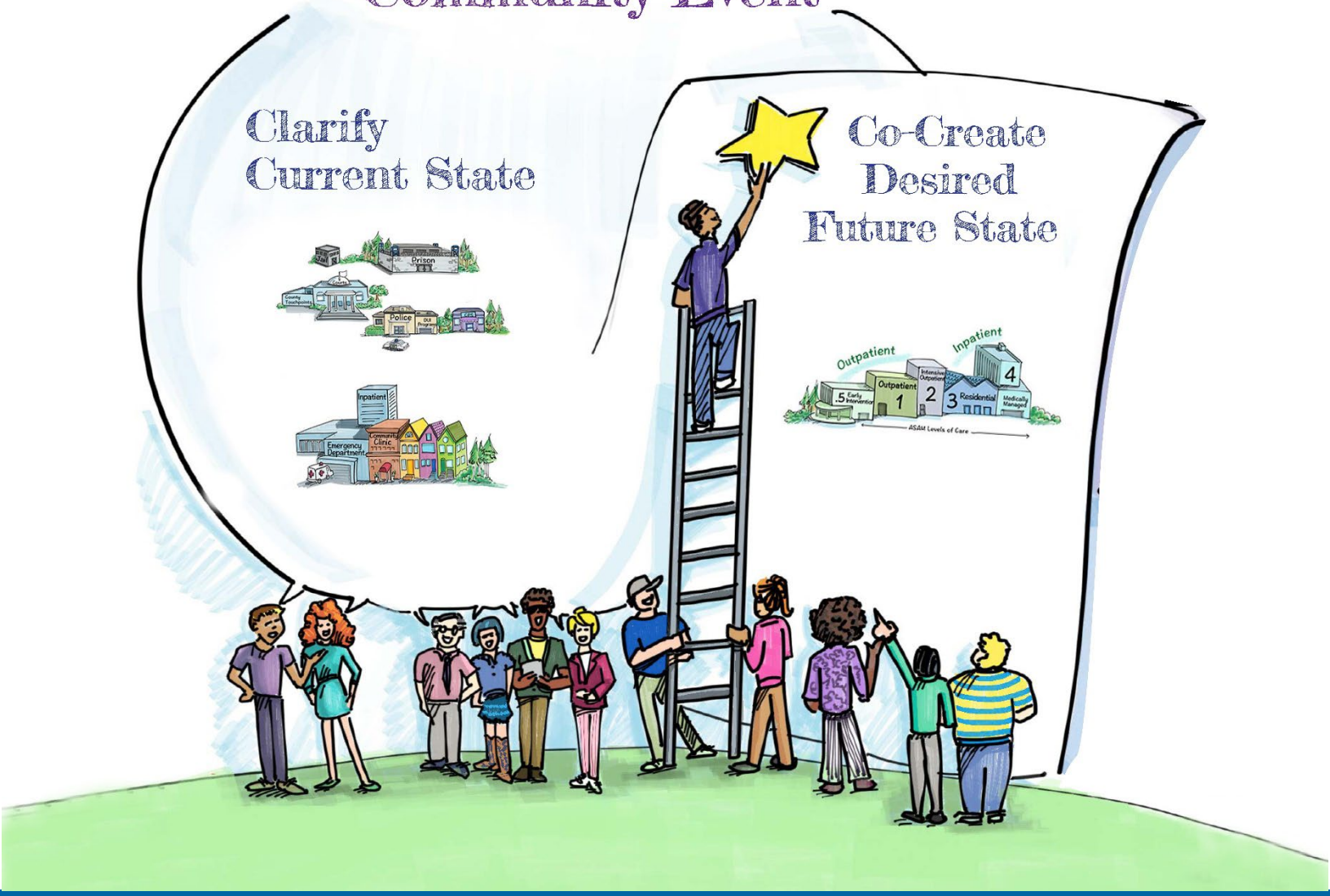
Collaborative Provider Community Event



BUILDING SUSTAINABLE TRANSITIONS OF CARE FOR PEOPLE WITH ADDICTIONS

Orange County Community Process Improvement Event

March 3, 2020

HEALTH MANAGEMENT ASSOCIATES

BUILDING SUSTAINABLE TRANSITIONS OF CARE FOR PEOPLE WITH ADDICTIONS

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HMA
HEALTH MANAGEMENT ASSOCIATES

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The views expressed in written event materials or publications and by facilitators and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

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Executive Summary

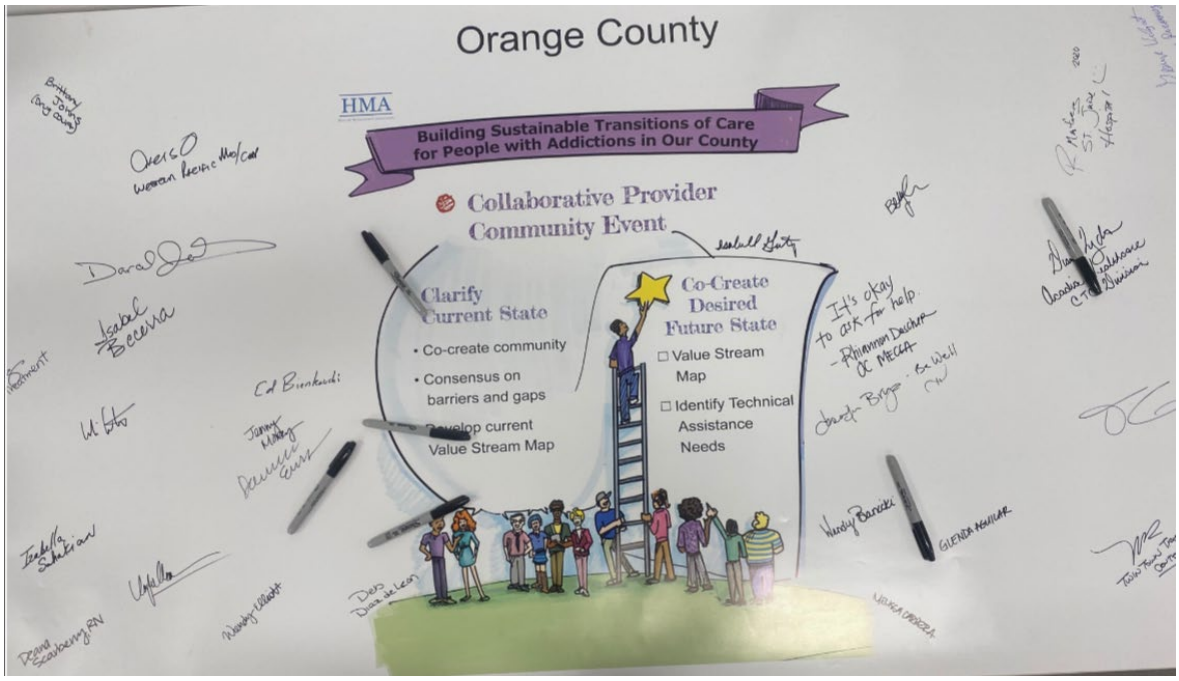
Overdose is the leading cause of accident-related death in the United States. The vast majority of these overdoses come from a combination of prescribed opioids and heroin. As the opioid crisis has worsened over the last ten years, we have reached a point where the treatment system, in its current state, 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 SUDs; 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 SUD 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 SUD treatment. Orange County, one of the ten counties selected, participated in a large-scale process improvement event on September 11th and 12th, 2019 that included members from different aspects of government, healthcare, SUD 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 Orange County residents in need of SUD treatment and support services.

Orange County Behavioral Health, Forensics and Substance Abuse Prevention partnered with HMA to convene stakeholders and examine the disease of SUD and evidence-based treatments, and to conduct an evaluation of the entire SUD treatment system in and around Orange County, CA.

The daylong 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 SUD 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.


Orange County
HMA
Building Sustainable Transitions of Care for People with Addictions in Our County
Collaborative Provider Community Event
Clarify Current State
• Co-create community
• Consensus on barriers and gaps
• Develop current Value Stream Map
Co-Create Desired Future State
☐ Value Stream Map
☐ Identify Technical Assistance Needs

01 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 SUDs, 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 helping communities develope predictable and consistent transitions of care to sustain SUD 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 Orange 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 Orange County, nine other counties were identified as key locations on which to focus these efforts.

The Transitions of Care project engages stakeholders in each selected county in a countywide process improvement event, followed by technical assistance (as needed) 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 Orange County will be eligible to receive individualized technical assistance from a team of national experts covering all aspects of knowledge required to build and sustain an evidence-based SUD treatment ecosystem.

Prior to this event, on September 16, 2019, the Be Well Orange County SUD Leadership Coalition (facilitated by MindOC) held a daylong workgroup session entitled “MAT Referral Pathways”. The event goals were to: 1) develop a vision for an ideal referral to treatment process; 2) map the current referral

pathways for MAT by population type; 3) identify gaps in referral pathways that need to be addressed; and 4) discuss outreach and engagement of new partners to improve the system. Attendees included: Dr. Nichole Quick, Dr. Mario San Bartolome, Mary Vu, Dr. Chun Chaing, Dr Michelle Miller-Day, Ian Kemmer, Deb Diaz De Leon, Michelle McNamera, Iliana Soto-Welty, Dr. Edwin Poon, Ellen Ahn, Dr. Bharath Chakravarthy, Dr. Clayton Chau, Jennifer Brya, and Lauren Brand. To ensure that the Process Improvement Event would build on this effort, HMA met with the organizers to better understand the outcomes of the September 16th meeting, and to discuss and leverage the important, foundational work done at that convening and other related work.

In designing the "Building Sustainable Transitions of Care" session, HMA worked principally with Dr. Nichole Quick and Ian Kemmer from the Orange County Health Care Agency. Collectively, Orange County staff assisted our team in launching the process improvement event as well as the subsequent ongoing technical assistance program. Orange County staff helped identify key stakeholders to engage, conducted outreach, arranged stakeholder discussions and distributed invitations. All organizations took an active role in ensuring the event included stakeholders from all areas of the SUD treatment ecosystem and their leadership set a strong tone of collaboration for the event.

B. County Leadership/ Key Change Agents

- Nicole Quick, MD, MPH, County Health Officer, Orange County Health Care Agency
- Ian Kemmer, LMFT, Division Manager, Adult and Older Adult Behavioral Health
- Clayton Chau, MD, Chief Clinical and Strategy Officer, BeWell/Mind OC
- Jennifer Brya, MA, MPP, BeWell/Mind OC
- Isabel Beccera, Chief Executive Officer, Coaliton of Orange County Community Health Centers
- Mario San Bartolome, MD, Addiction Medicine Specialist

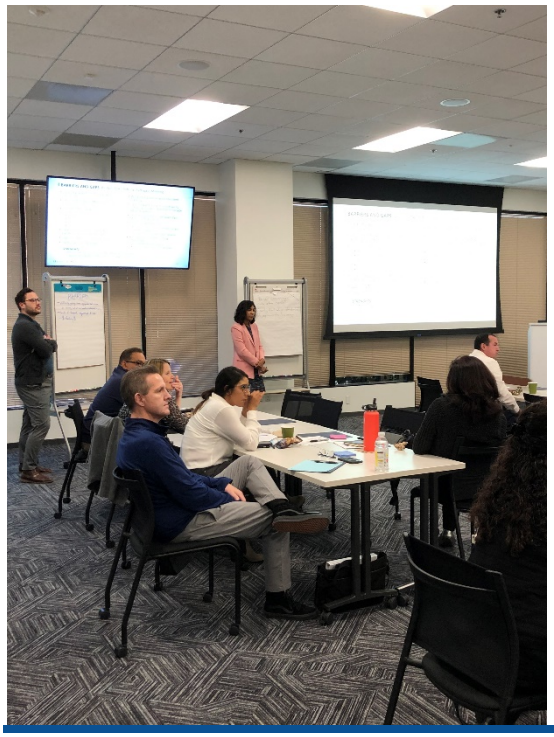
Who Was Involved:

- KCS Health Center
- Telecare AOT
- Orange County Health Care Agency
  - Substance Use Disorder
  - Collaborative Courts
  - Adult and Older Adult Behavioral Health Services
- The Coalition of Orange County Community Health Centers
- Orange County Public Defender
- BeWell/Mind OC
- Mercy House
- Western Pacific Medical Corporation
- California Bridge Program
- Phoenix House
- First 5 Orange County
- St. Jude Medical Center
- Hoag Hospital
- MECCA OC
- Orange County Probation
- FIRN- BreakFreely
- DUI and Drug Court Collaborative Courts of Orange County
- CalOptima
- Twin Town Treatment Centers
- Families Together of Orange County
- StepHouse Recovery
- Acadia Healthcare
- Coalition OC

C. Structure of the Intervention

In advance of the event, HMA worked with the county to electronically and directly gather high-level information on SUD treatment resources and capacity in Orange County. The event built on prior work and discussions that took place in convenings through BeWell/Mind OC, a non-profit dedicated to improving the behavioral health system in Orange County. Participants of the Be Well OC SUD Leadership Coalition identified gaps in the current MAT system, discussed workflows, mapped the funding streams for different levels of care, and began to identify potential outcomes .

This process improvement event included a broader variety of stakeholders who represent different aspects of the SUD space in Orange County: SUD treatment, residential providers, hospital, probation department, behavioral health, public health, people with lived experience, and many others. The morning began with an overview of the epidemiology of the opioid crisis in Orange county. Isabel Becerra, the CEO of the Orange County Coalition of Community Health Centers (COCCC), also provided an update on MATConnect, a new initiative recently funded by CalOptima, the County Organized Health System, to advance the capacity and organization of community organized health centers to deliver Medication Assisted Treatment (MAT) and other SUD treatment. Dr. Helen DuPlessisprovided an overview of the Transitions State Opioid Response (SOR) project and importantly, built a common knowledge base by describing the neurobiological basis of substance use disorder (SUD), and establishing SUD as a chronic medical conditionSUD. The group spent time discussing the role of screening, assessment, and Level of Care determination and the evidence-based tools available for each of these steps, and briefly reviewed the science of Medication Assisted Treatment. Dr. DuPlessis also previewed the goal of the



process improvement event – the development of an enhanced treatment abd recovery ecosystem – and briefly reviewed a scaffold for that future state ecosystem.

In the afternoon, participants Jennifer Brya, of Mind OC, provided an overview of the gaps identified during the Be Well September event. The group added gaps and barriers to that list, and spent time brainstorming potential solutions to the identified gaps and barriers.

Following the barriers, gaps, and solutions discussion, HMA staff described in more detail the scaffolding for a future state treatment and recovery ecosystem that had been built on the east wall of the meeting room. That scaffolding serves as a mapping of the treatment and recovery pathway through the system from a client's node of entry, through identification (through screening), assessment, referral and level of care determination, placement, support and aftercare (including the potential for relapse). Moreover, the scaffolding provided a framework for a brainstorming session about desired features for their enhanced ecosystem. Participants engaged in a small group table top exercise to identify and prioritize features of the future state. At the end of the table top exercise, each group presented their top 2-3 key features, and engaged in discussion to clarify features, and streamline the list to avoid duplication.

It is worth mentioning that the participants in attendance were a particularly engaged group representing a wide cross-section of organizations, departments, decision-makers, doers, and people with lived experience. The future state map was developed based on previously gathered information from in-person meetings, electronic surveys and the real-time input of the . The final list of prioritized key features was printed on post-it notes and positioned in the appropriate location in the future state scaffold. 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.

D. Screening and Level of Care Determination

The Orange County Level of Care Assessment

Orange County is contracted with the state Department of Healthcare Services (DHCS) as a Drug MediCal, Organized Delivery System (DMC-ODS). That contract began in July of 2018. DHCS requires ODS counties to utilize the ASAM criteria for making level of care and placement determinations. Although a number of subcontracts have been signed with SUD treatment providers, the Orange County DMC-ODS network is still being developed. As part of that development, the Orange County Health Care Agency (OCHCA) developed its own tool to meet that states required use of ASAM criteria need for assessing needed level of care (see Section 2 G). Although some commercial drug treatment providers in Orange had previously used the ASAM CONTINUUM and Co-Triage, all providers in the ODS are now required to use the OCHCA assessment tool . The section that follows describes the ASAM criteria in the context of the ASAM assessment tools (CONTINUUM and Co-Triage). While the criteria descriptions are pertinent to this report the County does not use the copyrighted ASAM assessment tools.

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

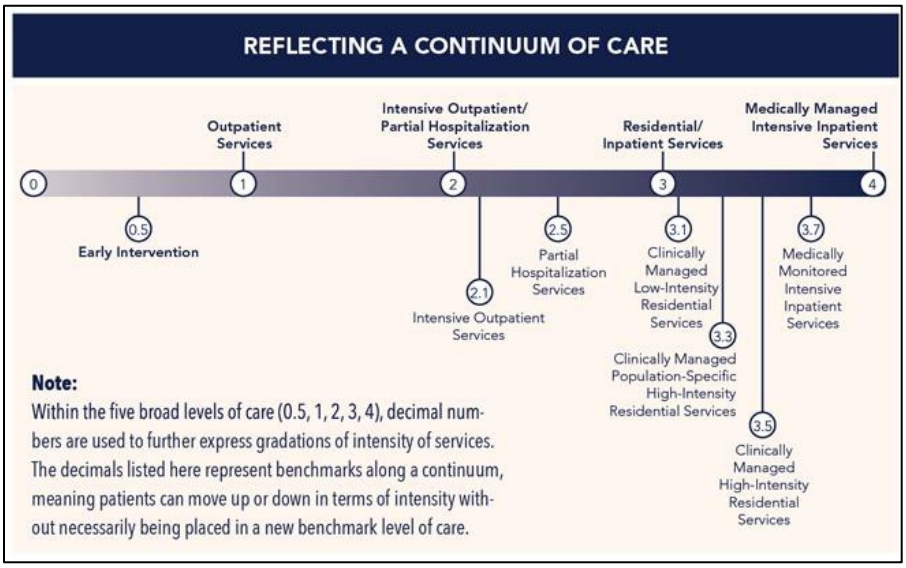
ASAM's criteria, formerly known as the ASAM patient placement criteria, is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-oriented and results-based care in the treatment of SUD. Today the criteria have become the most widely used and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

02 Section 2: Event Results

A. Gaps and Barriers – Inventory and Discussions

While there is much good work and effort happening in Orange County to address SUD, stakeholders agreed there were many challenges, particularly around stigma, staffing, and funding. The group started by going over a list of gaps and barriers identified during the September, 2019 Be Well OC SUD Leadership convening:

- Lack of prevention strategy and resources
- Lag in reactivation of Medi-Cal enrollment for re-entry populations
- Limited MAT Capacity
    - Beyond Methadone
    - Expansion strategies
    - Payor agnostic
    - No community-defined targets
    - Long wait times
- Lack of resources to which patients desiring or already on MAT can be transitioned
- Gaps in DMC-ODS service levels
- Data-sharing challenges
- Workforce pipeline and consistent training
- Lack of health system incentives to sustain provider interest and manage adverse selection
- Lack of coordination between Pain Mgmt, OTP and PCPs
- Financing and Payment
    - No enhanced reimbursement (or any APM) strategies
    - Support for specialty MAT network
- Recovery Ecosystem Cultural Challenges
    - Social Model dominance
    - Limited harm reduction services

The group then brainstormed additional gaps and barriers.

Identified Gaps/ Barriers

- Limited treatment capacity: real time access is limited for everyone, waitlists are impacted (including re-entry popoulations which have increased as OC Jail and Drug clinics embrace use of MAT)

- Significant challeneges with ransitions of care past at many levels:
    - Transitions after detox
    - Inadequate discharge planning, communication and coordination for clients leaving corrections
    - Difficulty getting clients appropriate level of care or raising level of care based on understood acuity
- Lack residential treatment facilities, especially inpatient facilities
    - Consequently, Patients are often subjected to longer stays in NTPs
    - Limited medical detox facilities
- Stigma (personal and institutional)
- Non-standard treatment protocols promoted or sanctioned by providers and medical directors
- Embedded Social Model/abstinence-only culture
- Variation in intake and treatment protocols and m essaging
- Reactive/defensive providers and staff
- Inadequate of funding (DMC-ODS)
- Providers are risk-averse and reluctant both to care for this population, and to prescribe MAT (i.e., there are far more X-waivered providers than those presecribing MAT)
- Medi-Cal enrollments/re-instatement barriers for re-enty clients
- Not enough data / tracking of access and utilization at multiple levels of care
- Lack of trust between providers/ state/ county
- Lack of updated directory for support resources
- Lack of by commercial insurance coverage for MAT
- Lack of support for families/ children impacted by OUD/ SUD
- Inadequate housing capacity (e.g., sober living)
- Lack of knowledge of MAT with juddges/court system – leads to antiquated sentencing based on abstinence only model of treatment
- Lack of support between treatments (i.e. no recovery support program similar to those on the mental health side)
- Agency siloes undermine system future state planning and care coordination
- Lack of standard requirements of care
- Funding
- Need critical mass of providers to effect change

Identified Solutions

- Build more capacity at higher levels of care
- Staff training on standardized messaging
- MDI model: managing daily improvement
- Integrated communication/ information sharing system across entire system
- Better data collection, analysis and information sharing
- Up-to-date rsource directory/database
- Support pregnant/parenting population in CPS
- Housing resources for those on MAT
- More opportunities for convening system providers

- Community support for residential treatment (e.g., stigma abatement, and county-level leadership to promote this)
- Regular convenings of Be Well OC
- County facilitated standardization of requirements/ messaging
- Value-based payments to improve quality of care

B. Future System Goals

During the afternoon, the participating organizations began to think about moving from their current state to an improved future state of the SUD treatment and recovery ecosystem. Stakeholders participated in small group discussions at their tables and were asked to identify a few key features that they most desired in a future system. The term "features" were defined as the characteristics, attributes or substructures of the key components of the treatment and recovery ecosystem (e.g., a key feature of the referrals process would be to have a centralized appointment slot/bed locator).

In order to build consensus across the small group discussions and create one list of ideal future system features, each small group chose two key features from their discussion to share with the larger group. The following list describes the top elements that stakeholders prioritized as most desirable in the future ecosystem of care:

- More collaborative information and education shared between agencies and community providers on how to access services within the Health Care Agency.
- Providers and staff trained in Traumainformed care practices
- Coordinate payor sources (e.g., DMC-ODS, CalOptima, others)
- Create pipeline and retention of workforce
- Better data sharing
- Ability for providers to sign patients up for emergency Medi-Cal (e.g., like Gateway program for children)
- Computerized screening and assessment tools to identify risk with auto-release of information (or other mechanism for streamlined consents)
- Streamline time frame for the screening and assessment (especially for assessment)
- 24/7 treatment access regardless of coverage
    - Simplify accessibility
    - On demand treatment
- Identify and meet consistently with key stakeholders to improve connectivity of referral sources

- Standard of care across the continuum of care including common metrics for accountability
- Change contracting model to encourage performance-based payment (i.e., for quality and outcomes)
- Adopt a principle of Housing 1st (transition, quality, and continuing treatment)
- Coverage portability across counties
- Improve coverage and benefits to allow for extended treatment (especially in cases of suspended treatment that "uses up" one of the 2 annual stays, and increase the annual benefit to 2 – *90*-day stays, rather than 60-day)
- Mobile MAT
- Advocate for state licensure and oversight of recovery homes (e.g., SLEs)
- More residential treatment resources
    - More residential treatment beds (especially ASAM 3.5)
    - More residential for pregnant and parenting women

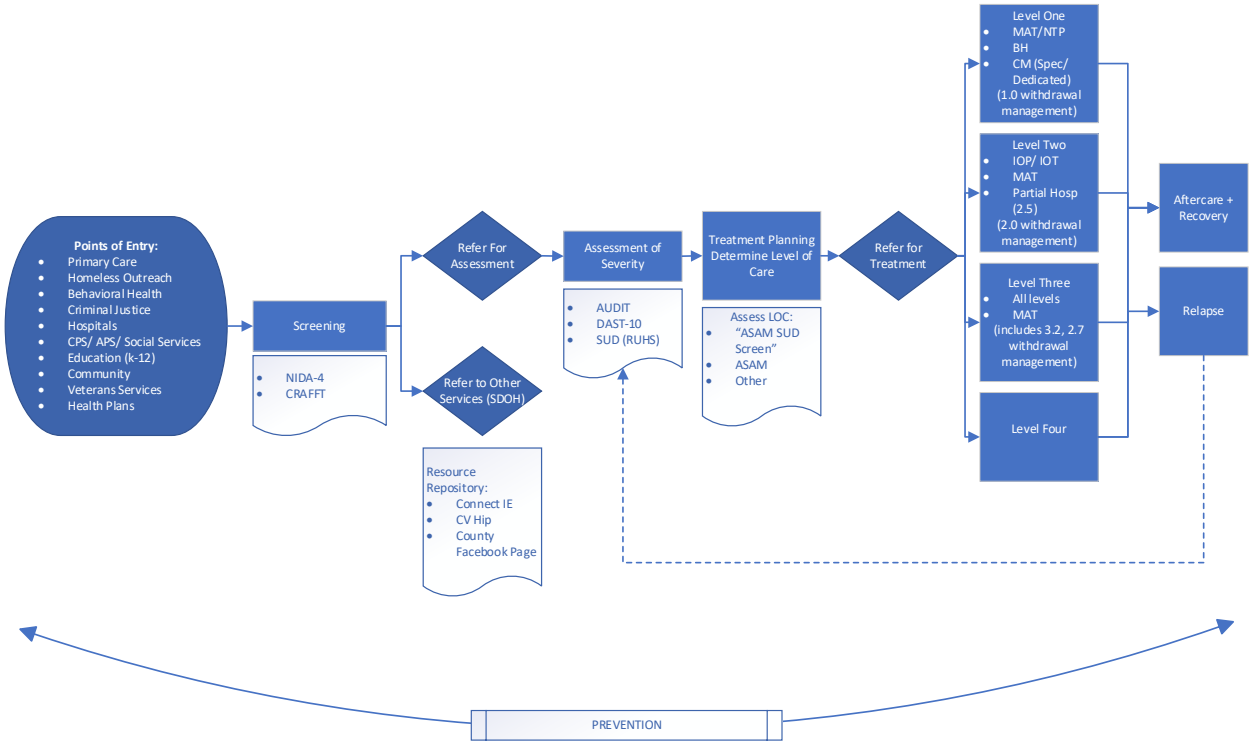
C. Triggers

Given that ubiquitous screening for substance use disorders is aspirational at this point in the development of county treatment and recovery ecosystems, HMA recommends that counties recognize and use "triggers" as other opportunities to determine when a given individual would be assessed for the severity of SUD. Triggers may be direct and unequivocal, such as an overdose episode, or a DUI arrest, while other triggers may be indirect, such as Child Protective Services reports of neglect, or frequent refills on opioid prescriptions. Whether the triggers are direct or indirect, they should motivate an assessment for diagnosis and severity of SUD (the trigger itself is an indication of risk factors, but a screening may still be warranted as a means to begin a motivational type conversation). Likely triggers include:

- Overdose (OD) episode
- DUI arrest
- High Intoxication
- Needle marks, abscesses complicating injection sites
- Positive screen via NIDA 4
- Arrest – for jails specifically

D. Building the Future State from the "Scaffolding"

After prioritizing the initial set of key features as a group, stakeholders moved into actually mapping out the process and structure of an ideal future state treatment and recovery ecosystem. With the understanding that there is some variation in process based on stakeholder type, Dr. DuPlessis guided the full group through mapping out the future state by building on the foundational scaffolding. The "scaffolding" is the basic structure or framework of the ecosystem and includes those elements and processes that are common across all programs and locations of service encountered by a patient with substance use disorder, and can be adapted and built upon in each stakeholder's unique program or setting.



In the ideal future state of the Orange Treatment and Recovery ecosystem participants recognized the need and desire for a "no wrong door" approach to those with SUD and identified a number of likely points of entry, such as those listed below:

- Primary Care: FQHCs, county health programs and clinics, private practice settings
- Criminal Justice: jail, courts, parole, prison, law enforcement workforce
- Educational Institutions: K-12 Schools, higher education settings
- Social services
- Health plans
- Community based organizations and programs: Homeless outreach, Faith-based settings
- Hospitals: emergency departments (with and without BRIDGE programs), inpatient wards
- Child and Adult protective services
- Group homes
- Behavioral health programs: public and private
- Recovery and aftercare and programs outside of the DMC-Organized Delivery System: 12-step Program, sober living and other aftercare settings
- Veterans Services: VA Hospital, Veterans' court, military diversion
- Family

The group also expressed two important desires regarding the screening, and we established the definition thereof as the identification of risk factors for substance use disorder that point to the need for a brief intervention or further assessment to determine if an individual should be diagnosed with SUD and referred for treatment. The first related to the need to establish a universal screening practice across all sight in the ecosystem. This is important in the County's desire to identify as many individuals with SUD or OUD as possible and link them to treatment, because if they are not identified, the

likelihood that they will seek treatment on their own is limited. The second desire was to establish consensus on a universal tool (or perhaps a limited number of tools in the event there is a need for a different validated tool for special populations such as pregnant women or teenagers) so that: 1) familiarity and routine use increase the use across all sectors and points of entry; and 2) the workers across the entire ecosystem understand and can easily interpret the results of screening. Among the likely candidates are the NIDA Quick Screen, the 4 Ps Plus (for pregnant women), and the CRAFFT for teenagers.

Once the screening occurs, the next step in the scaffold flow is referral for an assessment, that is, a more detailed evaluation undertaken to establish the presence and severity of the disease (i.e., OUD, SUD). As with process and tools for screening, the groups are interested in establishing the use of a common tool and the routine of performing assessments. Potential candidates include the (NM)ASSIST, the AUDIT (which only assess alcohol misuse) and the DAST (10). At the same time a diagnosis of SUD or OUD is being made, individuals may benefit from referrals related to other social determinants of health or which address persistent adverse childhood events (ACES) that may demand attention (especially in light of the Governor's recent allocation of $40 million to encourage ACEs screening of adults and children). The development of a treatment plan and an assessment of the level of care required by the affected individual are the next steps in the pathway through the treatment and recovery ecosystem. As mentioned previously, counties that are contracted with the Department of Healthcare Services (DHCS) as a Drug Medi-Cal Organized Delivery Systems (DMC-ODS)are required to use of a level of care determination that encompasses the criteria developed by the American Society of Addiction Medicine. Orange County created their own tool for this purpose

Although this was not discussed in any detail at the process improvement event, it it worth reminding the reader that DHCS requires that all individuals administering an ASAM screening have undergone two levels of training in using the ASAM criteria: training in the criteria, and training in administration of ASAM proprietary tools (even if the county is not using those tools).

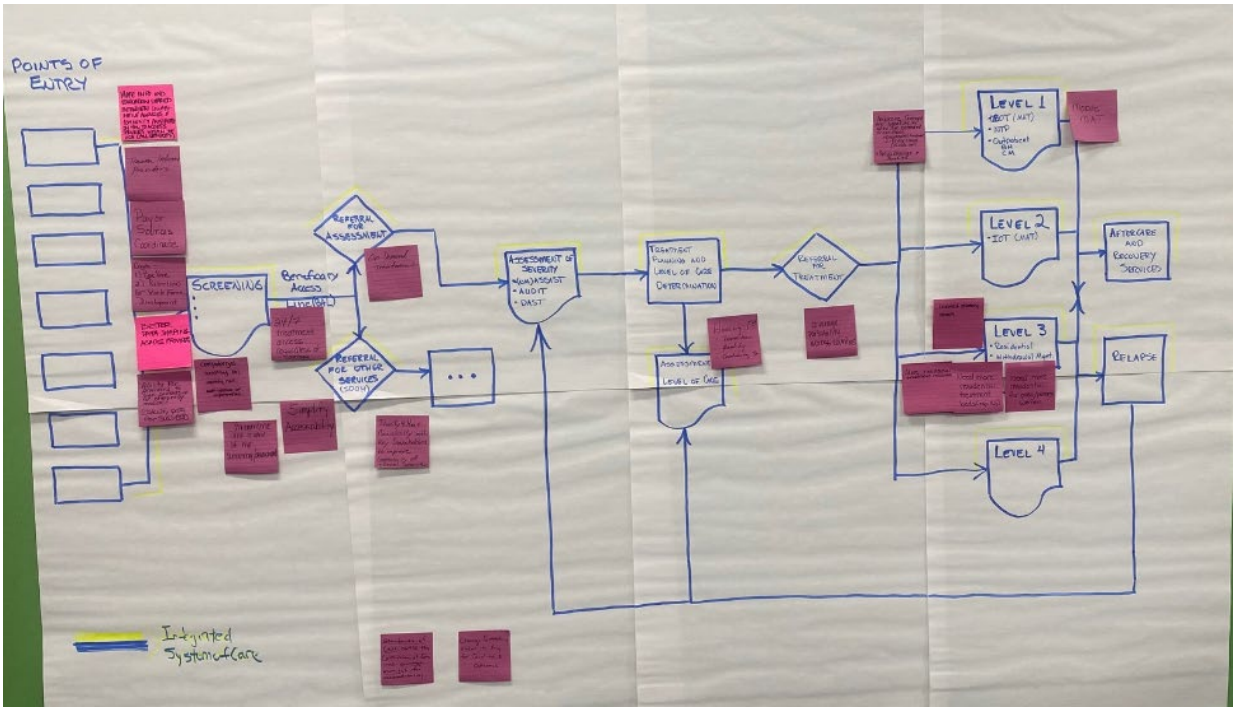
With the establishment of the DMC-ODS contract, Orange County now has treatment services in Level 1, 2 and 3, with additional services being developed in the near term. Moreover, Orange Health Care Agency operates the Beneficiary Access Line (800-723-8641), available 24 hours a day, 7 days per week, which serves as a central locator of available treatment and recovery appointment resources within the OCHCA.

At present, Orange County has treatment programs at ASAM level 1 through 3, with limited services at level 3 and no medical detox services. There are no plans for level 4 services inside of Orange County in the near future. It is not unusual for an individual to move between levels of care, however, in an ODS when that occurs there is a need to meet medical necessity criteria for the level to which an individual is moving or being referred.

The final activities in the treatment and recovery ecosystem involve aftercare and recovery continuation services such as sober living and other supportive housing arrangements, support groups, job training and placement and other recovery services. And because SUD is a chronic condition, relapse is a common occurrence that should be confronted with compassion and understanding rather than derision. The response to relapse may vary depending upon the cause or stimulus for the relapse, but in all cases, there should be a reassessment of disease severity and level of care required to address the

needs of the individual with SUD as they get plugged back into an appropriate setting and the overall flow of the ecosystem.

At the end of the session, the group connected the key features they had prioritized (listed in section E) back to the diagram of the ideal future state they had created in the previous discussion. It is worth noting that there was a general consensus that the entire system should adopt and integrated systems of care model, engaging medical, behavioral health, and SUD providers and principles in an integrated manner at every point along the treatment ad recovery ecosystem path. Participants wrote down the key features on post-it notes and affixed them on the section of the diagram to which they best corresponded:



03 Section 3: Implementation Strategy

A. Next Steps

In a matter of one day stakeholders from across Orange County were able to identify major aspects of the systems that touch patients with SUD, determine what the major gaps and barriers are, and develop a viable future state "scaffolding". It may be worthwhile for all sectors in the system to map the current state of their sector-specific processes and programs, so they ae better able to lay out startegies and implementation plans to move to the future state embraced by participants. That ideal future state treatment and recovery ecosystem in Orange County would include:

- Standardized screening pathways with integrated (collocated) behavioral health and substance abuse counselors in medical settings to increase screening and identification of those in need of services
- Smooth the journey through the treatment and recovery process by ensuring universal training in motivational interviewing and stigma reduction across all sectors to ensure that those engaging patients can optimallyfacilitate service access and utilization
- Streamlined, on demand access to all levels of care that would be facilitated by a 24/7 central locator systems that encompasses all treatment providers (whether or not they are DMC-ODS subcontractors), mobile clinics staffed with clinical providers able to prescribe MAT, better communication, streamlined and standardized movement of protected patient health information across the systemBetter coordination across sectors to ensure commitment to the development of the future state system, agreement on common outcomes and data capture measurement to ensure accountability and track progress. Special attention should be focused on developing better transitions of care, especially for: the re-entry population; clients moving between levels of care; clients completing detox; Bridge clients,
- Building capacity in the DMC-ODS system by adding more contractors at every level of care, but particularly for level 3 and 4 (and withdrawal amanegement, in general)
- Better coverage of treatment and recovery services that would be facilitated by easier coordination across payors, portability of coverage across counties, and expansion of the Medi-Cal residential treatment benefit to 2-90 day episodes of care
- And other features, such as, user-friendly digital/electronic versions of screening and assessment tools, more peer support, housing and transportation services to meet the needs of those for whom transportation is a challenge.

All the information in the preceding critical developmental sections of this report resulted from the generous participation of individuals and institutions who deliver care or are otherwise invested in SUD treatment in Orange County. At the end of the meeting Iam Kemmer and Dr. Clayton Chau laid out a strategy for monthly convenings of key stakeholders (most of whom were present at this meeting) as evidence of their commitment to advance the movement toward the future state treatment and recovery ecosystem .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 Orange County Behavioral Health to develop an attendee list and conduct broad outreach to invitees to encourage attendance. At the event, one "champion" per organization/team completed a paper technical assistance (TA) application with guidance from the Southern California Team Lead (Charles Robbins). 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 SUD 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 SUD 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 SUD treatment to pregnant and parenting women.

HMA will match subject matter experts (SMEs) with entities to provide specific topic support. Generalized TA offerings are also available, and include live and recorded webinars and access to a variety of resources on the Transitions of Care project website, AddictionFreeCA.org. Anyone may submit a specific TA request through the TA request portal on the AddictionFreeCA.org website. Organizations/teams can move to different tracks as their goals change.

During the process improvement event, the following 11 organizations applied for TA:

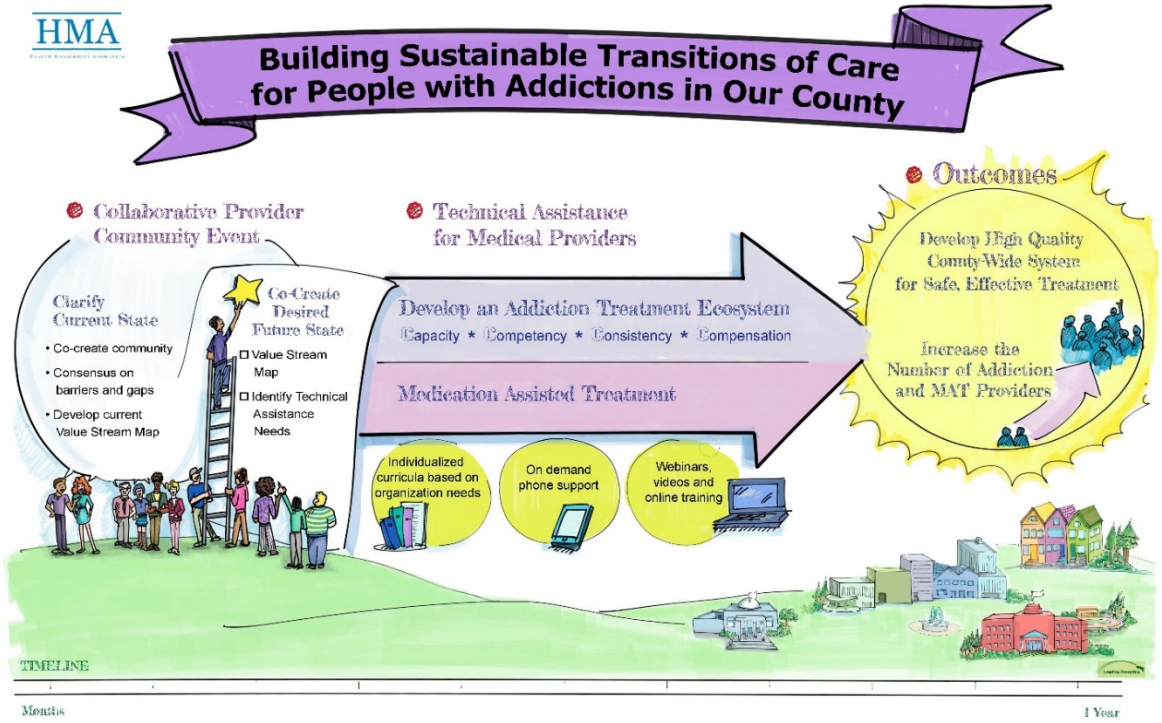
- Telecare
- Telecare AOT
- Hoage Memorial Hospital
- StepHouse Recovery
- Health Care Agency
- St. Jude Medical Center
- Families Together of Orange County
- Western Pacific Med/Corp
- Mind OC (Be Well OC)
- Orange County Probation Department
- Orange County Coalition of Community Health Centers

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

Goal	Frequency
Learn more about caring for people with SUD and provide more information and training to our staff.	6
Learn more about how our organization can participate in a community wide solution to the opioid epidemic.	7
Improve our role in managing the transitions of care as residents in our community move within SUD system of care.	9
Learn how to provide or improve SUD treatment to pregnant and parenting women.	4
Start providing MAT services at our organization.	2
Scale up our current MAT program by increasing the number of patients treated.	5

C. Conclusion

In conclusion, HMA thanks the Orange County community who turned out with their hearts and minds committed to this work. We hold the deep conviction that the Orange County community and stakeholder coalition of SUD 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 Orange County Behavioral Health 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 SUD, better care for the community members suffering from this disease and eliminate SUD related deaths in the County.



Appendix

A. Orange County Data

ORANGE COUNTY: POPULATION 2,189,641

STATISTICS

- OUD Death Rate
  - 2017: 5.7, Rank 6/9
  - 2016: 4.6, Rank 7/9
- All Drug Death Rate
  - 2017: 16.6, Rank 1/9
  - 2016: 14.3, Rank 4/9
- ED Opioid Rate
  - 2017: 22.7, Rank 6/9
  - 2016: 23.8, Rank 5/9
- 18 Hospitals
- 250 Pharmacies
- 4 FQHCs
- Methadone Pt Rate 61 : Rank 25/58

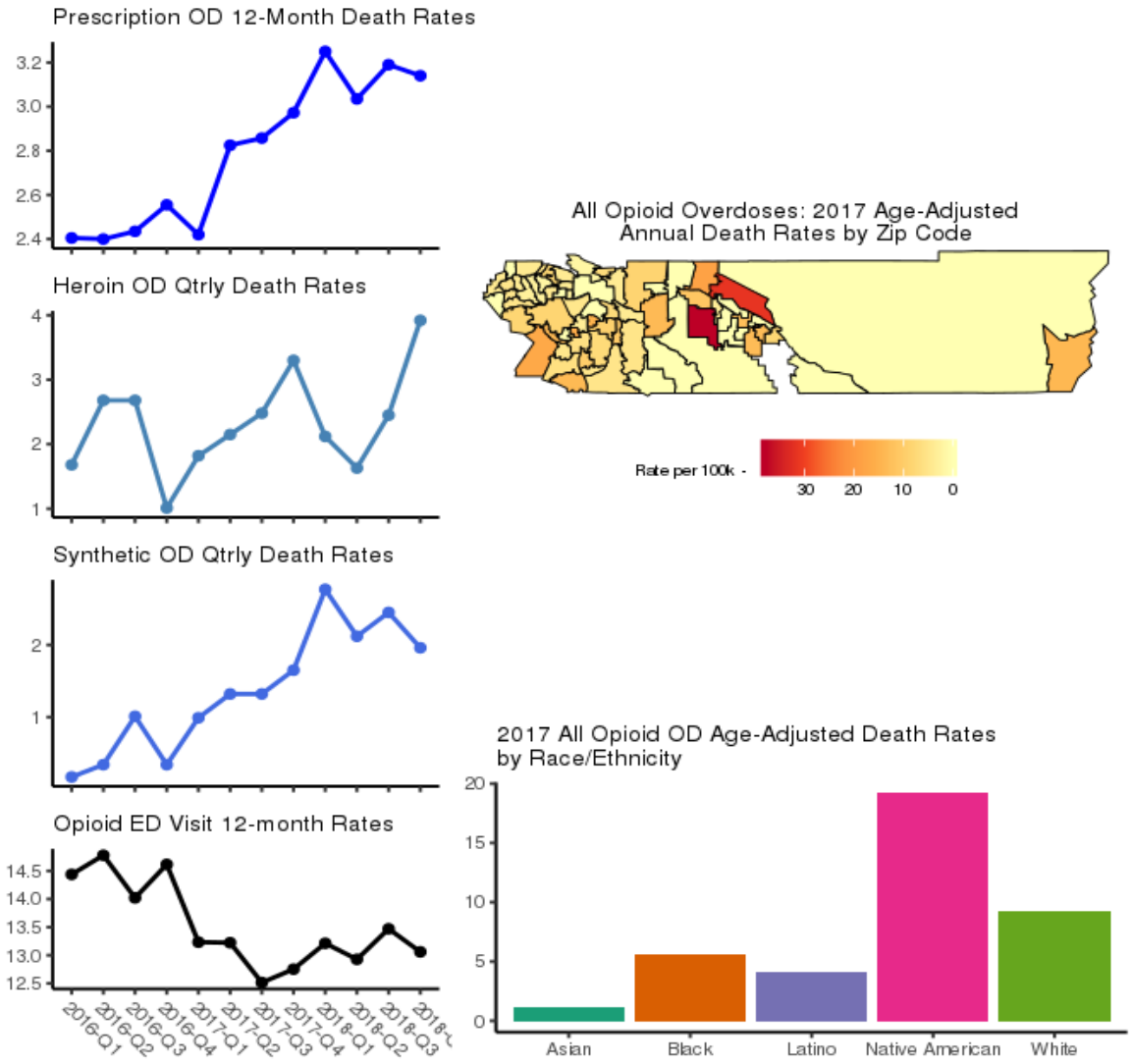
ADDITIONAL FACTORS

- Coalition: Inland Empire Opioid Crisis Coalition (IEOCC)
- SAMHSA Funds: $797,853
- Drug Medi-Cal Organized Delivery System: Yes
- Presence of CA Bridge: Yes

Orange Opioid Overdose Snapshot: 2016-Q1 to 2018-Q4

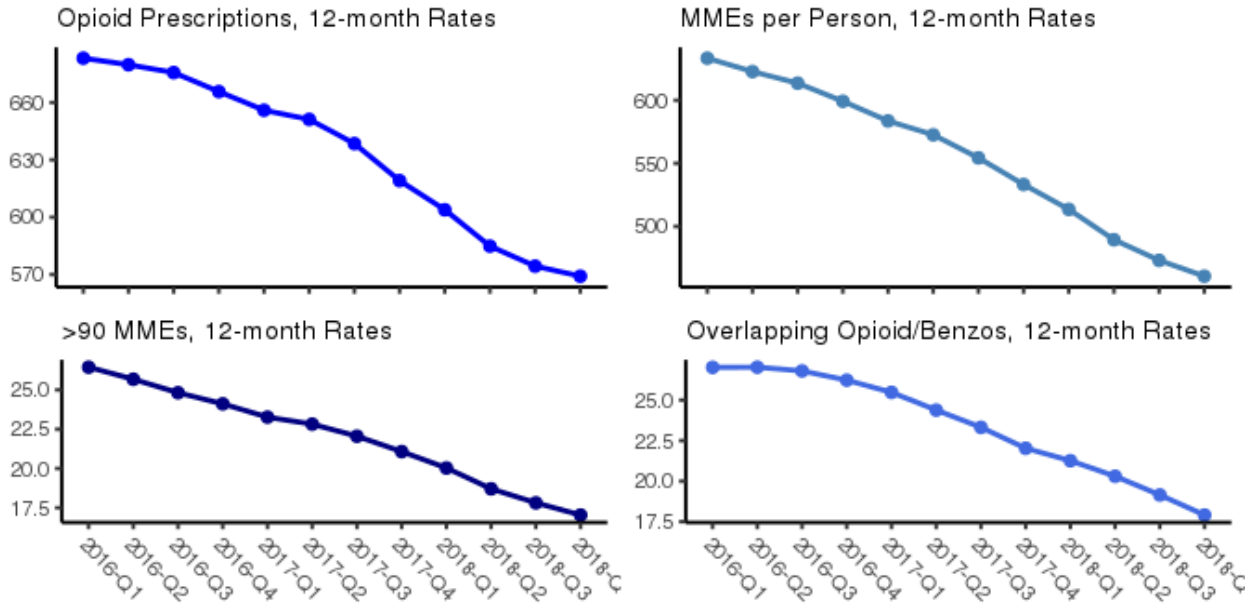
Report downloaded 09-12-2019

Orange experienced 140 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 5.7 per 100k residents. This represents a 19% 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.



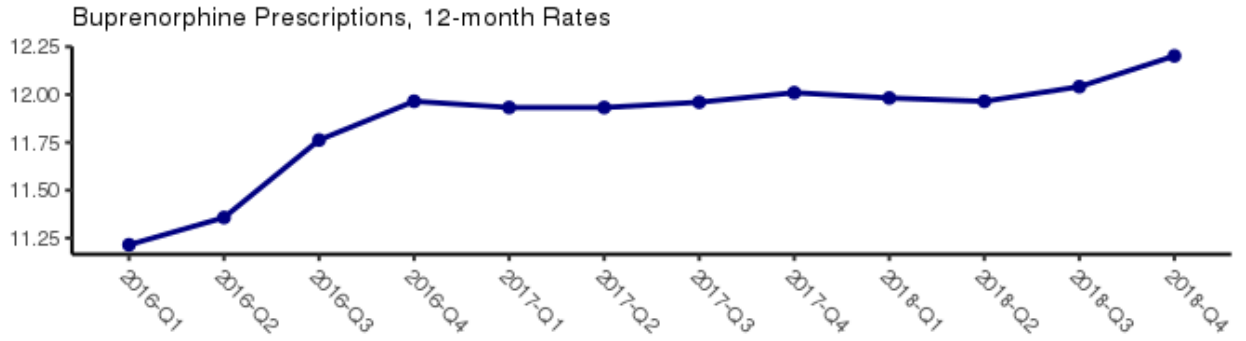
Prescribing

There were 1,500,256 prescriptions for opioids in Orange in 2017, excluding buprenorphine. The annual prescribing rate during that period was 574.4 per 1,000 residents. This represents a 14% 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 12 per 1,000 residents. This represents a 1% 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

HEALTH MANAGEMENT ASSOCIATES

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

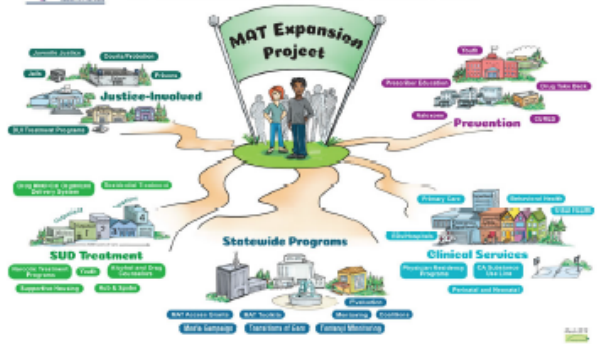
September 11 & 12, 2019

DHCS
California Department of Health Care Services

Funding for this event was made possible [in part] by H79TI081686 from SAMHSA. The views expressed in written event materials or publications and by facilitators and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

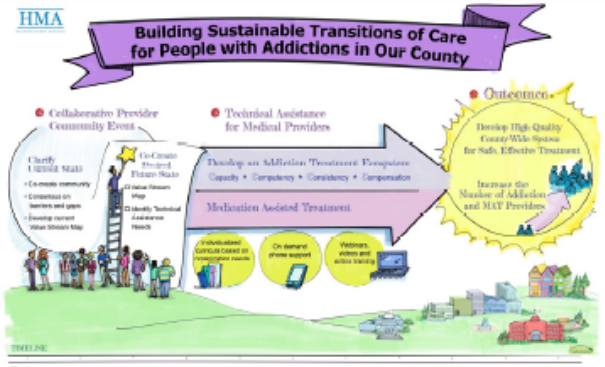
SAMHSA MAT EXPANSION GRANT

In California, Treatment Starts Here



HEALTH MANAGEMENT ASSOCIATES 2

HMA TRANSITIONS OF CARE PROJECT



HEALTH MANAGEMENT ASSOCIATES 3

AGENDA

DAY ONE	DAY TWO
Morning Session	**Morning Session**
+ Why are we all here?	+ MAT Basics
+ Addiction 101	+ Screening, Assessment and Levels of Care
+ Addiction Treatment Ecosystem	+ Future State Features
+ Barriers and Gaps Conversation	
Afternoon Session	**Afternoon Session**
+ Current State Value Stream Mapping (VSM)	+ Future State Key Features Table Top
+ Current State Group Presentations	+ Future State Mapping
+ Barrier Identification and Resolution	+ Next Steps
+ Future State Set-Up	

HEALTH MANAGEMENT ASSOCIATES 4

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.

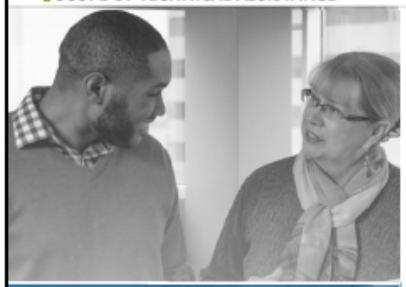
HMA will strengthen addiction treatment practice methods through comprehensive technical assistance that increases the level of local expertise available, establish a system-wide understanding and use of best treatment practices, and establishes a shared vernacular.

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

SCOPE OF TECHNICAL ASSISTANCE



WHAT DOES TECHNICAL ASSISTANCE MEAN FOR PARTICIPANTS?

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

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

6

COUNTY SELECTION DATA POINTS CONSIDERED

NEED

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

READINESS

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

OTHER CONSIDERATIONS

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

HEALTH MANAGEMENT ASSOCIATES 7

RIVERSIDE COUNTY: POPULATION 2,189,641

ADDITIONAL FACTORS

- Coalition: Inland Empire Opioid Crisis Coalition (IEOCC)
- SAMHSA Funds: $797,853
- Drug Medi-Cal Organized Delivery System? Yes
- Presence of CA Bridge: Yes

STATISTICS

- OUD Death Rate
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- ED Opioid Rate
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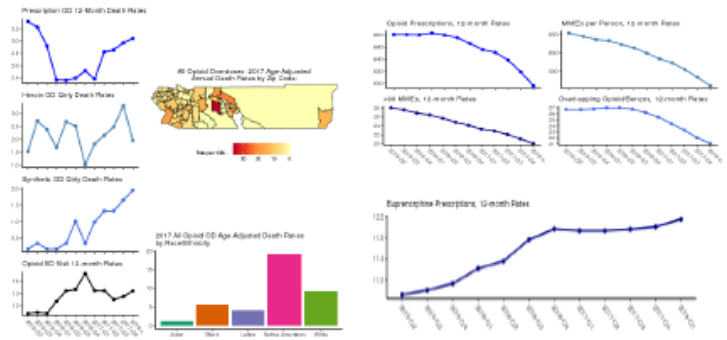
- 250 Pharmacies
- 4 FQHCs
- Methadone Pt Rate 61 : Rank 25/58

HEALTH MANAGEMENT ASSOCIATES 8

RIVERSIDE COUNTY: POPULATION 2,189,641



HEALTH MANAGEMENT ASSOCIATES 9

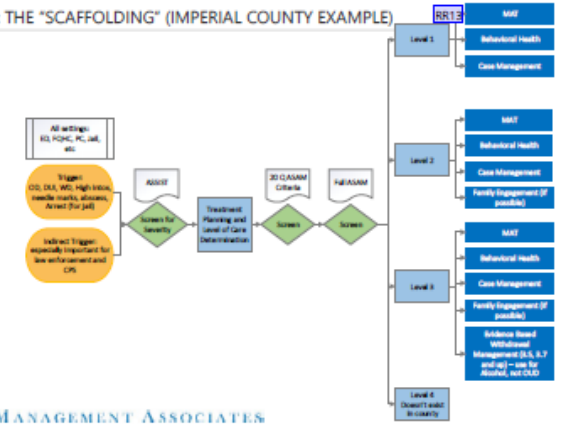
Healthcare in the US

HEALTH MANAGEMENT ASSOCIATES 10

WHAT IS OUR GOAL FOR BEING HERE TOGETHER THE NEXT TWO DAYS?

HEALTH MANAGEMENT ASSOCIATES 11

PREVIEW: THE "SCAFFOLDING" (IMPERIAL COUNTY EXAMPLE)



HEALTH MANAGEMENT ASSOCIATES 12

ADDICTION 101 – THE PROBLEM

What is Addiction?

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

HEALTH MANAGEMENT ASSOCIATES 13

ADDICTION 101 – HOW DID WE GET HERE?

Push by manufacturers

Poor acute and/or chronic pain management theory

Distribution of huge amounts of medication

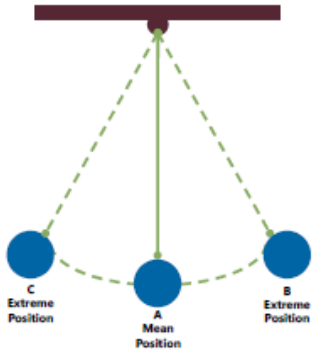
Increased prescribing of opioids
+Pain as 5th vital sign
+Expectation of no pain

Massive amount of prescriptions filled by pharmacies

Blind eye to the data

HEALTH MANAGEMENT ASSOCIATES 14

ADDICTION 101 – SAFE OPIOID PRESCRIBING



HEALTH MANAGEMENT ASSOCIATES 15

IS ALL ADDICTION THE SAME?

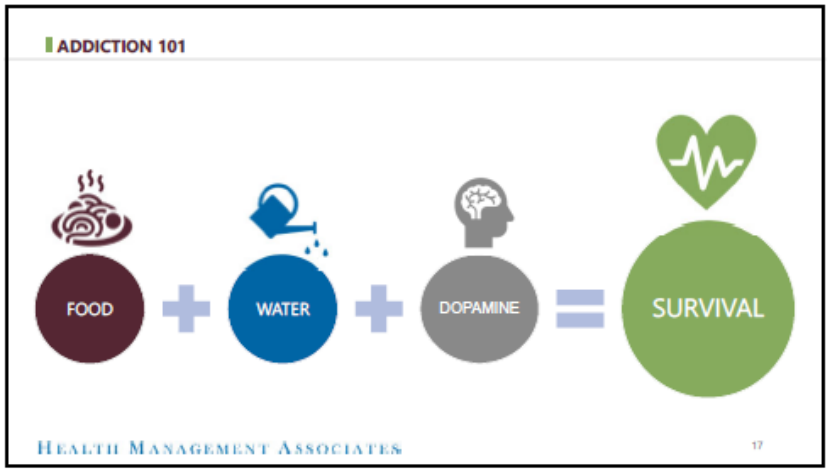
Patient 1

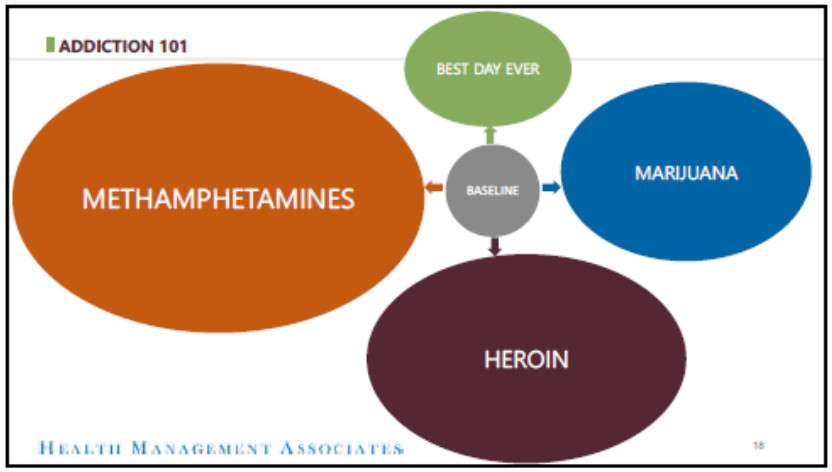
- Early life trauma
  - Neglect
  - Sexual assault
- Isolation from friends
- Early use of marijuana
- Heavy episodic drinking in early high school
- Opioids at 19 y/o
- Heroin at 22 y/o

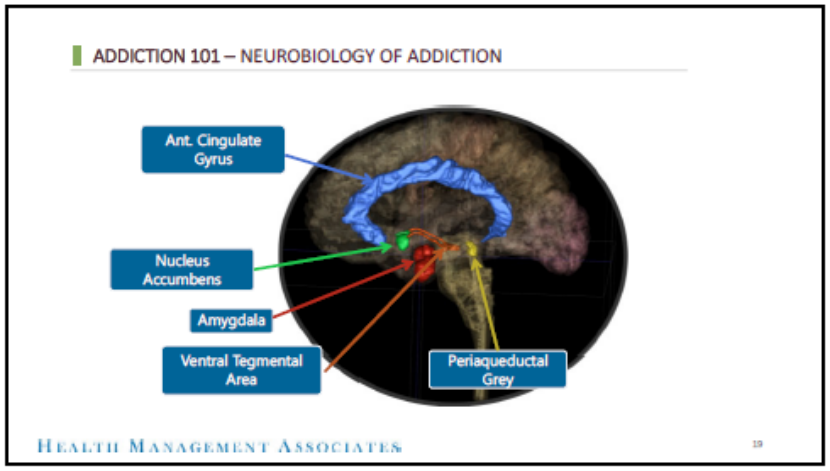
Patient 2

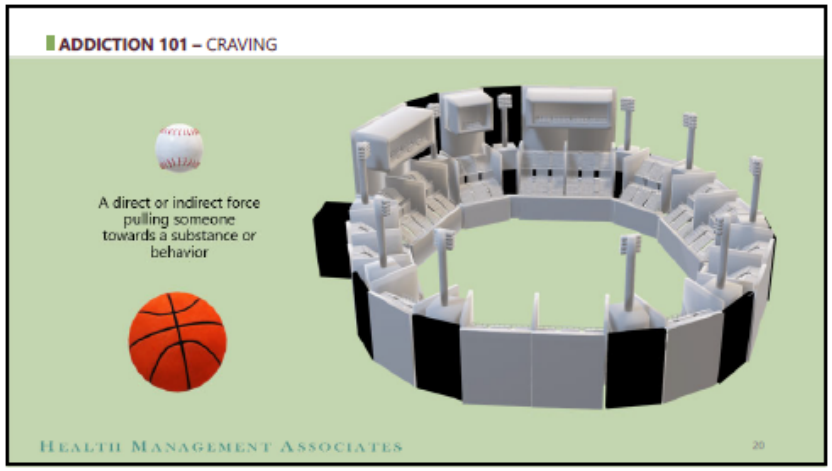
- Parents divorced and had shared custody
  - No neglect
  - No assault
- Lots of friends
- Tried MJ once in HS, used couple times per month in college
- Episodic binge drinking in college
- Finished college
- Went to medical school
- Given naloxone in the resident call room

HEALTH MANAGEMENT ASSOCIATES 16

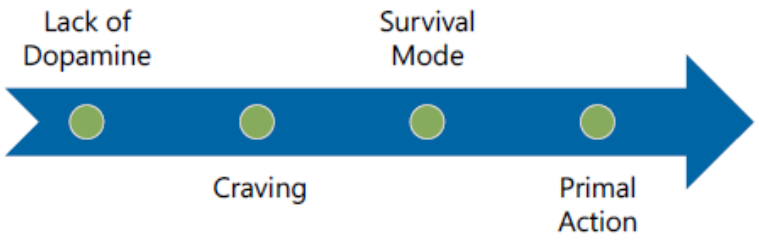

ADDICTION 101
FOOD
WATER
DOPAMINE
SURVIVAL
HEALTH MANAGEMENT ASSOCIATES
17


ADDICTION 101
BEST DAY EVER
METHAMPHETAMINES
BASELINE
MARIJUANA
HEROIN
HEALTH MANAGEMENT ASSOCIATES
18


ADDICTION 101 – NEUROBIOLOGY OF ADDICTION
Ant. Cingulate Gyrus
Nucleus Accumbens
Amygdala
Ventral Tegmental Area
Periaqueductal Grey
HEALTH MANAGEMENT ASSOCIATES
19


ADDICTION 101 – CRAVING
A direct or indirect force pulling someone towards a substance or behavior
HEALTH MANAGEMENT ASSOCIATES
20

ADDICTION 101 – BEHAVIOR



HEALTH MANAGEMENT ASSOCIATES 21

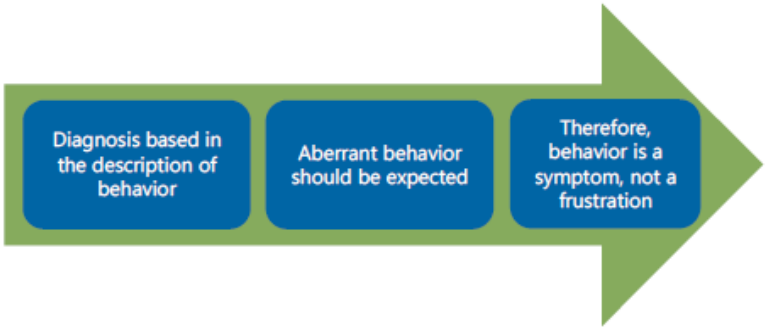
DSM-5 DIAGNOSIS OF OUD

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

HEALTH MANAGEMENT ASSOCIATES 22

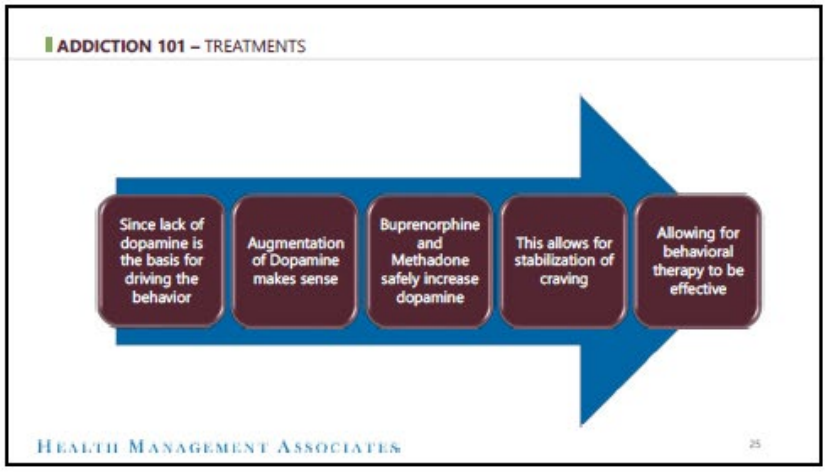
ADDICTION 101 – BEHAVIOR

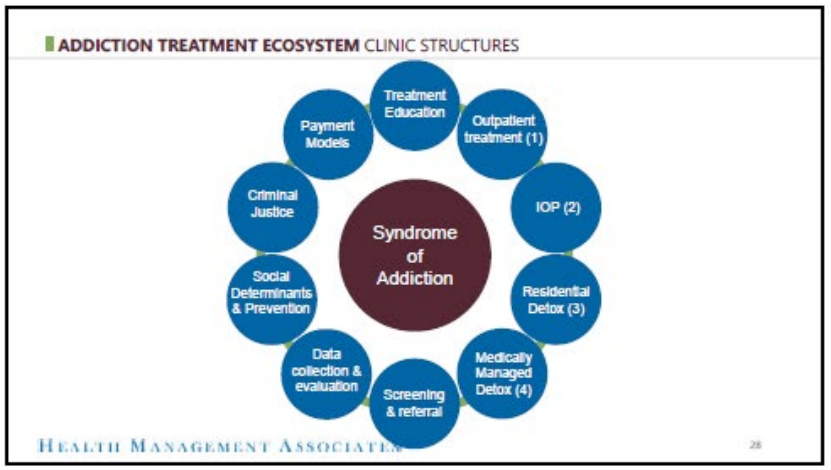


HEALTH MANAGEMENT ASSOCIATES 23

ADDICTION 101 – RELAPSE

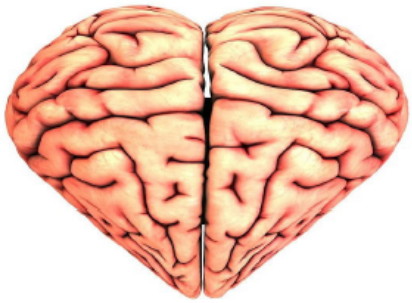
HEALTH MANAGEMENT ASSOCIATES 24


ADDICTION 101 – TREATMENTS
Since lack of dopamine is the basis for driving the behavior
Augmentation of Dopamine makes sense
Buprenorphine and Methadone safely increase dopamine
This allows for stabilization of craving
Allowing for behavioral therapy to be effective
HEALTH MANAGEMENT ASSOCIATES
25


ADDICTION TREATMENT ECOSYSTEM CLINIC STRUCTURES
Syndrome of Addiction
Treatment Education
Outpatient treatment (1)
IOP (2)
Residential Detox (3)
Medically Managed Detox (4)
Screening & referral
Data collection & evaluation
Social Determinants & Prevention
Criminal Justice
Payment Models
HEALTH MANAGEMENT ASSOCIATES
28

ADDICTION TREATMENT ECOSYSTEM CHANGING HEARTS AND MINDS

ADAPTIVE vs. TECHNICAL



HEALTH MANAGEMENT ASSOCIATES 29

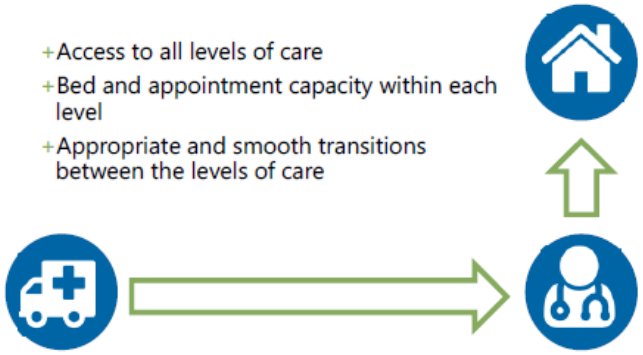
ADDICTION TREATMENT ECOSYSTEM IMPLEMENTATION

- Capacity
- Competency
- Consistency
- Compensation
- Community

HEALTH MANAGEMENT ASSOCIATES 30

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



HEALTH MANAGEMENT ASSOCIATES 31

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

HEALTH MANAGEMENT ASSOCIATES 32

ADDICTION TREAMENT ECOSYSTEM CONSISTENCY

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

HEALTH MANAGEMENT ASSOCIATES 33

ADDICTION TREAMENT ECOSYSTEM COMPENSATION

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

HEALTH MANAGEMENT ASSOCIATES 34

ADDICTION TREAMENT ECOSYSTEM COMMUNITY

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

HEALTH MANAGEMENT ASSOCIATES 35

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)

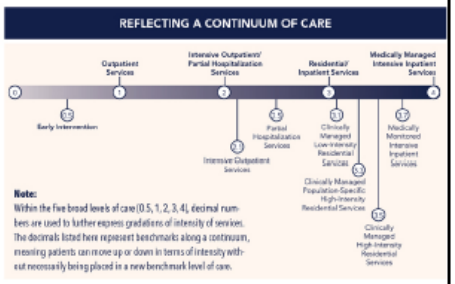
❑ **Level of Care Determination:**
Using an assessment and other factors, the most appropriate level of care for the severity of the condition is identified (outpatient vs inpatient).

HEALTH MANAGEMENT ASSOCIATES 36

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



ADDICTION TREAMENT ECOSYSTEM PHASES OF PROCESS

PHASE 1

Observation/Evaluation Phase

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

Leadership Alignment

(corporate and local)

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

ADDICTION TREAMENT ECOSYSTEM PHASES OF PROCESS

Phase 2

Cultural Alignment

- Listen to all sides
- Teaming
- Direct patient input

Goals & Scope

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

Data

- Payer
- Hospital
- HIE
- PDMP

ADDICTION TREAMENT ECOSYSTEM PHASES OF PROCESS

Phase 3

Structure

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

Tools

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

Knowledge

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

TABLE DISCUSSION

WHAT ARE THE BARRIERS AND GAPS IN YOUR CURRENT SYSTEM?

ROVING BRAINSTORM

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

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

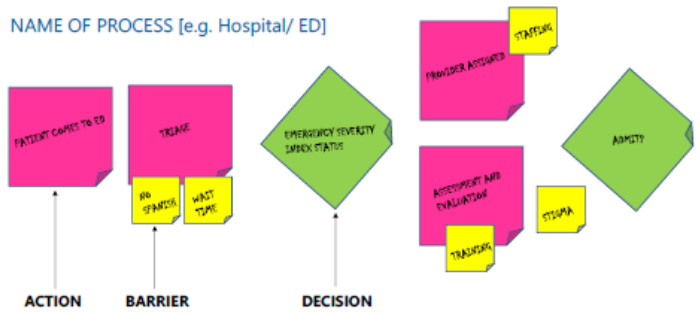
GALLERY WALK

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

SOLUTIONS

GROUP DISCUSSION: BARRIERS AND SOLUTIONS

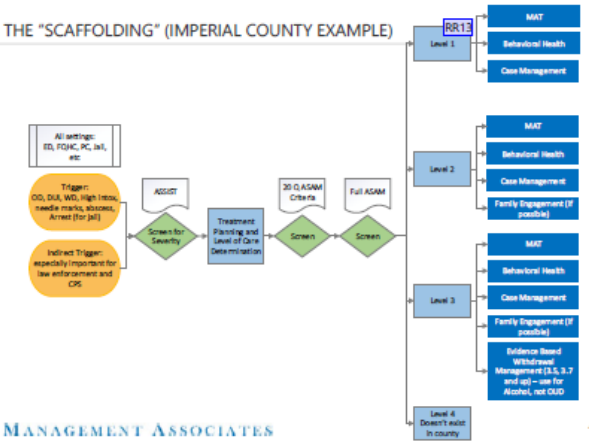
CURRENT STATE VALUE STREAM MAP EXAMPLE



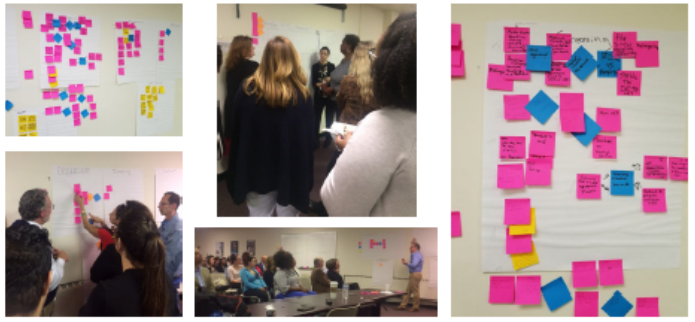
FUTURE STATE MAPPING ON DAY 2

IN A PERFECT WORLD…

Preview: THE "SCAFFOLDING" (IMPERIAL COUNTY EXAMPLE)

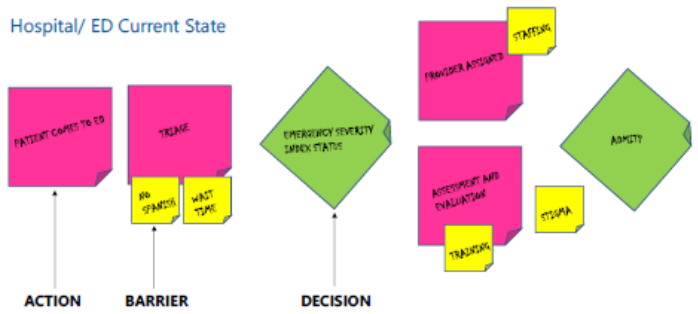


FIELD NOTES



VALUE STREAM MAP EXAMPLE

Hospital/ ED Current State



HEALTH MANAGEMENT ASSOCIATES

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

September 11 & 12, 2019

DAY 2

DHCS
California Department of Health Care Services

Funding for this event was made possible (in part) by H79TI081686 from SAMHSA. The views expressed in written event materials or publications and by facilitators and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

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

GOAL

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

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

AGENDA

DAY ONE

Morning Session
+ Why are we all here?
+ Addiction 101
+ Addiction Treatment Ecosystem
+ Current State Value Stream Mapping (VSM)

Afternoon Session
+ Current State Presentations
+ Barrier Identification and Resolution
+ Future State Set-Up

DAY TWO

Morning Session
+ MAT Basics
+ Screening, Assessment and Levels of Care
+ Future State Features

Afternoon Session
+ Future State Key Features Table Top
+ Future State Mapping
+ Next Steps

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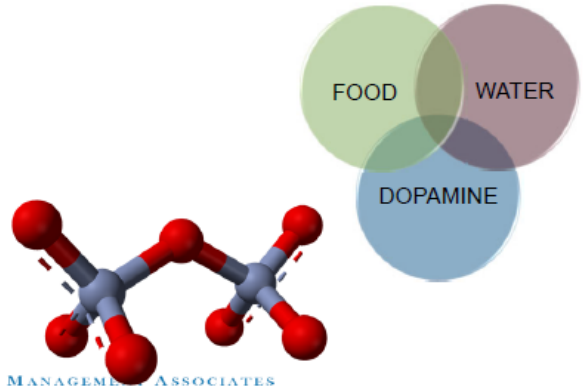
SURVIVAL



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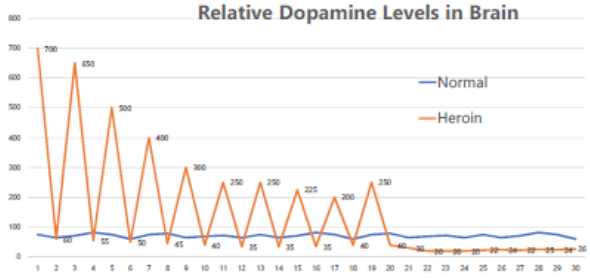

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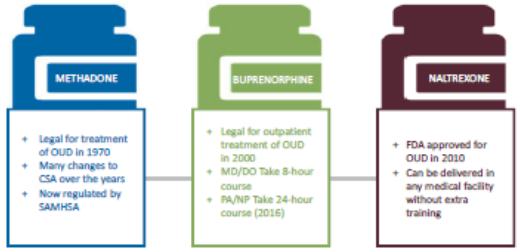
MEDICATION-ASSISTED TREATMENT (MAT) INTRODUCTION



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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 WHO IS APPROPRIATE?

- Patients with greater than a year of an OUD
- Patients who have been injecting opioids
- Patients who have transportation available
- Patients who have failed other MAT for OUD
- Patients with a more severe OUD

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METHADONE GENERAL REGULATIONS

- Delivered via observed dosing
- Once patient is stable and after 6 weeks, can be given take-home doses (varies by state)
- Highly monitored in an Opioid Treatment Program setting (OTP)
- Many requirements for treating patients

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METHADONE CLINIC REQUIREMENTS

- Required counseling for substance use disorders (not synonymous with psychotherapy for mental health issues)
- Documented full treatment planning
- Diversion control processes
- Drugs screens (urine, oral swabs). Drug testing for confirmations if necessary.
- Urine collections may be observed or unobserved.
- Call backs for both random urine drug screens (UDS) and to check that any take home medications are accounted for

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METHADONE 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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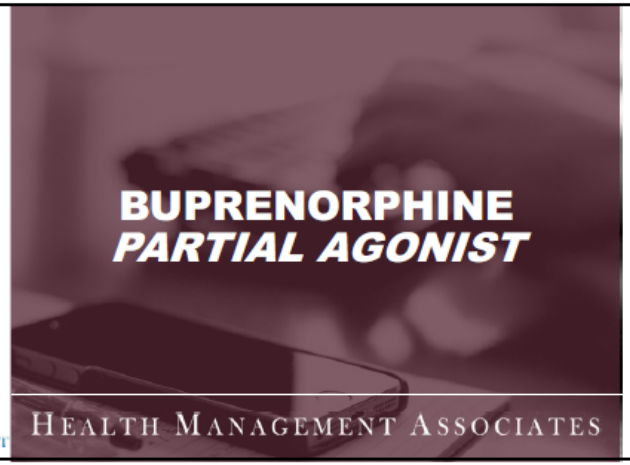
METHADONE PARTICULARS

- As the dose goes up so does retention in treatment
  - Best dose range 90-120 mg
  - Not considered therapeutic until at least 60 mg per day
- Common misunderstanding is that if you are on methadone you are covered for pain.
  - Methadone for pain is 3x a day
- Illegal to write prescription for methadone to treat OUD unless covering a gap in treatment.
  - Still no more than 3 days are allowed

METHADONE CAVEATS

- Not really available in Rural areas
- Requires transportation
- Dosing is non-linear
- Several significant drug-drug interactions
- Despite having the best outcomes, it has the highest level of stigma
- Requires good geographic association to patients
- Hard to get patients off after a few years of treatment



BUPRENORPHINE WHO IS APPROPRIATE?

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

BUPRENORPHINE GENERAL REGULATIONS

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

Approved in 2000 for use in maintenance treatment for OUD

Now multiple forms:

- SL tablet *(Subutex, Suboxone)*
- SL film *(Suboxone, Zubsolv)*
- Buccal Film *(Bunavail)*
- SL Oral dissolvable tablet
- Implantable rods
- Long acting injectable *(Sublocade)*

BUPRENORPHINE TRAINING REQUIRED

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

BUPRENORPHINE OUTCOMES

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

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
- Few little drug-drug interactions

BUPRENORPHINE CAVEATS

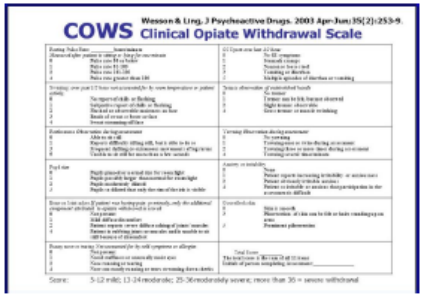
+ Many different ways to do an induction
+ Watch for diversion
+ Can be tough to wean and there are questions about if you should even try
+ Need to keep good records for possible DEA evaluation

BUPRENORPHINE INDUCTION

+ Starting buprenorphine when opioid receptors are saturated with another opioid can cause precipitated withdrawal
+ Start buprenorphine when patient in mild-moderate withdrawal
+ Induction protocol needed
+ Taking other opioids while on buprenorphine will **not** cause withdrawal (they will be less effective)

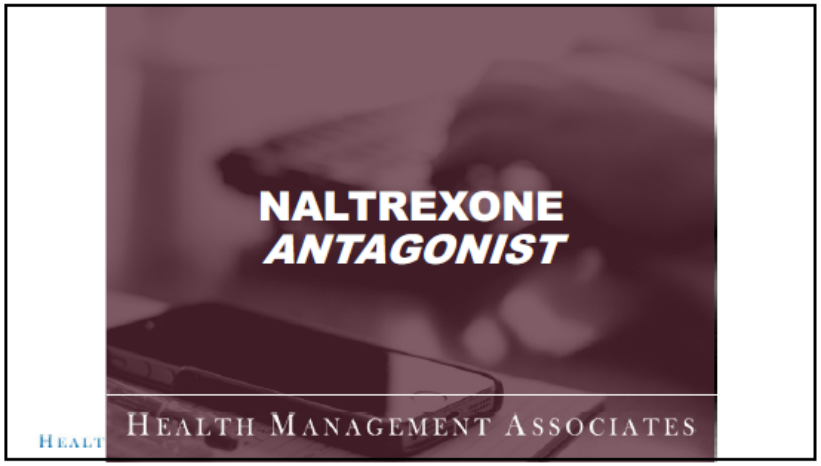
Induction/Starting Buprenorphine

The science and art of avoiding precipitated withdrawal



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



NALTREXONE WHO IS APPROPRIATE?

- Patients with a high degree of motivation (dopamine)
- Patients leaving the criminal justice system with a history of OUD and AUD
- Patients who had poor results with methadone or buprenorphine

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NALTREXONE GENERAL REGULATIONS

- No Federal regulations inhibit the use
- Newer implants not FDA approved
- Some payer restrictions make it difficult to obtain the long acting injectable form

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NALTREXONE MEDICATION FORMS

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

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NALTREXONE PROPERTIES

- Does not address underlying issue of dopamine depletion
- No diversion potential
- More widespread acceptance in criminal justice and "abstinence-only" communities
- Can be very useful after discontinuation of methadone or buprenorphine (insurance policy)

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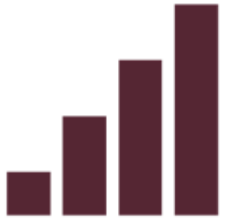
NALTREXONE OUTCOMES

- Least studied of the 3 medications
- Retention in treatment rates ranging from 23-60% depending on the study.
- Injection has better retention than oral pills
- Implant seems to show promise however needs more study



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NALTREXONE CAVEATS

- Best in patients with high motivation (i.e. increased or normalized dopamine)
- Difficult to get started due to need for 7-10 days of abstinence (UDS)
- Retention in treatment may be hard for many patients
- Pain management in patients on Naltrexone is challenging
- Current head to head trial of buprenorphine and naltrexone is underway

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MAT CONCLUSIONS

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

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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 CONCLUSIONS

+ Methadone and Buprenorphine seem to have no difference if efficacy whether patient is injecting or using oral pills
+ Use of evidence-based medications is the standard of care
+ There is no perfect answer!
+ Involve your patients (informed consent) and have access to all of the medications
+ Build an *addiction* treatment ecosystem (not an *opioid* treatment system)

SCREENING, ASSESSMENT AND LEVEL OF CARE DETERMINATION

SCREENING, ASSESSMENT & LEVEL OF CARE DETERMINATION

❑ **Screening:**
A rapid evaluation to determine the possible presence (risk) 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).

IS THERE A ROLE FOR TOX SCREENING?

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

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

Best Start to the Conversation: Screening Questionnaires

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

The NIDA 4 +1 (MJ for CA)

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

*Added due to legalization of MJ in CA

ASSESSMENT TOOLS

- If a patient screens positive, then they need to assess 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 (NM-ASSIST)

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

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

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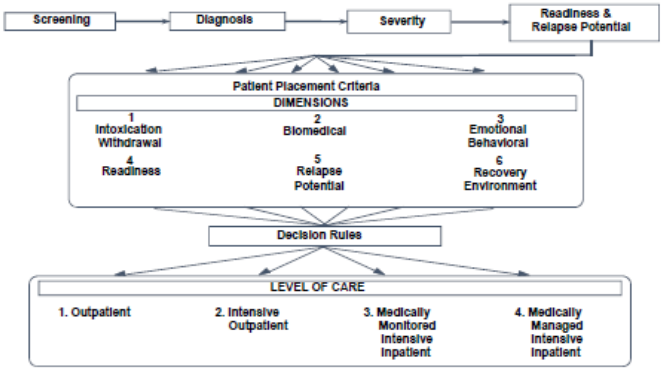
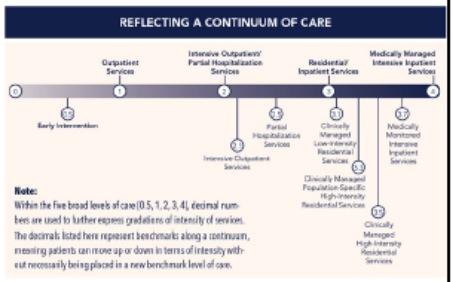
The ASAM Criteria Decision Process



LEVEL OF CARE DETERMINATION

Evaluating for placement

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



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ASAM CRITERIA METHODS OF DELIVERY

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

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INFORMATION SHARING/ 42 CFR

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DISCLAIMER

- I am not a lawyer
- (I do not want to be a lawyer)
- This is not legal advice
- Consult legal counsel with any questions

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WHAT IS 42 CFR?

- Privacy law to protect individuals from discrimination based on receiving treatment for an SUD by:
  - Federally assisted SUD Providers
  - Entities that "hold themselves out" to be an SUD provider
- 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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PROPOSED 42 CFR PART 2 CHANGES

- Recent changes did not meet expectations
  - Proposed rules:
    - Records created by non-Part 2 providers not covered by Part 2
    - Accidental communication from SUD patient to provider can/should be sanitized
    - SUD patient can consent to release Part 2 records to an agency without naming a specific individual
    - OTP may become eligible to view PDMP (CURES) to verify if patient already receiving treatment
    - Additional permitted disclosures:
      - ✓ Audits
      - ✓ Payment and Healthcare operations
      - ✓ Research
  - Language is confusing

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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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CONSTRUCTING THE FUTURE STATE

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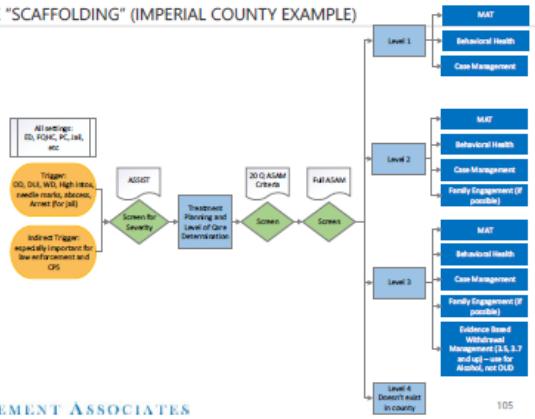
FUTURE STATE THE "SCAFFOLDING" (IMPERIAL COUNTY EXAMPLE)

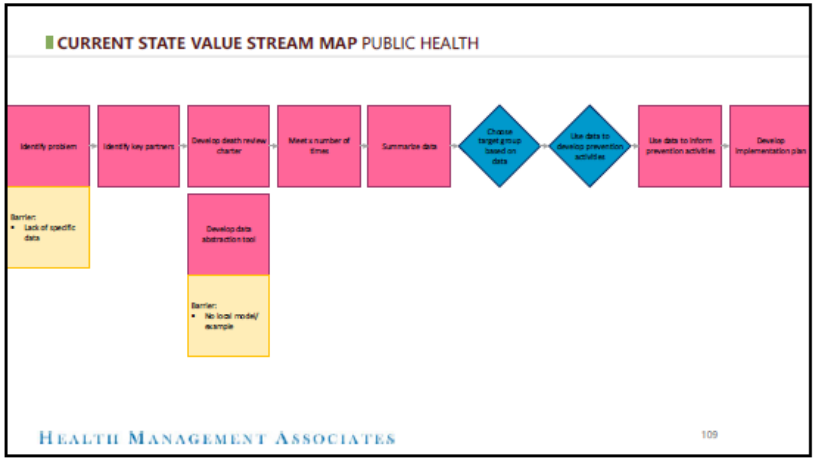


BARRIERS – Draft for Riverside County

- Lack of housing/homelessness
  - Lack of services for families experiencing homelessness
  - Without an address, it is difficult to access some services (e.g. Medi-Cal, DPSS)
- Lack of collaboration
- Lack of treatment services (geographic)
- Lack of (skilled) staffing
- Transportation
- Lack of withdrawal management services (levels of care 3.7 and 4.0)
- Lack of residential treatment services (level of care 3.3)
- Lack of services for mothers/fathers with their children
- Lack of transitions of care, including pre- and post-MAT
- Lack of field-based staff and services
- Lack of education/stigma
- Lack of universal data
- Lack of common language and definitions
- Lack of awareness of resources
- Lack of language and cultural competency among providers
- Lack of trust between patients and providers

REVIEW OF THE CURRENT STATE

CURRENT STATE VALUE STREAM MAP OUTPATIENT SUD


CURRENT STATE VALUE STREAM MAP PUBLIC HEALTH
Identify problem
Identify key partners
Develop death review charter
Meet a number of times
Summarize data
Choose target group based on data
Use data to develop prevention activities
Use data to inform prevention activities
Develop implementation plan
Barrier:
Lack of specific data
Develop data abstraction tool
Barrier:
No local model/ example
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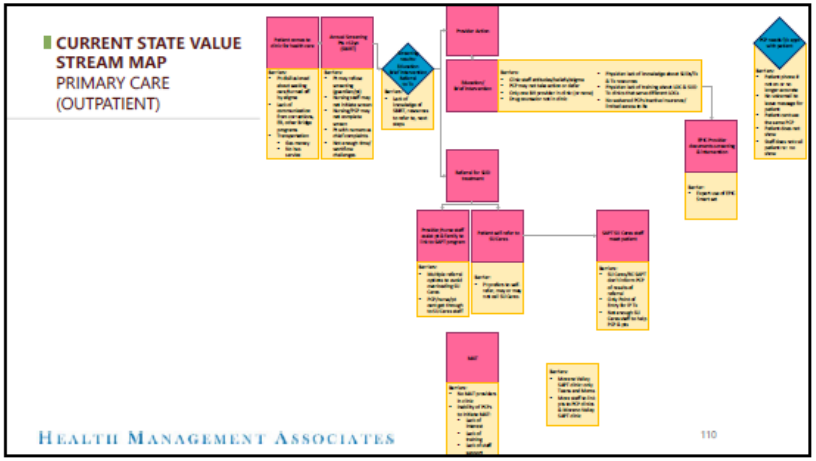
CURRENT STATE VALUE STREAM MAP
PRIMARY CARE
(OUTPATIENT)
HEALTH MANAGEMENT ASSOCIATES
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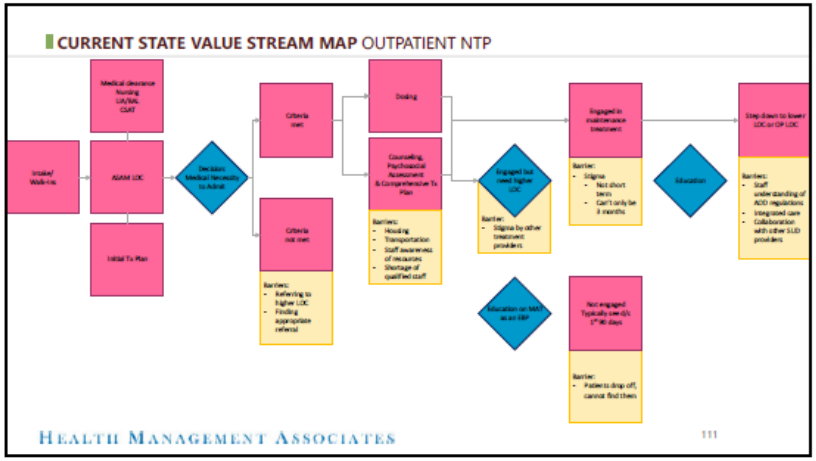
CURRENT STATE VALUE STREAM MAP OUTPATIENT NTP
Intake/ Walk-ins
ASAM LOC
Initial Tx Plan
Decision: Medical Necessity to Admit
Criteria met
Criteria not met
Barriers:
Referring to higher LOC
Finding appropriate referral
Dosing
Counseling, Psychosocial Assessment & Comprehensive Tx Plan
Barriers:
Housing
Transportation
Staff awareness of resources
Shortage of qualified staff
Engaged but need higher LOC
Barrier:
Stigma by other treatment providers
Education or MAT as an ERP
Engaged in maintenance treatment
Barrier:
Stigma
Not short term
Can't only be 6 months
Not engaged Typically see d/c 1st 90 days
Barrier:
Patient is drop off, cannot find them
Education
Step down to lower LOC or OP LOC
Barriers:
Staff understanding of ADD regulations
Integrated care
Collaboration with other SUD providers
HEALTH MANAGEMENT ASSOCIATES
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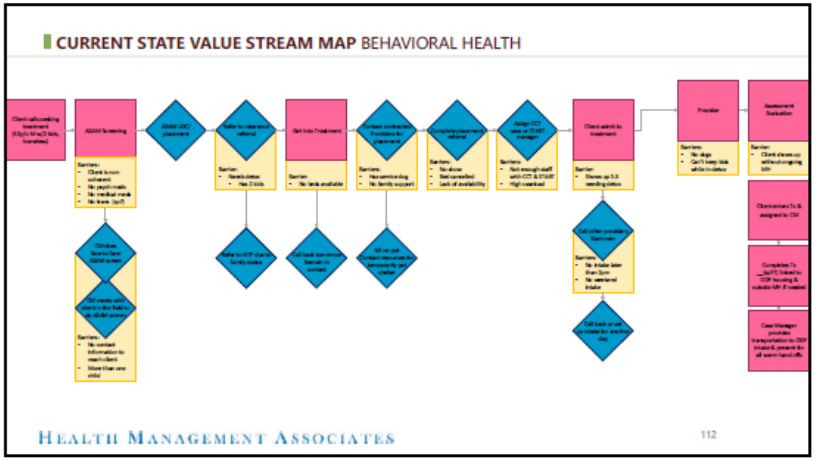
CURRENT STATE VALUE STREAM MAP BEHAVIORAL HEALTH
HEALTH MANAGEMENT ASSOCIATES
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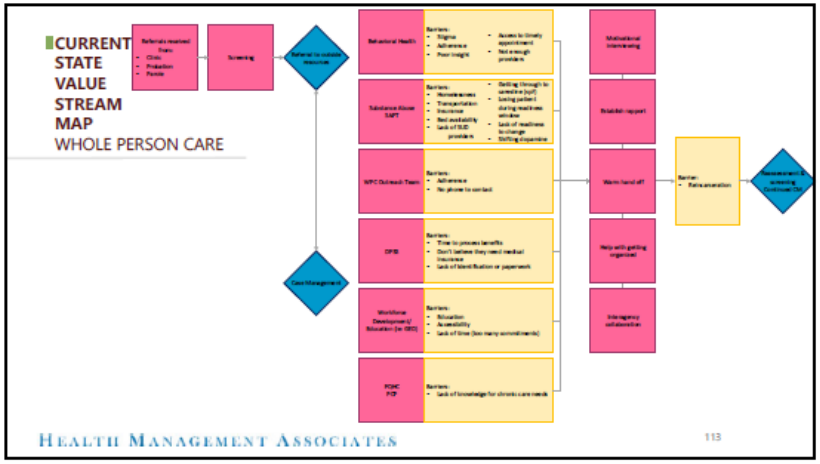
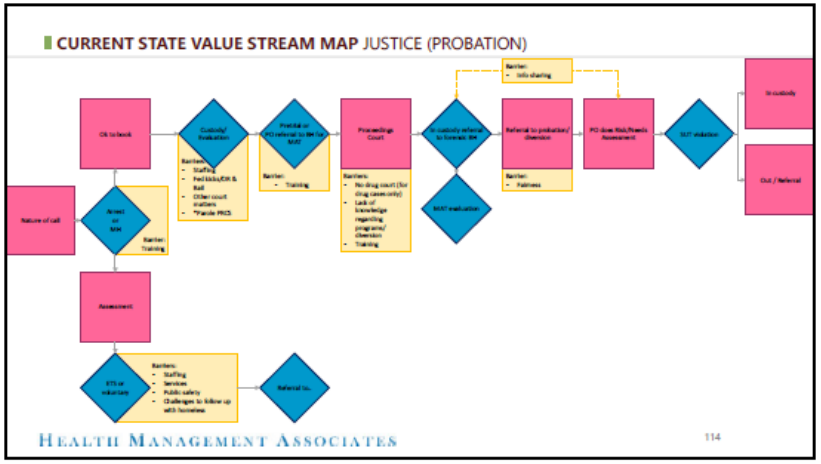

CURRENT STATE VALUE STREAM MAP
WHOLE PERSON CARE
HEALTH MANAGEMENT ASSOCIATES
113


CURRENT STATE VALUE STREAM MAP JUSTICE (PROBATION)
HEALTH MANAGEMENT ASSOCIATES
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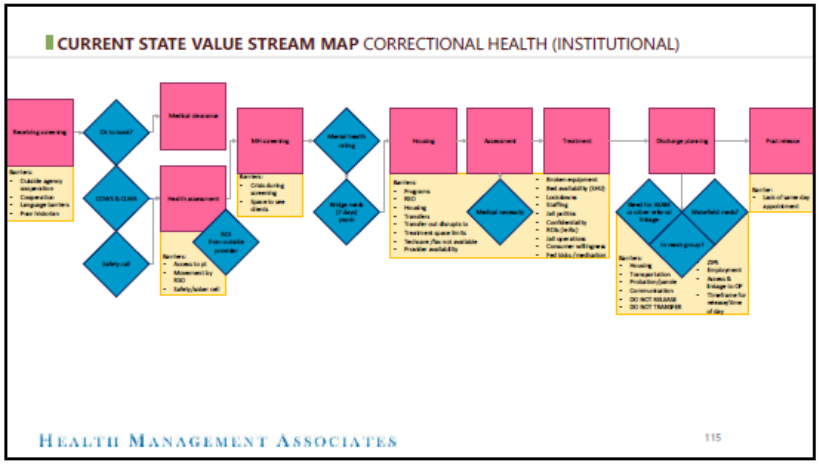
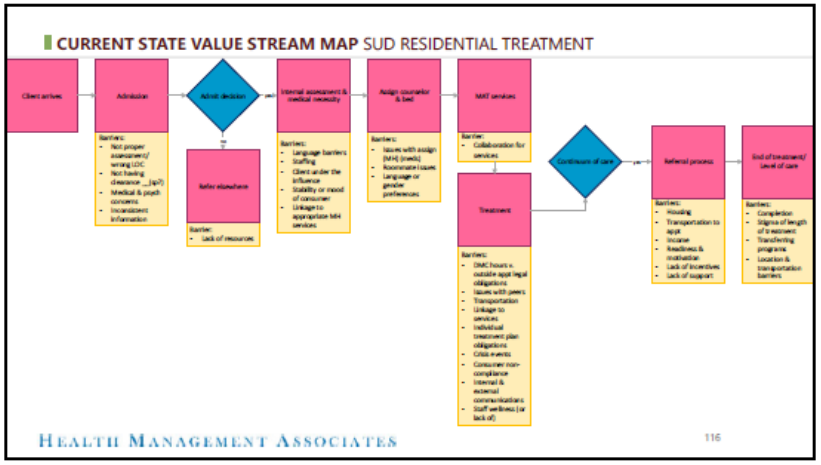

CURRENT STATE VALUE STREAM MAP CORRECTIONAL HEALTH (INSTITUTIONAL)
HEALTH MANAGEMENT ASSOCIATES
115


CURRENT STATE VALUE STREAM MAP SUD RESIDENTIAL TREATMENT
HEALTH MANAGEMENT ASSOCIATES
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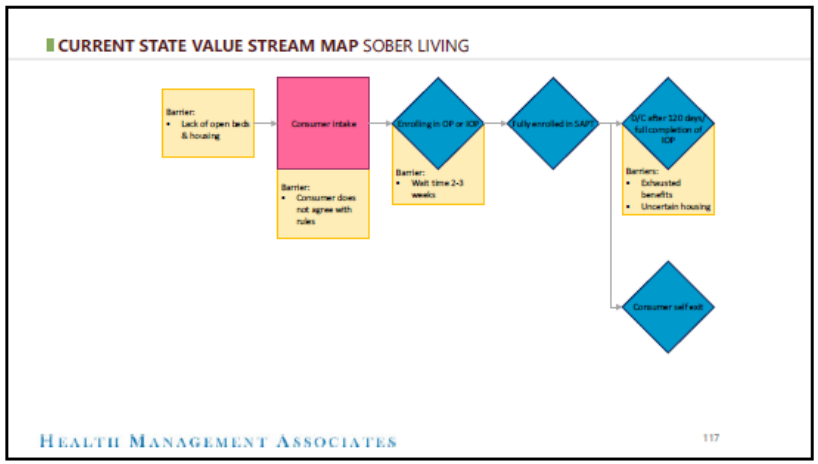
CURRENT STATE VALUE STREAM MAP SOBER LIVING
Barrier:
Lack of open beds & housing
Consumer Intake
Barrier:
Consumer does not agree with rules
Enrolling in OP or IOP
Barrier:
Wait time 2-3 weeks
Fully enrolled in SARP
D/C after 120 days full completion of IOP
Barriers:
Exhausted benefits
Uncertain housing
Consumer self exit
HEALTH MANAGEMENT ASSOCIATES
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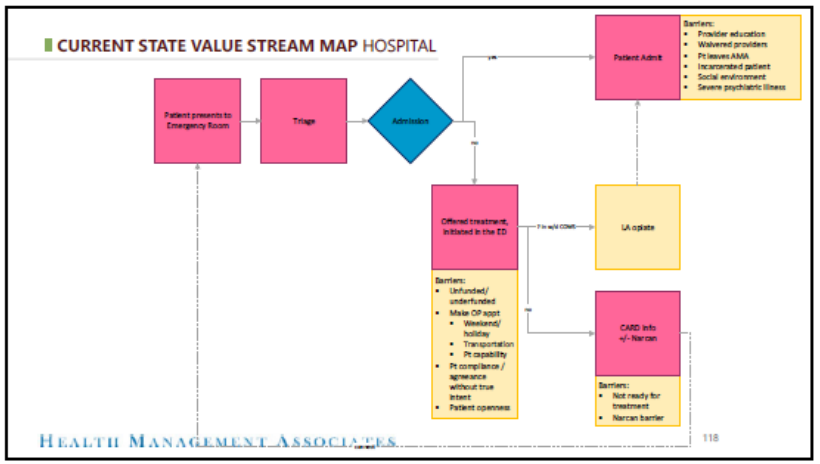
CURRENT STATE VALUE STREAM MAP HOSPITAL
Patient presents to Emergency Room
Triage
Admission
Patient Admit
Barriers:
Provider education
Waivered providers
Pt leaves AMA
Incarcerated patient
Social environment
Severe psychiatric illness
Offered treatment, initiated in the ED
Barriers:
Unfunded/ underfunded
Make OP appt
Weekend/ holiday
Transportation
Pt capability
Pt compliance / agreeance without true intent
Patient openness
LA opiate
CARD info +/- Narcan
Barriers:
Not ready for treatment
Narcan barrier
HEALTH MANAGEMENT ASSOCIATES
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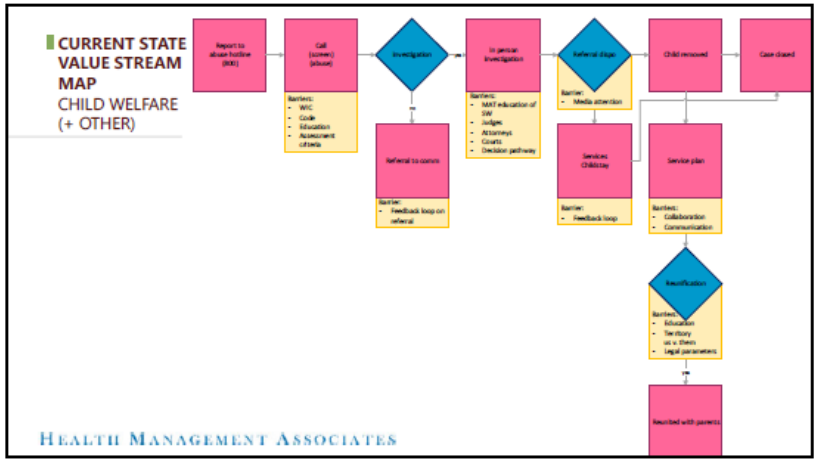

CURRENT STATE VALUE STREAM MAP
CHILD WELFARE (+ OTHER)
Report to abuse hotline (800)
Call (screen) (abuse)
Barriers:
WIC
Code
Education
Assessment criteria
Investigation
Referral to comm
Barrier:
Feedback loop on referral
In person investigation
Barriers:
MAT education of SW
Judges
Attorneys
Courts
Decision pathway
Referral dcpp
Barrier:
Media attention
Services Child stay
Barrier:
Feedback loop
Child removed
Service plan
Barriers:
Collaboration
Communication
Reunification
Barriers:
Education
Territory us v. them
Legal parameters
Reunited with parent(s)
Case closed
HEALTH MANAGEMENT ASSOCIATES


FUTURE STATE OF
ADDICTION TREATMENT
IN RIVERSIDE COUNTY

IN A PERFECT WORLD...

FUTURE STATE FEATURES:

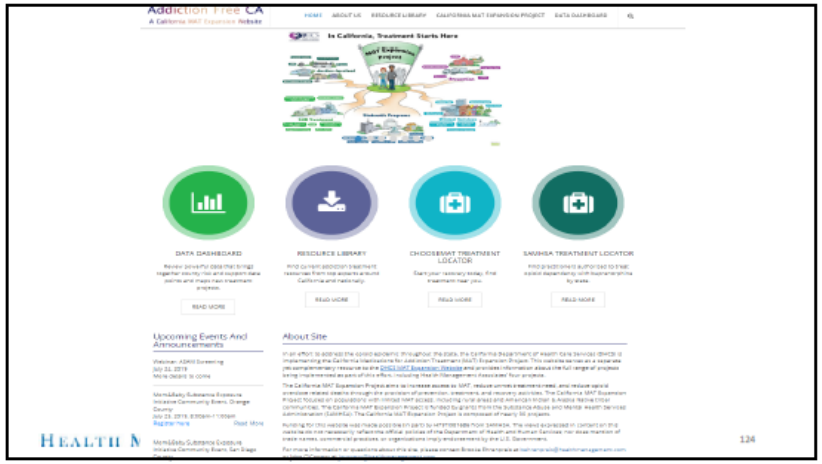
- TABLE TOP
- GALLERY WALK
- DISCUSSION

HEALTH MANAGEMENT ASSOCIATES

SOLUTIONS FOR THE RIVERSIDE COUNTY FUTURE STATE

ADDICTIONFREECA.ORG

HEALTH MANAGEMENT ASSOCIATES




Addiction Free CA
TRANSITIONS OF CARE
California MAT Expansion Project
Partner Projects
HMA Projects
Upcoming Events
Transitions Of Care
The work will include:
The work will be complemented by:
Goals - County System Work
Goals - California Department of Corrections and Rehabilitation (CDCR) Strategic Planning
Impact
HEALTH MANAGEMENT ASSOCIATES
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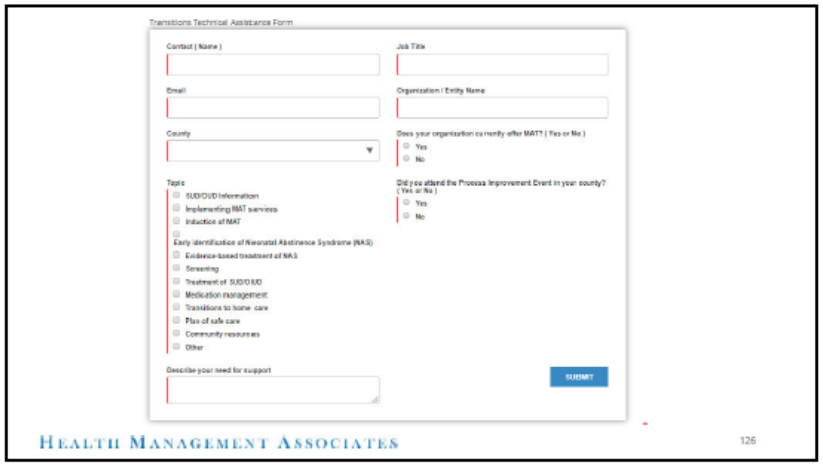
Transitions Technical Assistance Form
Contact (Name)
Job Title
Email
Organization / Entity Name
County
Does your organization currently offer MAT? (Yes or No)
Yes
No
Topic
SUD/OUD Information
Implementing MAT services
Induction of MAT
Early identification of Neonatal Abstinence Syndrome (NAS)
Evidence-based treatment of NAS
Screening
Treatment of SUD/O.UD
Medication management
Transitions to home care
Plan of safe care
Community resources
Other
Did you attend the Process Improvement Event in your county? (Yes or No)
Yes
No
Describe your need for support
SUBMIT
HEALTH MANAGEMENT ASSOCIATES
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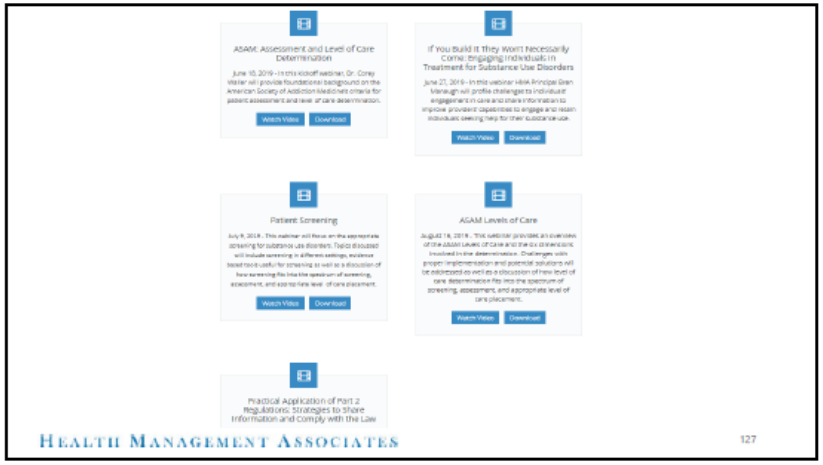
ASAM: Assessment and Level of Care Determination
If You Build It They Won't Necessarily Come: Engaging Individuals in Treatment for Substance Use Disorders
Patient Screening
ASAM Levels of Care
Practical Application of Part 2 Regulations: Strategies to Share Information and Comply with the Law
HEALTH MANAGEMENT ASSOCIATES
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NOW WHAT DO WE DO?
HEALTH MANAGEMENT ASSOCIATES

C. Summary of Evaluation Results

1. What did you like MOST about this forum?
    a. Networking
    b. Collaboration
    c. Presentations by Dr. DuPlessis and Charles
    d. Meeting other providers
    e. Time was used wisely
    f. Learning about other organizations
    g. Identifying barriers
    h. Sharing information and resources
    i. Educational components
    j. Learning about barriers and looking for solutions
2. What did you like LEAST? What changes would you recommend?*
    a. Provide the PowerPoint slides
    b. More time for networking
    c. Key stakeholders missing (health plans, RUHS ER, hospital case managers, FQHCs)
3. Give an example of something new you learned about SUD.
    a. Dopamine
    b. Medi-Cal benefits for substance use disorder treatment
    c. Science of SUD
    d. Resources available in the county
    e. Treatment for opioid use disorder can be lifelong
    f. Screening and assessment tools
    g. MAT and methadone
4. What topics would you like to learn more about?
    a. Other drugs in addition to opioids
    b. Available resources
    c. Reducing stigma
    d. Mental health
    e. Overcoming objections to MAT from clients and other providers
    f. Experience implementing MAT in a primary care setting
    g. Motivational interviewing
    h. Cultural competency
    i.
5. Other comments/questions.
    a. Best event I have attended since joining the county
    b. Great job
    c. Thank you. I learned a lot.
    d. Need greater engagement and training for physicians
    e. Provide CEUs

* Many participants responded that they would not change anything and felt that the program was excellent as is

D. Citations

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