

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SCOPE OF TECHNICAL ASSISTANCE

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

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

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

6

6

COUNTY SELECTION DATA POINTS CONSIDERED

NEED

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

READINESS

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

OTHER CONSIDERATIONS

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

HEALTH MANAGEMENT ASSOCIATES 7

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LAKE COUNTY: POPULATION 64,665

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- All Drug Death Rate
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  - 2016: 23.3, Rank: 13/41
- ED Opioid Rate
  - 2017: 48.8, Rank: 3/41
  - 2016: 59.8, Rank: 6/41
- 2 Hospitals
- 6 Pharmacies
- 0 FQHCs
- Methadone Pt Rate 0, Rank n/a

ADDITIONAL FACTORS

- Coalition: Safe/Sx Lake County
- SAMHSA Funds: $0
- Drug Medi-Cal Organized Delivery System? No
- Presence of CA Bridge: Yes
- PHF recommends as receptive
- "Lake is very organized, impressive, making use of 4 visits, very receptive"

HEALTH MANAGEMENT ASSOCIATES 8

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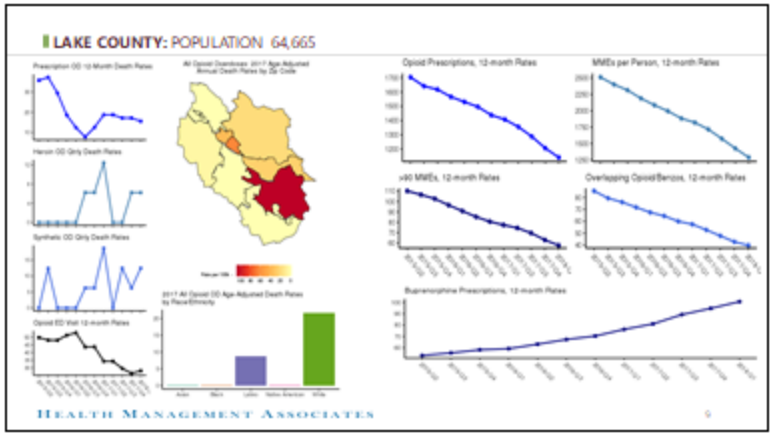
LAKE COUNTY: POPULATION 64,665
Opioid Prescriptions, 12-month Rates
MMEs per Person, 12-month Rates
>90 MMEs, 12-month Rates
Overlapping Opioid/Benzos, 12-month Rates
Buprenorphine Prescriptions, 12-month Rates
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Healthcare in the US
HEALTH MANAGEMENT ASSOCIATES

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WHAT IS OUR GOAL FOR BEING HERE TOGETHER THE NEXT TWO DAYS?
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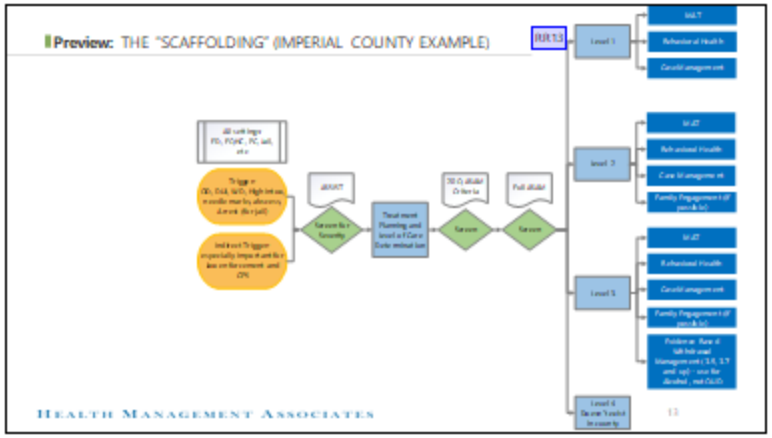
Preview: THE "SCAFFOLDING" (IMPERIAL COUNTY EXAMPLE)
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ADDICTION 101 – THE PROBLEM

What is Addiction?

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

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ADDICTION 101 – HOW DID WE GET HERE?

- Push by manufacturers
- Poor acute and/or chronic pain management theory
- Distribution of huge amounts of medication

- Increased prescribing of opioids
  - Pain as 5th vital sign
  - Expectation of no pain
- Massive amount of prescriptions filled by pharmacies
- Blind eye to the data

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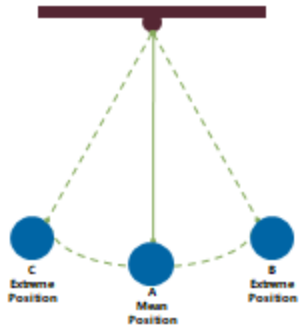
ADDICTION 101 – SAFE OPIOID PRESCRIBING

Set appropriate expectations → Don't start with opioids for minor injuries → Don't finish with opioids for chronic pain → Post-Op: 3-7 day prescriptions → No Benzos



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IS ALL ADDICTION THE SAME?

Patient 1

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

Patient 2

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

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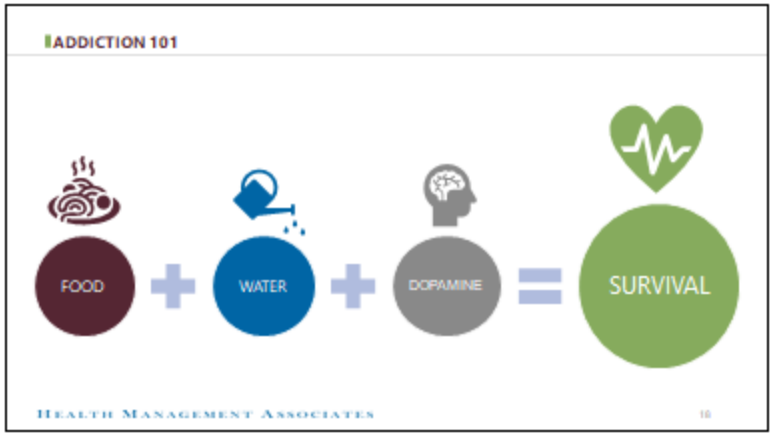
ADDICTION 101
FOOD
WATER
DOPAMINE
SURVIVAL
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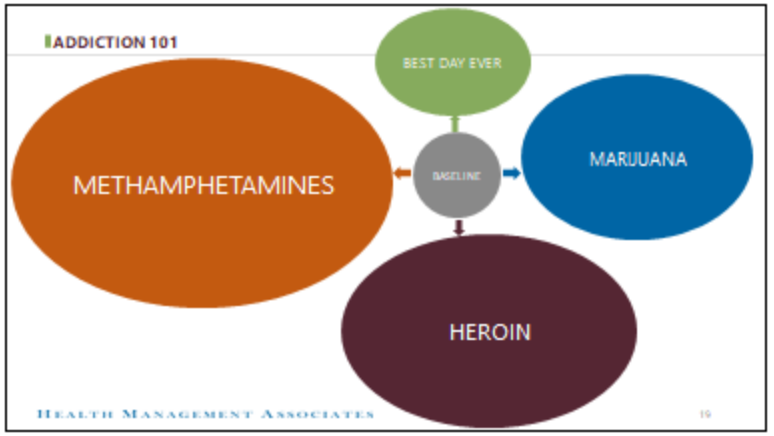
ADDICTION 101
BEST DAY EVER
METHAMPHETAMINES
BASELINE
MARIJUANA
HEROIN
HEALTH MANAGEMENT ASSOCIATES

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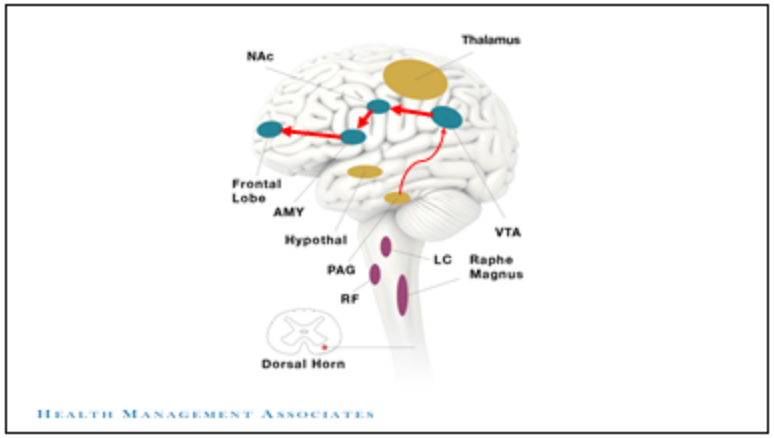
NAc
Thalamus
Frontal Lobe
AMY
Hypothal
VTA
PAG
LC
Raphe Magnus
RF
Dorsal Horn
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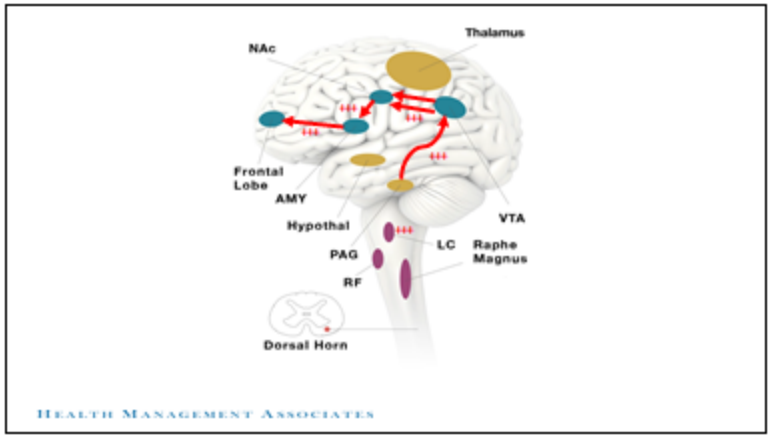
NAc
Thalamus
Frontal Lobe
AMY
Hypothal
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LC
Raphe Magnus
RF
Dorsal Horn
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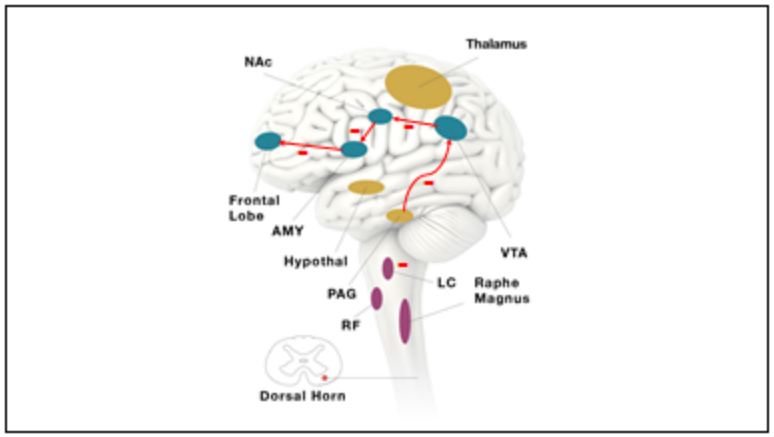
Thalamus
NAc
Frontal Lobe
AMY
Hypothal
VTA
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LC
Raphe Magnus
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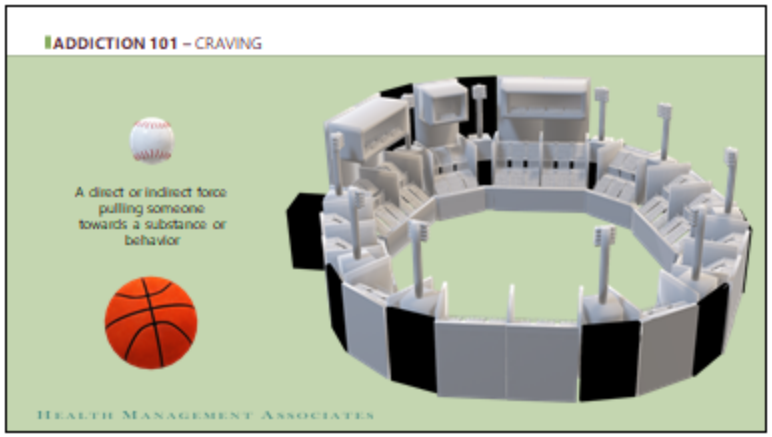
Dorsal Horn

22


ADDICTION 101 – CRAVING
A direct or indirect force pulling someone towards a substance or behavior
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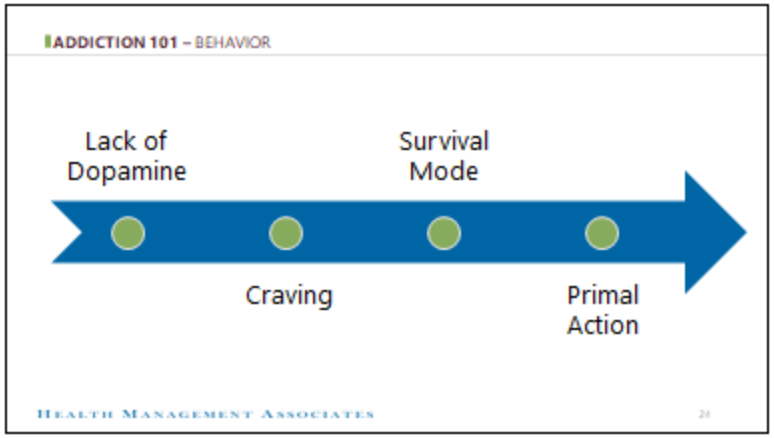
ADDICTION 101 – BEHAVIOR
Lack of Dopamine
Survival Mode
Craving
Primal Action
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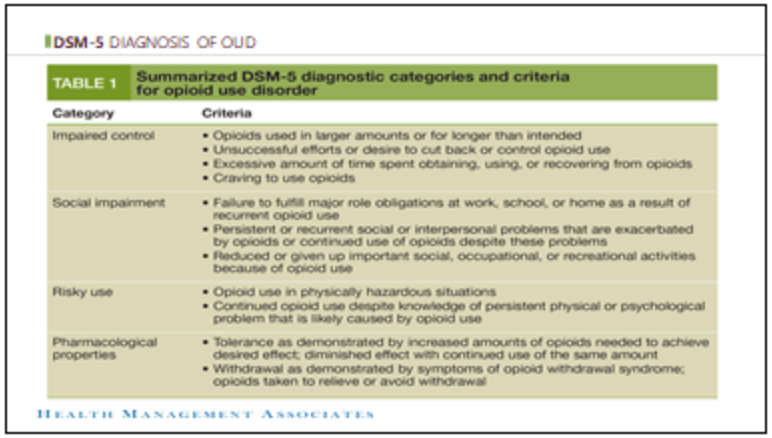
DSM-5 DIAGNOSIS OF OUD
TABLE 1 Summarized DSM-5 diagnostic categories and criteria for opioid use disorder
Category
Criteria
Impaired control
• Opioids used in larger amounts or for longer than intended
• Unsuccessful efforts or desire to cut back or control opioid use
• Excessive amount of time spent 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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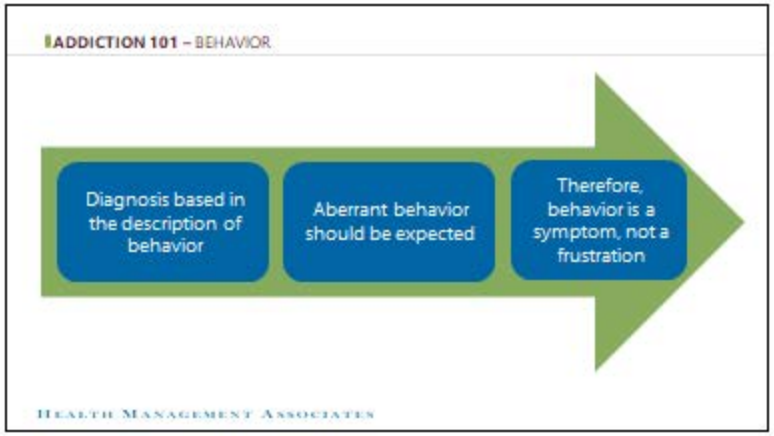
ADDICTION 101 – BEHAVIOR
Diagnosis based in the description of behavior
Aberrant behavior should be expected
Therefore, behavior is a symptom, not a frustration
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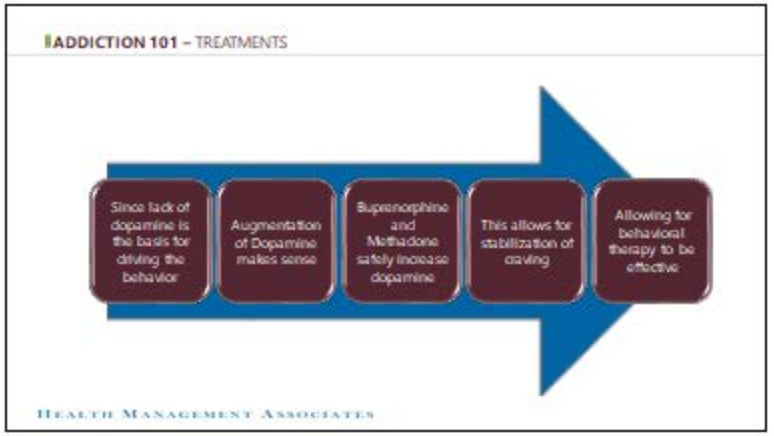
ADDICTION 101 – TREATMENTS
Since lack of dopamine is the basis for driving the behavior
Augmentation of Dopamine makes sense
Buprenorphine and Methadone safely increase dopamine
This allows for stabilization of craving
Allowing for behavioral therapy to be effective
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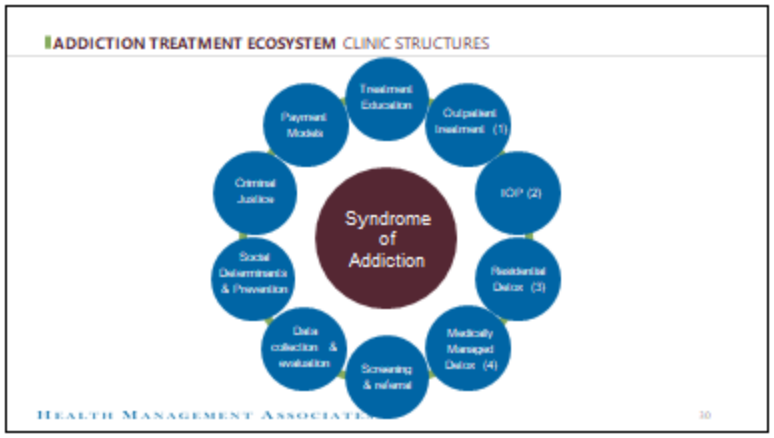
ADDICTION TREATMENT ECOSYSTEM CLINIC STRUCTURES
Syndrome of Addiction
Treatment Education
Outpatient Treatment (1)
IOP (2)
Residential Detox (3)
Medically Managed Detox (4)
Screening & referral
Data collection & evaluation
Social Determinants & Prevention
Criminal Justice
Payment Models
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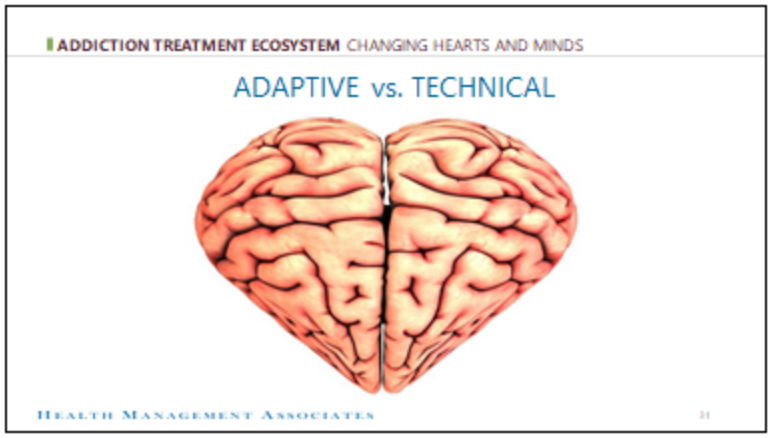
ADDICTION TREATMENT ECOSYSTEM CHANGING HEARTS AND MINDS
ADAPTIVE vs. TECHNICAL
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ADDICTION TREATMENT ECOSYSTEM IMPLEMENTATION
Capacity
Competency
Consistency
Compensation
Community
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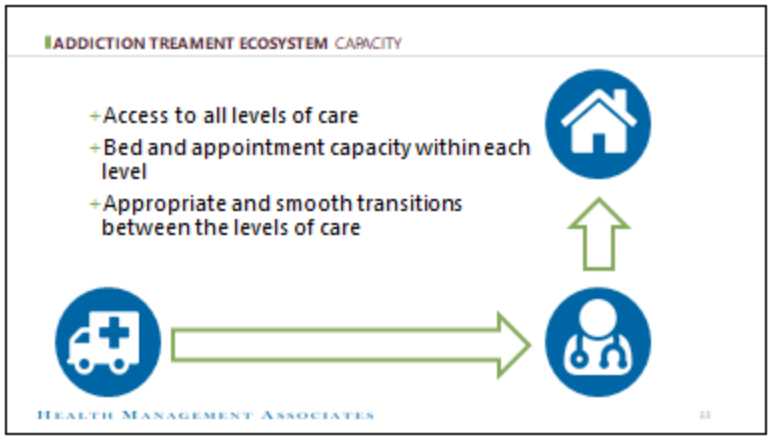
ADDICTION TREAMENT ECOSYSTEM CAPACITY
+Access to all levels of care
+Bed and appointment capacity within each level
+Appropriate and smooth transitions between the levels of care
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ADDICTION TREAMENT ECOSYSTEM COMPETENCY

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

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ADDICTION TREAMENT ECOSYSTEM CONSISTENCY

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

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ADDICTION TREAMENT ECOSYSTEM COMPENSATION

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

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ADDICTION TREAMENT ECOSYSTEM COMMUNITY

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

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SCREENING, ASSESSMENT & LEVEL OF CARE DETERMINATION

- **Screening:**
  A rapid evaluation to determine the possible presence of a condition (high sensitivity, usually low specificity)
- **Assessment:**
  A deep evaluation meant to solidify the presence and severity of a disease (lower sensitivity, high specificity)
- **Level of Care Determination:**
  Using an assessment and other factors, the most appropriate level of care for the severity of the condition is identified (outpatient vs inpatient).

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IS THERE A ROLE FOR TOX SCREENING?

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

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SCREENING TOOLS

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

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ASSESSMENT TOOLS

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

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LEVEL OF CARE DETERMINATION

Evaluating for placement

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

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FIELD NOTES

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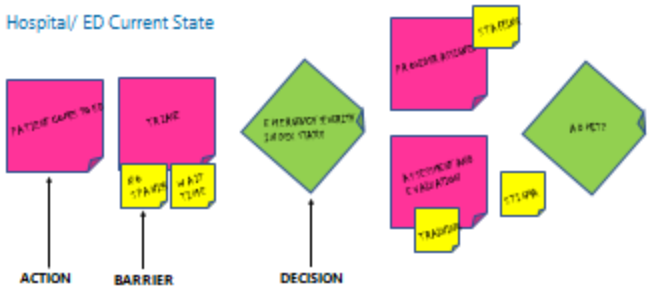
VALUE STREAM MAP EXAMPLE

Hospital/ ED Current State



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EXERCISE: GAPS & BARRIERS

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

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GOAL

THE THING THAT KEEPS ME FROM EFFECTIVELY TREATING IS....

IN A PERFECT WORLD WE WOULD LIKE TO....

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AGENDA

DAY ONE	DAY TWO
Morning Session + Why are we all here? + Addiction 101 + Addiction Treatment Ecosystem + Current State Value Stream Mapping (VSM)	**Morning Session** + MAT Basics + 42 CFR part 2 + Future State Features
Afternoon Session + Current State Presentations + Barrier Identification and Resolution + Future State Set-Up	**Afternoon Session** + Future State Group Session + Next Steps

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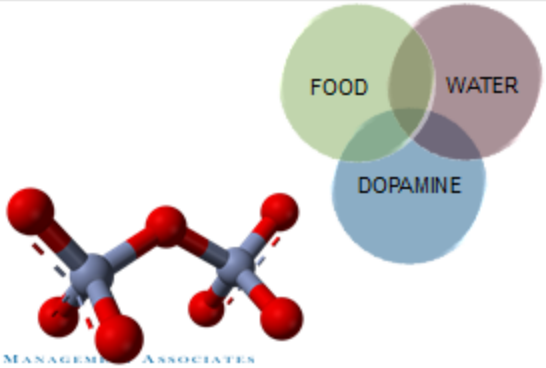
SURVIVAL



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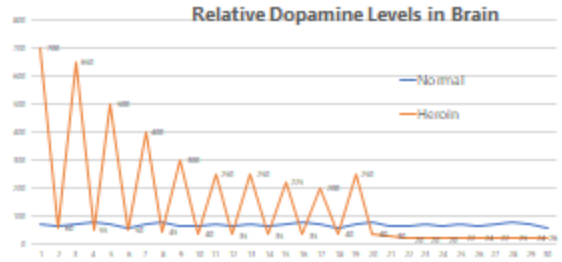

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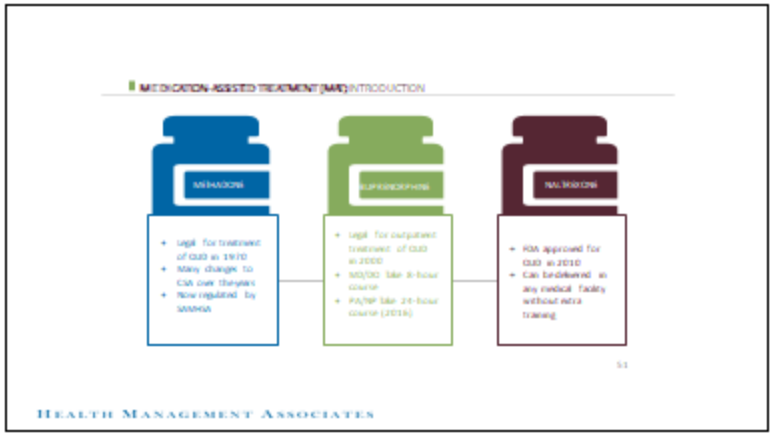
MEDICATION-ASSISTED TREATMENT (MAT) INTRODUCTION
METHADONE
BUPRENORPHINE
NALTREXONE
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CATEGORIES OF MAT FOR OUD
METHADONE
full agonist
activates opioid receptors which eliminates craving for other opioids
BUPRENORPHINE
partial agonist
activates opioid receptors in the brain, but to a much lesser degree, which reduces craving for other opioids
NALTREXONE
antagonist
blocks opioid receptor without activating it which eliminates opioid effect if opioids are taken
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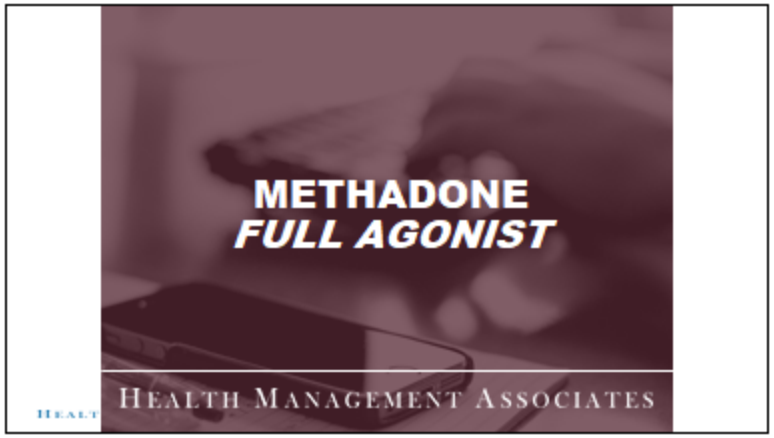
METHADONE
FULL AGONIST
HEALTH MANAGEMENT ASSOCIATES

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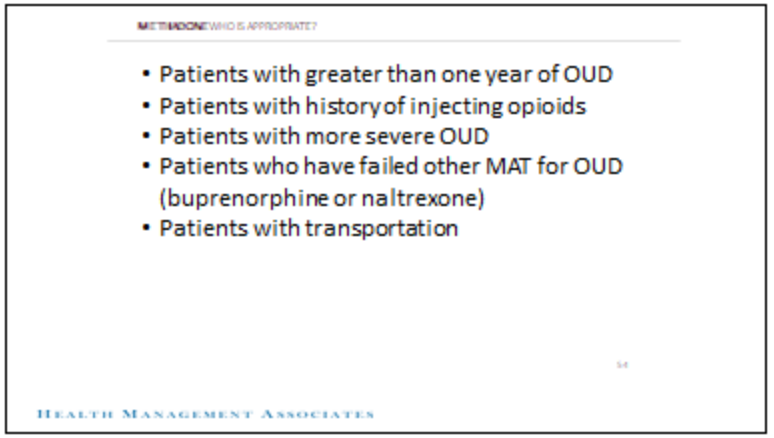
METHADONE WHO IS APPROPRIATE?
• Patients with greater than one year of OUD
• Patients with history of injecting opioids
• Patients with more severe OUD
• Patients who have failed other MAT for OUD (buprenorphine or naltrexone)
• Patients with transportation
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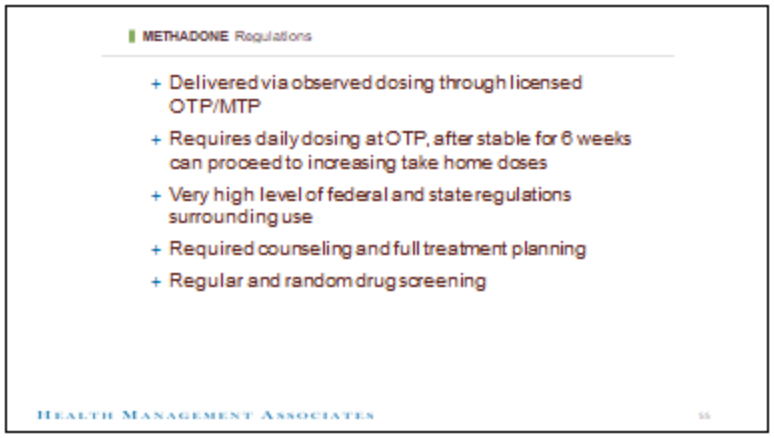
METHADONE Regulations
+ Delivered via observed dosing through licensed OTP/MTP
+ Requires daily dosing at OTP, after stable for 6 weeks can proceed to increasing take home doses
+ Very high level of federal and state regulations surrounding use
+ Required counseling and full treatment planning
+ Regular and random drug screening
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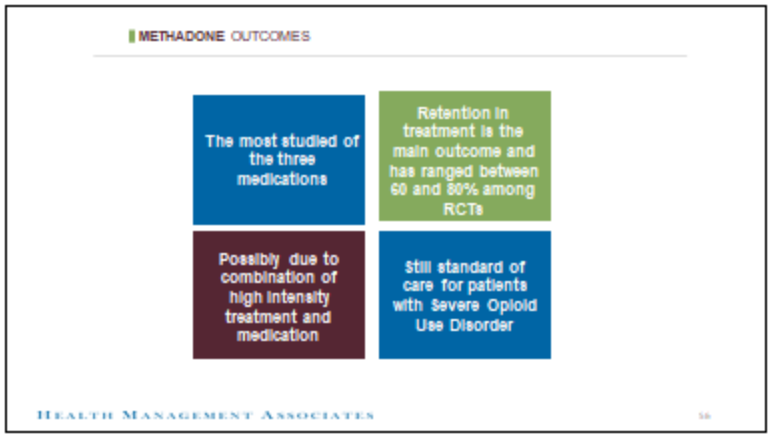
METHADONE OUTCOMES
The most studied of the three medications
Retention in treatment is the main outcome and has ranged between 60 and 80% among RCTs
Possibly due to combination of high intensity treatment and medication
Still standard of care for patients with Severe Opioid Use Disorder
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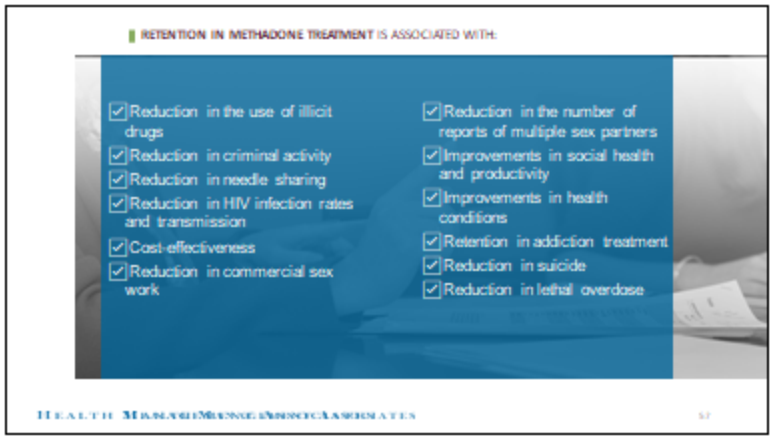
RETENTION IN METHADONE TREATMENT IS ASSOCIATED WITH:
Reduction in the use of illicit drugs
Reduction in criminal activity
Reduction in needle sharing
Reduction in HIV infection rates and transmission
Cost-effectiveness
Reduction in commercial sex work
Reduction in the number of reports of multiple sex partners
Improvements in social health and productivity
Improvements in health conditions
Retention in addiction treatment
Reduction in suicide
Reduction in lethal overdose

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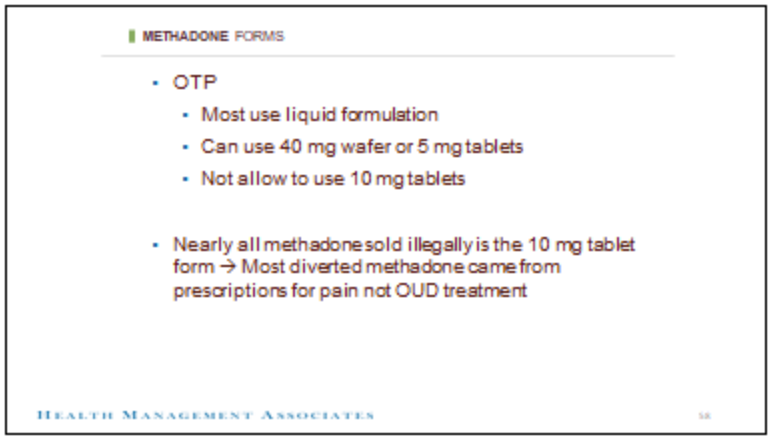
METHADONE FORMS
• OTP
• Most use liquid formulation
• Can use 40 mg wafer or 5 mg tablets
• Not allow to use 10 mg tablets
• Nearly all methadone sold illegally is the 10 mg tablet form → Most diverted methadone came from prescriptions for pain not OUD treatment
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METHADONE

- 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: if you are on methadone you are covered for pain
  - Methadone for pain is 3x/day
- Illegal to write prescription for methadone to treat OUD unless covering a gap in treatment under "emergency prescribing"
  - This allows all providers to prescribe methadone for up to 3 days while arrangements for longer term treatment through OPT are established

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METHADONE CAVEATS

- Often unavailable or difficult to access in rural settings
- Transportation to OTP often very challenging
- Greatest stigma exists around methadone despite having the best data
- Multiple interactions with other medications
- Non-linear dosing
- Most difficult MAT to discontinue

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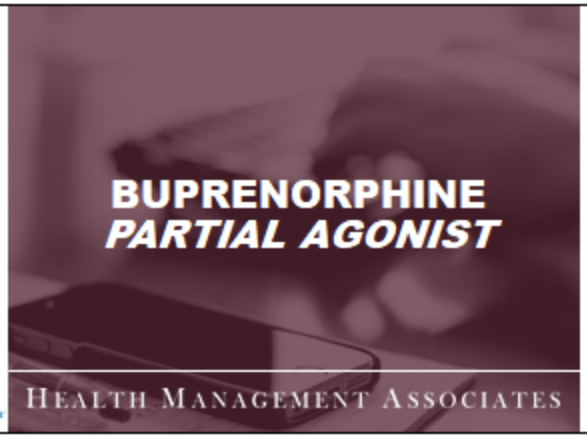

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BUPRENORPHINE TRAINING REQUIRED

- MD or DO
  - 8-hour course
  - 30 patients 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, CNM
  - 24-hour Course
  - 30 patients in first year then can apply to go to 100
  - Held to state oversite rules

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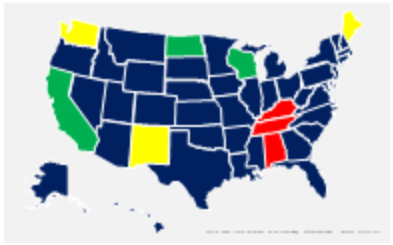
STATE LAWS ALLOWING PA NP TO PRESCRIBE BUPRENORPHINE



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BUPRENORPHINE FORMULATIONS

- Comes in multiple forms
  - Oral (Sublingual, not effective if swallowed)
    - Some forms have naloxone
      - Naloxone is added to prevent injection, is not absorbed if medication is used under tongue
    - Sublingual tablet (*Subutex, Suboxone*)
      - Slow dissolving, but can be crushed to speed up dissolving
    - Sublingual film *(Suboxone, Zubsolv)*
    - Buccal film *(Bunavail)*

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BUPRENORPHINE FORMULATIONS

- Implantable rod
- Injection (*Sublocade*)
  - Need to start on sublingual
  - Lasts 28 days
  - Very limited diversion potential
  - Gradual withdrawal if discontinued

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BUPRENORPHINE PROPERTIES

- Partial agonist with strong binding affinity
  - Ceiling effect
    - Dosing above ~32 mg do not cause more euphoria
    - Doses above 24-32 mg no more effective for treatment of OUD
  - Less tolerance over time compared to methadone
  - Other opioids are not as effective when buprenorphine is present

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BUPRENORPHINE INDUCTION

- Because buprenorphine is a partial agonist with strong binding affinity, starting buprenorphine when opioid receptors are saturated with drug can cause precipitated withdrawal
- Need to start buprenorphine when patient is in mild to moderate opioid withdrawal
- Need to have induction protocol when starting buprenorphine
- Taking other opioids while on buprenorphine will **not** cause withdrawal (they will be less effective)

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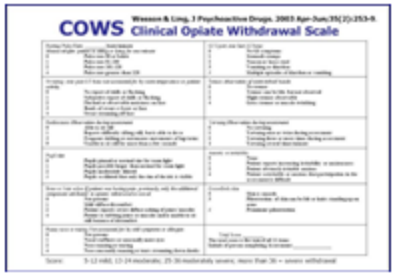
The science and art of avoiding precipitated withdrawal



68

BUPRENORPHINE OUTCOMES

OUTCOMES AT 1 YEAR HAVE RANGED FROM 45% TO 65% USING THE SUBLINGUAL MEDICATION

HIGH DEGREE OF VARIABILITY IN THE DELIVERY MODELS AND PATIENT SEVERITY

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BUPRENORPHINE CAVEATS

- Fewer regulations than methadone but some do exist
  - Access to counseling (state specific)
  - Restriction on number of patients treated
  - Need to keep accurate records for DEA
  - Need X waivered prescribers
- Weaning medications can be slow and uncertainty when this is appropriate
- Treatment of pain requiring opioids can be more complicated

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WHO IS APPROPRIATE FOR NALTREXONE?

- Patients with a high degree of motivation (high dopamine)
- Patients with previous poor outcomes with buprenorphine and methadone
- Patients, especially in criminal justice system, with history of OUD and Alcohol Use Disorder

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NALTREXONE

- Does not address underlying issue of dopamine depleted brain
- No diversion potential
- More widespread acceptance in criminal justice community
- Can be very useful after discontinuation of methadone or buprenorphine (insurance policy)

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NALTREXONE OUTCOMES

- Least studied medication for OUD
- Retention better with injectable vs. oral (oral not indicated for OUD)
- Mixed results in studies, if individual is able to get to opioid free state may be effective treatment
- Need to think

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NALTREXONE IN JAILS AND PRISONS

- Must conduct drug screening before starting; cannot start if opioids are in use
- Can convert from injectable (in the community) to oral form while in jail
- Restart injectable at release (if release planning supports this)
- Little potential for diversion

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NALTREXONE CAVEATS

- Starting naltrexone can be very difficult as patient needs to be off all opioids for 7-10 days, sometimes longer (methadone can be weeks)
- MUST do UDS and confirm opioid free before starting → induced withdrawal
- Retention in treatment can be difficult for many patients
- Some stigma against methadone and buprenorphine can result in preference for naltrexone even when it is not the most appropriate treatment
- Treatment of pain requiring opioids can be very difficult if patient has received naltrexone

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WHAT TO DO WHEN PATIENT ON MAT TEST POSTIVE FOR OTHER DRUGS

- Consider inadequate dose of MAT
- May be diverting MAT and using other drugs
- May need to switch to different MAT drug
- Relapse is expected in the chronic disease of addiction
- MAT is being used for OUD, not other substances

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MAT CONCLUSIONS

- Methadone and Buprenorphine seem to have no difference if efficacy whether patient is injecting or using oral pills
- Using medications is the standard of care
- There is no perfect answer!
- Involve your patients and have access to all of the medications
- Building an addiction treatment ecosystem is the way. Not just an opioid treatment system.

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INFORMATION SHARING/ 42 CFR

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DISCLAIMER

1. I am not a lawyer
2. (I do not want to be a lawyer)
3. This is not legal advice
4. Consult legal counsel with any questions

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HMA will be presenting a webinar (week of August 30) specifically focused on 42 CFR and disclosure of SUD information. Watch your email for information in the next day or two!

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WHAT IS 42 CFR?

- Privacy law to protect individuals from discrimination based on receiving treatment for an SUD
- 42 CFR was created with the understanding of the role of stigma and bias play in SUD
- When 42 CFR was enacted addiction treatment was very different
- Rules have changed many times

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WHAT IS 42 CFR?

- Major changes are very likely soon
  - SAMHSA proposed changes
  - (H.R. 2062/S. 1012
  - Letter from state AG's (including Xavier Becerra – California)

"Replace the cumbersome, out-of-date, privacy rules contained in 42 CFR Part 2 with the effective and more familiar privacy rules contained in the Health Insurance Portability and Accountability Act (HIPAA)."

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WHO IS COVERED BY 42 CFR

1. Holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment

2. Federally assisted

HEALTH MANAGEMENT ASSOCIATES

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WHO IS COVERED BY 42 CFR

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WHEN CAN INFORMATION BE DISCLOSED?

1. Valid release
2. Report of cause of death
3. Report of child abuse
4. Report of crime against program or individual acting on behalf of program
5. Court order

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WHAT IS REQUIRED IN A VALID CONSENT

1. Patient name
2. Agency disclosing information
3. Description of information being disclosed, including an explicit inclusion of SUD records
4. Name of entity information is to be disclosed to
5. Purpose of disclosure

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WHAT IS REQUIRED IN A VALID CONSENT

- Any records disclosed must include statement prohibiting redisclosure

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MYTHS ABOUT 42 CFR

- Please remember I'm not a lawyer...

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CONSTRUCTING THE FUTURE STATE

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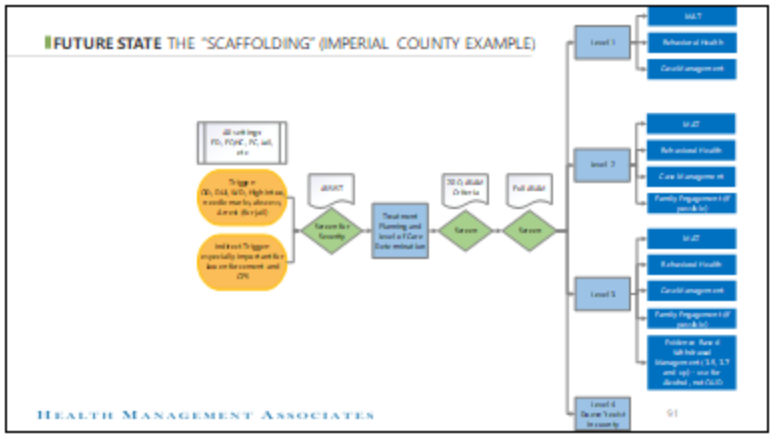
FUTURE STATE THE "SCAFFOLDING" (IMPERIAL COUNTY EXAMPLE)
HEALTH MANAGEMENT ASSOCIATES

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REVIEW OF THE CURRENT STATE
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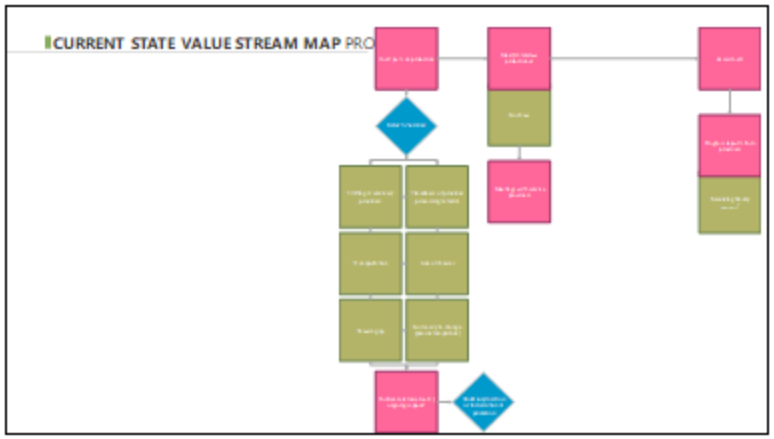
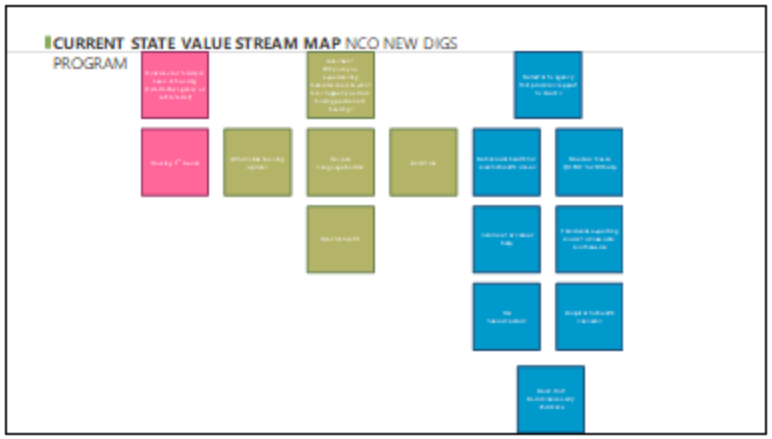
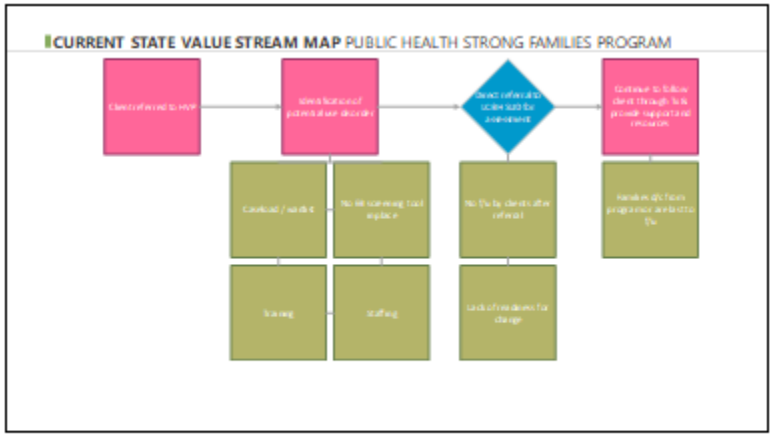

CURRENT STATE VALUE STREAM MAP PRO

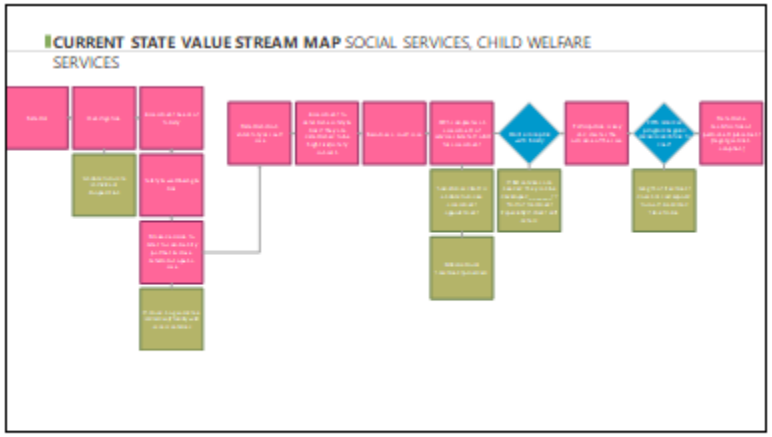
93


CURRENT STATE VALUE STREAM MAP NCO NEW DIGS PROGRAM

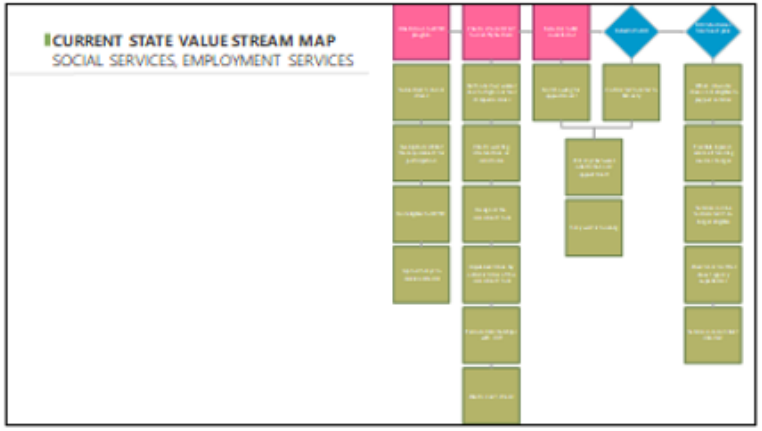
94


CURRENT STATE VALUE STREAM MAP PUBLIC HEALTH STRONG FAMILIES PROGRAM

95


CURRENT STATE VALUE STREAM MAP SOCIAL SERVICES, CHILD WELFARE SERVICES

96


CURRENT STATE VALUE STREAM MAP
SOCIAL SERVICES, EMPLOYMENT SERVICES

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C. Summary of Evaluation Results

1. What did you like MOST about this forum?
    - The setting was very welcoming
    - Simplified complex information
    - Learning about MAT prescriptions, how and why they work
    - Table top discussions and activities
    - Opportunity to network and collaborate
    - Honest, informative and opened up communication in the community
    - Learning about county-wide barriers
    - Team was very capable, knowledgeable
    - Language used was gentle, patient friendly
2. What did you like LEAST? What changes would you recommend?
    - Some information was redundant
    - Too much information about the medications
    - Too many acronyms
    - Got in the weeds too much when discussing future state
    - Assumption that all drug users should and want to change
2. Give an example of something new you learned about addiction.
    - The physiological effects of addiction on the brain
    - Medications used for MAT, including benefits and downsides of each
    - Screening and assessment tools
    - Importance of dopamine
    - Screening process and tools
2. What topics would you like to learn more about?
    - Resources for the those in relationships with people who are addicted
    - Suggestions about building transitions of care
    - Examples of what other counties have implemented to build transitions of care
    - Funding for harm reduction
    - How to support change in the community
    - Emergency overdose response
    - The proper use of naloxone
    - Proper screening tools to use in the clinic
2. Other comments/questions.
    - Distribute some educational materials ahead of the event, including basic information about addiction, screening and assessment.
    - Provide things on tables for people to occupy their hands (play dough, other small toys).

D. Citations

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