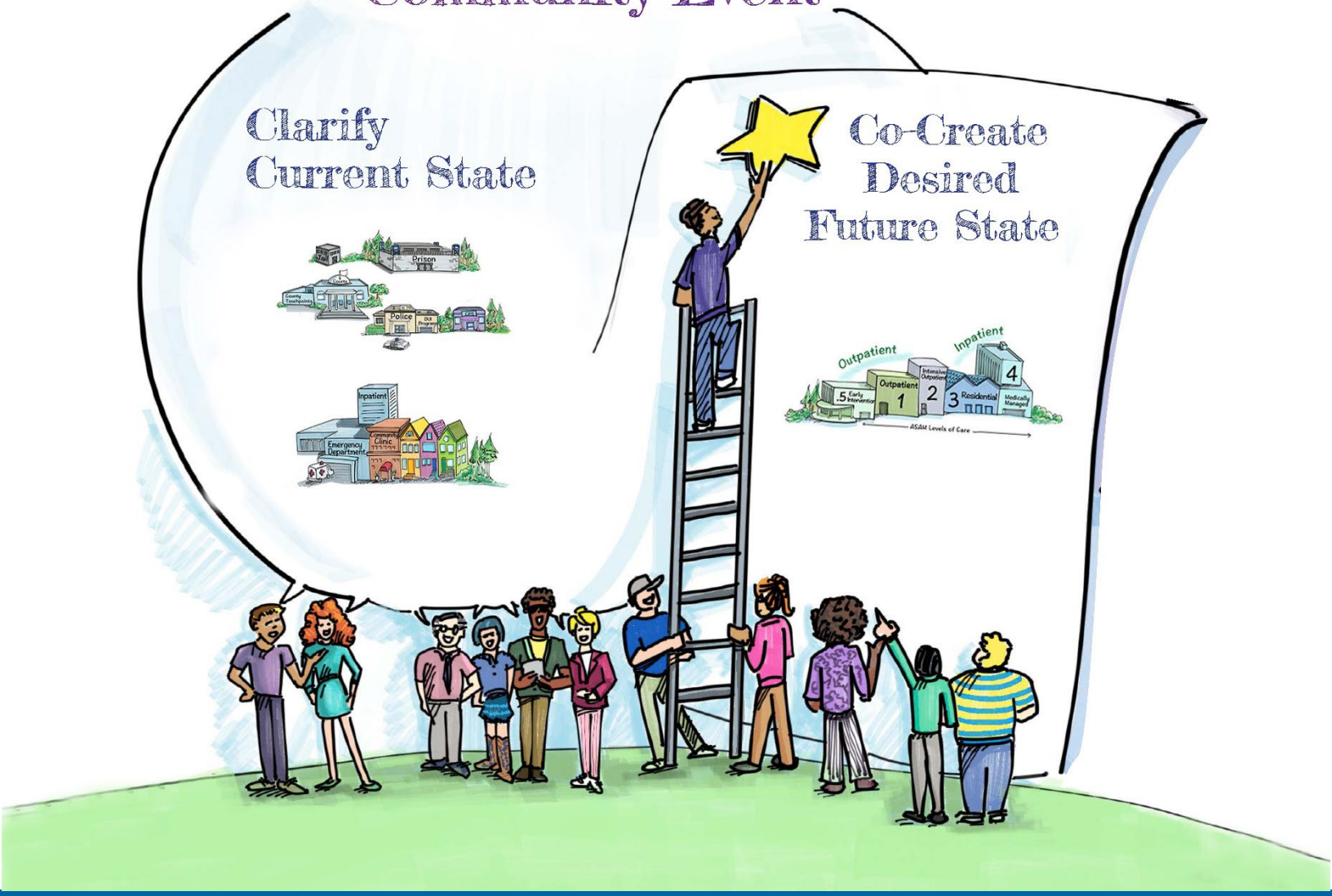
Collaborative Provider Community Event



BUILDING SUSTAINABLE TRANSITIONS OF CARE FOR PEOPLE WITH ADDICTIONS

Riverside County Community Process Improvement Event

September 11-12, 2019

HEALTH MANAGEMENT ASSOCIATES

BUILDING SUSTAINABLE TRANSITIONS OF CARE FOR PEOPLE WITH ADDICTIONS

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Executive Summary

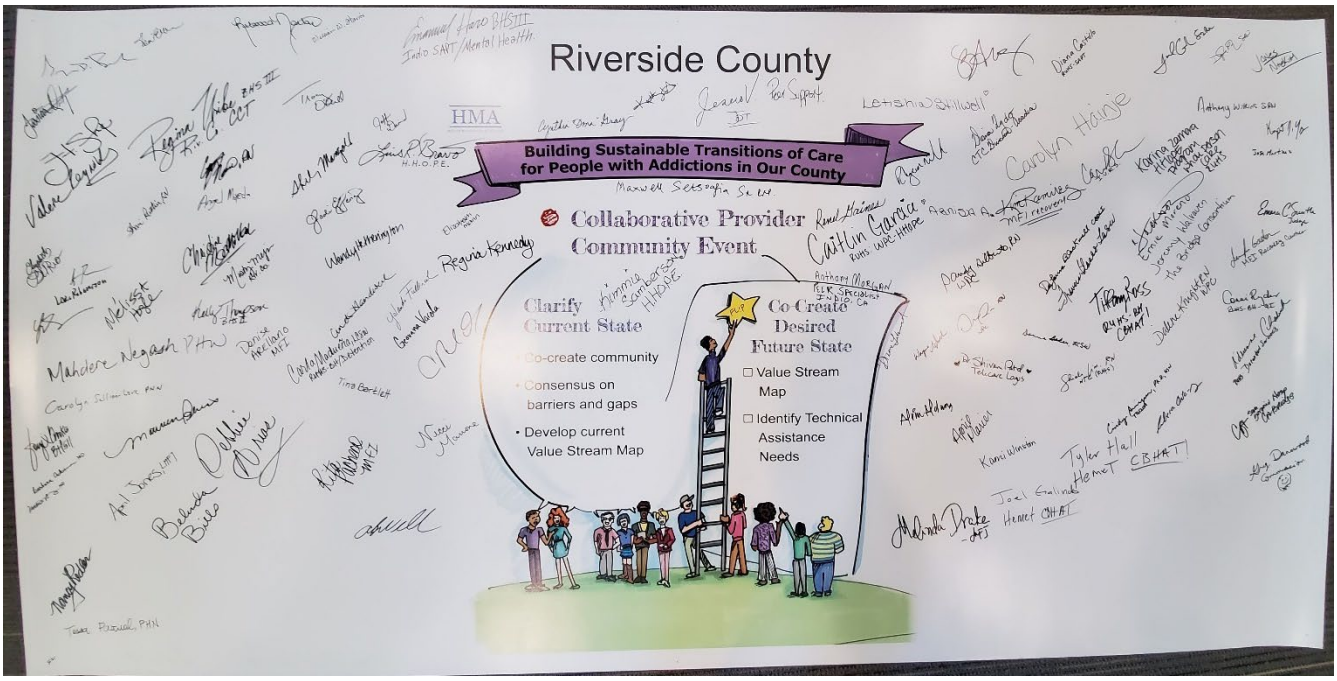
Overdose is the leading cause of accident-related death in the United States. The vast majority of these overdoses come from a combination of prescribed opioids and heroin. As the opioid crisis has worsened over the last ten years, we have reached a point where the treatment system, in its current state, 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 addictions; including the State Treatment Response (STR) and State Opioid Response (SOR) grants. The California Department of Health Care Services (DHCS) received STR and SOR grants which support project funding for the California Medication Assisted Treatment (MAT) Expansion Project. This initiative aims to serve an estimated 290,000 individuals with Opioid Use Disorders (OUD), prevent drug overdoses, and treat OUD as a chronic disease. Health Management Associates (HMA) received SOR funding from DHCS to focus on developing predictable and consistent transitions of care to sustain addiction treatment as individuals' transition from locations such as emergency departments, jails, primary care clinics, the community at large and/or inpatient hospital settings. Ten counties across California were selected to participate in the Transitions of Care project based on need and capacity within the county. The Transitions of Care project: 1) engages stakeholders in each selected county in a two-day countrywide process improvement event and; 2) subsequently provides 12 months of ongoing technical assistance to support the county in achieving their ideal future state for addiction treatment. Riverside 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, addiction treatment, law enforcement and those who pay for that treatment. During the event, attendees participated in intense work sessions with a focus on identifying current treatment processes, barriers, and gaps in these processes and a future state treatment system to support transitions of care for Riverside County residents in need of addiction treatment and support services.

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

The two-day event set the stage for adopting universal evidence-based tools for screening, assessment, and level of care determination. This coupled with the didactic training of all parties involved, will yield a more comprehensive and easy-to-use addiction treatment ecosystem.

To implement the future state as envisioned by this group, there will need to be ongoing collaborative interaction and a bevy of systems developed to receive and track patients as they flow through the system. However, given the strong buy-in by the participants, we should be able to achieve significant progress over the next year.


Riverside County
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


Public Health

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

HMA received SOR funding from DHCS to focus on developing predictable and consistent transitions of care to sustain addiction treatment as an individual transition from locations such as emergency departments, jails, primary care clinics, the community at large and/or inpatient hospital settings. Through rigorous assessment of all 58 counties in California, HMA identified Riverside 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 Riverside County, nine other counties were identified as key locations on which to focus these efforts.

The Transitions of Care project engages stakeholders in each selected county in a two-day countywide process improvement event, followed by 12-months of ongoing technical assistance so the community-defined “ideal future state value stream map” can be fully realized. Those who are directly involved with the development of the transitions plan for Riverside County will be eligible to receive ongoing individualized technical assistance from a team of national experts covering all aspects of knowledge required to build and sustain an evidence-based addiction treatment ecosystem.

HMA worked with Rhyan Miller, Deputy Director of Forensics and Substance Abuse Prevention for Riverside County Behavioral Health, and the Riverside County Behavioral Health Forensics and Substance Abuse Prevention program leadership. Specifically, we held planning meetings with Deputy

Director Rhyan Miler, Amy McCann, Assistant Director of Behavioral Health; and April Marier, Administrator, Substance Abuse Prevention and Treatment Programs; along with their respective staff.

Collectively, Riverside County staff assisted our team in launching the process improvement event and subsequent ongoing technical assistance program. Riverside 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 addiction treatment ecosystem and their leadership set a strong tone of collaboration for the event.

B. County Leadership/ Key Change Agents

- Rhyan Miller, Deputy Director of Forensics and Substance Abuse Prevention, Riverside County Behavioral Health
- April Marier, Administrator, Substance Abuse Prevention and Treatment Programs
- William Harris, Assistant Regional Manager, Substance Abuse Prevention and Treatment Program
- Amy McCann, Assistant Director of Behavioral Health
- Deborah Johnson, Assistant Director of Behavioral Health

Who Was Involved:

- Riverside University Health System
  - Behavioral Health
  - Whole Person Care
  - HHOPE Program
  - Substance Abuse Prevention and Treatment
  - Correctional Health Services
  - Internal Medicine Clinic
  - Public Health
- MFI Recovery Center
- San Gorgonio Memorial Hospital
- Department of Public Social Services
- Riverside Public Defender
- Cedar House Life Change Center
- Detention Services
- Riverside County Latino Commission
- Awareness Group
- Riverside University Health System Medical Center
- Riverside Treatment Center
- University of California Riverside Family Medicine Residency
- Riverside County Probation Department
- Hemet Police Department
- The Bridge-Consortium
- Hemet Unified School District
- Riverside County SU CARES
- Soroptomoist House of Hope
- Robert Presley Detention Center
- Inland Valley Recovery Services
- Cedar House Life Change Center
- Coachella Valley Rescue Mission
- The Ranch Recovery Centers
- Riverside Superior Court
- Evexia Health Services
- Transition Clinic Network
- Riverside County District Attorney's Office
- Acadia
- County of Riverside Detention
- High Road Program

C. Structure of the Intervention

In advance of the event, HMA worked with the county to electronically and directly gather high-level information on addiction treatment resources and capacity in Riverside County. All of the gathered information was collated and reviewed in preparation for two days of intensive on-site value stream mapping, presentation, and discussion.

Most healthcare professionals are familiar with LEAN processing and the need to improve the efficiency of an existing system. Some are familiar with the technique of agile innovation (or SCRUM) and the role it can play in developing and managing an entirely new process. However, the field of addiction medicine is neither fully built nor just being born. Given this, HMA facilitated a hybrid process to obtain the current state structure and build the proposed new pathways and future state around it.

This event included a variety of stakeholders who represent different aspects of the addiction space in Riverside County: SUD treatment, residential providers, hospital, probation department, behavioral health, public health, people with lived experience, and many others. HMA used the morning of day one to provide an overview of the project as well as taking time to provide a common knowledge base on the neurobiological basis of addiction. The group also spent time discussing the role of screening, assessment, and Level of Care determination and the evidence-based tools available for each of these steps.

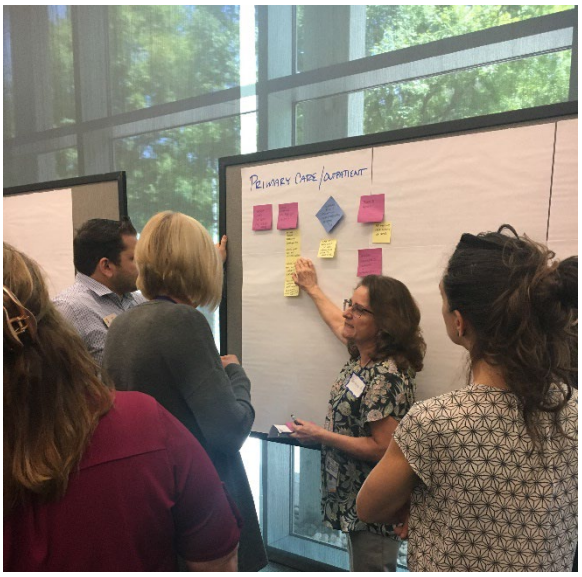
Participants discussed specific gaps and barriers within 10 small groups. Following these discussions, participants viewed the barriers of the other groups and came back together as a large group to discuss the most common barriers across agencies. This exercise is done to allow a discussion of how barriers

are experienced within the larger system of care, resulting in useful dialogue and many ideas for potential solutions going forward.

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

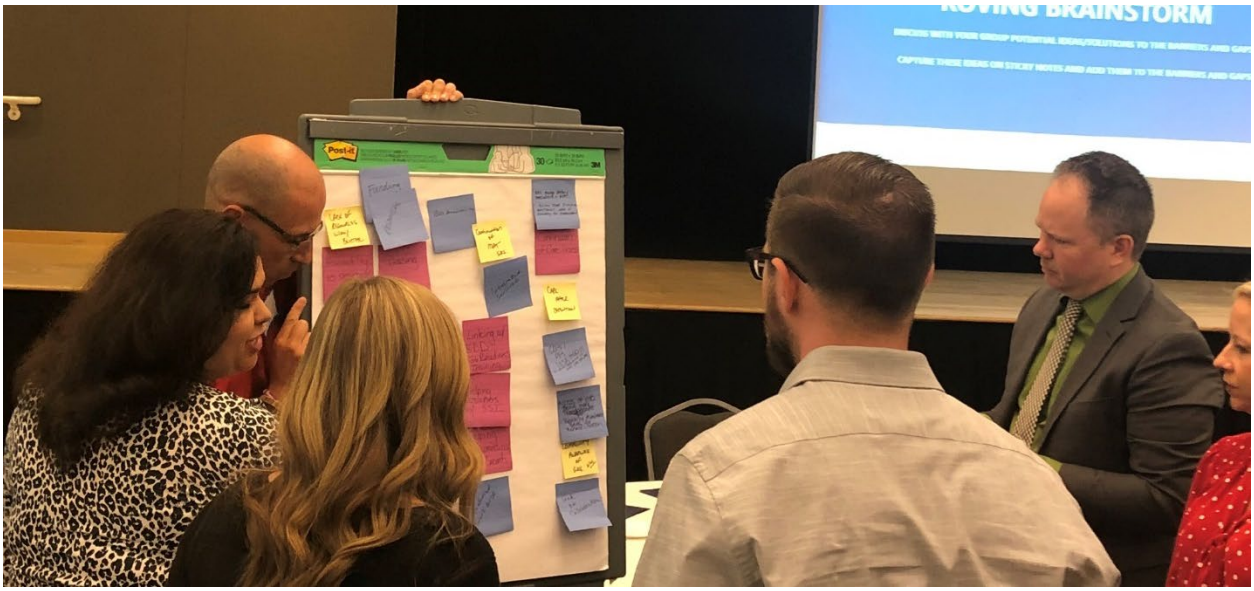
Participants were tasked with including all interventions and decision points. Stakeholders were also instructed to discuss both intervention-specific and global barriers and gaps. While the work produced had some variation in depth, scope, and structure, we were able to get a good sense of the current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

Each program gave an oral description to the group that highlighted the flow through the value stream. This reporting out on current state processes allowed everyone in the room to understand how others were serving those with addiction and the struggles involved in doing so.



On the morning of day two, the group returned to review the science of Medication Assisted Treatment, screening, assessment and level of care determination, as well as details of information release and 42 CFR. These presentations resulted in the need for further discussion and clarification around screening and assessment in Riverside County. Following the presentations, we held a brainstorming session on desired features in a future state treatment and recovery ecosystem and the creation of consensus to build a future state "scaffolding" map. Participants worked in small groups representing diverse organizations to identify and prioritize future state features. The "scaffolding" is the part of the future state map that all providers have in common and can build on for their specific setting.

It is worth mentioning that the participants in attendance were 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 the previously gathered information from in-person meetings, electronic surveys and the real-time input of the groups that had developed the current state maps and prioritized the key features for the future state. 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 Riverside County Level of Care Assessment

Riverside County is contracted with the state Department of Healthcare Services (DHCS) as a Drug MediCal, Organized Delivery System (DMC-ODS). That contract began in February 2017. DHCS requires ODS counties to utilize the ASAM criteria for making level of care and placement determinations. Riverside University Health System developed its own tool to meet that need (see Section 2 G). Although some commercial drug treatment providers in Riverside had previously used the ASAM CONTINUUM and Co-Triage, all providers in the ODS are now required to use the assessment tool developed in-house. 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.

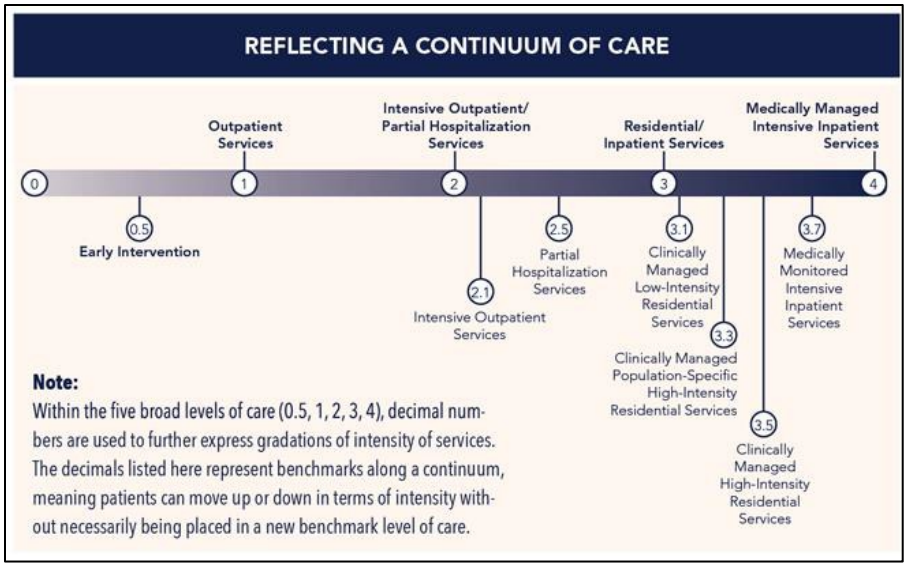
The “long-form” of the American Society of Addiction Medicine (ASAM) Criteria

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 addiction. Today the criteria have become the most widely used and comprehensive set of guidelines for placement, continued to stay, and transfer/discharge of patients with addiction and co-occurring conditions. ASAM's criteria are required in over 30 states.*

ASAM's treatment criteria provide separate placement criteria for adolescents and adults to create comprehensive and individualized treatment plans. Adolescent and adult treatment plans are developed through a multidimensional patient assessment over five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided, and the intensity of treatment services provided. Oversight and revision of the criteria is a collaborative process between ASAM leadership and the Steering Committee of the Coalition for National Clinical Criteria. The coalition represents major stakeholders in addiction treatment and has regularly been meeting since the development of the first ASAM Patient Placement Criteria in 1991. The coalition addresses feedback and ensures that the Criteria adequately serves and supports medical professionals, employers, purchasers, and providers of care in both the public and private sectors.

The “short form” of the ASAM Criteria

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



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

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

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

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

02 Section 2: Event Results

A. Goals of the Participants

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

- Build awareness of current available resources for addiction treatment and create real-time information systems in order to increase access
- Offer more wraparound services in the child welfare system to serve parents with substance use disorder in the interest of family reunification
- Build personal connections between stakeholders in the community to increase collaboration
- Identify and adopt evidence-based practices on MAT
- Understand how addiction impacts and is impacted by all stakeholders in the community, beyond addiction treatment providers (e.g. criminal justice, social services, etc.)

All goals named above can be grouped under one overarching goal for Riverside County.

THE OVERARCHING GOAL:

ELIMINATE ADDICTION-RELATED DEATHS IN RIVERSIDE COUNTY

B. Stories of Experience with Addiction in Riverside County

Building a person-centered system of addiction treatment in Riverside County must be driven by the voices of those with lived experience. During and following the event, we asked participants who have experience with addiction (either first-hand or that of a family member or loved one) and the addiction treatment system in Riverside to share their stories with us if they were willing. Below is a response we received. This response is the personal experience of a community member, and some descriptions may not be consistent with the evidence on this topic.

> *I am a resident of Riverside County, and I will be one year sober on September 25th, 2019. I was addicted to opiates for eight years and have struggled throughout the years to be able to get clean. This is part of my journey of recovery.*
>
> *I was incarcerated due to my drug addiction and had to find out through a friend about the ROC program (drug court) because my public defender failed to inform me about the ROC Program as an option rather than spending five years in prison. Due to the failed information I had to really advocate for myself to get into the ROC Program. One of the requirements was to test clean from all drugs. During this whole process I was on methadone maintenance at a 120mg and had to do a rapid detox, which caused me to have severe withdrawals. Due to those withdrawals my body went into fight or flight mode so I chose to use heroin to avoid getting sick. This decision made me have to do a two week dry out period, which is when you go into the county to detox with no medication to assist withdrawals.*
>
> *After I completed this dry out period, I began the ROC Program where I had a few struggles in the beginning. I relapsed within the first week and was sentenced to sixty meetings in sixty days and that weekend I relapsed again. As a sentence for that I requested rehab but didn't complete due to relapsing in the program, which I had to turn myself in for a two-week probation violation and until a bed was available for a treatment program. During this time, I got Fed kicked (early released) and relapsed as soon as I was released. The staff and the legal team from ROC offered me to go back on methadone or other MAT services because they thought it would help me stay clean like it did in the past. The bed at MFI A Women's Place became available which then I successfully completed in thirty days. After returning to ROC I considered to go on MAT services specifically suboxone but questioned if that was the right option for*

me due to my past experiences with detoxing. I managed to stay clean for ninety days without medical assistance but struggled with intensive heroin cravings. I would have very realistic drug dreams and wake up feeling like I was having withdrawals. Throughout the day I would day dream about using which caused me to not be present in program.

After these experiences I weighed out the pros and cons for starting MAT services which I then decided to go on suboxone. After becoming stable on my medications, I was finally able to engage in group/therapy and started to really open up. Being on suboxone I have very low drug cravings but I am able to use coping skills to overcome them. MAT services have helped me succeed in staying clean for a year it has also allowed me to grow and change for the better in my recovery process.

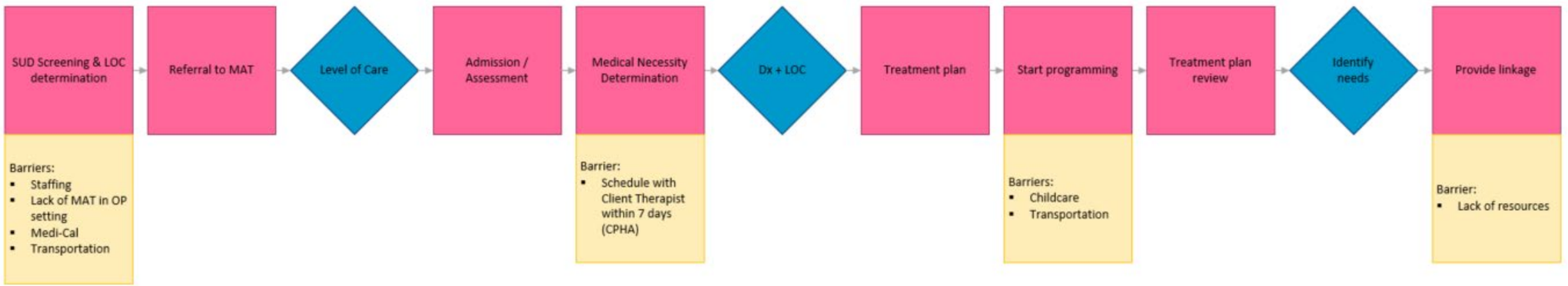
C. Current State Value Stream Maps (VSM)

Action

Decision

Barrier

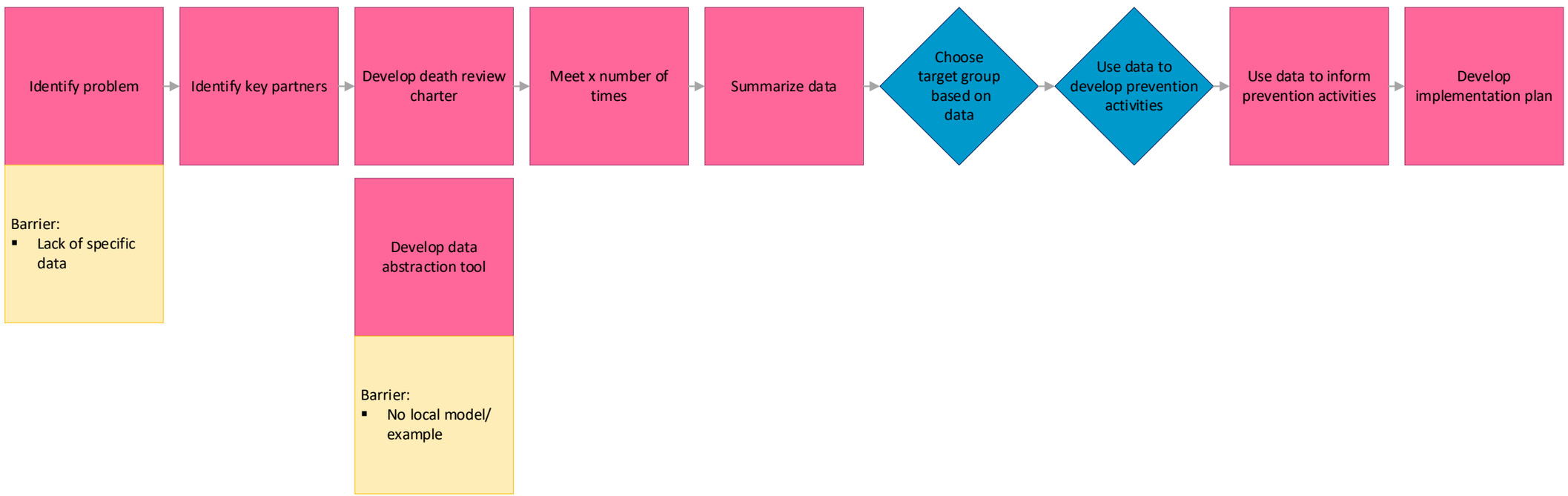
Outpatient SUD Current State VSM



Outpatient SUD

In order to engage in outpatient treatment, a client needs to have an SUD screening and level of care determination (NB: although not captured in correct sequence in this map, the patient would, of course, require an assessment for diagnosis and severity before referral to MAT). Some barriers to doing this include staffing, lack of adequate MAT capacity in the outpatient setting, partners in the community not accepting Medi-Cal (i.e., not contracted with the Fresno Drug MediCal Organized Delivery System), and transportation. Once a screening is completed, a diagnosis is made and it is determined that a client needs MAT, they are referred. Currently, there are limited MAT referral resources MAT. Once they are referred, a level of care is determination is undertaken to determine the appropriate setting for the individual to receive MAT. They then move to an admission and intake process, during which time they are assessed again. They then are assigned a primary counselor. The next step is medical necessity determination. A barrier at this point is that a determination of medical necessity needs to happen within seven days of admission. Scheduling can be challenging as there may not be enough Licensed Practitioners of TheHealing Arts (LPHAs) to meet the medical assessment demand. Once medical necessity and level of care have been determined have been , a treatment plan is prescribed and implemented. Childcare and transportation are barriers to following through on the treatment plan. In this client-centered treatment model, staff regularly review the treatment plan, and if the client's needs are not being met, the treatment plan or services can be adjusted. The linkage to other resources is an important aspect of any SUD treatment programs; however, resources to address those myriad needs are also limited.

Riverside County Public Health Current State VSM

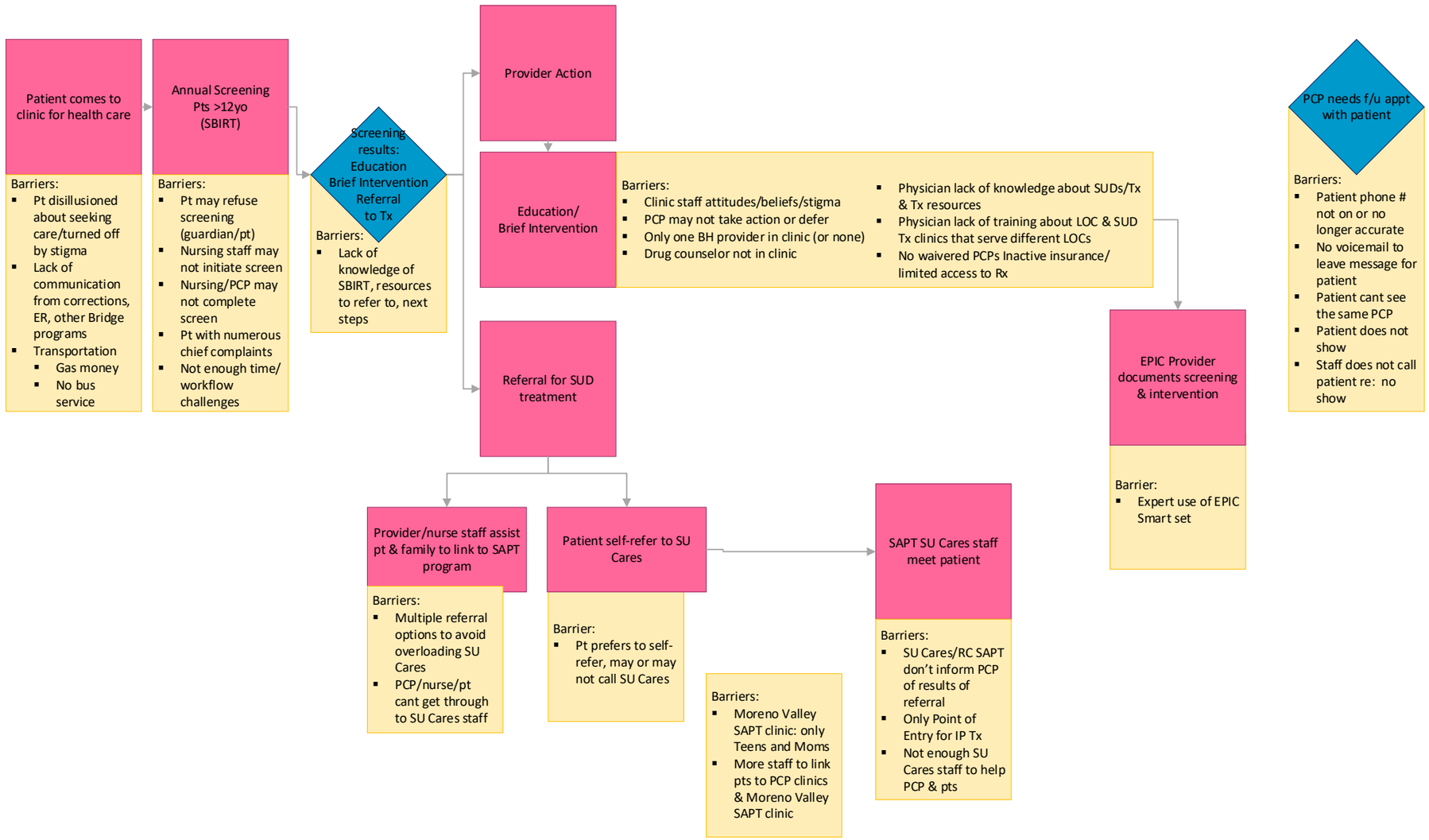


Riverside County Public Health

The Riverside Public Health Department doesn't currently provide substance use disorder services. They are, however, a recipient of recent funding from the Centers for Disease Control for a prevention grant called Overdose: Data to Action. The purpose of this funding is to enhance data surveillance and reporting to partners on overdose morbidity and mortality in the county. Enhanced data will be used to guide prevention efforts.

Under this funding, Public Health is forming an overdose death review team. The county does not currently have the population level data to show the specific risk factors for people in the county for overdose. Riverside will address this barrier by forming an overdose death review team. Once members of the death review team members have been identified, a charter for the team will be created, critical data identified, and a data abstraction tool developed. Data collection and analysis will drive the identification of target areas for which preventions activities will be designed and implemented. A barrier to this effort is the lack of local models or examples upon which to base the design of the data collection tools.

Primary Care Current State VSM

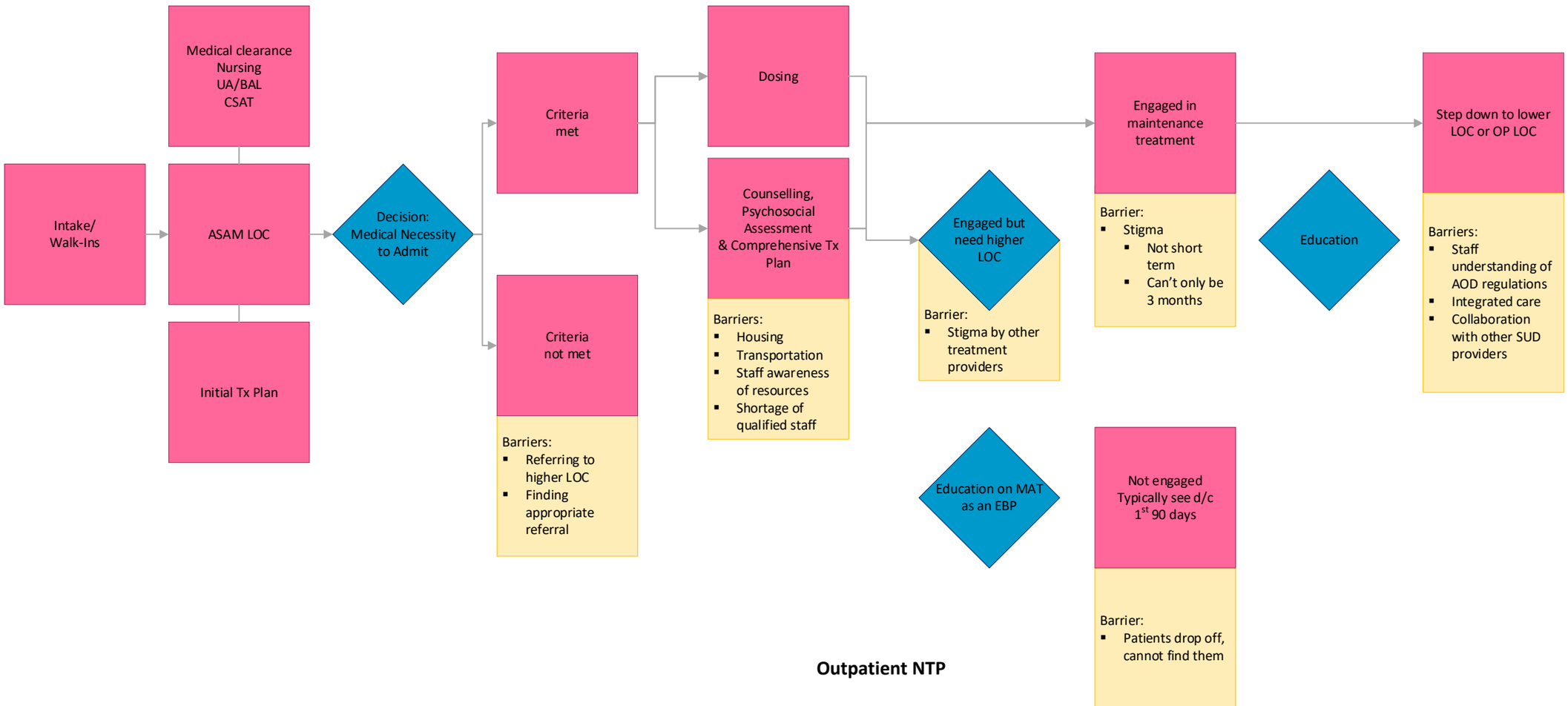


Primary Care

This process is focused on Screening, Brief Intervention and Referral to Treatment (SBIRT) for drug and alcohol misuse in the primary care setting. The first step is getting patients to come to the clinic for healthcare services. Barriers encountered include disillusionment about seeking care, stigma, inadequate communication from referrals sources such as corrections, ED Bridge- or other Bridge programs, and lack of transportation to get to the primary care setting. Additional barriers include patient refusal of services once they arrive at the clinic andmissed opportunities for screening by nursing staff or primary care providers. On occasion, the patient may have multiple, complex complaints that leave insufficient time to conduct the screen. The clinic uses one of three screening tools based on the type of patient: CRAFT for teenagers, and either the AUDIT or DAST-10 for adults (the latter two tools are incorporated as “smartforms” embedded in the electronic health record). Once a patient (12 years or older) is screened and tests positive, the provider makes a determination about whether the patient requires a brief education or intervention, or a referral to treatment. If, after the screening, a provider decides the patient only requires education or other brief intervention, there may be insufficient behavioral health providers or drug counselors to provide counselling and education, insufficient time if providers are to provide that brief intervention, and judgmental attitudes, beliefs and stigma of clinic staff.

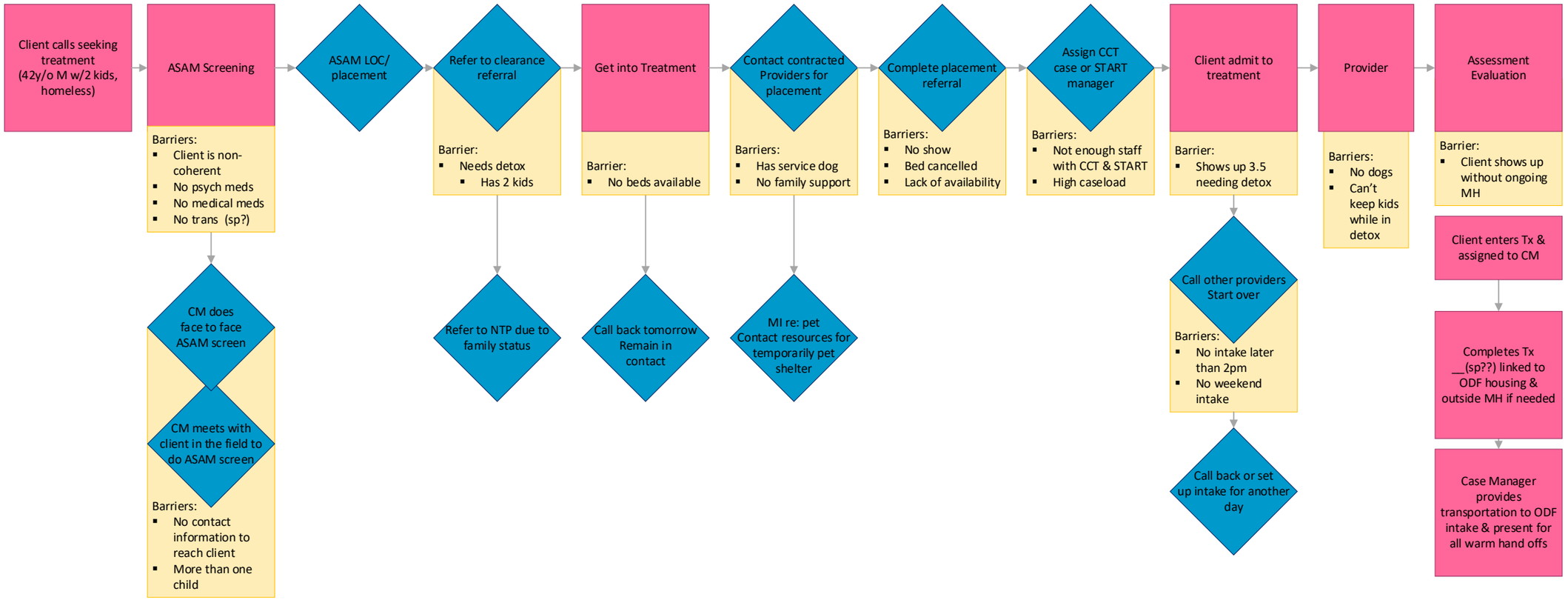
Another barrier is that some primary care providers may lack knowledge about SUD, and not recognize the need for any intervention. After education or brief intervention is delivered, the provider is required to document the screening and the intervention conducted in the electronic medical record (EMR) (this clinic uses EPIC as their EMR). If the provider lacks facility in the EMR, this may be a barrier (to securing reimbursement if the PCP is not an FQHC, or to meeting performance requirements). When referrals are made they are sent to the County Substance Abuse and Treatment Program(SAPT). If the patient decides to self-refer one barrier is that they don’t follow through. Once a patient begins MAT, some barriers encountered include lack of MAT providers in the same clinic location, inability of X-waivered primary care practitioners to initiate MAT either due to lack of interest, lack of experience, or lack of staff support. There may also be geographic barriers, insufficient treatment resources, or lack of training about the levels of care and treatment facilities that provide different levels of care. Regardless of whether a brief intervention or a referral occurs after screening, the primary care provider needs to schedule a follow up appointment with the patient. That follow-up may be impeded by inaccurate or missing patient contact information, patient no-shows, or failure to conduct patient reminder calls.

Outpatient NTP Current State VSM



At present, most clients to Narcotics Treatment Programs (NTP) arrive as walk-ins. Regardless of how they enter the NTP, the intake process is extensive and lengthy (3-5 hours). Clients must go through a comprehensive medical clearance, nursing clearance, and the history of addiction is reassessed before an initial treatment plan is developed. Once the intake process is complete, staff must determine medical necessity for admission. If the criteria are not met, the client is referred to a different level of care. A barrier may be finding an appropriate referral. If the criteria are met, the client is dosed (medication) and counseling is begun. Every client is assigned a primary counselor. Counselors contribute to the creation of a comprehensive treatment plan informed by a psychosocial assessment, all of which must be completed by day 14. Some challenges and barriers here include housing, transportation, staff awareness of resources, and limited qualified staff to carry out all required assessments in a timely manner. Outpatient NTP employs a harm reduction model. Consequently, once clients are engaged in treatment, they would not be discharged for using other substances, although that is not ideal. Clients struggling with multiple substance use disorders may require a higher level of care. Referrals to higher levels of care can be challenging when clients are actively engaged in MAT for a variety of reasons including stigma from staff at abstinence-only programs (or historic programs that have yet moved beyond that culture), and the lack of readily available MAT services at that higher level of care placement. In general, there is a need for general staff at NTP and other levels of care to receive more education about MAT. Once patients are engaged in maintenance treatment, drop out, stigma and lack of understanding around length of MAT treatment remains a barrier, as does drop out. Eventually, when ready, the goal is to have clients step down to a lower level of care, and eventually transition to a sober living environment or other aftercare program. Barriers include staff understanding of Alcohol and other Drug Program (AOD) regulations (and how that affects transitions to other levels of care), the absence of integrated care, and lack of coordination with other SUD providers.

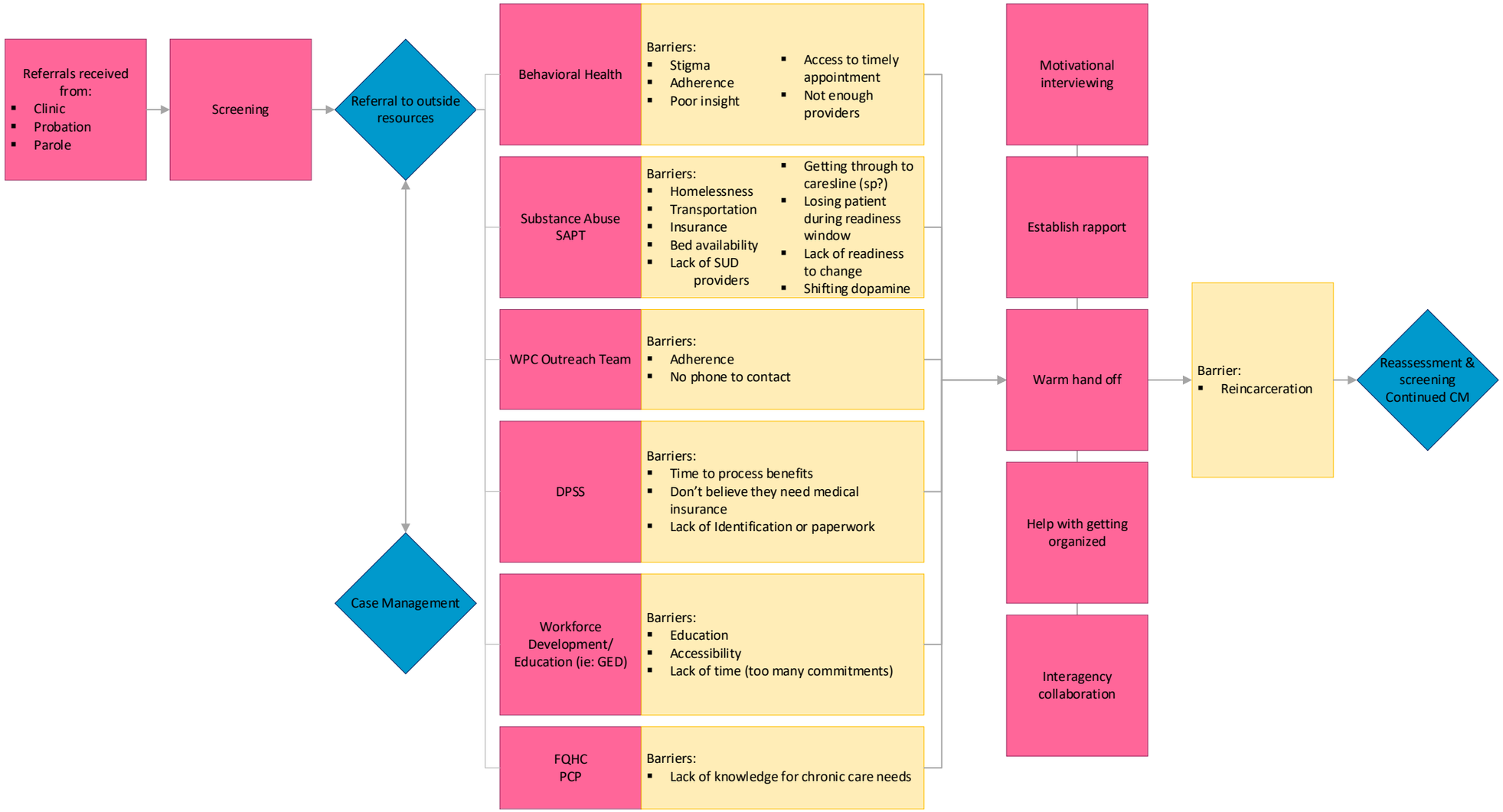
Riverside County Behavioral Health Current State VSM



Riverside County Behavioral Health

A client calls seeking substance abuse treatment either directly or through SU CARES. They receive an ASAM screening (for the purposes of this report, in most instances when Riverside treatment providers use the term ASAM screening, they usually are referring to the RUHS screening tool, based on the ASAM CONTINUUM). Some barriers encountered include clients being non-coherent, not having access to necessary psychiatric or other medications, and no transportation to arrive for their screening. To overcome some of these barriers, staff sometimes go out into the field to meet the client to conduct their ASAM screening. Barriers encountered include not having accurate contact information for the client, and the client having a child or more than one child in need of child care supervision. Once the screen is completed, the client is referred to the most appropriate level of care. If the client is willing to proceed, the case manager refers them to get their clearances. In the example depicted in the above diagram, the client needs detox but has two kids, so he is referred to NTP. A barrier to getting a client into treatment could be an insufficient number of beds. Staff overcome this barrier by calling back every day and staying in close contact with the client to let them know of any progress in finding them a bed. Once a bed is available, staff contact the contracted treatment provider for placement. In this example, the client has a service dog, and doesn't have any family support to help while he is in treatment. A technique used to overcome this barrier might be motivational interviewing regarding the client's service dog and contact their resources to find a temporary shelter for the dog. Once a placement is secured for the client, there is always the possibility that the client will not show up, the bed will be cancelled or there will be a lack of availability. When a spot is truly secured, the client should be assigned a Care Coordination Team (CCT) case or a Substance Abuse Treatment and Recovery Team (START) manager. There are often inadequate staff to take the new client on, and/or the assigned case managers has a very high caseload. Once clients are admitted to treatment, they may show up having recently used and needing detox, which necessitates a restart of the process so the client is ready to begin MAT. Because there is no intake after 2 PM or on the weekends, staff have to put the intake off or set up an intake appointment for another day. Once a client is successfully admitted into treatment and assigned a provider, they receive an assessment evaluation. If the client has behavioral health needs and shows up without ongoing mental health treatment, that is a barrier. After the assessment, the client enters into treatment with a case manager and works to successfully complete treatment. They are linked with outpatient drug-free (ODF) housing and outside mental health services if needed. The case manager provides transportation to ODF intake and is present for all warm handoffs.

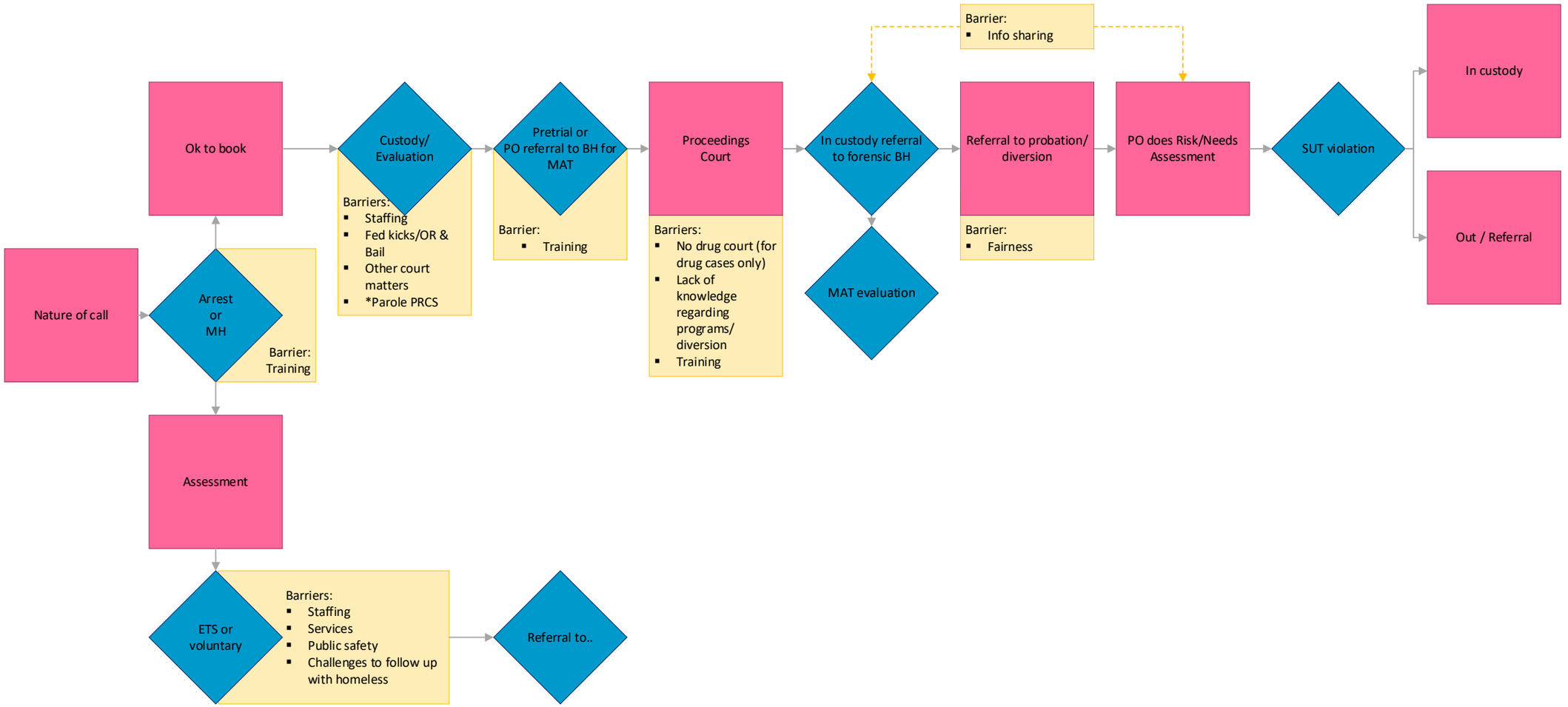
Riverside County Whole Person Care Current State VSM



Riverside County Whole Person Care

The Riverside Whole Person Care Program (WPC) was established to address the needs of justice involved individuals who are on parole or probation and reentering society. Referrals to this program come from clinics, probation or parole offices. Clients are initially screened by a nurse to identify risk factors for behavioral health, physical health and substance use conditions. Based on the results, the nurse determines how the client should be referred: in-house or to case management. Those with greater needs are referred to case management. The options for in-house referrals include: behavioral health, substance abuse (SAPT), the WPC Outreach Team, DPSS, workforce development/education, and FQHC/primary care provider. There are unique barriers involved with a referral to any of the aforementioned options. For those with behavioral health needs, barriers include stigma, non-adherence, poor client insight, lack of access to timely appointments, and insufficient providers. For those with substance use disorders, barriers include homelessness, lack of transportation, insurance, bed availability, and SUD providers. Other barriers include long wait times or failure to connect to staff on the SU CARES line, loss of the client during the treatment readiness window, lack of readiness to change, and shifting dopamine or mood changes. For those engaging the WPC outreach team, barriers include non-adherence and the inaccurate or missing client contact information. For those with DPSS needs, barriers include time to process benefits, clients not thinking they need medical insurance because they think they are healthy, and lack of identification or paperwork that meets application requirements. For those accessing workforce development services, barriers include education, accessibility, and lack of time because of other commitments. For those seeking FQHC/primary care services, barriers include lack of knowledge and appreciation about chronic care needs. To address some of these barriers, staff do motivational interviewing, establish rapport with clients, conduct warm handoffs between services, help clients with getting organized, and work toward interagency collaboration. If a client is reincarcerated at some point after entering the WPC program, the process begins over again. Staff reassesses and screens regularly until the plan is complete.

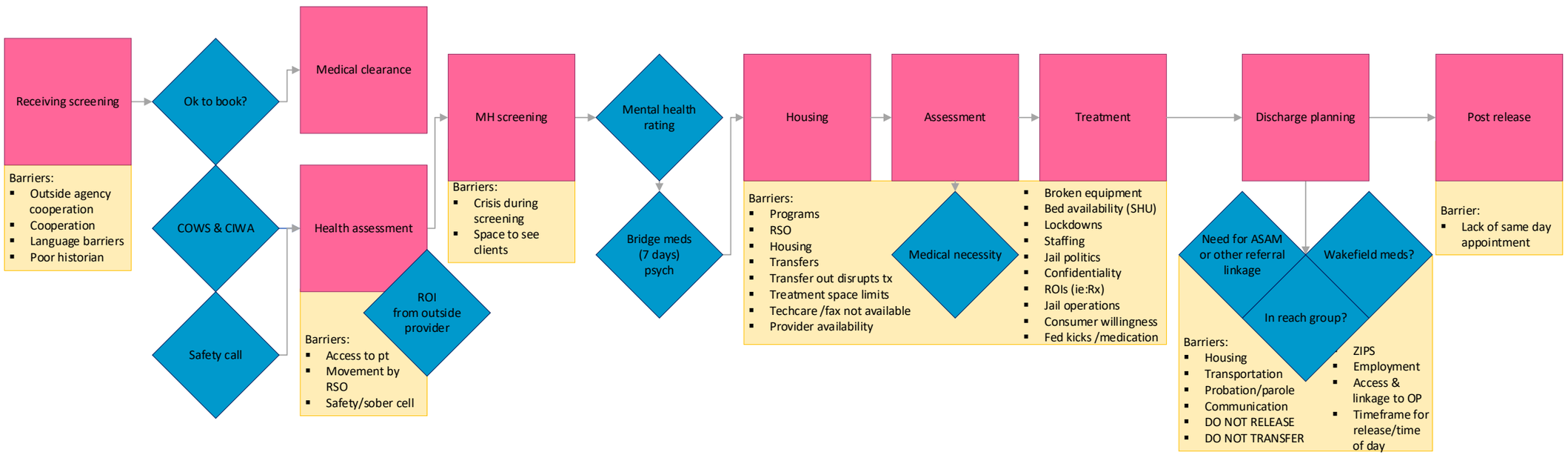
Riverside County Drug Court Current State VSM



Riverside County Drug Court

The process begins with the nature of the call. The officer determines if it is an arrest or mental health situation. Training on how to properly assess and distinguish between the two is a barrier at this point. If it is an arrest, the individual will be remanded into custody. As of now, only pregnant women are able to get SUD services while in custody in Riverside. Some barriers encountered when a person is in custody include staffing, fed kicks (i.e., early release from jail owing to overcrowding), O.R. and Bail, and other court matters such as Parole, Post Release Community Supervision (PRCS). These early release programs undermine the incentives and options for treatment for individuals with SUD. Once an individual gets to the court proceedings, some barriers encountered include a lack of attorney training and knowledge regarding programs and diversion opportunities. If, due to the nature of their charge, a person is placed on probation, the probation officer will then conduct a risk/needs assessment. If the individual was being treated for SUD or some other conditions while in jail, the probation officer doesn't have access to that information. There is, however, a WPC nurse in-house, who can address those needs if an individual requests SUD services. If an individual tests positive for drugs, and that positive test is determined to be a violation of their probation, the individual could end up back in custody and the process would begin again. Alternatively, they could be referred to treatment outside of custody.

Correctional Health Current State VSM

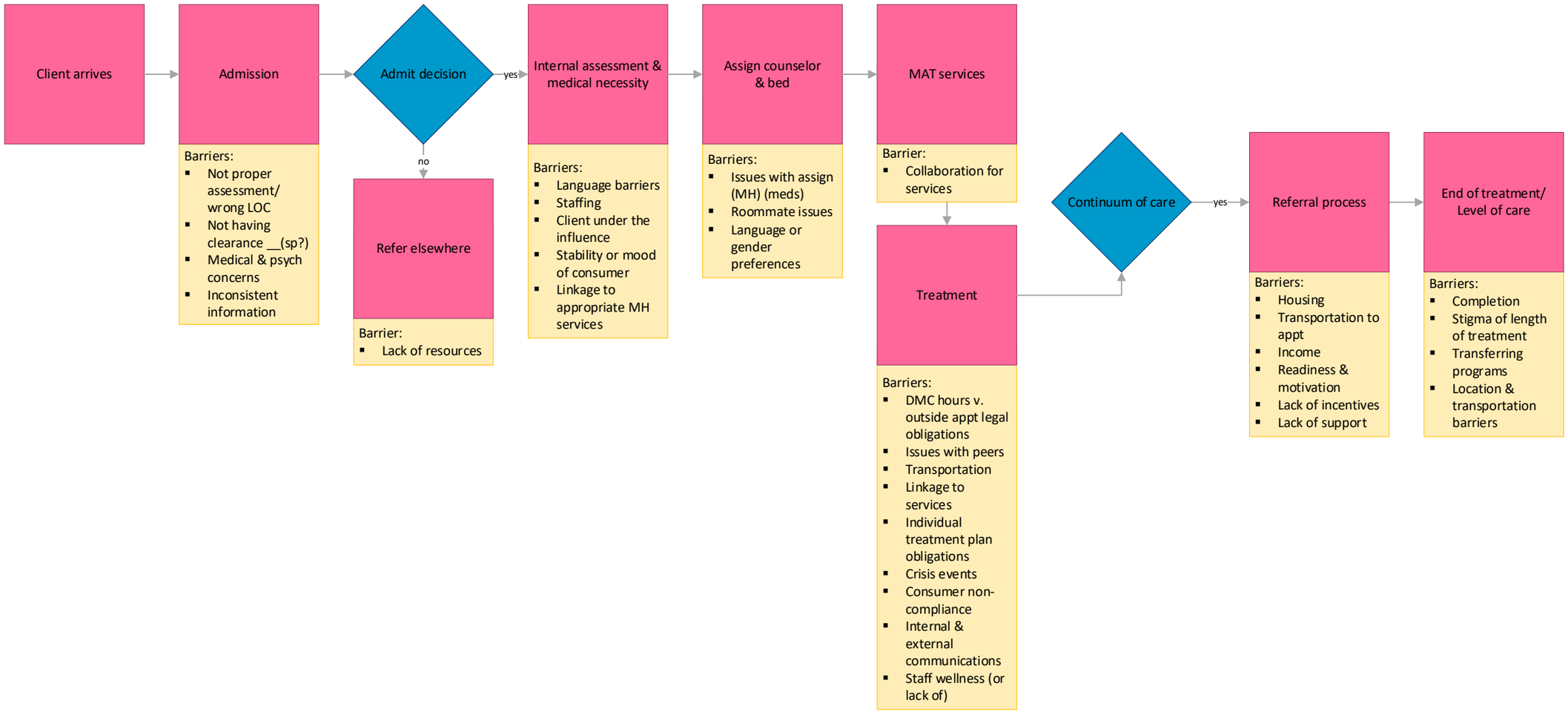


Correctional Health

Riverside County is in the process of implementing access to MAT in correctional institutions; however, the value stream map above reflects the current process.

Inmates are initially screened by an RN. Barriers include language barriers, outside agency cooperation, general cooperation from the inmate, and the inmate not being able to give an accurate history of past substance use. The RN decides if the inmate should be sent to an outside agency for emergency care (e.g., pregnant women on methadone would need to be assessed by hospital staff to determine if the client is OK to book), needs a Clinical Opiate Withdrawal Scale (COWS) and the Clinical Institutes Withdrawal Scales for Alcohol Withdrawal (CIWA), and/or be placed in a safety cell. From there, a health assessment is conducted. The RN may need to get a signed release of information (ROI) from the inmate to get information on current medications in use prior to incarceration, for example. Then, a mental health screening is conducted. The mental health professional decides what the mental health rating should be for the individual, which impacts where they are housed, and what level of treatment they receive. During the mental health assessment, the need for Bridge medications is also assessed (i.e., if a patient was previously on medications, RNs work to get access to those medications within 24 hours of the inmate's arrival). Barriers during the health and mental health assessment include movement by the Riverside Sheriff's Office (RSO), safety or sober calls, having adequate access to the clients, any crises during scheduling, and inadequate space to see clients. Next, an inmate is housed where appropriate, and treatment begins. Barriers encountered include RSO programs, treatment space limits, staff/providers not being available, transfers, Tech Care electronic health record and fax not available, jail operations, transfer out disrupting treatment, broken equipment, ROIs (ex: prescriptions), lack of housing, bed availability SHU, confidentiality, lockdowns, additional staff needed, and jail politics. When an inmate is ready to be released, staff does discharge planning. Staff decides if the inmate needs ASAM or other referral linkage, discharge medications or Wakefield meds (i.e. temporary supply of medications while awaiting complete discharge medications) or in reach groups. Some barriers encountered at this point include fed kicks (focused on reducing inmate population), and consumer willingness. After an inmate is released, barriers encountered include transportation, inadequate or ineffective communication, housing, employment, access and linkage to outpatient care, etc. The ultimate goal is to release clients from their system and connect them with services they need in the community.

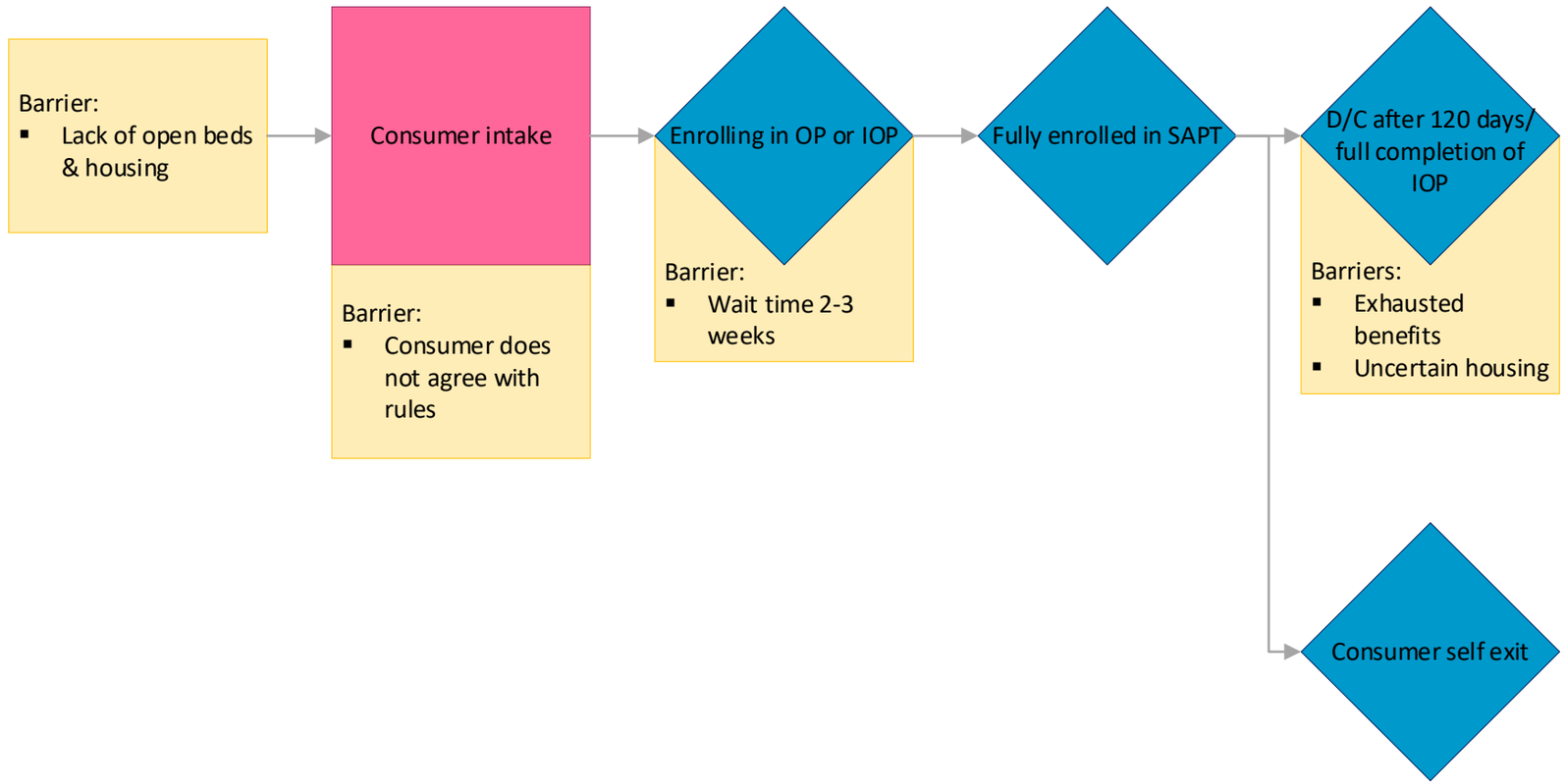
SUD Residential Treatment Current State VSM



SUD Residential Treatment

Clients are usually referred to Residential treatment settings, and upon arrival an assessment is undertaken to confirm the need for admission. During the admissions determination process, some of the barriers encountered include improper assessment of level of care; not having mental health clearance, medical and psychological concerns of the client; the client providing inconsistent information. If it is determined that a client should not be admitted, they are referred elsewhere. A barrier is that sometimes there is a lack of responsiveness from the places to which they are referred. If it is determined that a client should be admitted and/or there is a medical necessity, some barriers include language barriers, staffing, client being under the influence, the client not being stable, and linkages to appropriate mental health services. Once a client is admitted, they are assigned a counselor and a bed. Sometimes there are issues with the assignments made related to mental health concerns or medications; roommate issues; or language or gender preferences. Once a bed has been established, the client will get connected to necessary MAT services or other treatment. Some barriers include difficulty in collaborating between services; DMC hours [i.e. SUD residential facility] vs availability of outside appointments and legal obligations; issues with peers; transportation to outside services; individual treatment plan obligations; crisis events; non-compliance; and staff wellness or lack thereof. The counselor then decides if a client should receive the full continuum of care. If yes, the client goes through a referral process. Some barriers that arise at this point are housing; lack of support, transportation to appointments; income; readiness and motivation; and lack of incentives. When discharge planning is complete, treatment ends (at least in that facility); however some barriers include not completing treatment, the stigma related to the length of treatment, and transferring progress.

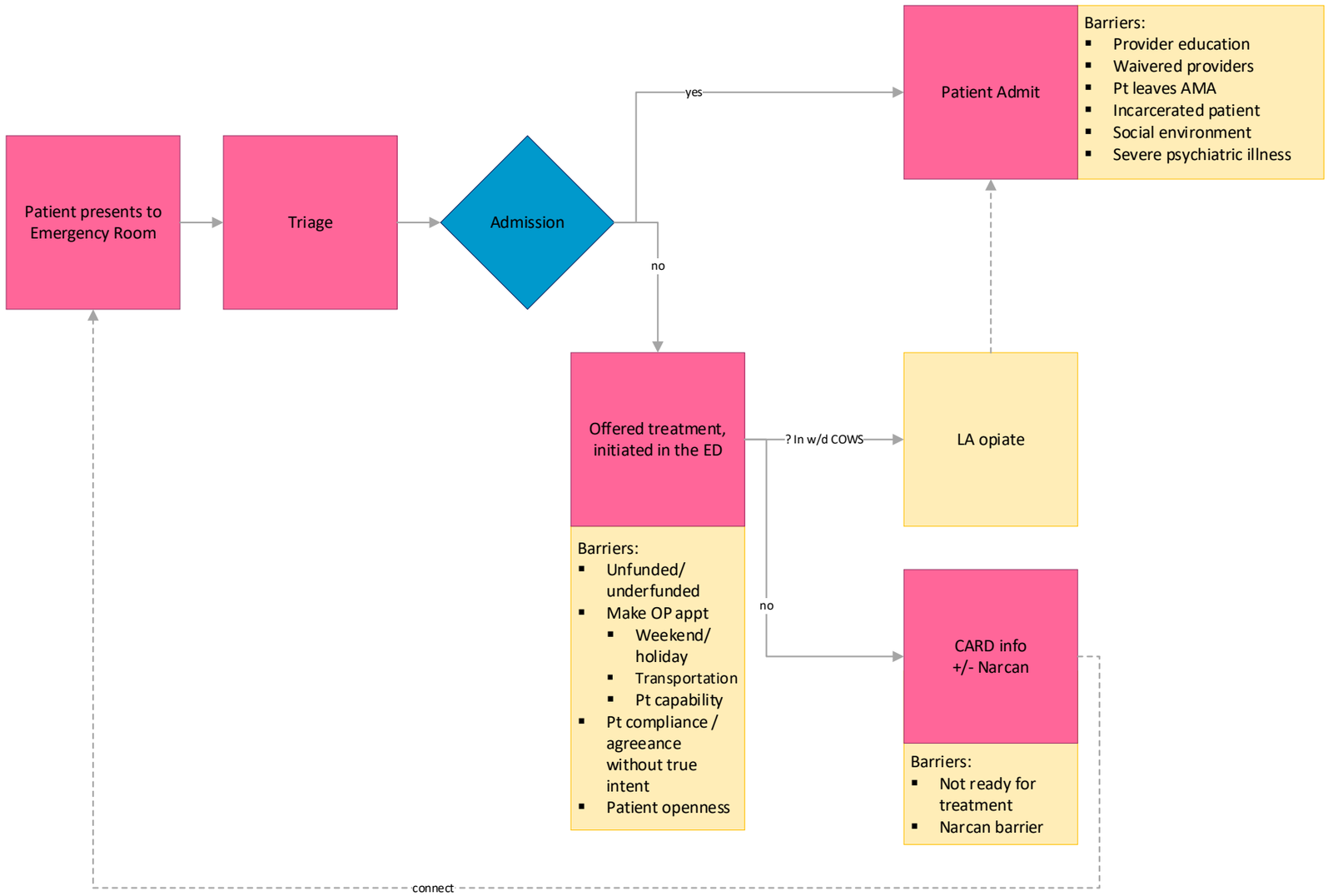
Sober Living (Bridge Consortium) Current State VSM



Sober Living (Bridge Consortium)

Access to sober living and supportive housing is limited in Riverside, and this is a huge barrier to successfully transitioning individuals with SUD back into the community. Once a bed becomes available a consumer intake is completed. A main barrier in Sober Living is when consumers do not agree with the rules such as drug tests. If they agree, they are then enrolled in outpatient or IOP classes. The wait time is 2-3 weeks which is a barrier. Once they enroll in outpatient or IOP classes, they are fully enrolled and do an SAPT. Sober living beds are generally accessible for only 120 days, after which clients are discharged. The exhaustion of these benefits and/or the uncertainty surrounding housing options is a huge gap in the system.

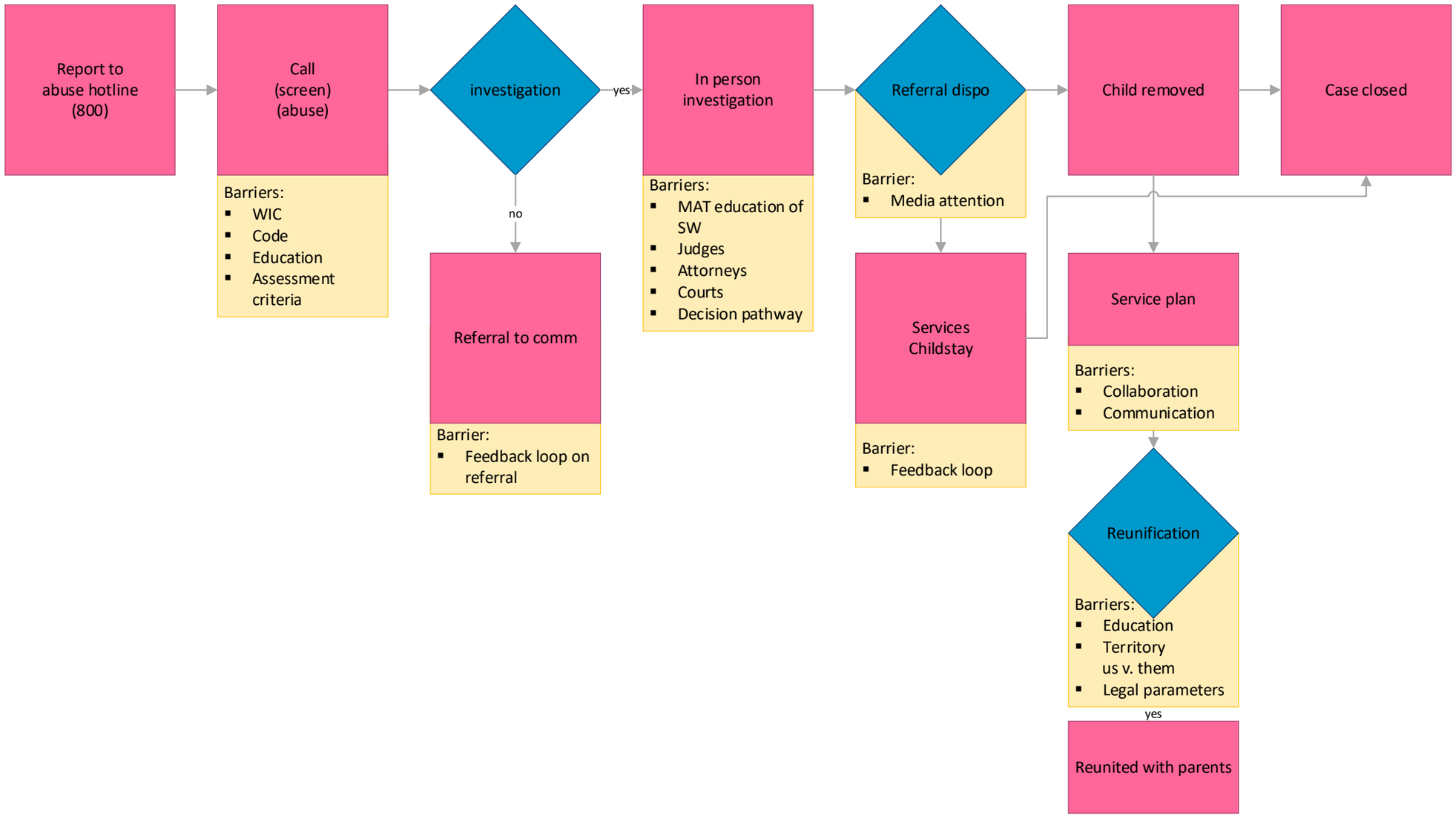
Hospital Current State VSM



Hospital

When a patient presents to the emergency department with risk factors for OUD, they are assessed for opioid dependence and last use. The doctor evaluates them and decides if they are eligible for treatment. In order to be eligible to receive treatment, they must be in withdrawal for 12 to 24 hours. If they are able to be induced in the emergency room with suboxone, the doctor also can put in a referral to a Substance Use Navigator (SUN). The SUN then assists the patient in getting connected to an outpatient facility to continue treatment. The SUN initially visits the patient every day, and over time decreases the frequency of visits to once per week for the first 30 days. Alternatively, the patient will call SUN to share how they are doing. The SUN program has been underway since February [2019] and during that period only two patients have discontinued treatment. Barriers include not being able to provide Narcan; some patients not being ready for treatment; providers not comfortable providing suboxone or are not X waivered to do so; some patients leave against medical advice; those on holds (e.g., 5150 Lanterman Petris Short Act holds) aren't able to enter outpatient treatment; and incarcerated patients are difficult to connect to services because of the inconsistent availability of MAT services in the correctional facilities.

Child Welfare Current State VSM



Child Welfare

This is an overview of one type of case; one that begins with a report of child abuse to the child abuse hotline. That call is screened to determine if an investigation needs to take place. Before that determination is made, some of the barriers that are encountered include a lack of knowledge or understanding about substance abuse and appropriate assessment criteria. Additionally, communication back to the person(s) who made a referral and the community at large is a barrier (feedback loop). If it is determined that it is necessary, an in-person investigation takes place to determine if child abuse is occurring or has occurred.

Among the barriers encountered at this point are lack of education among staff, including judges and attorneys about SUD and treatment options for SUD and the related acronyms (e.g., MAT), and about addiction and addiction treatment. Once it is determined that a child needs to be removed [because of abuse], Child Welfare works with the family to provide services for the child and family. Some additional barriers include an us vs them mentality and media attention.

D. Gaps and Barriers – Inventory and Discussions

In order for any community-wide transformation to take place, it is a powerful and important exercise for the community stakeholders to clearly identify the current state of their treatment and recovery ecosystem. While there is much good work and effort happening in Riverside County to address SUD, stakeholders agreed there were many challenges, particularly around stigma, staffing, and funding.

Group Barrier Discussion Summary

On Day 1, the Riverside County Stakeholders in attendance were broken up according to their sector or program, and asked to gather around 10 easels. In some instances, the stakeholders in each of these 10 groups represented a mix of programs, rather than just one agency. In these small groups, the stakeholders brainstormed to identify the top barriers in the current treatment ecosystem as a whole. They were asked to identify systemic barriers, to contrast or compare to the barriers identified during the sector/agency-specific current state value stream mapping. The systemic barriers and gaps are listed in the table below. A subsequent discussion on Day 2 focused on solutions to address the barriers identified on day one.

Barrier	Proposed Solution
Lack of housing/ homelessness	More resources
Lack of collaboration	Advertise/open up county provider meetings (every other month) to wider community stakeholders
Lack of (skilled) staffing, language and cultural competency among providers	More professional development
Transportation	Continue dialogue with health plans on transportation issues Have conversations with Sunline or RTA on bus passes
Lack of services for mothers/fathers with their children	More family advocates specializing in SUD
Lack of services for levels of care 3.3, 3.7-4.0	More resources
Lack of transitions of care, including pre and post MAT	Warm hand-offs between providers, more communication across system
Lack of services to meet individuals where they are	Wrap-around in-home care
Stigma, lack of education, common language and definitions	Community education

Lack of universal data	One standard data system
Lack of awareness of resources	Enhance Connect IE resource index (https://connectie.org/)
Lack of trust between patients and providers	Motivational Interviewing

Agency-Specific Gaps and Barriers

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

	Structural Barriers	Structural Inefficiencies	Structural Gaps	Capacity	Knowledge/ Training	Inconsistency	Stigma/ Criminalization	Social Correlates	Funding	Insurance	Cultural Competency
Outpatient SUD			1	2				3		1	
Riverside County Public Health					2						
Primary Care	2	2	1	4	5	1	2	3			
Outpatient NTP	3	1		2	3		2	2			
Riverside County Behavioral Health	3	3	4	3		2		6			
Riverside County Whole Person Care		1		2	2		1	4		2	
Riverside County Drug Court				3	4			1			
Correctional Health		4	2	9			1	3			1
SUD Residential Treatment		2		3	1	1	1	6			2
Sober Living				2					1	1	
Hospital			2		2			2	1		
Child Welfare	4	2			3						

E. Future System Goals

During the afternoon of day two, the participating organizations began to think about moving from their current states to an improved future state of addiction treatment. 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). The groups then left their own tables and did a “gallery walk” to see what other groups had prioritized.

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 36 elements that stakeholders prioritized as most desirable in the future ecosystem of care:

- Warm handoffs/ transitions of care that increase communication and continuity of care
- One standardized electronic health record platform for the county
- Pre-recovery services: stabilization 7-30 days on MAT medication (LOC 3.7)
- Medical site clearances alongside an upcoming appointment for further services for co-occurring conditions
- "One stop shop” service delivery that includes wrap-around supports
- Medication management for mental health and medical issues
- An electronic pre-questionnaire so clients have basic information already in the system when they meet with BHS: historical info, demographics, history of use, criminal justice involvement
- Trained SUD counselors for the deaf community (sign language): use telehealth
- Mobile NTP to overcome transportation difficulties
- More certified drug and alcohol counselors in primary medical settings: PCP clinics, OB/GYN, ED
- Education/ professional development for providers on SUD
- Professional development training on SUD for the larger community (first responders, urgent care, teachers, justice system, mental health, physicians, parole, DPSS, police) on available resources, assessment, referral, MAT, etc.
- Better collaboration across the county
- More resources: housing, SUD, transportation, etc.
- Early prevention and education (K-12)
- More policies and legislation that support having more training/education
- Continue treatment for patient already on an MAT program when they enter jails
- Develop a system-wide process across jails for MAT
- When client enters jail, have an automatic referral process for SUD treatment if a client is flagged by nursing for SUD
- Discharge groups: standardize having clinic staff come in and engage with inmates prior to discharge and create a relationship (pre-discharge clinic warm hand-off)
- Provide transportation for clients to get to CSUs, SUD/MH clinics
- Cross-reach teams doing outreach: have a behavioral specialist III on these teams
- Streamline process around transitioning between levels of care- advocate at state level to reduce burden on client
- Develop same-day access models in all outpatient clinics across the county
- Whole person care- an increased number of universal navigators to stay with clients and guide them through the entire process
- Restructuring of assessments (e.g. adding back questions on trauma)
- Universal Medi-Cal-instead of counties dispersing Medi-Cal, state does this so burden of paperwork is reduced, easier to transfer clients across county lines
- Patient education- help clients understand stigma, MAT can help DCFS cases

- "No wrong door"- universal screening across system, hotline
- Mobile clinic for doctors to address chronic physical health issues at SUD treatment sites
- Increased communication and fluid collaboration across county
- Bed inventory based on necessity of consumers: recovery, residency, treatment facilities, etc.
- Real information exchange between provider and referral source
- Real-time mobile app with entire continuum of care throughout county, to be able to see facility hours, bed availability, waiting list for enrolling clients
- More diversion sites, CSU for people we are looking to enroll in SUD care at any level
- Improve SU CARES

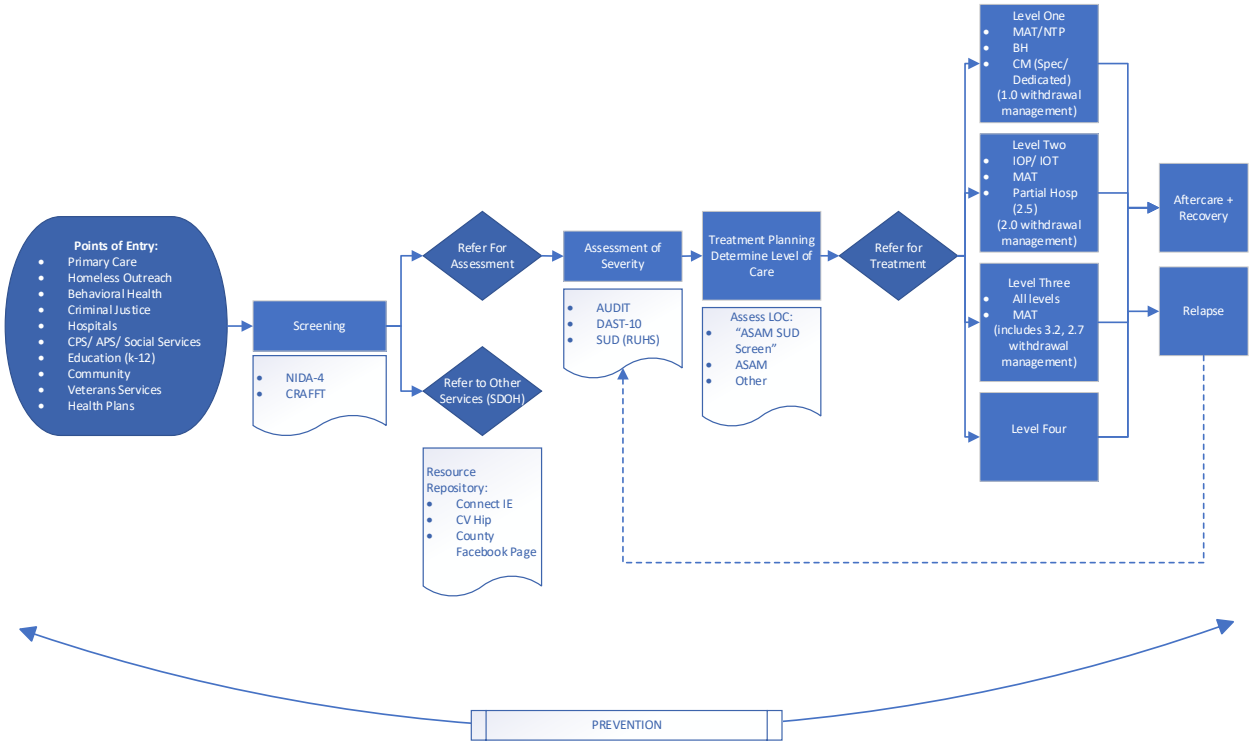
F. Triggers

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 addiction. 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

G. 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 Riverside 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.
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. In most counties that are contracted with the Department of Healthcare Services (DHCS) as a Drug Medi-Cal Organized Delivery Systems (DMC-ODS), such as Riverside County, the state requires the use of a level of care determination developed by the American Society of Addiction Medicine. The ASAM Continuum Triage (ASAM CO-Triage) is a provisional level of care determination tool, and the full CONTINUUM is more complete, and often completed soon after the CO-Triage. In Riverside County, however, the Riverside University Health System (RUHS) felt that they needed a more robust version of the ASAM assessment tool that created a structured motivational interview in order to better understand the unique needs of each consumer. It was decided that RUHS-BH would create such a tool: one for adults and one for adolescents. A workgroup was convened that included an Addiction Specialist (MD), clinical managers, contracted provider staff, research staff, and line counselors who worked to develop these tools. Each tool was designed to enable the counselor to garner the pertinent information needed to assign a score for each dimension that gave a true picture of the consumer's needs in that area. Additionally, the adolescent version was designed to get input from both the adolescent and the parent/caregiver. Once the two versions were finalized, they were field tested for a short period of time. There was no formal statistical validation performed. It was felt that since the ASAM has validity in its original form and that this version was developed and tested to include more information than the short version, that formal validation was not necessary. In looking back at the data since Riverside County went live with the Waiver, we have administered 37,547 adult level of care assessment and 1,500 adolescent level of care assessments using our tools developed in-house. With the adults, our records indicate that 94% of level of care placements agreed with those assigned by the formal ASAM assessment. For adolescents, 96% of level of care placements agreed with those assigned by the formal ASAM assessment.

DHCS requires that all individuals administering an ASAM screening have undergone two levels of training in using the ASAM. Riverside County received special permission to be able to provide those trainings in-house in order to meet the needs of our County. The use of our tools created in-house were approved for use by DHCS and are used by all county operated clinics and all DMC contracted entities providing substance abuse treatment services within Riverside County. Each individual that provides ASAM screening within the County is required to go through two levels of general ASAM training

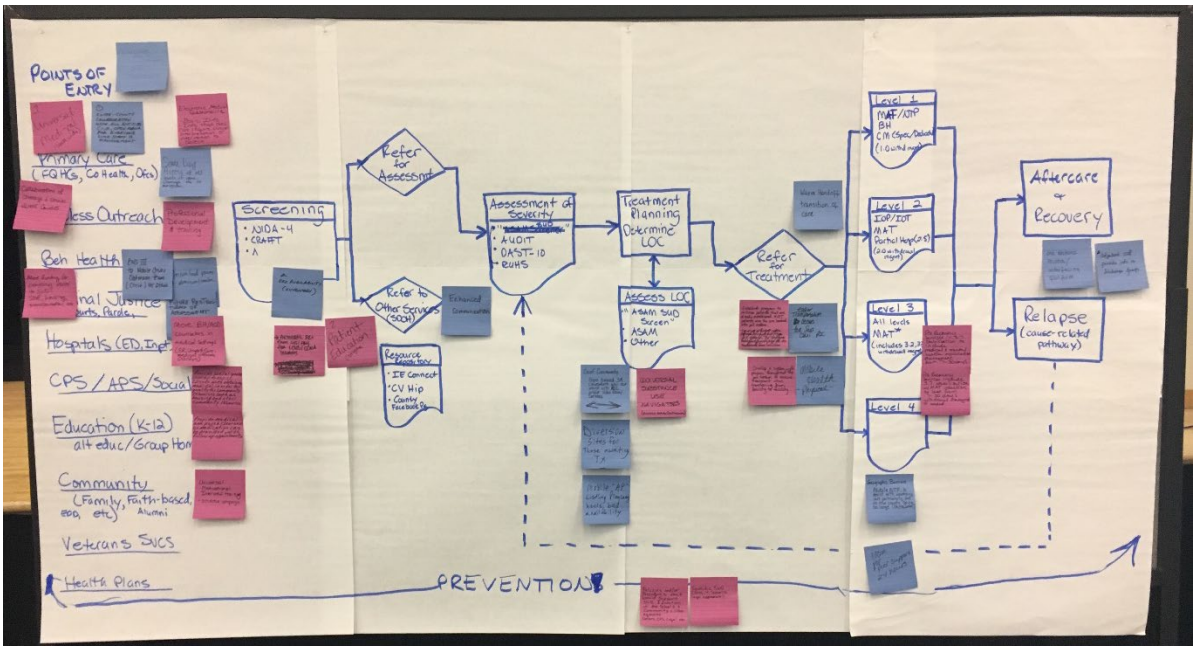
indicated above as well as training in the use of ASAM tools developed in-house before they are allowed to administer an ASAM screening.

With the establishment of the DMC-ODS contract, Riverside County now has treatment services in Level 1, 2 and 3, with additional services being developed in the near term. Moreover, Riverside University Health Systems operates the Substance Use Community Access, Referral, Evaluation, and Support (SU CARES) line, which serves as a central locator of available treatment and recovery appointment resources for the ODS. Clients looking for outpatient or recovery services can now access services by contacting one of the ten county operated substance abuse clinics or the SU CARES line. In accordance with the ODS waiver requirements, however, all requests for residential placement or withdrawal management must be accessed and authorized through the SU CARES line. The SU CARES line went live in 2016 (one year before the roll out of the ODS waiver) and was tested with referrals coming in through our local Medi-Cal Managed Care Health Plan. The service provided by SU CARES is in high demand and call line resources are still ramping up to fully meet the demand. Currently, the SU CARES line is processing over 5,000 calls per month.

At present, Riverside County has treatment programs at ASAM level 1 through 3, with additional development and contracting in place that will expand withdrawal management at multiple levels as well as Level 3 services. There are no plans for level 4 services inside of Riverside 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. Participants wrote down the key features on post-it notes and affixed them on the section of the diagram to which they best corresponded:


POINTS OF ENTRY
Primary Care
(FQHCs, CoHealth, Ofcs)
Outreach
Beh Health
Justice
Hospitals (ED, Inpt
CPS / APS / Socia
Education (K-12)
alt educ / Group Hom
Community
(Family, Faith-based,
Alumni
Veterans SVCS
Health Plans
Screening
• NIDA-4
• CRAFT
• A
Refer for Assessment
Refer to Other Services (SDOH)
Resource Navigation
• IE Connect
• CV Hip
• Country
Assessment of Severity
• AUDIT
• DAST-10
• eWHS
Treatment Planning Determining LOC
Assess LOC
• ASAM SUD Screen
• ASAM
• Other
Refer for Treatment
Level 1
MAT/OTP
BH
Level 2
IOP/EOT
MAT
Partial Hosp(OS)
Level 3
All levels
MAT
Level 4
Aftercare or Recovery
Relapse
(cause-related pathway)
PREVENTION

03 Section 3: Implementation Strategy

A. Next Steps

In a matter of two days stakeholders from across Riverside County were able to identify major aspects of the systems that touch patients with addiction, determine what the major gaps and barriers are, and develop a viable future state "scaffolding". The ideal future state treatment and recovery ecosystem in Riverside County would include:

- Standardized screening pathways with 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 insure that those engage patients can optimize, and access to a substance use navigator to facilitate service access and utilization
- Streamlined, same day access to all levels of care that would be facilitated by enhanced staffing in SU CARES (i.e., the appointment/bed locator) and user-friendly (mobile) applications, mobile clinics staffed with clinical providers to perform medical screening, better communication and standardized movement of protected patient health information across the system, and diversion sites for those who cannot get into treatment immediately
- Targeted services and supports for the deaf with SUD
- And other features, such as, user-friendly electronic versions of screening and assessment tools, more peer support and transportation services to meet the needs of those for whom transportation

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 addiction treatment in Riverside County. Given this, we know there is a highly motivated group of people to build stronger transitions of care for individuals suffering from the disease responsible for the number one cause of injury related death in our country (opioids) and an enormous source of tragedy and suffering for any community to have to endure.

B. Technical Assistance Program

Prior to the process improvement event, we collaborated with the Riverside County Behavioral Health to develop an attendee list and conduct broad outreach to invitees to encourage attendance. Prior to the event, Riverside County Behavioral Health completed a survey to document existing substance use disorder (SUD) capacity and resources in Riverside County, as well as understand barriers to coordinated care for individuals with SUD. 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 addiction and provide more information and training to our staff; (2) Learn more about how our organization can participate in a community wide solution to the opioid epidemic; (3) Improve our role in managing the transitions of care as residents in our community move within addiction system of care; (4) Start providing MAT

services at our organization; (5) Scale up our current MAT program by increasing the number of patients treated; (6) Learn how to provide or improve addiction treatment to pregnant and parenting women. Based on their selection(s) on the TA Application, organizations are put into one of two TA tracks:

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

Those who checked options 1, 2, 3, or 6 were put into the Generalized TA track, and those that checked options 4 or 5 were put into the TA Coaching group where there will receive more hands-on coaching to begin providing MAT services or scale up existing services.

Following the process improvement event, organizations in the TA Coaching group will be asked to complete a TA Assessment survey that includes more specific questions about TA interests and needs and will be used to match each organization with a TA coach. Once matched with a TA Coach, the Coach will reach out to the Organization Lead identified in the TA Assessment to schedule an initial coaching call. The Coach will provide individualized coaching to their organizations, or "sites", for 12 months.

Generalized TA offerings are available to both groups, 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 25 organizations applied for TA:

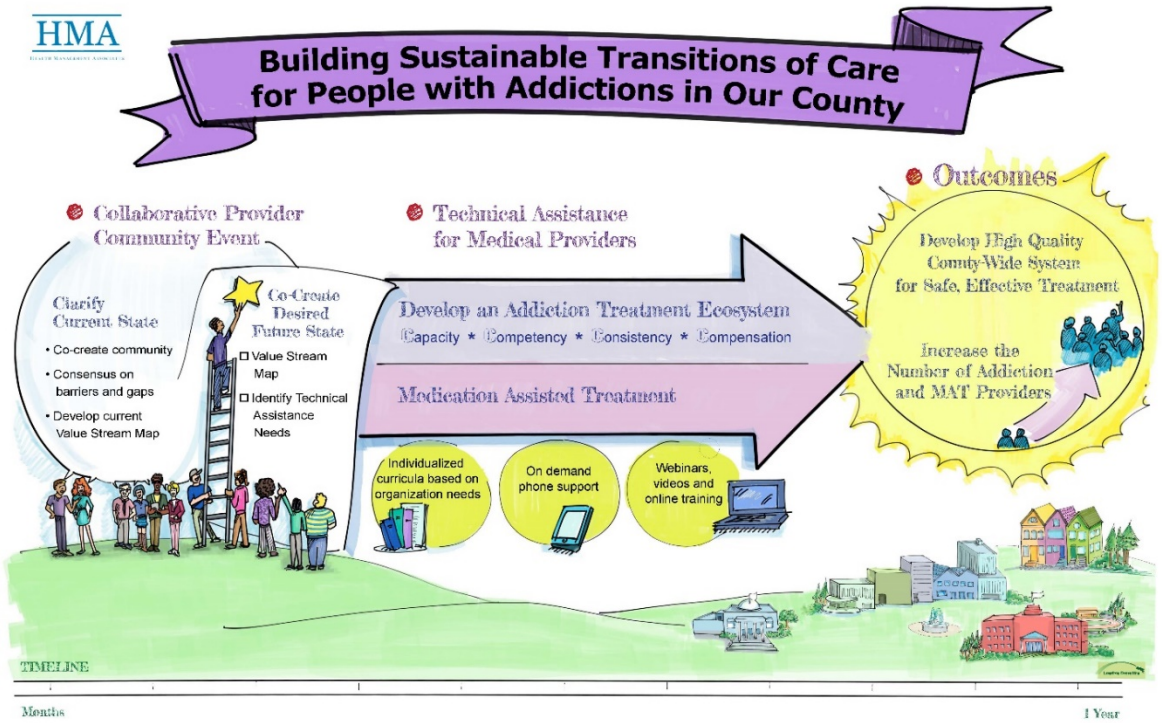
- Riverside County Probation
- The Ranch Recovery Centers, Inc.
- Riverside University Health System Behavioral Health Indio Substance Abuse Prevention and Treatment/Mental Health
- Riverside University Health System – SUD Program
- Riverside University Health System – UC Riverside Family Medicine Residency Program
- Riverside University Health System Internal Medicine (inpatient)
- Riverside University Health System Internal Medicine (outpatient)
- Riverside County Whole Person Care
- Riverside Correctional Health Services Pharmacy
- Riverside Correctional Health Services
- San Gorgonio Hospital
- Soroptomist House of Hope, Inc.
- Riverside University Health System Community Health Centers
- Riverside County DPSS – CSD
- The Bridge Consortium
- The High Road Program
- Awareness Program
- Riverside County Public Defender
- MFI Recovery Center
- Riverside County Public Health
- Riverside University Health System – Substance Abuse, Desert Hot Springs
- Riverside University Health System – Behavioral Health/Detention (Indio and Blythe)
- Inland Empire Disability Collaborative (Inland Empire Health Plan)
- CTC Division – Acadia Healthcare
- Inland Valley Recovery Services

The 23 organizations/teams who requested TA requested the following specific goals:

Goal	Frequency
Learn more about caring for people with addiction and provide more information and training to our staff.	20
Learn more about how our organization can participate in a community wide solution to the opioid epidemic.	17
Improve our role in managing the transitions of care as residents in our community move within addiction system of care.	16
Learn how to provide or improve addiction treatment to pregnant and parenting women.	11
Start providing MAT services at our organization.	7
Scale up our current MAT program by increasing the number of patients treated.	10

C. Conclusion

In conclusion, HMA thanks the Riverside County community who turned out with their hearts and minds committed to this work. We hold the deep conviction that the Riverside County community and stakeholder coalition of addiction treatment providers, medical professionals, hospitals, law enforcement, and CBO community has what it takes to rethink one of the most complex medical conundrums in modern history. With resources mobilizing throughout the state and within the county, the strong leadership of Riverside 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 addiction, better care for the community members suffering from this disease and eliminate addiction related deaths in the County.



Appendix

A. Riverside County Data

RIVERSIDE 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

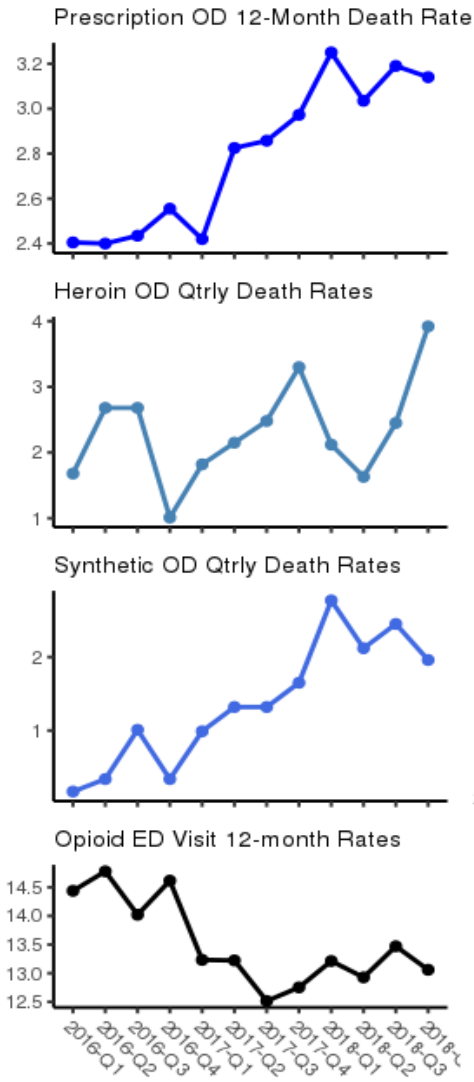
ADDITIONAL FACTORS

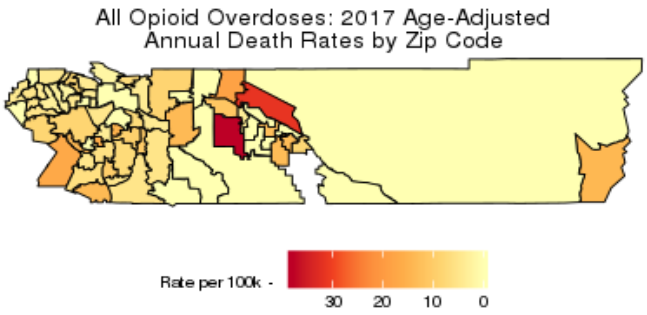
- Coalition: Inland Empire Opioid Crisis Coalition (IEOCC)
- SAMHSA Funds: $797,853
- Drug Medi-Cal Organized Delivery System: Yes
- Presence of CA Bridge: Yes

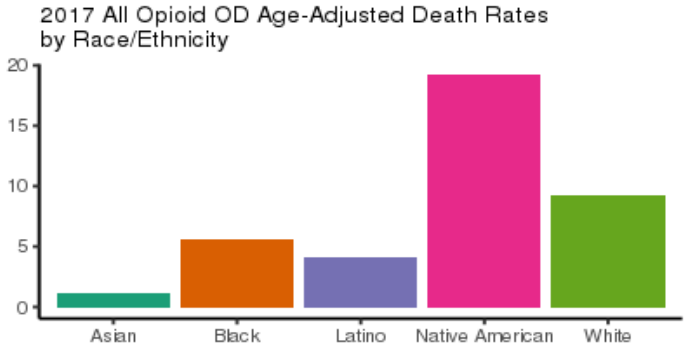
Riverside Opioid Overdose Snapshot: 2016-Q1 to 2018-Q4

Report downloaded 09-12-2019

Riverside 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.

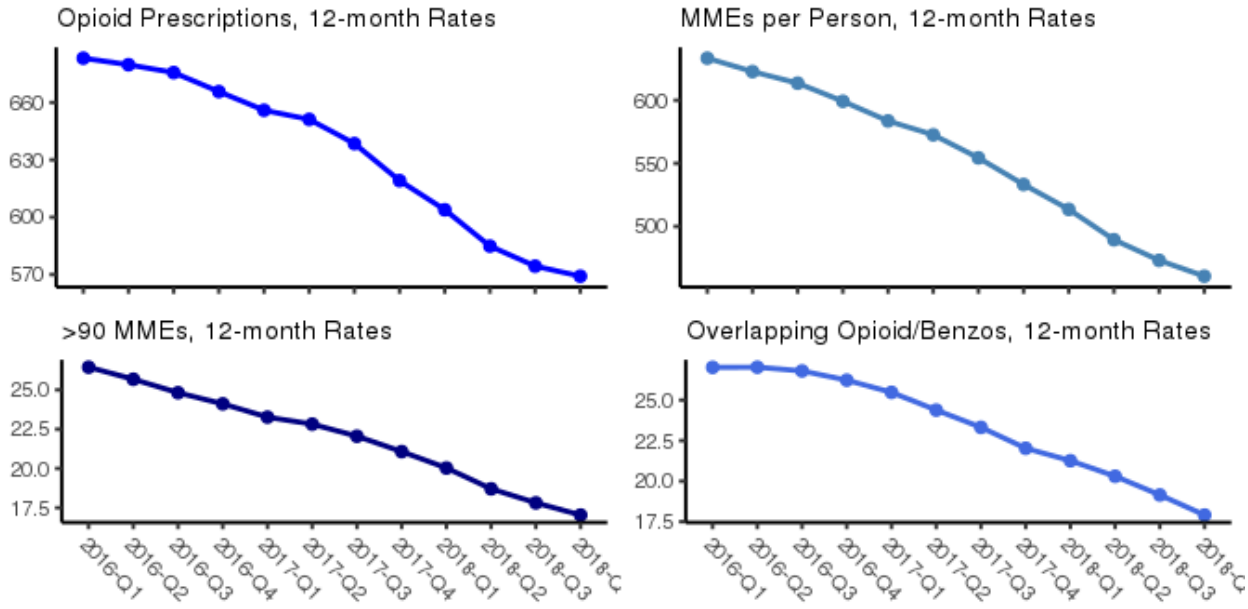






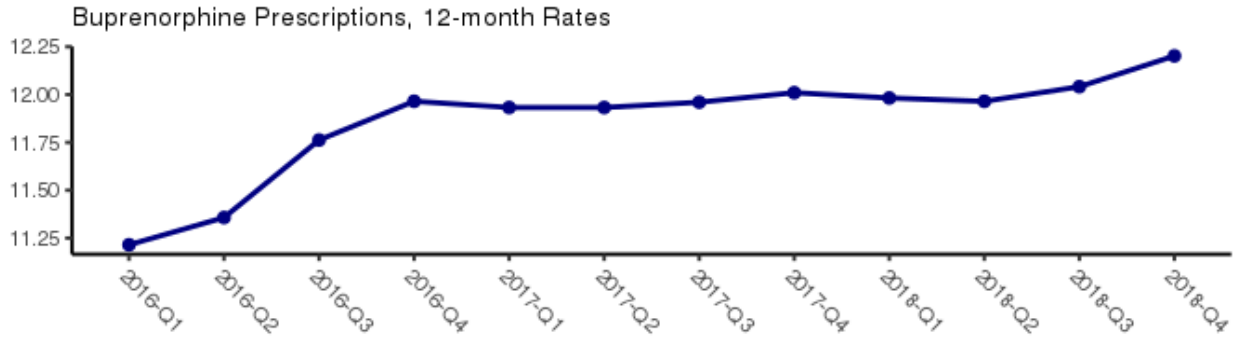
Prescribing

There were 1,500,256 prescriptions for opioids in Riverside 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

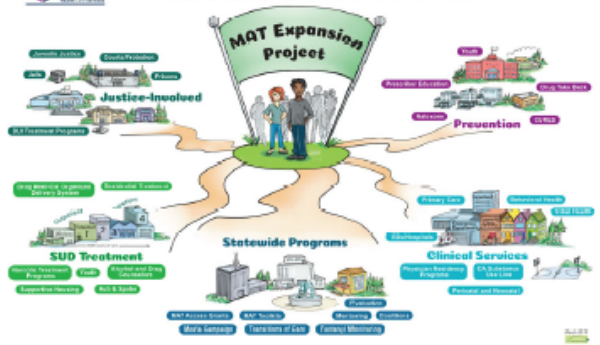
September 11 & 12, 2019

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.

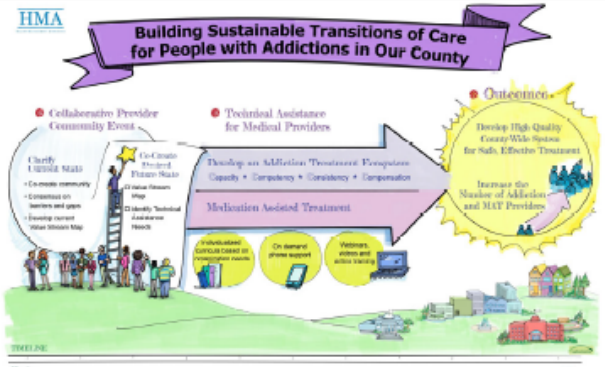
SAMHSA MAT EXPANSION GRANT

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

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.

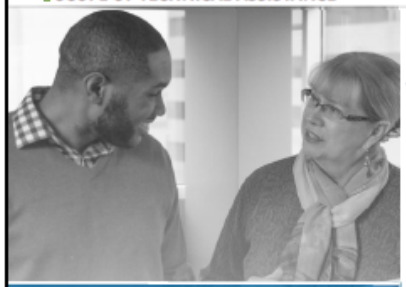
HMA will strengthen addiction treatment practice methods through comprehensive technical assistance that increases the level of local expertise available, establish a system-wide understanding and use of best treatment practices, and establishes a shared vernacular.

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
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STATISTICS

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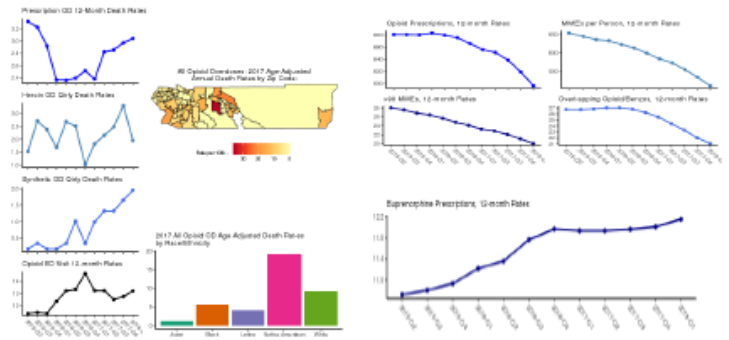
HEALTH MANAGEMENT ASSOCIATES 8

RIVERSIDE COUNTY: POPULATION 2,189,641



HEALTH MANAGEMENT ASSOCIATES

9

Healthcare in the US

HEALTH MANAGEMENT ASSOCIATES

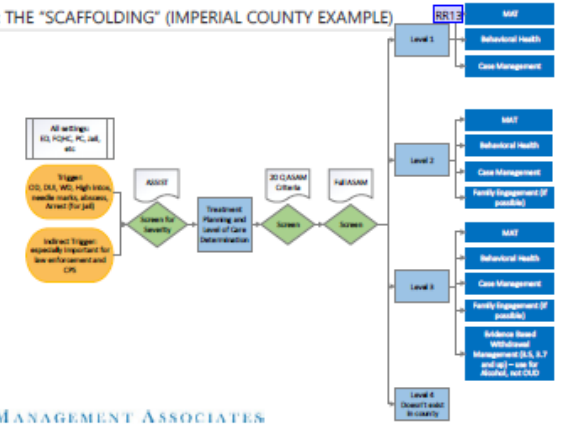
10

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

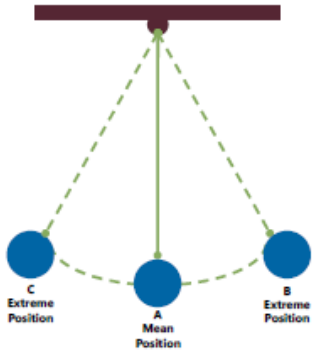
Increased prescribing of opioids
+Pain as 5th vital sign
+Expectation of no pain

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?

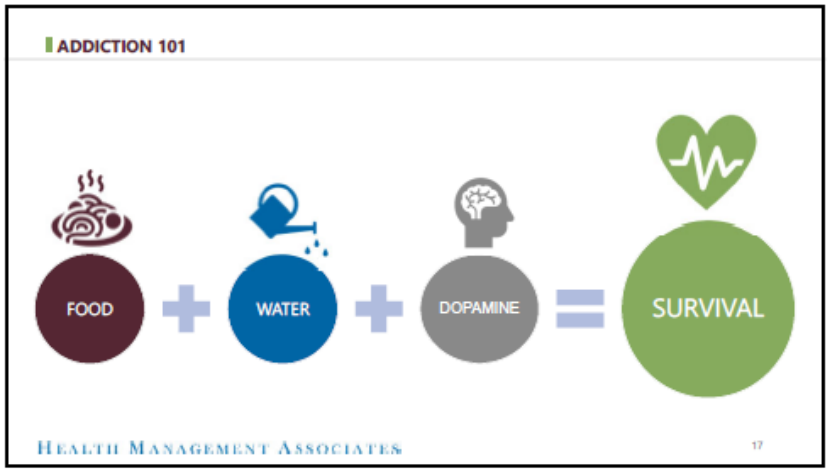
Patient 1

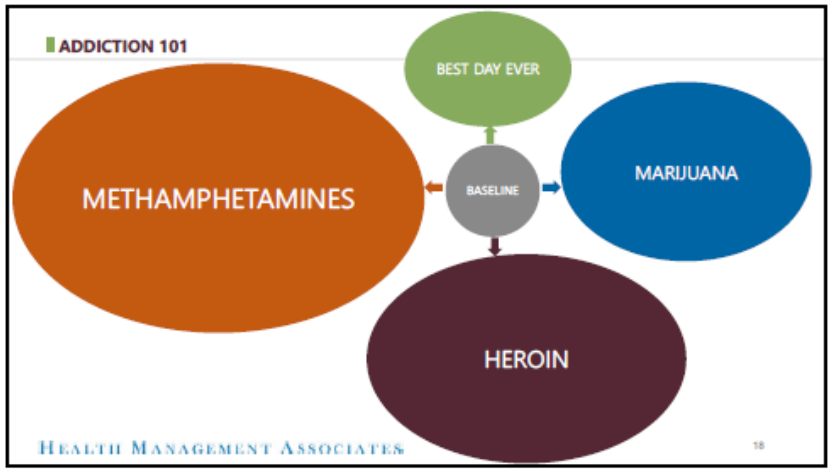
- Early life trauma
  - Neglect
  - Sexual assault
- Isolation from friends
- Early use of marijuana
- Heavy episodic drinking in early high school
- Opioids at 19 y/o
- Heroin at 22 y/o

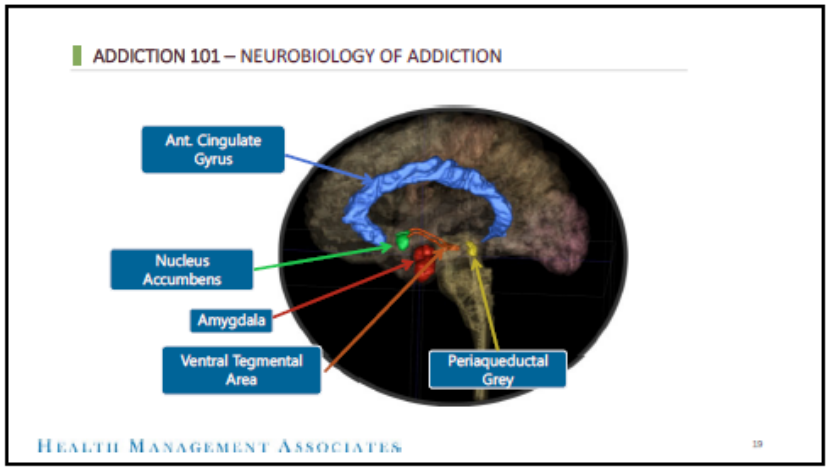
Patient 2

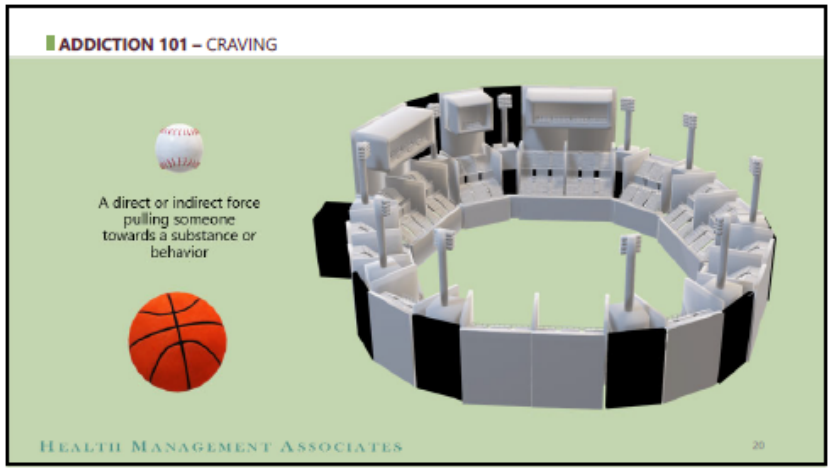
- Parents divorced and had shared custody
  - No neglect
  - No assault
- Lots of friends
- Tried MJ once in HS, used couple times per month in college
- Episodic binge drinking in college
- Finished college
- Went to medical school
- Given naloxone in the resident call room

HEALTH MANAGEMENT ASSOCIATES 16

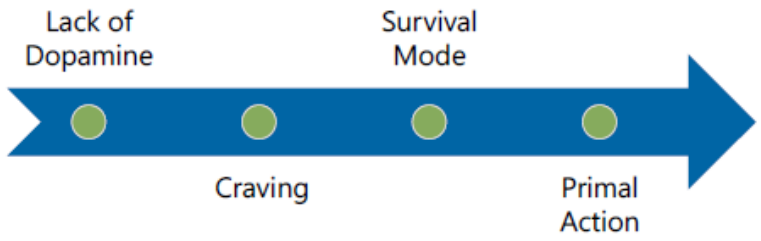

ADDICTION 101
FOOD
WATER
DOPAMINE
SURVIVAL
HEALTH MANAGEMENT ASSOCIATES
17


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

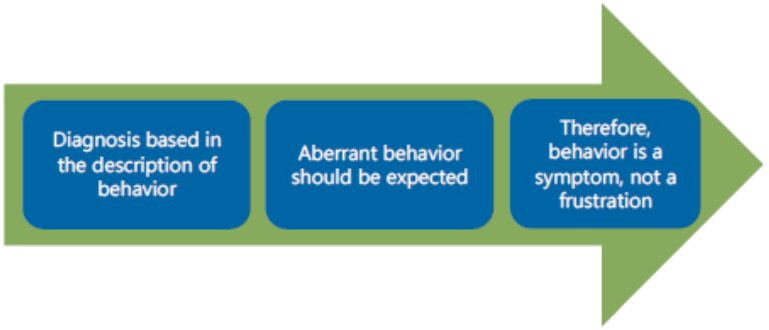
DSM-5 DIAGNOSIS OF OUD

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

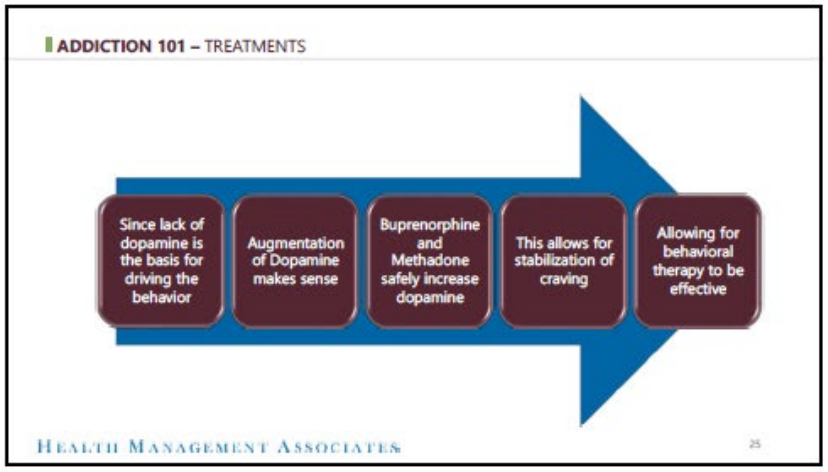
ADDICTION 101 – BEHAVIOR

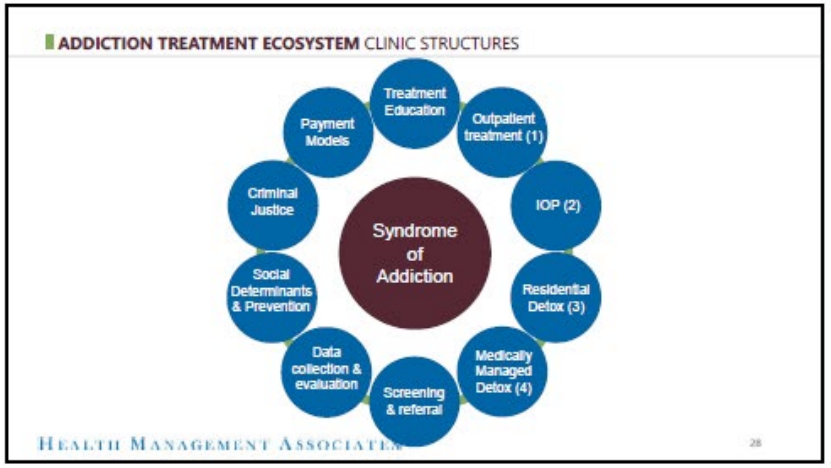


HEALTH MANAGEMENT ASSOCIATES 23

ADDICTION 101 – RELAPSE

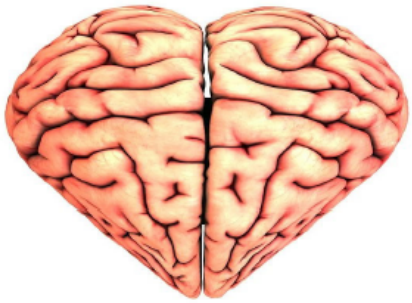
HEALTH MANAGEMENT ASSOCIATES 24


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

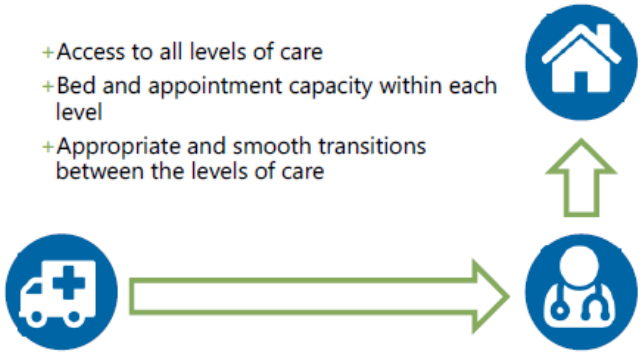
ADDICTION TREATMENT ECOSYSTEM IMPLEMENTATION

- 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

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ADDICTION TREAMENT ECOSYSTEM CONSISTENCY

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

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ADDICTION TREAMENT ECOSYSTEM COMPENSATION

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

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ADDICTION TREAMENT ECOSYSTEM COMMUNITY

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

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SCREENING, ASSESSMENT & LEVEL OF CARE DETERMINATION

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

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

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

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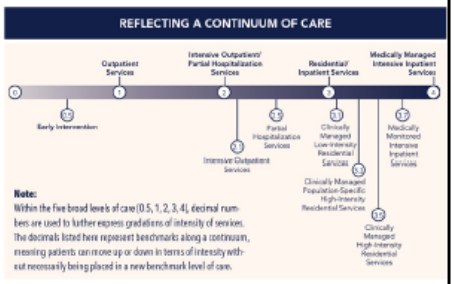
LEVEL OF CARE DETERMINATION

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?

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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

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GALLERY WALK

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

SOLUTIONS

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GROUP DISCUSSION: BARRIERS AND SOLUTIONS

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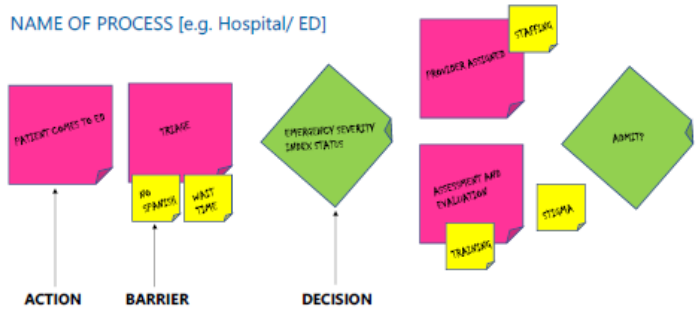
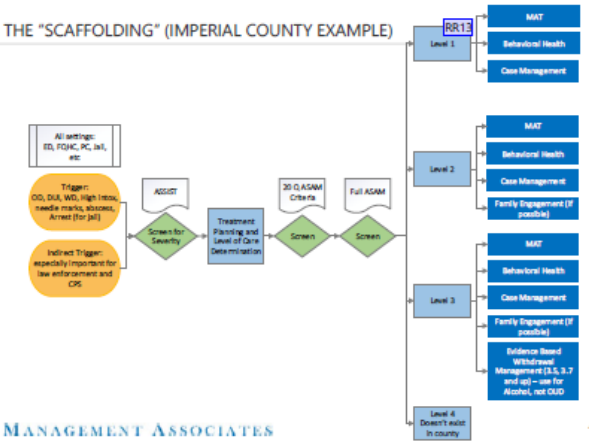
CURRENT STATE VALUE STREAM MAP EXAMPLE



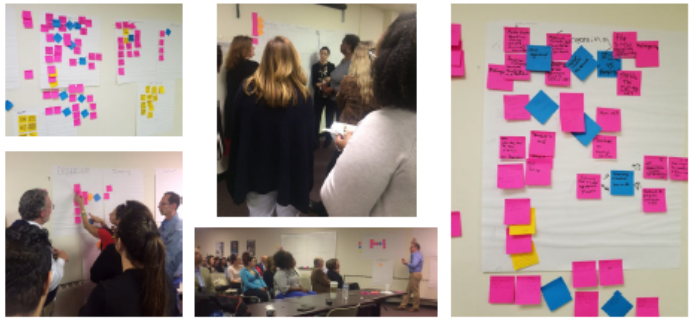
FUTURE STATE MAPPING ON DAY 2

IN A PERFECT WORLD…

Preview: THE "SCAFFOLDING" (IMPERIAL COUNTY EXAMPLE)

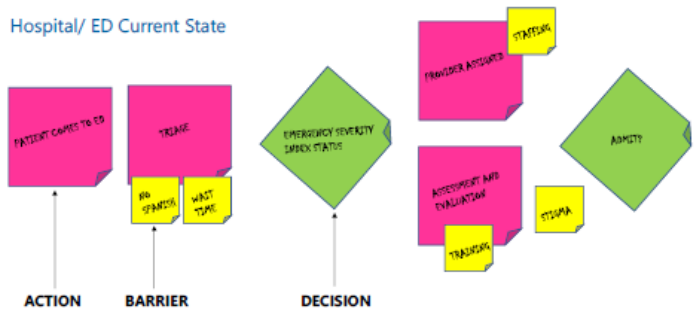


FIELD NOTES



VALUE STREAM MAP EXAMPLE

Hospital/ ED Current State



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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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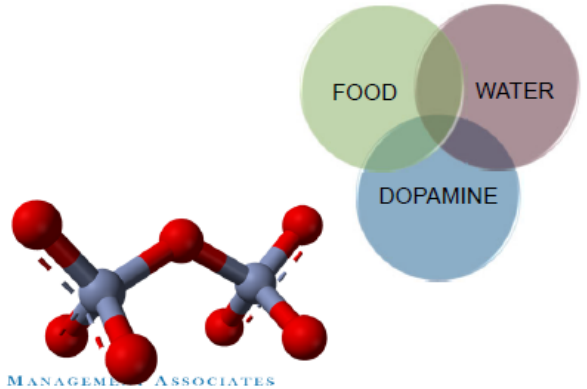
SURVIVAL



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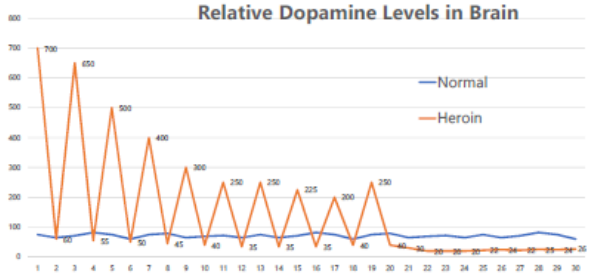

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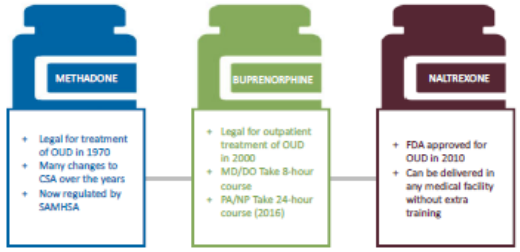
MEDICATION-ASSISTED TREATMENT (MAT) INTRODUCTION



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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

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

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

METHADONE FORMS

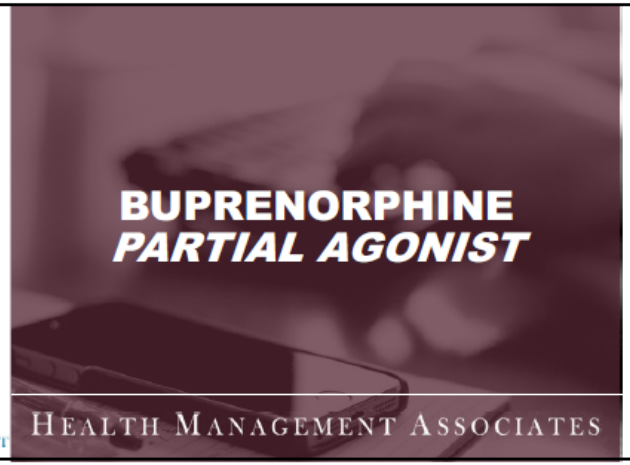
- OTP
  - Most use liquid formulation
  - Can use 40 mg wafer or 5 mg tablets
  - Not allow to use 10 mg tablets
- Nearly all methadone sold illegally is the 10 mg tablet form → Most diverted methadone came from prescriptions for pain not OUD treatment

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)*

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BUPRENORPHINE TRAINING REQUIRED

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

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BUPRENORPHINE OUTCOMES

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

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BUPRENORPHINE 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

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BUPRENORPHINE CAVEATS

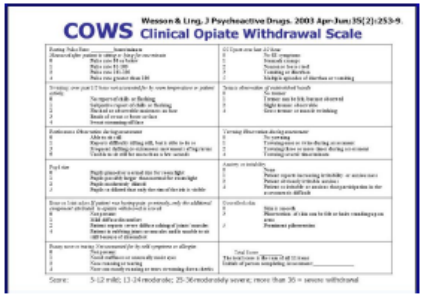
+ Many different ways to do an induction
+ Watch for diversion
+ Can be tough to wean and there are questions about if you should even try
+ Need to keep good records for possible DEA evaluation

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)

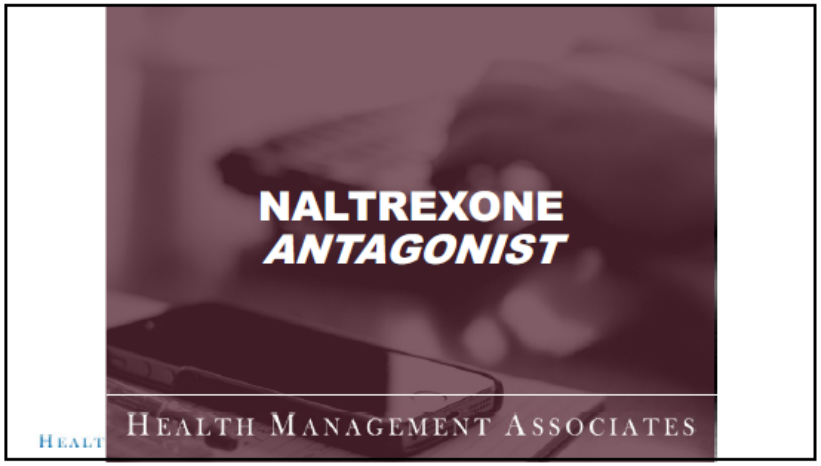
Induction/Starting Buprenorphine

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 motification (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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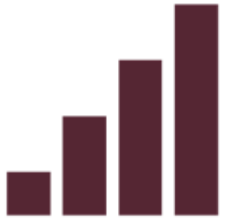
NALTREXONE OUTCOMES

- 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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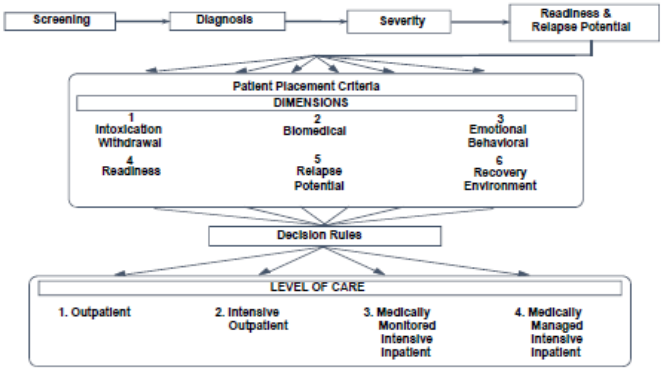
The ASAM Criteria Decision Process



LEVEL OF CARE DETERMINATION

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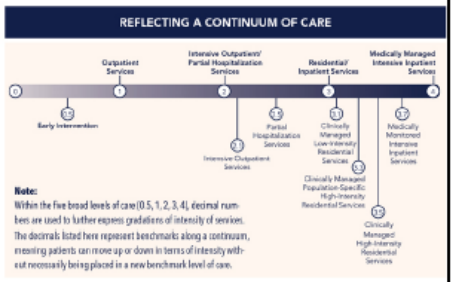

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ASAM CRITERIA METHODS OF DELIVERY

- 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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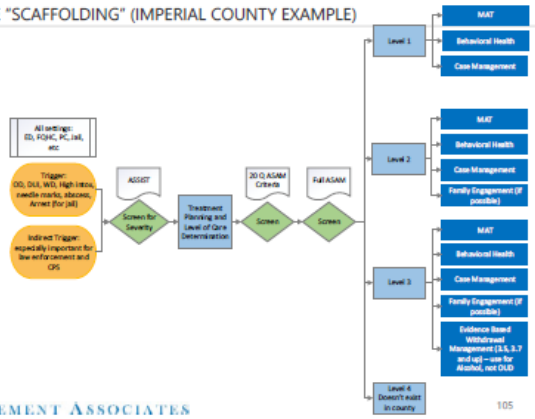
FUTURE STATE THE "SCAFFOLDING" (IMPERIAL COUNTY EXAMPLE)

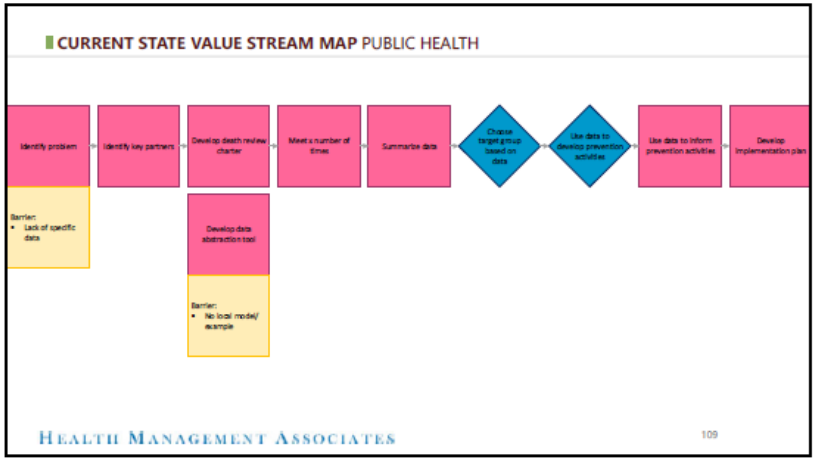


BARRIERS – Draft for Riverside County

- 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
HEALTH MANAGEMENT ASSOCIATES
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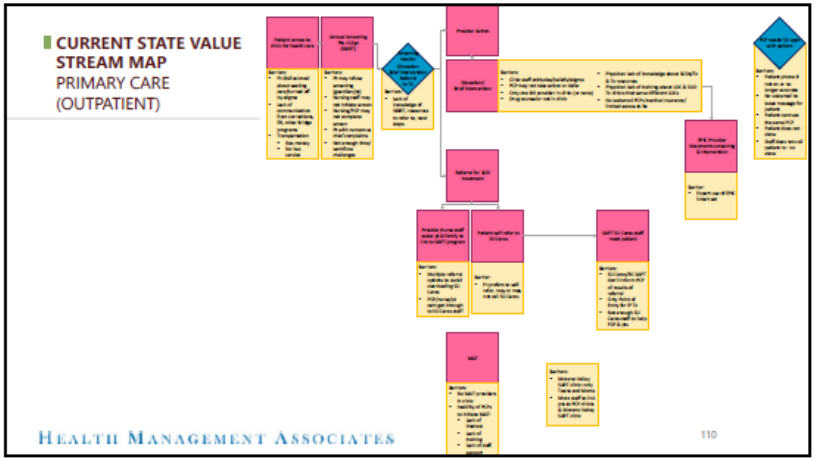
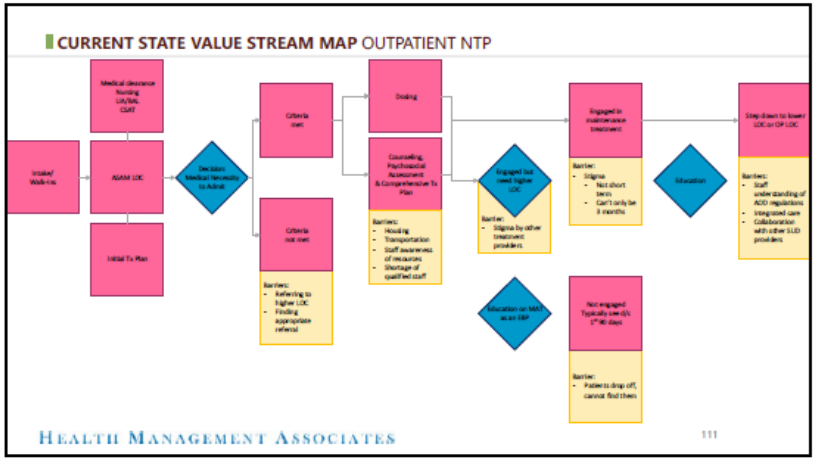
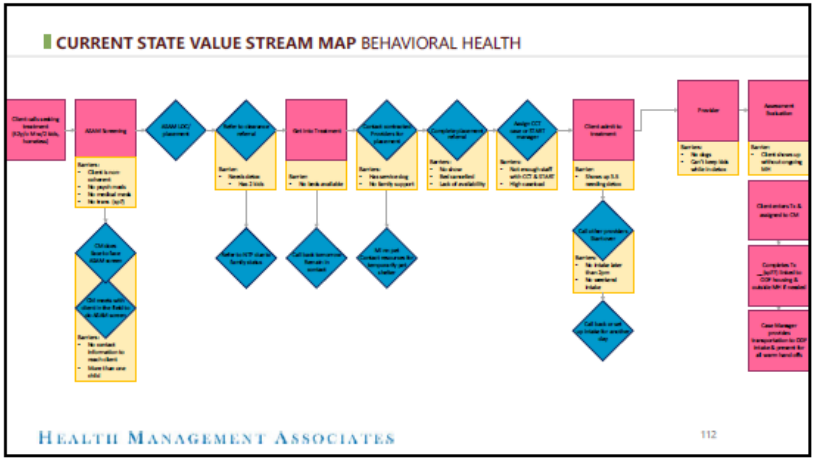
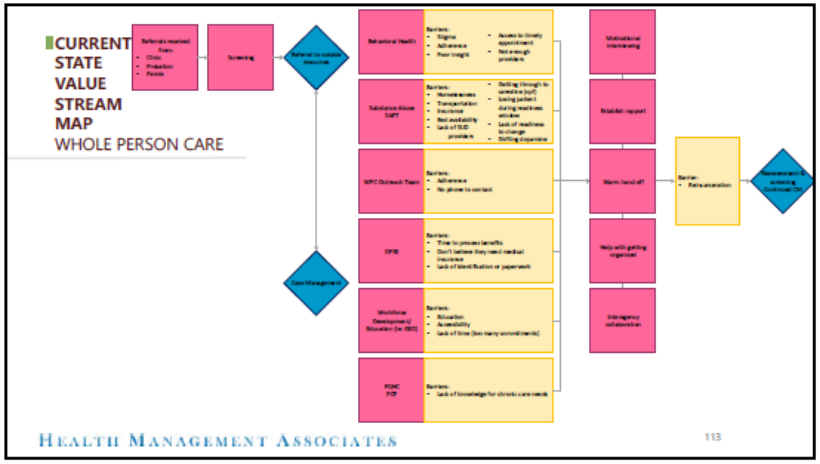
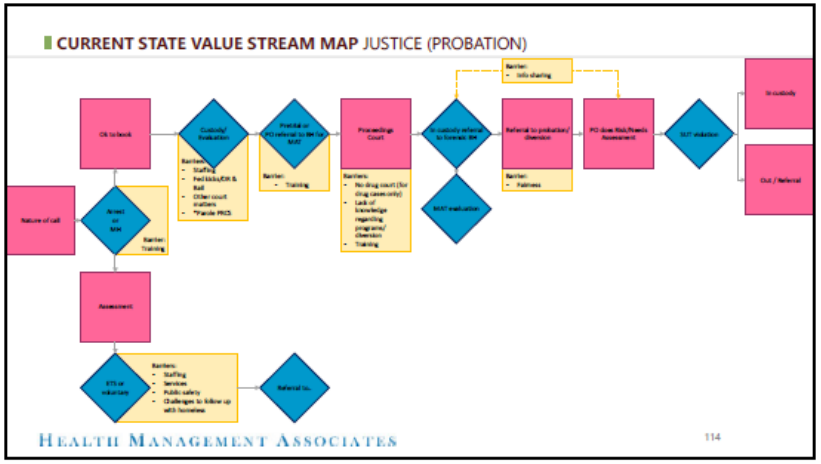
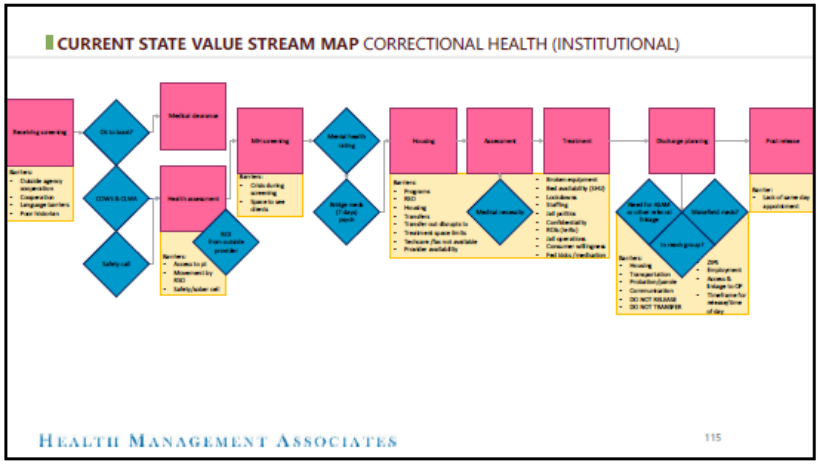

CURRENT STATE VALUE STREAM MAP
PRIMARY CARE
(OUTPATIENT)
HEALTH MANAGEMENT ASSOCIATES
110

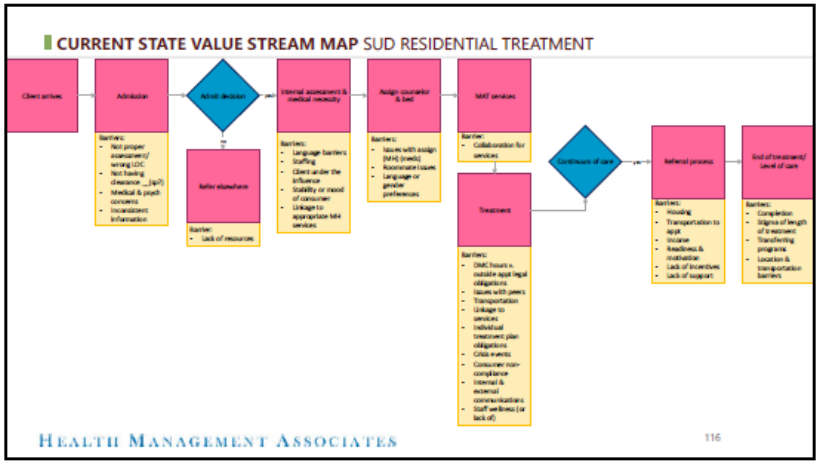

CURRENT STATE VALUE STREAM MAP OUTPATIENT NTP
Intake/ Walk-ins
Medical clearance Nursing CIA/RAL CIMT
ASAM LOC
Initial Tx Plan
Decision: Medical Necessity to Admit
Criteria met
Criteria not met
Barriers:
Referring to higher LOC
Finding appropriate referral
Dosing
Counseling, Psychosocial Assessment & 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 to 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
111

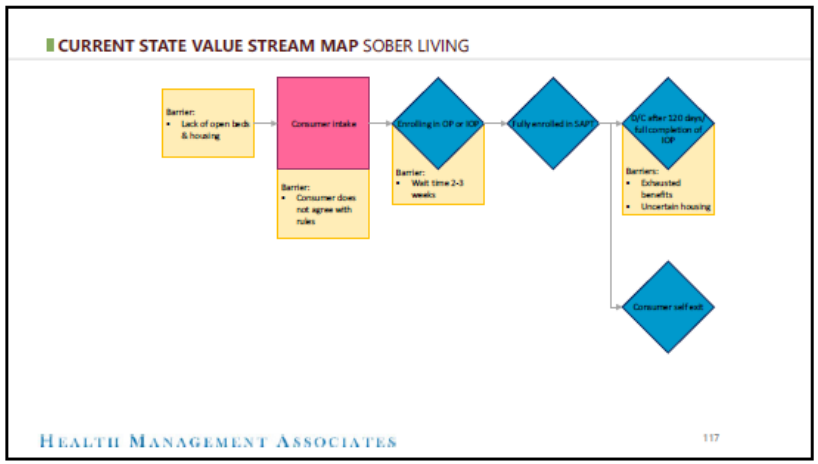

CURRENT STATE VALUE STREAM MAP BEHAVIORAL HEALTH
HEALTH MANAGEMENT ASSOCIATES
112


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


CURRENT STATE VALUE STREAM MAP JUSTICE (PROBATION)
HEALTH MANAGEMENT ASSOCIATES
114


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


CURRENT STATE VALUE STREAM MAP SUD RESIDENTIAL TREATMENT
HEALTH MANAGEMENT ASSOCIATES
116


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 SARF
D/C after 120 days full completion of IOP
Barriers:
Exhausted benefits
Uncertain housing
Consumer self exit
HEALTH MANAGEMENT ASSOCIATES
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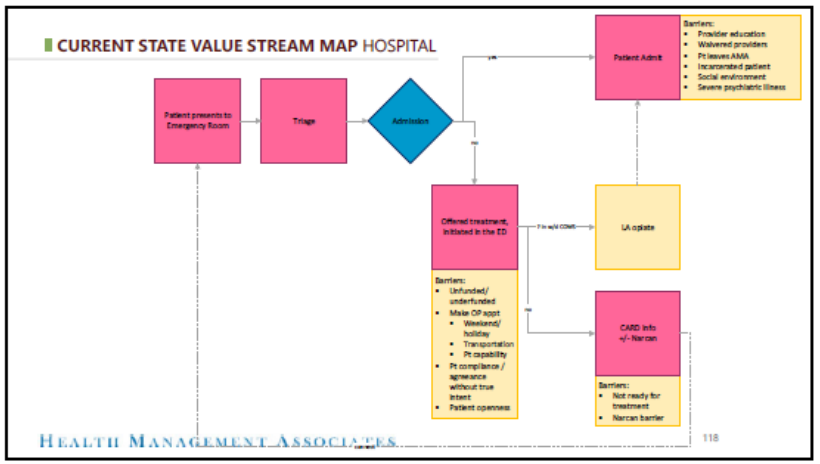
CURRENT STATE VALUE STREAM MAP HOSPITAL
Patient presents to Emergency Room
Triage
Admission
Patient Admit
Barriers:
Provider education
Waivered providers
Pt leaves AMA
Incarcerated patient
Social environment
Severe psychiatric illness
Offered treatment, initiated in the ED
Barriers:
Unfunded/ underfunded
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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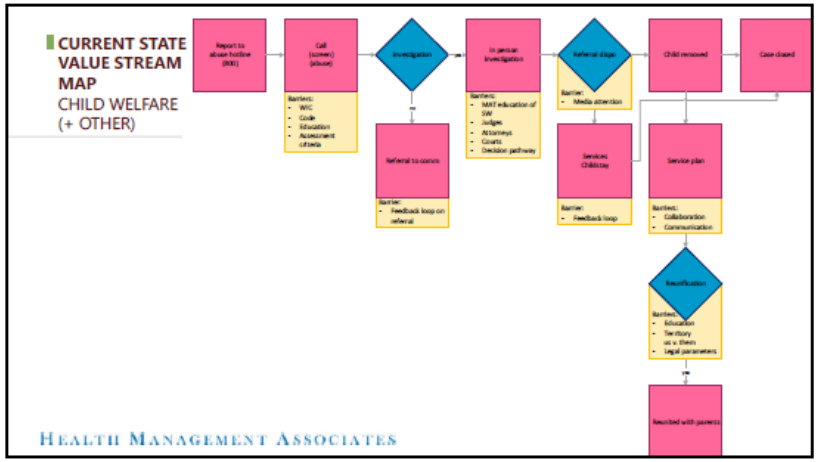

CURRENT STATE VALUE STREAM MAP
CHILD WELFARE (+ OTHER)
Report to abuse hotline (800)
Call (screen) (abuse)
Barriers:
WIC
Code
Education
Assessment criteria
Investigation
Referral to comm
Barrier:
Feedback loop on referral
In person investigation
Barriers:
MAT education of SW
Judges
Attorneys
Courts
Decision pathway
Referral dispo
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:

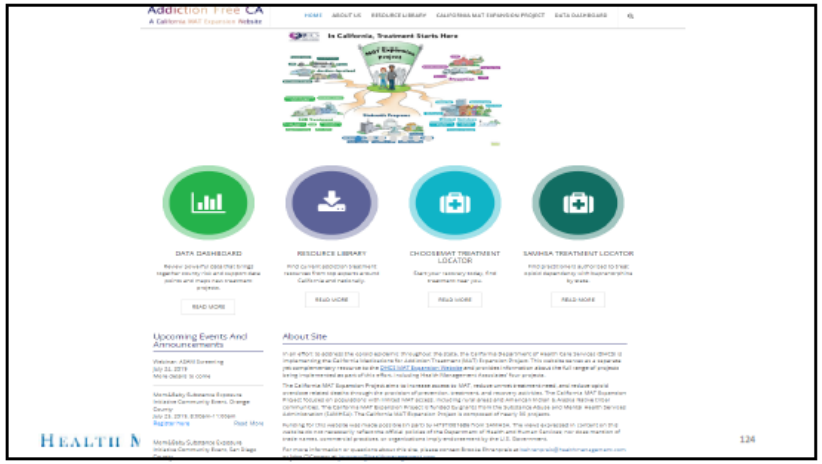
- TABLE TOP
- GALLERY WALK
- DISCUSSION

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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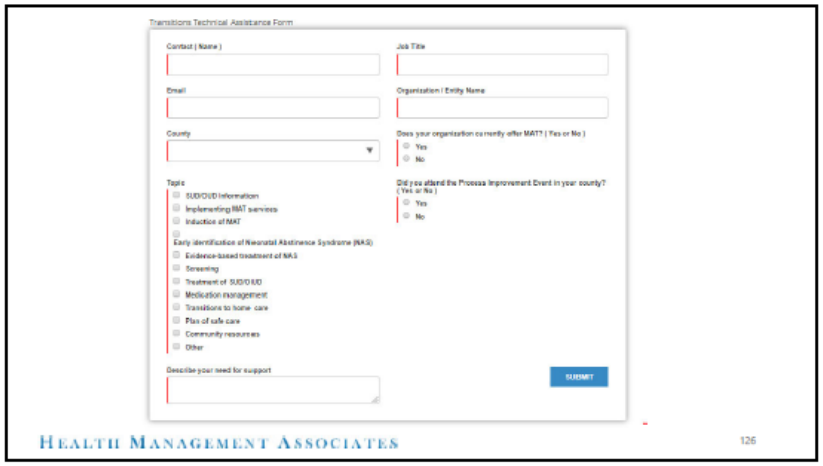
Transitions Technical Assistance Form
Contact (Name)
Job Title
Email
Organization / Entity Name
County
Does your organization currently offer MAT? (Yes or No)
Yes
No
Topic
SUD/OUD Information
Implementing MAT services
Induction of MAT
Early identification of Neonatal Abstinence Syndrome (NAS)
Evidence-based 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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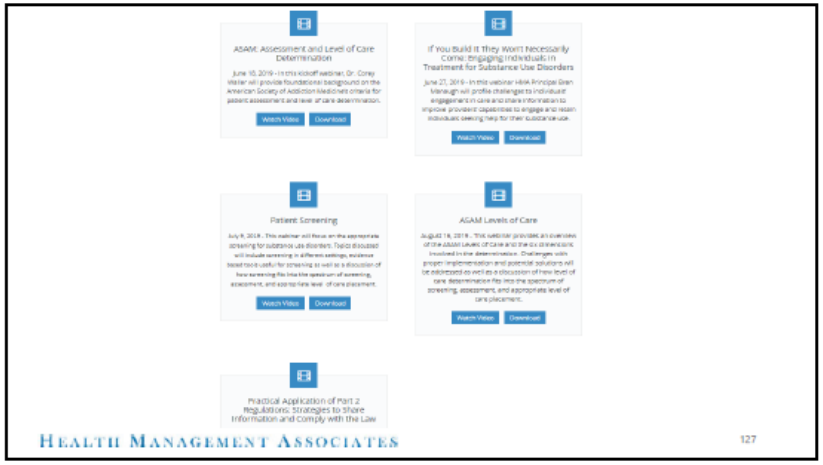
ASAM: Assessment and Level of Care Determination
If You Build It They Won't Necessarily Come: Engaging Individuals in Treatment for Substance Use Disorders
Patient Screening
ASAM Levels of Care
Practical Application of Part 2 Regulations: Strategies to Share Information and Comply with the Law
HEALTH 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 addiction.
    a. Dopamine
    b. Medi-Cal benefits for substance use disorder treatment
    c. Science of addiction
    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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