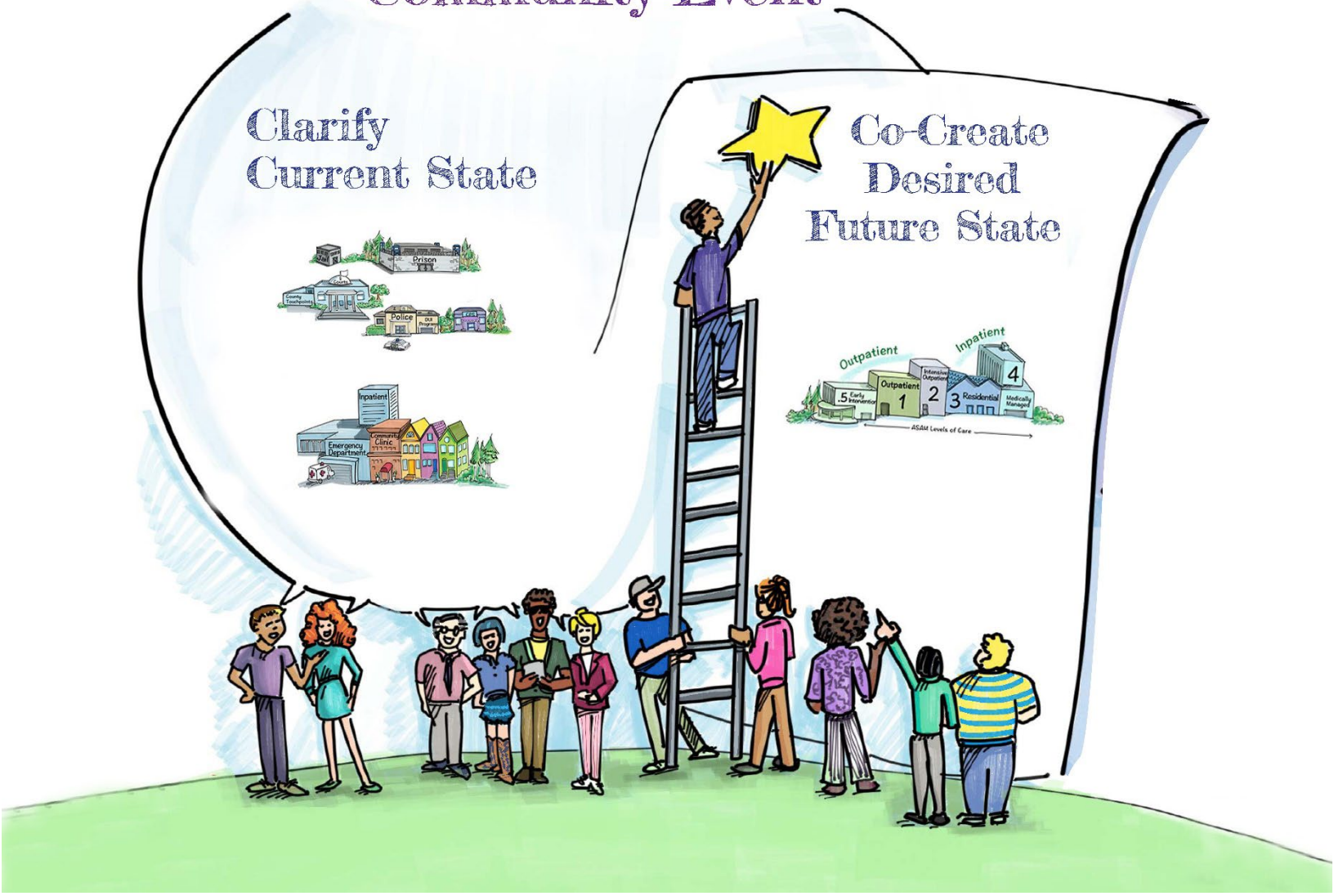
Collaborative Provider Community Event



BUILDING SUSTAINABLE TRANSITIONS OF CARE FOR PEOPLE WITH ADDICTIONS

Shasta County Community Process Improvement Event

October 29th - 30th , 2019

HEALTH MANAGEMENT ASSOCIATES

BUILDING SUSTAINABLE TRANSITIONS OF CARE FOR PEOPLE WITH ADDICTIONS

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Executive Summary

Overdose is the leading cause of accident-related death in the United States. The vast majority of these overdoses come from a combination of prescribed opioids and heroin. As we have watched the opioid crisis worsen over the last 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.

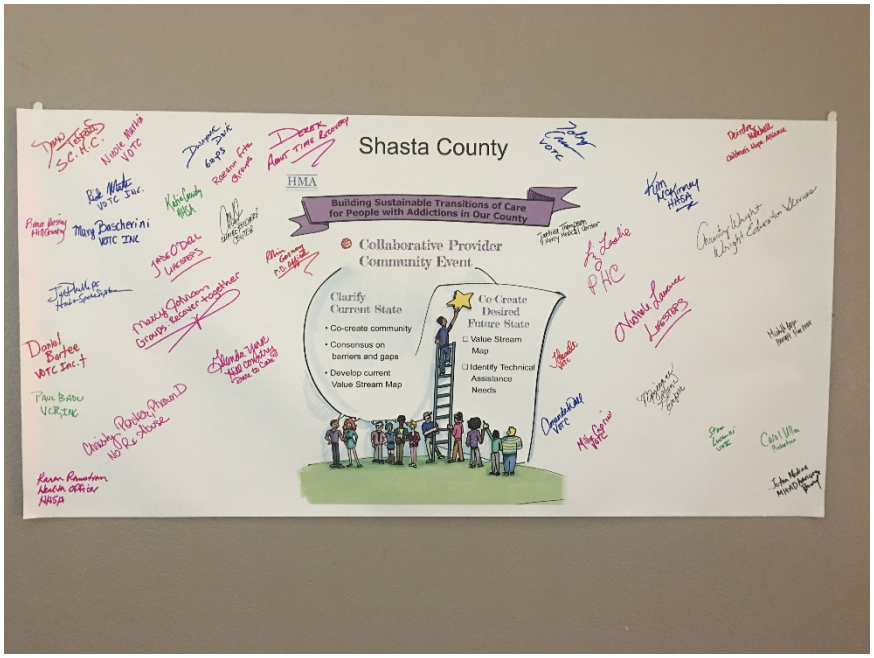
Understanding this reality, the federal government has allocated billions of dollars to states to build appropriate systems of care for patients with opioid use disorder (OUD) and other addictions; including the State Treatment Response (STR) and State Opioid Response (SOR) grants. The California Department 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 (Fresno, Humboldt, Imperial, Kern, Lake, Mendocino, Orange, Riverside, Shasta, and Ventura) 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 ongoing technical assistance through September 30th, 2020, to support the county in achieving their ideal future state for addiction treatment. Shasta County, one of the ten counties selected, participated in a large-scale process improvement event on October 29th and 30th, 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 Shasta County residents in need of addiction treatment and support services.

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

The two-day event was held at Simpson University in Redding, CA. The Process Improvement 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.



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

HMA received SOR funding from DHCS to focus on developing predictable and consistent transitions of care to sustain addiction treatment as 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 Shasta 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 Shasta County, nine additional counties were identified as key locations on which to focus these efforts. The Transition's project counties were organized by their location in either the Northern, Central and Southern part of the state. In Northern California, the four counties selected include Humboldt, Lake, Mendocino and Shasta Counties. These four rural counties are all served by Partnership Health Plan. Partnership Health Plan is contracted by DHCS to serve eligible Medi-Cal members through a unique 16-county regional

County Operated Health System model or COHS model. In addition, eight of the Partnership northern counties are engaged in a Regional Model DMC-ODS program administered by the Partnership Health Plan (PHP) that will go-live on March 1st, 2020. The PHP Regional DMC-ODS SUD Treatment Model aims to increase access to care and provider performance of SUD Treatment services across the eight-county regional SUD model that includes: Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Solano, and Trinity counties.

The Transitions of Care project engaged The Shasta County Health and Human Services Agency Behavioral Health Services Division, the Partnership Health Plan, SUD providers and community stakeholders in each selected county in a two-day countrywide process improvement event, followed by ongoing technical assistance through September 2020 so the community-defined "ideal future state value stream map" can be fully realized. Those who are directly involved with the development of the transitions plan for the County will be eligible to receive ongoing individualized technical assistance from a team of national experts covering all aspects of knowledge required to build and sustain an evidence-based addiction treatment ecosystem.

HMA worked with Katie Cassidy, Shasta County HHSA Adult Services Program Manager and the BHS program leadership. Specifically, we held planning meetings with Shasta County's Health and Human Services Agency Director, Donnel Ewert, Adult Services Branch Director and SUD Administrator, Dean True and the county's Adult Services Program Manager Katie Cassidy, as well as their respective staff.

In addition to the Shasta County Health and Human Services Agency, HMA also coordinated with the Partnership Health Plan to help our team understand the work already underway by Partnership in standing up the Drug Medi-Cal Organized Delivery System Regional Model in Shasta County and their community preparedness work related to SUD and addiction treatment services within the County. Collectively, the County and Partnership staff assisted our team in launching the process improvement event and subsequent ongoing technical assistance program. Together, both the County and Partnership teams 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

Shasta County Health and Human Services Agency

- Donell Ewert, Shasta County Health and Human Services Director

Shasta County Behavioral Health Services Division Services

- Dean True, RN, MPA Adult Services Branch Director and Substance Use Disorder Administrator
- Katie Cassidy, Shasta County HHSA, Adult Services Program Manager

Partnership Health Plan

- Liz Leslie, Program Manager, Wellness and Recovery Program
- Matthew Ramsey, Behavioral Health Clinical Specialist

Who Was Involved:

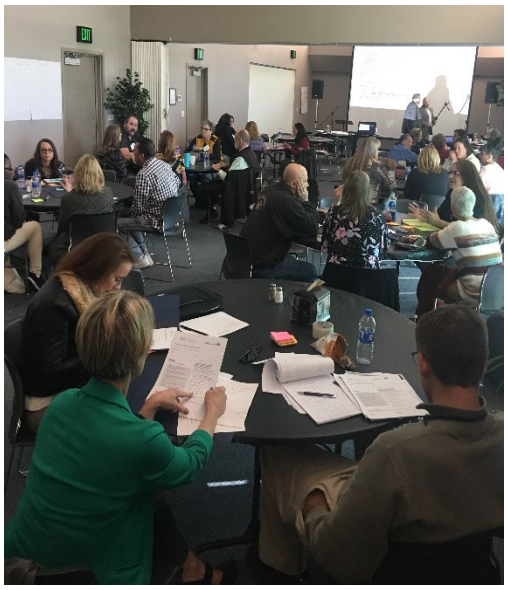
- About Time Recovery
- California Hub & Spoke Shasta County – Aegis Redding
- Children's Hope Alliance
- Dignity Healthcare – Mercy Medical Center County Behavioral Health Services Hospital
- Empire Recovery Center
- Groups Recover Together
- Hill County Health and Wellness Center
- Life Steps
- Mental Health Alcohol and Drug Advisory Board
- Partnership Health Plan
- Shasta County HHSA Public Health Branch
- No RX Abuse-Shasta County
- Shasta County Health and Human Services Agency
  - Physical Health Branch
  - Adult Services
  - Children's Services
  - Regional Services
- Shasta County Probation
- Shasta County Public Defender's Office
- Visions of the Cross Treatment
- Wright Education Services

D. Structure of the Intervention

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

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

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

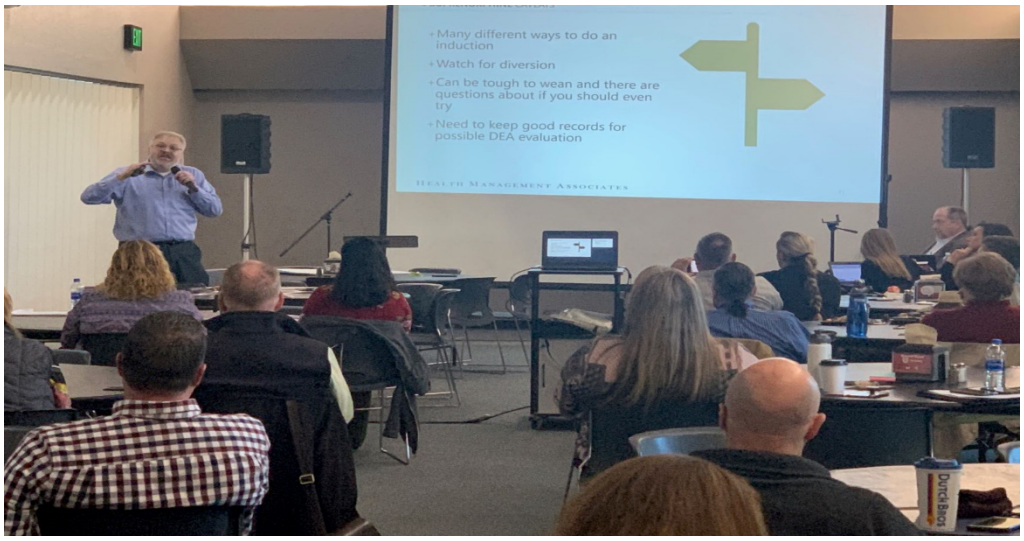


The group completed a current state mapping exercise that helped all programs outline their current path for persons with addiction. Each program was encouraged to document as fully as possible the path an individual would follow when engaging with their agency.

Participants were tasked with including all interventions and decision points. Stakeholders were also instructed to discuss both intervention-specific and global barriers and gaps. While the work produced had some variation in depth, scope, and structure, we were able to get a good sense of the current state of addiction screening, placement, and treatment in Shasta 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 get an idea about how others were approaching those with addiction and the struggles that are involved.

During each agency specific current state presentation gaps and barriers experienced within the program were discussed. Following these presentations, participants were encouraged to split into groups, intermingling agencies and perspectives, to discuss how barriers were experienced between agencies. This exercise created discussion about barriers experienced within the larger system of care and resulted in useful dialogue as well as many ideas for potential solutions to employ moving forward.



On the morning of day two, the group returned to review the science of MAT as well as details of information release and confidentiality of substance use disorder patient records referred to as 42 CFR Part 2. These presentations resulted in lively discussions and a consensus that both of these topics are often misunderstood in the community. Following this we held a brainstorming session on desired features in a future state and creation of consensus to build a future state “scaffolding” map. The “scaffolding” is the part of the future state map that all providers have in common and can build on for their specific setting.

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

E. Screening and Level of Care Determination

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

ASAM's criteria, formerly known as the ASAM patient placement criteria, is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. Today the criteria have become the most widely used and comprehensive set of guidelines for placement, continued to stay, and transfer/discharge of patients with addiction and co-occurring conditions. ASAM's criteria are required in over 30 states.[1]

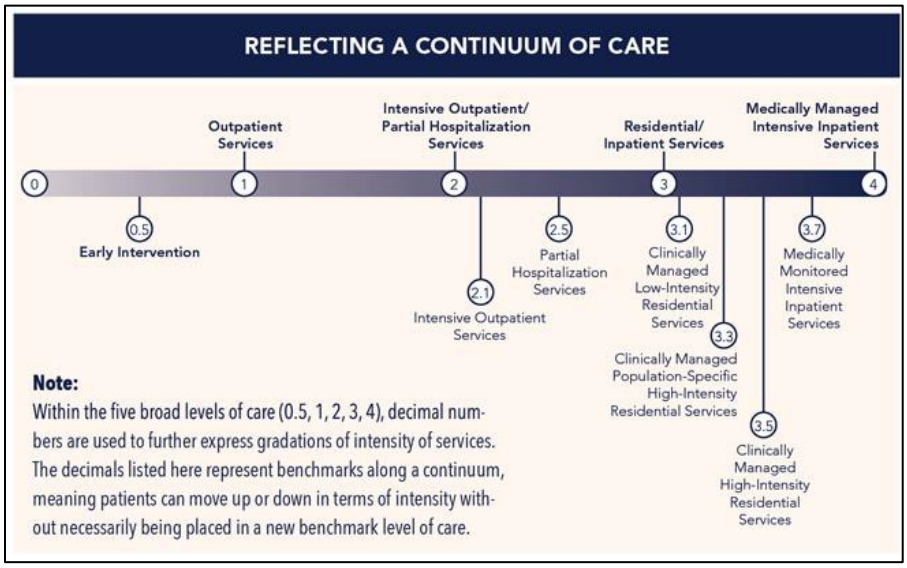
ASAM's treatment criteria provide separate placement criteria for adolescents and adults to create comprehensive and individualized treatment plans. Adolescent and adult treatment plans are developed through a multidimensional patient assessment over five broad levels of treatment that are based on the 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

[1] *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.*

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)

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:

- Create a system where clients can get immediate access to the care they need
- Create a fully integrated system of care from start to finish
- Create a system that meets clients where they're at
- Get rid of stigma in the community related to SUD
- Improve collaboration across the system
- Discuss strategies to improve client engagement
- Acknowledge gaps in the system related to treatment for juveniles

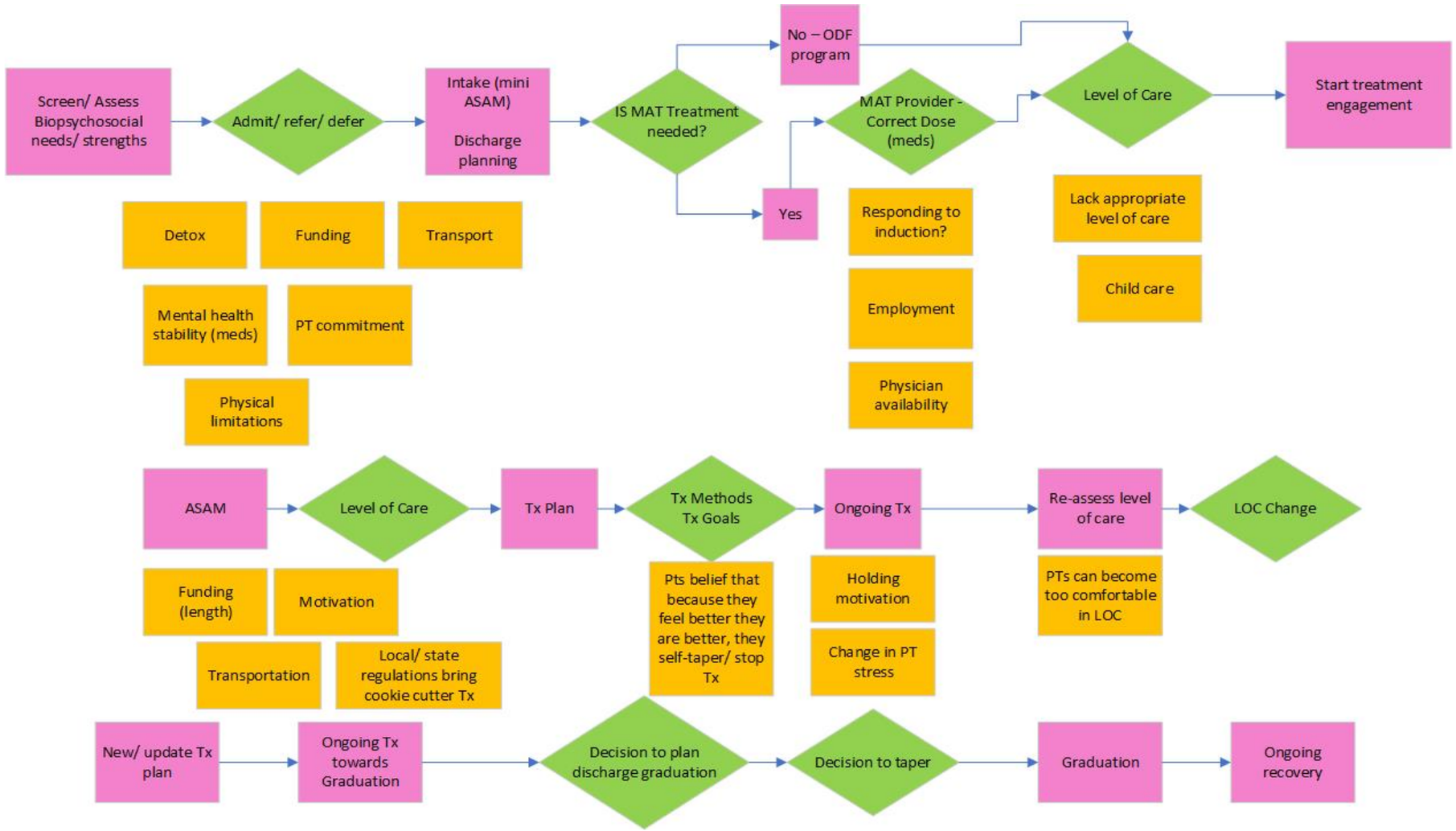
An overarching goal for Shasta County, under which all the goals named above can be placed.

THE OVERARCHING GOAL:

ELIMINATE ADDICTION-RELATED DEATHS IN SHASTA COUNTY

B. Current State Value Stream Maps (VSM)

SUD Treatment Providers



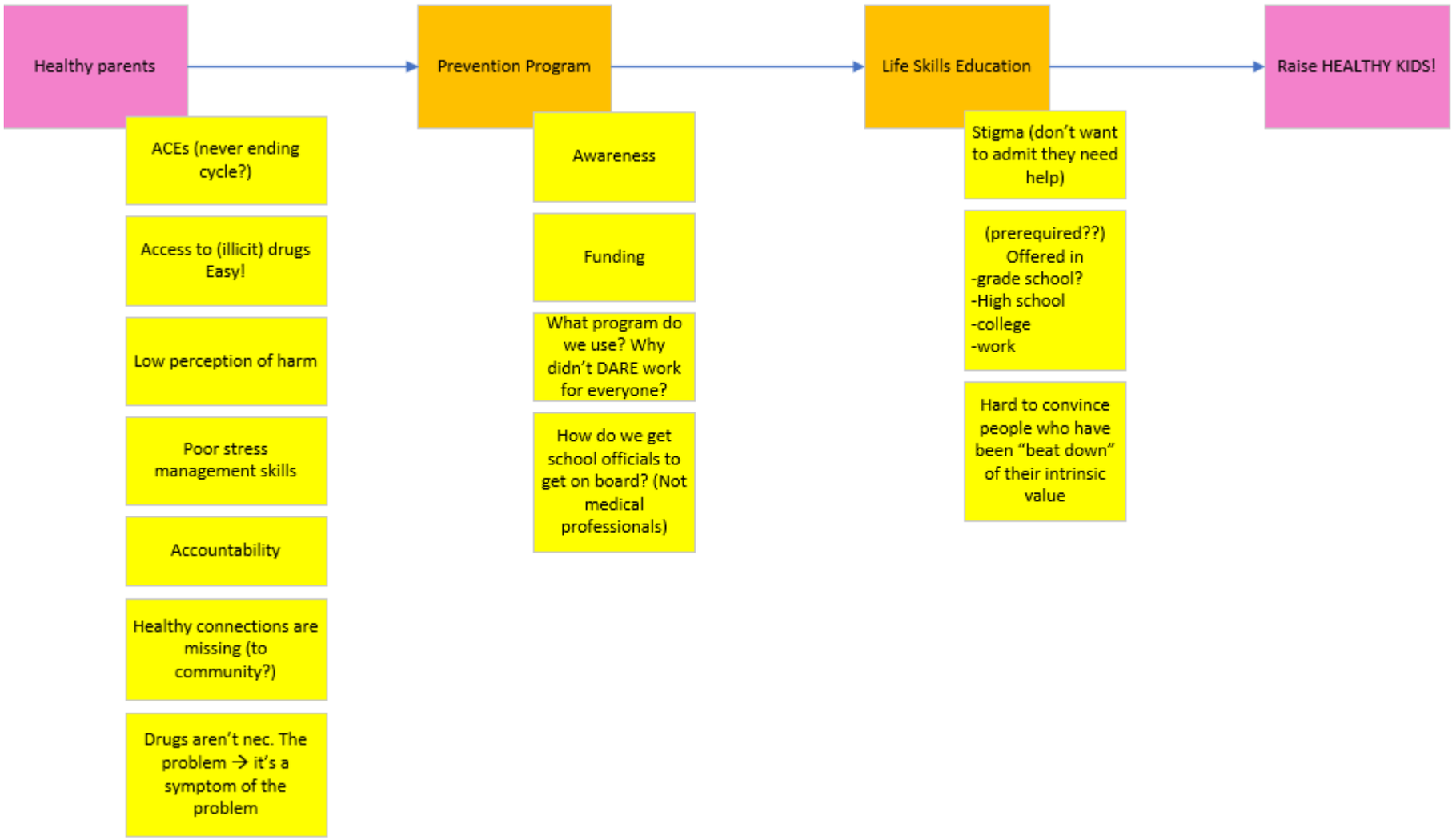
SUD Treatment Providers (includes Empire Recovery Center, Groups Recover Together, Visions of the Cross, and Native Roots)

The exact pathways of these three organizations differ slightly, but this CSVSM captures the general pathway each takes. The organizations listed above were grouped together as SUD treatment providers, but it should be noted that some offer MAT, whereas others offer outpatient recovery services, and drug-free services.

Each organization begins with screening and assessment, to understand a client's biopsychosocial needs and strengths. Some barriers that occur at this point are related to detox, funding, transportation, mental health stability, patient commitment, and physical limitations. Next, they decide if the client should be admitted, treated or referred out. If the client is admitted into a treatment center, they will conduct an intake assessment. At Visions of the Cross, they use a mini- ASAM as their assessment tool. Discharge planning also starts at intake.

If a patient is in need of MAT based on the assessment, SUD treatment providers who provide MAT (again, not inclusive of all groups listed above) decide about appropriate dosage for the client. Providers who do not offer MAT treatment can refer clients out to a MAT provider as needed. Some barriers encountered at this point include how a client responds to induction, employment and physician availability. The next decision that needs to be made is related to the level of care. Barriers encountered at this point are availability of appropriate level of care in the community, and childcare. Once the appropriate level of care is determined, a client can then begin engagement with treatment. Once a client has been engaged, a full ASAM assessment is conducted to ensure the correct level of care has been assigned. Some barriers encountered at this point are length of funding availability, motivation of the client, transportation, and local and state regulations leading to treatment that is generic and not client- specific. Once a client has been assigned to the correct level of care based on the full assessment, a treatment plan is developed. The provider determined appropriate treatment methods and goals. Patients sometimes believe, however, that because they feel better, they are better, and therefore they may self-taper or stop treatment all together. Holing a client's motivation and adjusting based on their stress level are barriers to ongoing treatment. After a certain amount of time, a patient's level of care will be reassessed, and their level of care reassigned as needed. At that point, their treatment plan would be updated to ensure they proceed toward either ongoing treatment or graduation.

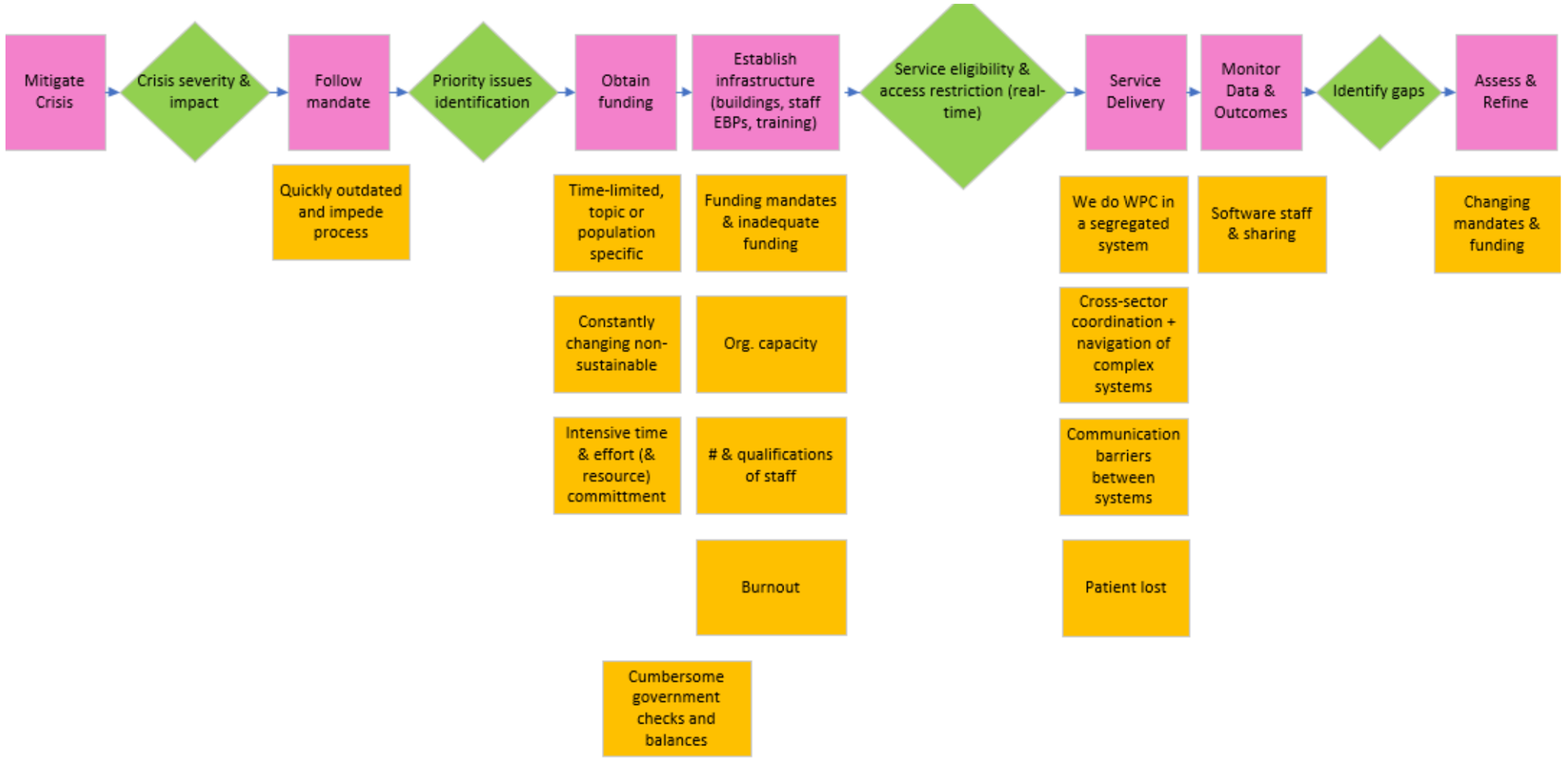
Prevention


Healthy parents
Prevention Program
Life Skills Education
Raise HEALTHY KIDS!
ACEs (never ending cycle?)
Access to (illicit) drugs Easy!
Low perception of harm
Poor stress management skills
Accountability
Healthy connections are missing (to community?)
Drugs aren't nec. The problem → it's a symptom of the problem
Awareness
Funding
What program do we use? Why didn't DARE work for everyone?
How do we get school officials to get on board? (Not medical professionals)
Stigma (don't want to admit they need help)
(prerequired??) Offered in
-grade school?
-High school
-college
-work
Hard to convince people who have been "beat down" of their intrinsic value

Prevention

This value stream map represents the concept of prevention, rather than prevention programs in existence in Shasta County. This value stream map related to prevention begins with healthy parents. Some barriers encountered are related to adverse childhood experiences (ACES), access to illicit drugs, low perception of harm, poor stress management skills, accountability, lack of healthy connections (i.e. connections to the community). Drugs aren't necessarily the problem, but rather a symptom of the problem. From healthy parents, the map moves to prevention programs. Barriers encountered here are related to awareness, funding, ineffective programs, and need for schools to participate in prevention programming. Next, the map moves to life skills education. The presenter explains that stigma and fear of admitting they need help is a barrier to participation and buy-in to life skills education. Additionally, life skills training aren't necessarily a required component of grade school, high school, college or work environments.

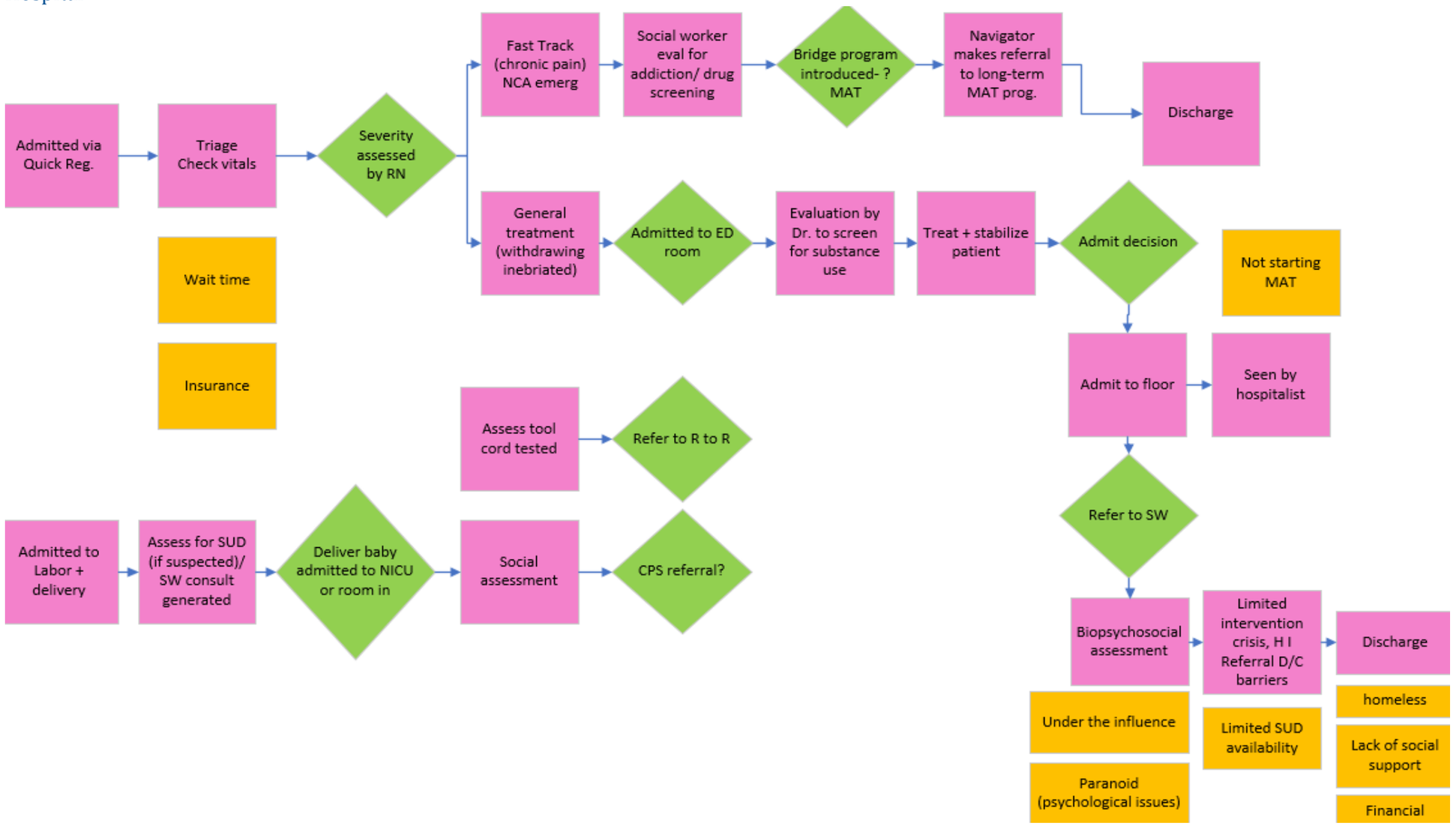
Systems Administration



Systems Administration (includes MHADAB, Wright Education, Aegis, Shasta County Adult Services & Shasta County Public Health)

This map was developed from diverse perspectives related to systems administration. The map begins with the crisis that needs to be mitigated. At that point a decision is made about severity of the crisis and its impact. Oftentimes, there is a mandate in place for the way in which a crisis is dealt with. At times these mandates are outdated and impede progress. Next, funding needs to be obtained. Barriers related to funding include being time-limited or population-specific, constantly changing, non-sustainable, intensive in time, effort and resource commitment. After funding is secured, the next step is to establish infrastructure to carry out the requirements. Barriers related to this include funding requirements, inadequate funding, requirement of a high number of qualified staff, organizational capacity and staff burnout. A barrier related to both funding and establishment of infrastructure is cumbersome government checks and balances. After a program instrastrucutre has been established, the next step is determining service eligibility and access restrictions . Then, services can be provided. Barriers related to service provision include patients lost to follow up, communication between systems, cross-sector coordination, navigation of complex systems, and functioning in a segregated system. Next, outcomes and related data must be monitored. A barrier related to this is data sharing between staff and systems. Through data, gaps can be identified, and programs can be assessed and refined.

Hospital

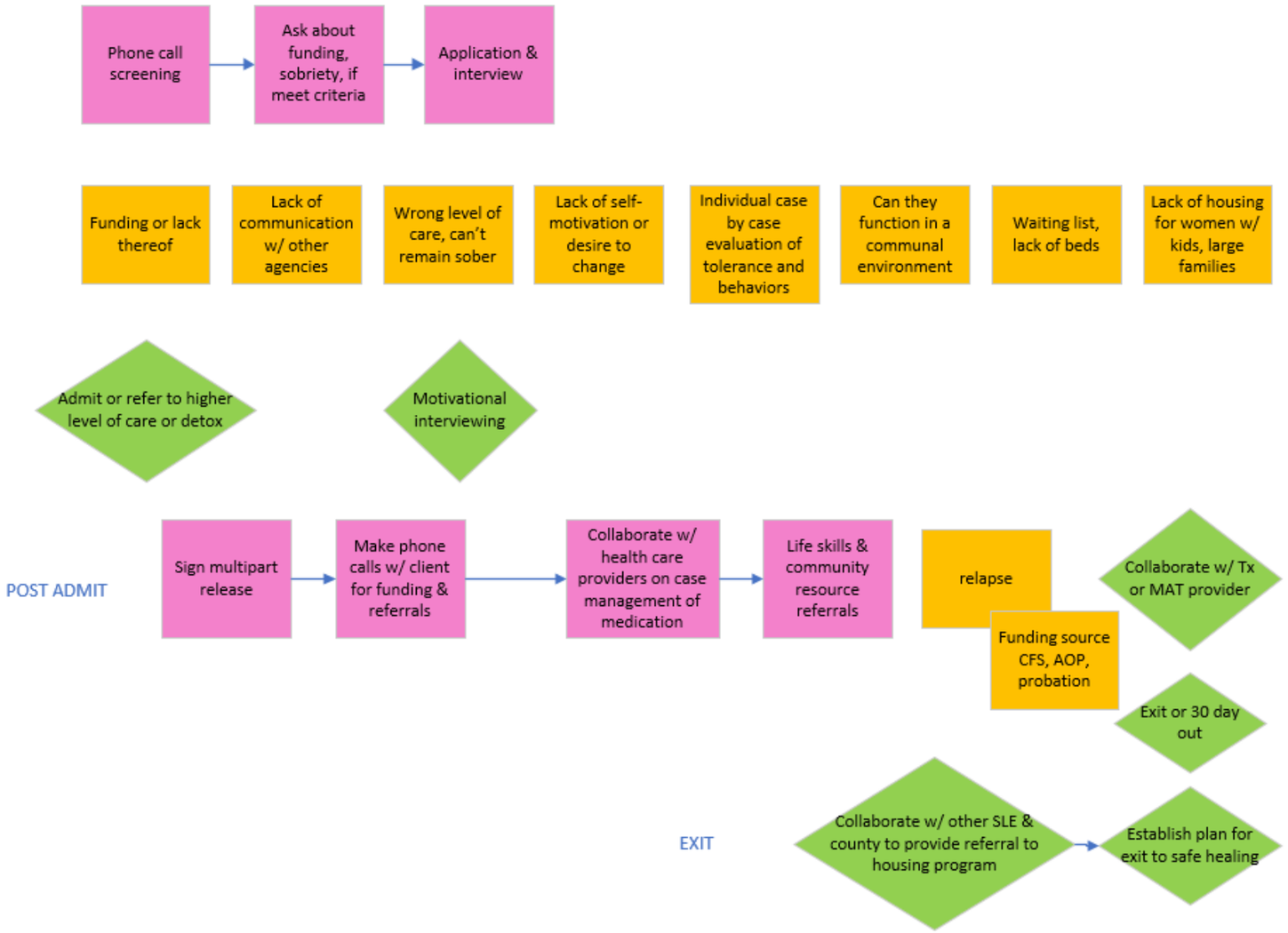

Admitted via Quick Reg.
Triage Check vitals
Severity assessed by RN
Fast Track (chronic pain) NCA emerg
Social worker eval for addiction/ drug screening
Bridge program introduced- ? MAT
Navigator makes referral to long-term MAT prog.
Discharge
General treatment (withdrawing inebriated)
Admitted to ED room
Evaluation by Dr. to screen for substance use
Treat + stabilize patient
Admit decision
Not starting MAT
Admit to floor
Seen by hospitalist
Wait time
Insurance
Assess tool cord tested
Refer to R to R
Admitted to Labor + delivery
Assess for SUD (if suspected)/ SW consult generated
Deliver baby admitted to NICU or room in
Social assessment
CPS referral?
Refer to SW
Biopsychosocial assessment
Limited intervention crisis, H I Referral D/C barriers
Discharge
homeless
Under the influence
Limited SUD availability
Lack of social support
Paranoid (psychological issues)
Financial

Hospitals (includes Dignity Health and Mercy Medical Center)

This process map depicts two pathways: emergency department and labor and delivery. In the emergency department, a patient is first admitted and triaged. Barriers include wait time and insurance status. Once a patient is triaged, a nurse will assess their severity place them into one of two tracks. The first is the fast track (i.e. chronic pain). Here, a social worker will evaluate the patient for addiction and decide if they are a fit for the Bridge program. A patient navigator will then refer them to a long-term MAT program and discharge them. The second track is general treatment. The nurse will decide if the patient needs to be admitted to the emergency department. If they are, they will then be evaluated by a doctor, and screened for substance use. The doctor will then treat and stabilize the patient and decide if they need to be admitted. If the patient is admitted, they will be seen by a hospitalist, then referred to a social worker. The social worker will then conduct a biopsychosocial assessment. A barrier encountered at this point is the patient may be under the influence of drugs or alcohol and/or have psychological issues that complicate the assessment process. After the assessment is complete, refer the patient to treatment and ultimately discharge them. Other barriers include limited SUD treatment options, homelessness, lack of social support and financial barriers.

When a patient is admitted in labor and delivery, they will be assessed for SUD if suspected, and a social work consult will be generated. After the baby is delivered, the patient will be assessed and if appropriate, a CPS referral will be mad, and/or the patient will be referred to appropriate programs and resources.

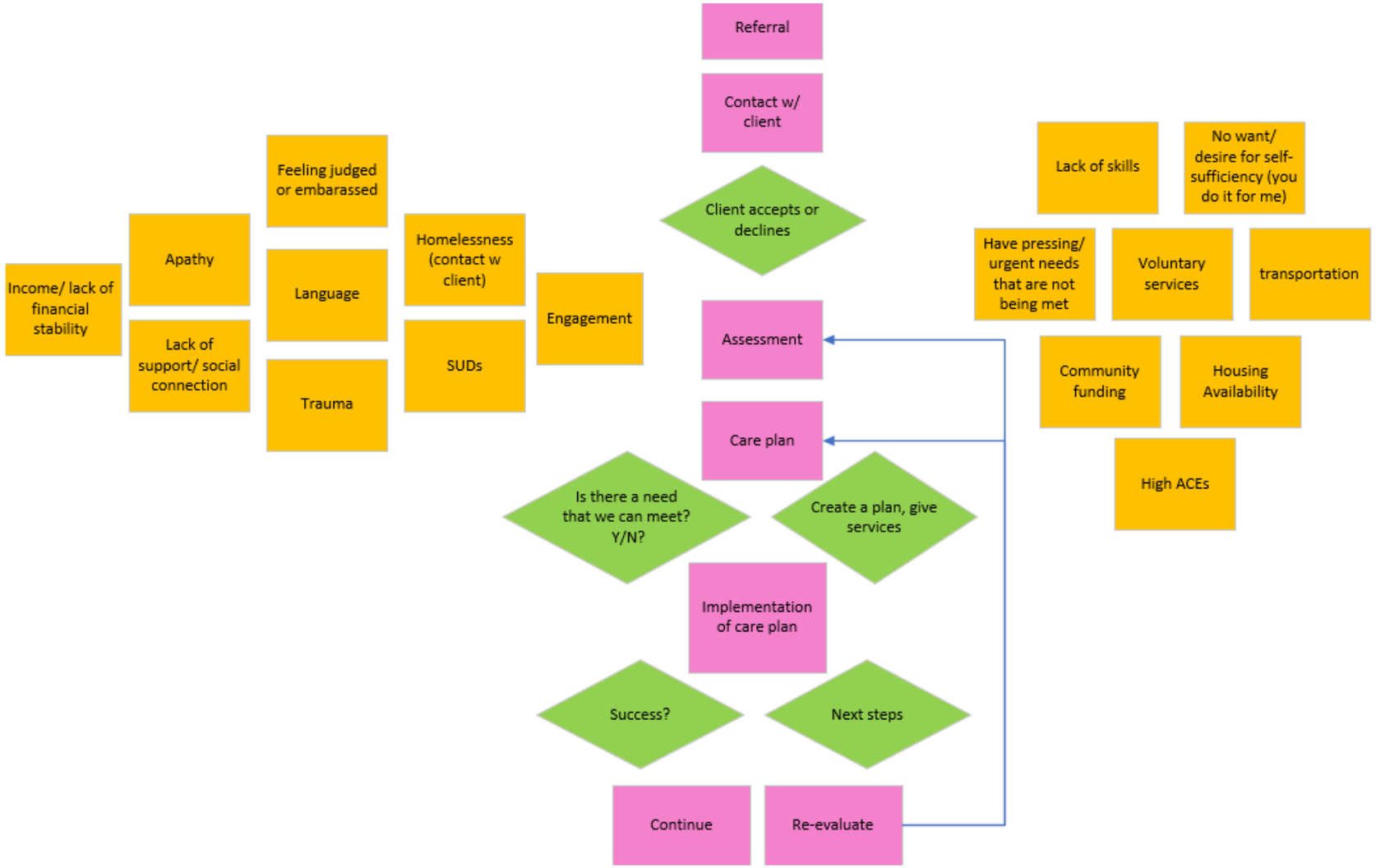
Sober Living



Sober Living (includes Visions of the Cross and About Time Recovery)

The sober living process map begins with a phone referral and screening. Usually a brief screening is used. Following the screening, the intake coordinator asks the client about their funding, sobriety status, and determines if they meet criteria for sober living. The client then completes an application and a formal interview. Barriers encountered include lack of funding, lack of communication with other agencies, inability to remain sober (i.e. inappropriate level of care), lack of motivation or desire to change, individual case-by-case evaluation of tolerance and behaviors, ability to function in a community environment, waiting list, lack of beds, lack of capacity for women with children and large families. After screening, a client is either admitted, deferred or referred. If they are admitted, they sign a multipart release form. Then the coordinator makes phone calls with the client for funding a referrals. Coordinators collaborate with health care providers on case management of medications, and work with clients on life skills, and community resource referrals. Barriers encountered include relapse, and time or condition limited funding. Coordinators continue to collaborate with treatment or MAT providers, and ultimately establish a plan for exit to safe housing.

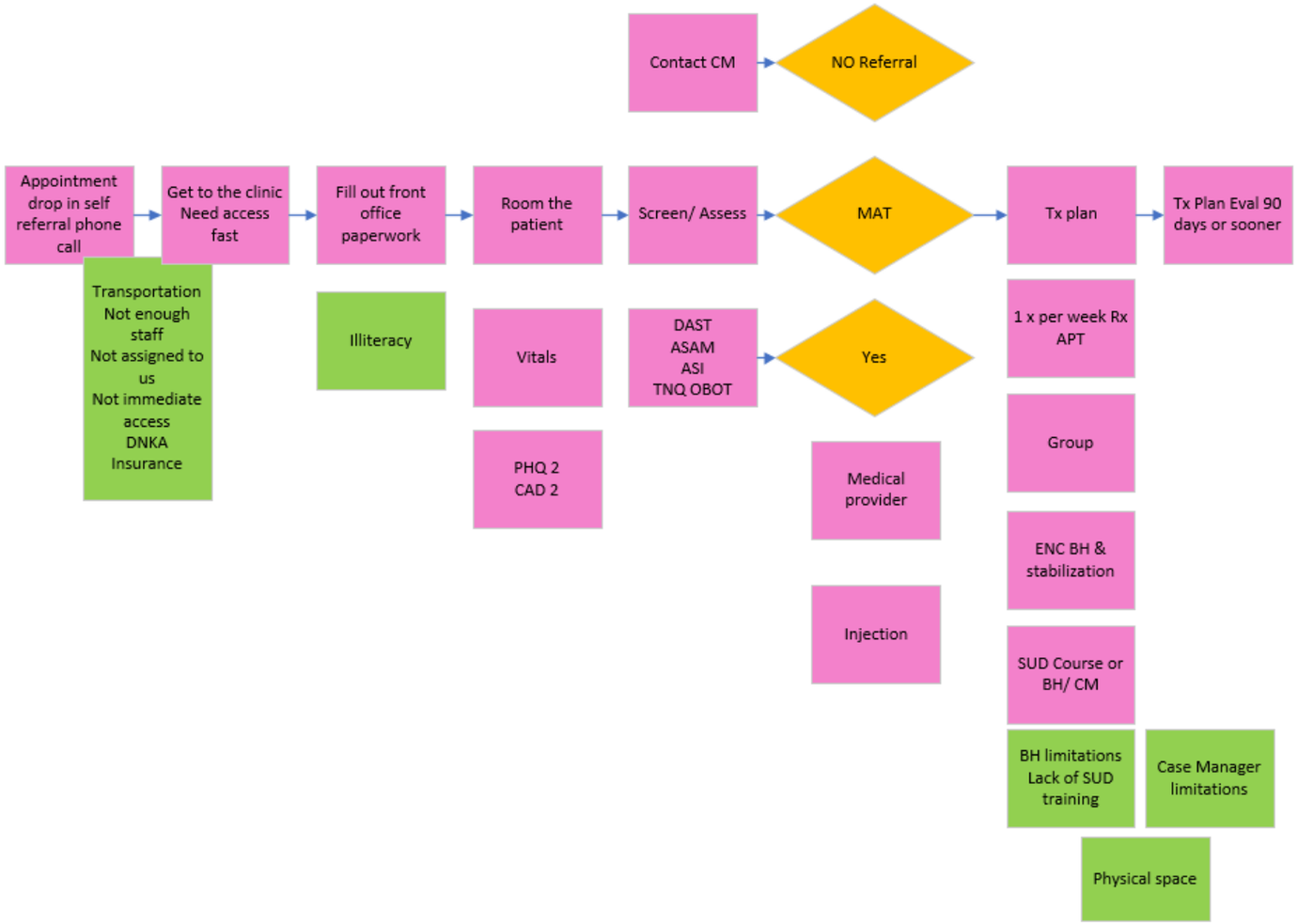
Complex Care Management



Complex Care Management (includes Children's Hope Alliance including Road to Resilience Program and Life Steps)

All clients start with a referral either self-referral, Children and Family Services, doctor's office etc.). Next, program staff outreaches to the client. The client can then decide to accept or decline services. Then, the client's needs are assessed, their goals are set, and a care plan is determined. The next decision that needs to be made is whether the program(s) can address the needs of the client. If yes, the care plan will be implemented. Barriers include feelings of judgement, being embarrassed, apathy from the client, homelessness, engagement, difficulty communicating due to language, financial stability, SUDs, trauma, lack of skills, no want or desire for self-sufficiency, having other pressing needs that are not being met, community funding (i.e. is there a program available to meet their needs), transportation, housing, voluntary services, and high ACEs.

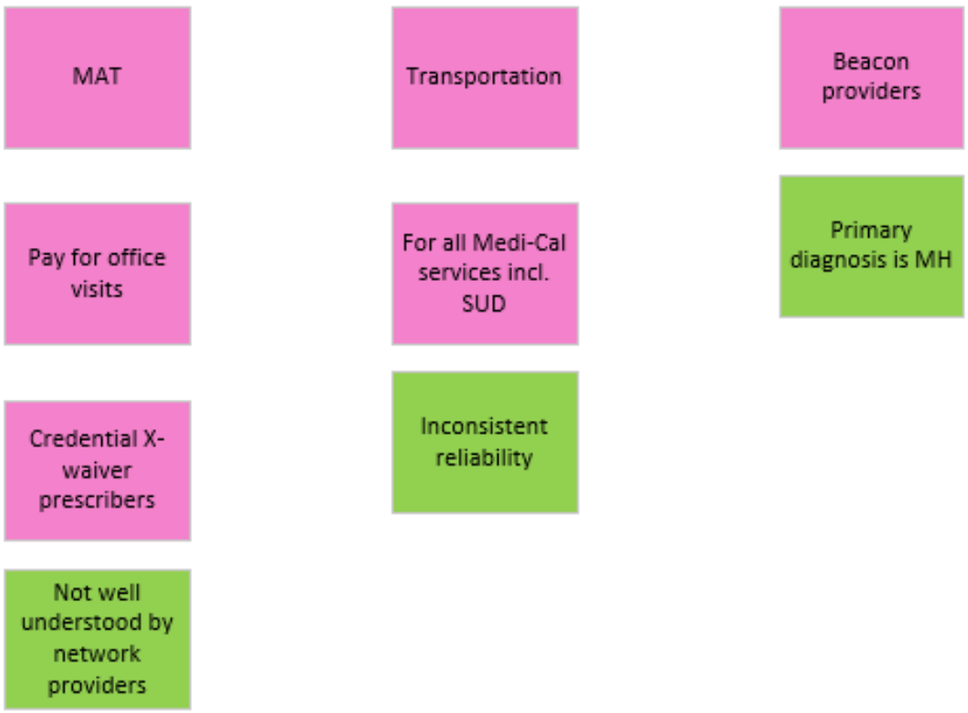
Federally Qualified Health Centers



Federally Qualified Health Centers (includes Shasta Community Health and Hill County Clinic)

Both of these FQHCs provide team-based care for MAT. Patients either self-refer, are referred from treatment providers in the community or from doctors within the health centers. This pathway therefore begins with patients making an appointment or dropping in. Barriers encountered include transportation, insufficient number of staff, and insurance status. Once at the clinic, patients fill out paperwork and are roomed. There their vitals are taken, and they are screened using the PHQ2 and CAD2. Usually behavioral health also enters the room and does further screening and assessment with the patient to determine if they are MAT eligible and appropriate. If they are, they do an induction with the provider. The provider will establish a treatment plan with the patient which includes but is not limited to either individual or group therapy, case management to address social determinants of health, etc. Barriers include lack of SUD training with behavioral health, capacity, case manager limitations and physical space.

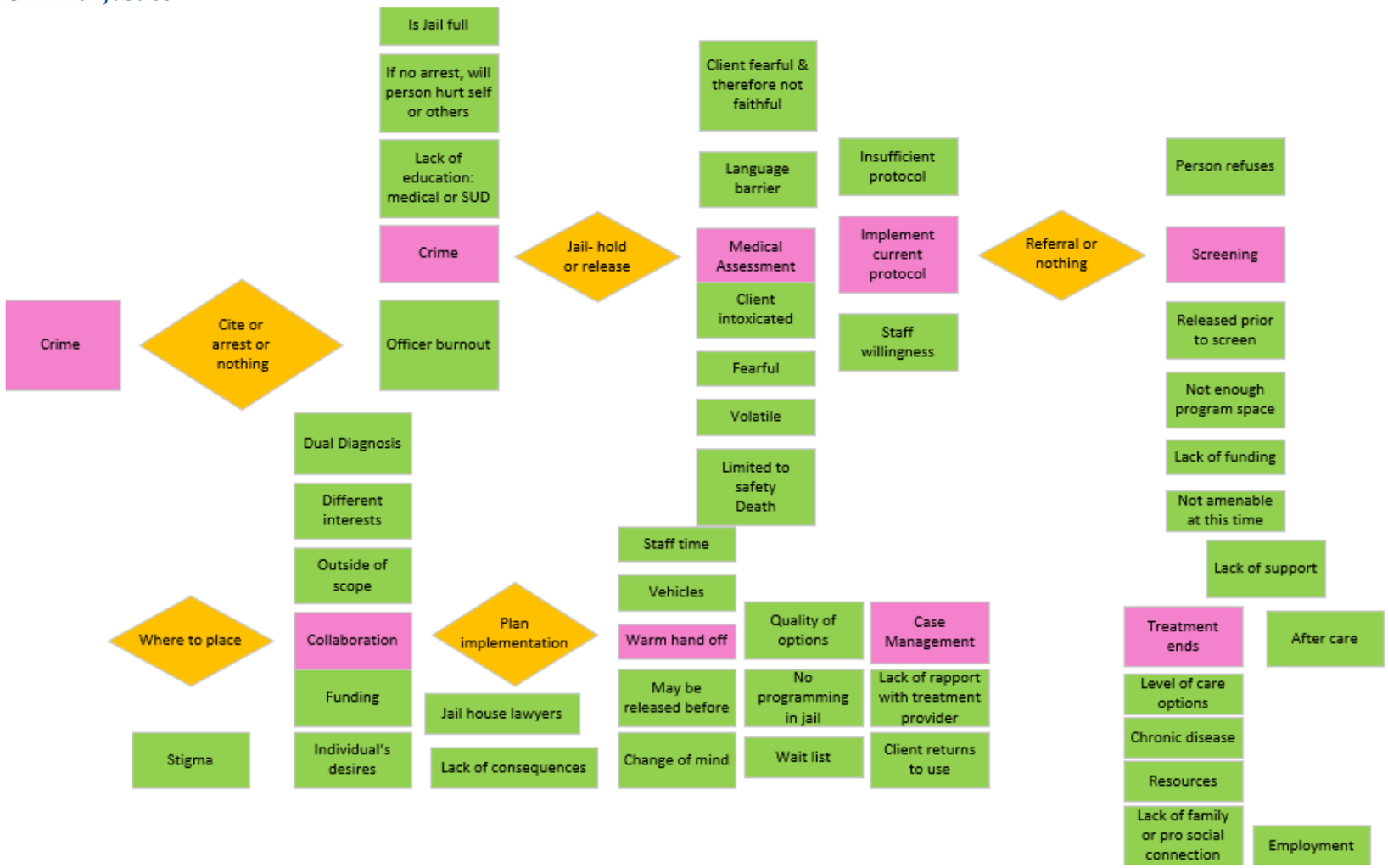
Partnership Health Plan



Partnership Health Plan (PHP)

This map depicts the ways in which PHP supports SUD services. This includes paying for MAT services, including office visits, credentialing X waivered providers, offering transportation benefits for all Medical services including SUD. Barriers include that that MAT is not well understood by providers, and another is related to unreliable and inconsistent transportation which makes taking advantage of the transportation benefit difficult at times.

Criminal Justice



Criminal Justice (includes: HHSA, Probation and Public Defenders office)

The point of entry for this value stream map is when a crime is committed. At that point a decision is made to either cite, arrest or do nothing. If the person is arrested, related barriers and/or challenges include jail being full, fear that if the person is not arrested, they may hurt themselves or others, lack of education among staff about SUD, and officer burnout. Next, it must be decided if the person should be put in jail or released. If they are put in jail, they will undergo a medical assessment by medical providers contracted by the jail. Barriers related to this step include client fearful, language barriers between staff and client, client intoxicated or volatile. Based on the results of the assessment, staff will implement the appropriate protocol. Barriers include insufficient protocol and staff willingness. Because screening for SUD in jail isn't currently an option, clients must be referred. Barriers to screening include client refusing, client released prior to screening, insufficient program space, lack of funding, and lack of support.

The next step is to decide where to place the client. After a decision is made, it is important to collaborate with partners in the community in order to make an appropriate treatment plan. Some barriers related to this include stigma, dual diagnosis, balancing different interests, partners working and making decisions outside of scope, funding and the desires of the individual client. Next, a decision is made about plan implementation. Then, a client will be given a warm handoff to whomever they are referred to. Barriers include staff time, vehicles/transportation, client being released before the handoff can be made, the client changing their mind, the quality of options for referral, no programming in jail and waitlists. Once a client is in services, they also receive case management. Barriers to case management include lack of rapport with the treatment provider, and relapse/client returning to use. When appropriate, treatment will end. Barriers include availability of other levels of care, after care, chronic disease, resources, lack of family and pro social connections and employment.

D. Gaps and Barriers – Inventory and Discussions

In order for any community-wide transformation to take place, it is a powerful and important exercise for the community stakeholders to identify clearly where they are currently. While there is much good work and effort happening in Shasta County to address addiction, stakeholders agreed there were many challenges, particularly related to structural gaps, knowledge and training, and social correlates (i.e. social determinants of health).

Agency-Specific Gaps and Barriers

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

	Structural Barriers	Structural Inefficiencies	Structural Gaps	Capacity	Knowledge/ Training	Inconsistency	Stigma/ Criminalization	Social Correlates	Funding	Insurance	Cultural Competency
SUD Treatment Providers	2	1	5		1	1		5	2		
Prevention			1		5		1	6	1		
Systems Administration	2	5		3	1	1		1	2		
Hospitals		1	1	1				5		2	
Sober Living		1	2	1	1	1		2	2		
Complex Care Management			1				1	10	1	1	1
FQHCs	4			1	2			2		1	
Partnership Health Plan		1			1	1					
Criminal Justice	1		8	2	6		2	13	1		1

Group Barrier Discussion Summary

Shasta County Stakeholders in attendance were asked to have discussions at their tables about gaps and barriers that exist in their current system (i.e. within current state). The following question was posed to help spark ideas: “The thing that keeps me from effectively treating is…”. Next, participants were asked to think about potential solutions

to the systems-level barriers they came up with. They were asked: "In a perfect world we would like to…". After the brainstorm was complete, each group presented their gaps, barriers and potential solutions aloud to the larger group. Below is a summary of the discussion:

Gaps and Barriers	Potential Solutions
Training	Match newer employees with more experienced ones; mentorship
Stigma (by professionals and users)	Educate communities and professionals about SUD in general, statistics related to SUD (it is more common than some think), and resources available.
Lack of Education	Engage those most in need of information/education in educational opportunities on the topic; start training early among new employees.
Feelings of mistrust toward medical professionals	Address biases in the medical community during medical training; hold community forums for medical professionals and others to discuss SUD and treatment together.
Insufficient funding	Seek out new/additional grant funding; negotiate service contracts; collaborative funding resources.
Lack of options for inpatient treatment	Related to funding (above).
Lack of funding for treatment, sober living, and other levels and types of care	Related to funding (above).
Red tape/bureaucracy interfering with treatment	Policy change.
Poly substance use	Greater collaboration across systems of care; enhance the referral network.
Billing (ex: cannot bill same day)	Payment reform.
Abstinence and harm reduction not feeling fully a part of the treatment ecosystem	Payment reform.
Barriers to prescribing MAT	Get rid of X waiver process
Number of trained/waivered providers	Offer more trainings.
Gaps in skilled workforce	Hold trainings and educational opportunities in the community.
Poly substance use	Provider trainings on how to address poly substance use effectively.
Transportation, child care, other basic needs	Provide in the community; use waiver to fullest capacity.
Lack of warm handoffs	More collaboration between community partners; education about each other's services.
Minimal assessments and MAT offered in jails	Jail MAT project; other pilots.

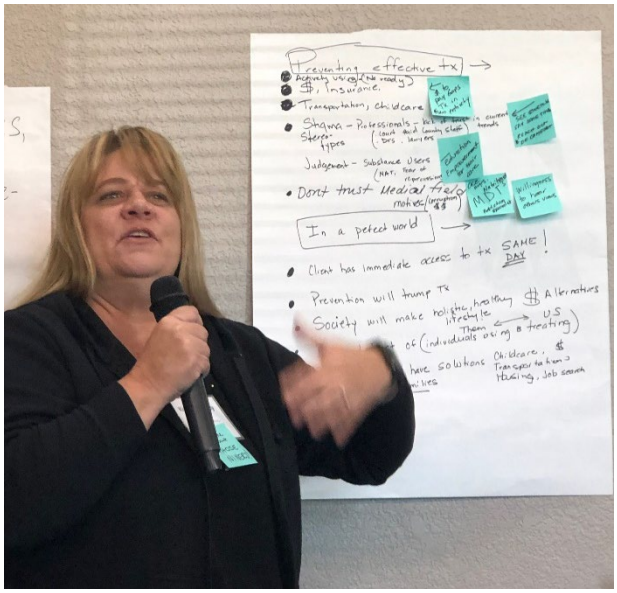
Difficulty sharing information	Improved coordination and communication; 42 CFR part 2 training *(recorded webinar offered by HMA).*
Inadequate number of grace beds	Create a day center for low income people experiencing homelessness and/or mental health challenges; have clinical staff on site in shelters.
Client engagement	Offer incentives; advertise array services available.
Knowledge of programs and services available in the community	Create and take advantage of more networking opportunities in the community.
Insurance eligibility requirements.	Make it affordable and available to everyone
Insufficient treatment options for every demographic (ex: team moms)	Creation of new programs to meet basic needs of all people in the community.

E. Future State System of Care Goals

On the afternoon of day 2, the participating organizations began to think about moving from their current states to an improved Future State System of Care (i.e. future state). We asked each table group to discuss their most desired features in a future state, and the positive impact it would have on the Shasta County community. As each table shared what they would most like to see, some clear consensus emerged:

Integration/ Coordination

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



and will participate in the Partnership Health Plan Regional Model for SUD Services effective March 1, 2020.

Access to Care

Many groups mentioned the difficulties in getting clients to treatment. There are lots of barriers that impact access to care. The rural nature of the county and limited public transportation to get to and from treatment services and appointments to be assessed for appropriate level of services. Since Shasta County is served by the Partnership Health Plan there is opportunity for Medi-Cal eligible enrollees to obtain transportation assistance through Partnership's Medi-Cal transportation benefit. This Medi-Cal benefit providers enrollees with transportation assistance to medically necessary medical appointments.

Stigma was also identified as a barrier. The treatment community mentioned that patients with relapses often feel that they have burned their bridges to treatment. Both the treating providers and patients say there is a perceived perception that can prevent this population from accessing future care. Participants mentioned the importance of addressing this stigma. Shasta County also has some additional limitations with limited levels of services within its DMC State Plan program. The county has limited MAT treatment options with a limited number of DEA authorized X waivered physicians that can offer MAT services and one methadone treatment program operating within Shasta County. Methadone treatment is most frequently accessed in the city of Redding through the Narcotic Treatment Program. Aegis Treatment Centers is the methadone treatment provider serving the greater Redding Area. There are eight California Bridge contracted sites that provide MAT treatment through a network of providers within the greater Redding - Interstate 5 and CA State Route 299 corridor. https://www.google.com/maps/d/viewer?mid=1OvkCsODLNjAEbmveELpO70n4UaEUt9FO&hl=en&ll=40.523121079969904%2C-121.93215775388364&z=9 The distance to a methadone treatment provider can vary depending on proximity of a client's residence to an NTP treatment provider site. Some clients experience travel times in excess of an hour plus travel time.

Evidence-Based Care

Groups stated that they would like to see more MAT resources in the county, more training for providers, and more data and evaluation to drive strategic capacity building at the appropriate levels of care. In order to accomplish this, ten applications for ongoing technical assistance (TA) were received from participating participants. Four organizations expressed interest in either expanding or developing new MAT capacity. The four provider sites include Empire Recovery Center, Hill Country Health and Wellness Center, Shasta County Health and Human Services Agency and Visions of the Cross. Three organizations, Shasta County Probation, Shasta County Public Defender's Office and LifeSteps all requested TA, these three programs are already participating in the Jail MAT and Touchpoints projects and will be referred to these programs for

additional Technical Assistance. In Addition, HMA has assigned TA coaches to assist both organizations with their expansion goals.

Resources for People Living with Addictions

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

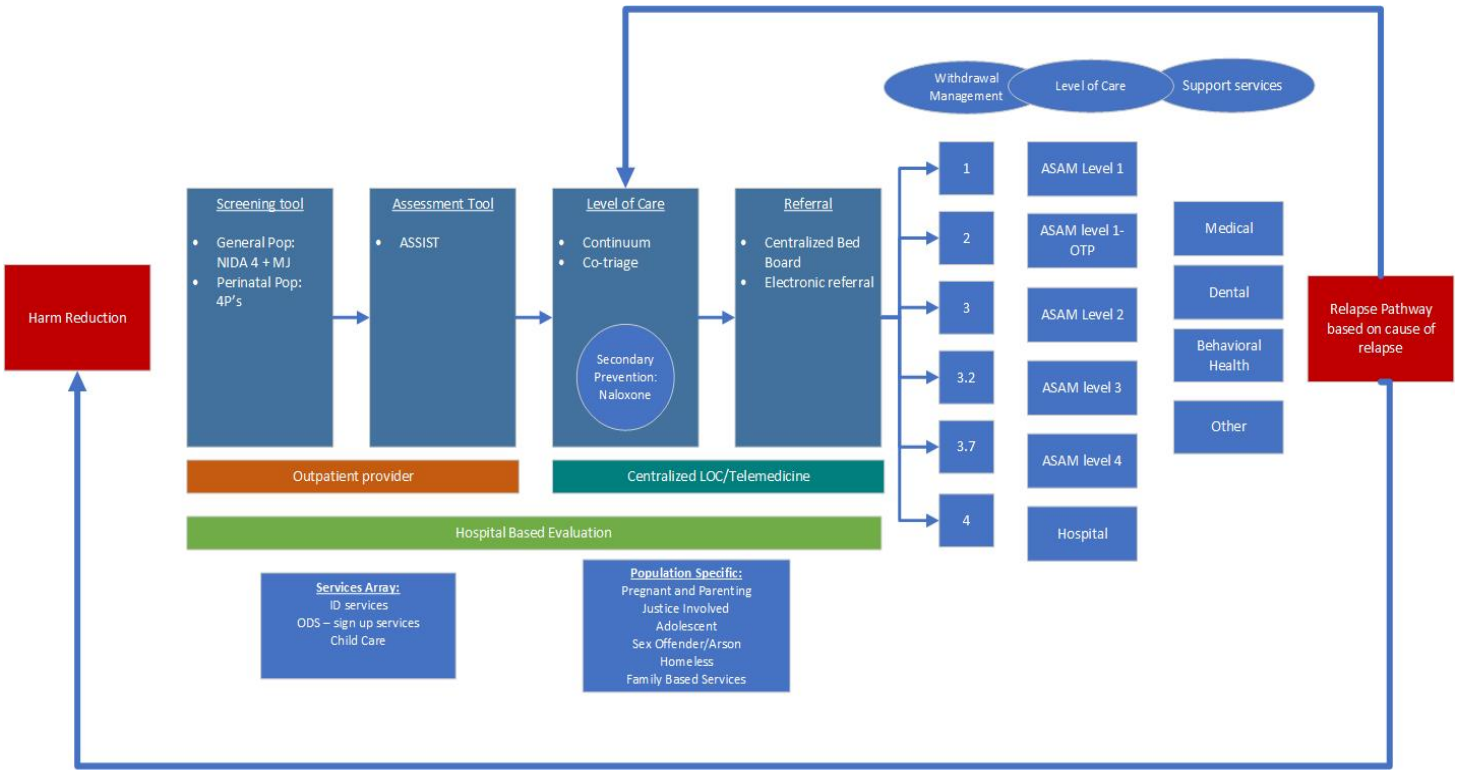
F. Triggers

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

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

G. The "Scaffolding of the Future State"

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



Considerable time was spent during the process improvement event considering the current state of the SUD ecosystem and barriers that exist within this system. These conversations informed the Future State discussion of the whole group. HMA's facilitator, Scott Haga, MPAS, PA-C, presented an overview of all of the evidence-based screening and assessment tools that are publicly available free of charge to the entire eco-system. The Future State System of Care discussions focused on the need for the countywide treatment eco-system to utilize the same standardized, evidence-based screening and assessment tools. The participants discussed the tools that their organizations are currently using, and the need for the eco-system to move to the use of the same evidence-based and culturally competent tools to ensure coordinated, and clinically appropriate outcomes.

During a structured discussion, the group discussed the advantages of using the same screening and assessment tools throughout the treatment ecosystem. The participants discussed the benefits of all providers being able to quickly assess the clients' needs and identify available treatment capacity within the county. The group also discussed the positive effects of eliminating time consuming and redundant screening from both a provider and client perspective. Ultimately, the group identified the NIDA 4 screening tool plus a marijuana question, as the current most commonly used screening tool, and one that is standardly available within the community and on most provider's Electronic Medical Record systems. There was less emphasis on affirmatively identifying a specific screening tool as the discussions identified that use of an evidence-based screening tool would still identify a positive screening that would lead to the conducting of an assessment that will lead to patients getting into treatment. The group placed more importance on identifying a standardized, evidence-based assessment tool as countywide use will provide the ability to quickly assess and connect people in need of services with available service providers. The World Health Organization's ASSIST tool was the dominant tool identified and in use within the treatment ecosystem.

Partnership Health Plan, the Medi-Cal health plan that is standing up the Regional DMC-ODS program in the Northern California counties, has provided the HMA project team with their assurance of support for the county's selection of screening and assessment tools. Partnership Health Plan already uses the ASSIST tool as their physical health assessment for SUD treatment conducted by Partnership's contractor, BEACON Health Options. Shasta County is a Regional ODS opt-in county, making it logical to align with the same screening and assessment approach that Partnership Health Plan has outlined for use in their Regional DMC-ODS Model.

Scott Haga led a detailed discussion on all of the industry-standard screening and assessment tools along with a pros and cons discussion to help the county participants in the identification of the screening and assessment tools that will meet the needs of the future state ecosystem, and assist in provider's data and reporting needs.

Screening

The participants agreed on the use of the *National Institute on Drug Abuse or NIDA-4 Quick Screen tool*. The NIDA 4 Quick Screen is a validated screening tool designed to assist providers in screening adults for alcohol and substance use concerns. The NIDA 4 is a structured screening tool that asks quick screen questions about alcohol and drug use within the last year. An affirmative response to the quick screen questions triggers follow-up questions on lifetime alcohol and drug use, more recent alcohol and drug use, and determines the patient's risk level based on a calculated patient substance involvement or SI Score. Individuals with moderate to high scores are typically assessed and referred to supportive services.

Assessment

Considerable discussion surrounded the selection of an appropriate tool for SUD assessment for Shasta County. County providers are currently utilizing a variety of assessment tools. The consensus of the group was to examine and utilize the World Health Organization's *Alcohol, Smoking and Substance Involvement Screening Test* or ASSIST tool as the county-wide assessment tool. The ASSIST is already validated in multiple languages, is available without cost, and has a large number of resources to support its use in primary care.

Level of Care Determination

The state of California's Drug Medi-Cal Organized Delivery System (DMC-ODS) requires that the ASAM criteria be used to determine the level of care for patients with addiction. The Criteria looks at six dimensions of the patient's condition to determine their treatment plan and the most appropriate location for that treatment plan to be executed. This determination can be completed through a structured interview or an online tool called the CONTINUUM™ Triage (CO-Triage™). It is recognized by all payers as the standard of care and allows for the location of care to be based on a set of parameters, rather random chance

Partnership Health Plan's Central Access Line staff will use the web based ASAM level of care placement tool as the initial screening tool. Face-to-face assessments at the provider sites will involve a bio psychosocial assessment to determine if the client meets medical necessity criteria based on the current Diagnostic Statistical Manual (DSM); ASAM criteria will then be applied to make the appropriate level of care recommendation(s).

The county has expressed interest in further researching and exploring the ASAM Continuum. ASAM Continuum will require a financial commitment from the county to ascertain necessary funding, training, and licensing tools. This transition to the ASAM Continuum is necessary to ensure compliance with state requirements and best practices. The long-term use of the ASAM Continuum will ensure that the county is

developing a robust data reporting archive on the required need for all ASAM levels of care needed to meet the county's long-term planning and strategic reporting needs.

Treatment Ecosystem

Within and outside of Shasta County there are many levels of service that can be delivered for both withdrawal management and treatment of the SUD. Shasta County's DMC system offers a full array of most levels of care, more so than non-ODS Counties that offer limited ASAM levels of care for individuals with addiction. Regardless, all levels of care need to be identified and vetted to determine how many program slots or residential beds are available at each level of care, what services are delivered, how fast the patients can have access to MAT, and who treats co-occurring and all of the other aspects of care necessary to complete addiction care. Once this is done, the eco-system can overlay the needed support services.

Transportation was also mentioned more than once as a significant need and should be addressed to ensure that people in care can get timely access to treatment services. There are many ways to do this, especially with the Medi-Cal expansion and the adaption of the Regional Model of SUD services soon to be offered by Partnership Health Plan effective March 1, 2020. Partnership Health Plan can already assist its members in getting the transportation services needed to get to and from healthcare appointments. Community Partners can also help patients in addressing their Social Determinants of Health (SDOH), this includes assistance with obtaining an ID, getting housing and having appropriate food should all be coordinated through a central "hub" for information and referral.

Relapse

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

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

03 Section 3: Implementation Strategy

A. Next Steps

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

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

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

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

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

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

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

Organizations/teams were asked to sign up for TA during the process improvement event and provided initial goals for the TA program. The following 10 organizations applied for TA:

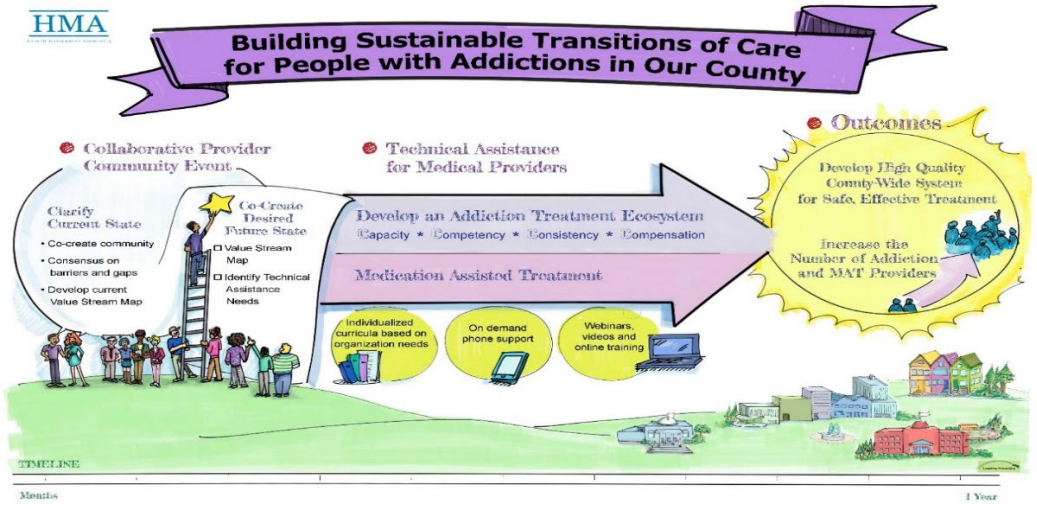
+ Children's Hope Alliance
+ Dignity Health Mercy Medical Center
+ Empire Recovery Center
+ Groups Recover Together
+ Hill County Health & Wellness Center
+ LifeSteps
+ Shasta County Health & Human Services Agency
+ Shasta County Probation
+ Shasta County Public Defender's Office
+ Visions of the Cross (VOTC)

The 10 organizations/teams who requested TA requested the following specific goals:

Goal:	*Action:*	Frequency
1	*Learn more about caring for people with addiction and provide more information and training to our staff.*	7
2	*Learn more about how our organization can participate in a community wide solution to the opioid epidemic.*	10
3	*Improve our role in managing the transitions of care as residents in our community move within addiction system of care.*	7
4	*Scale up our current MAT program by increasing the number of patients treated.*	2
5	*Start providing MAT services at our organization.*	3
6	*Learn how to provide or improve addiction treatment to pregnant and parenting women.*	6

C. Conclusion

In conclusion, HMA thanks the Shasta County SUD Providers and Treatment community, who turned out with their hearts and minds committed to this work. We hold the deep conviction that the Shasta 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 Shasta County Health and Human Services Agency and their Behavioral Health Services Department, along with Partnership Health Plan, the and the hospital community have the vision, leadership and ability to fully implement the envisioned future state pathway within the next two to three years. Together, we have the power to normalize the disease of addiction, better care for the community members suffering from this disease and eliminate addiction related deaths in the County.



Appendix

A. Shasta County Data

SHASTA COUNTY: POPULATION 64,665

STATISTICS

- OUD Death Rate
  - 2017: 14.20
  - 2016: 8.64
- All Drug Death Rate
  - 2017: 19.24
  - 2016: 23.3
- 5 Hospitals
- 1 Pharmacy
- 6 FQHCs

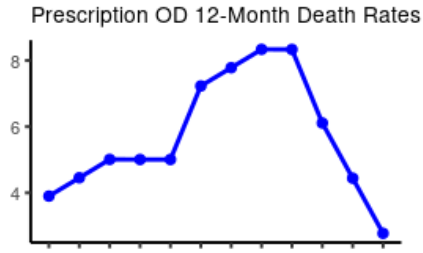
ADDITIONAL FACTORS

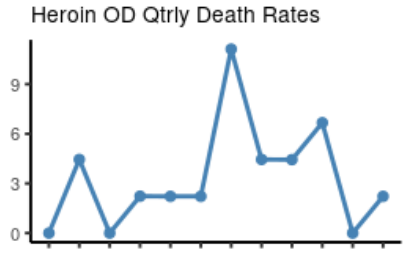
- SAMHSA Funds: $887,500
- 1 Hub and 9 Spoke sites
- Presence of CA Bridge: Y
- Drug Medi-Cal Organized Delivery System?: Y

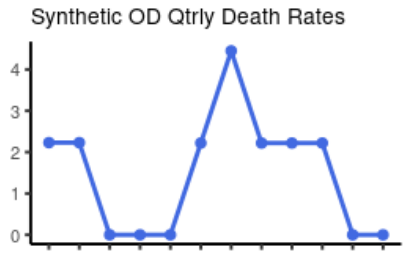
Shasta Opioid Overdose Snapshot: 2016-Q1 to 2018-Q4

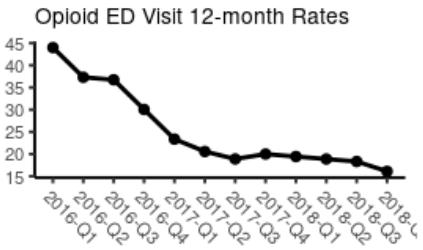
Report downloaded 11-11-2019

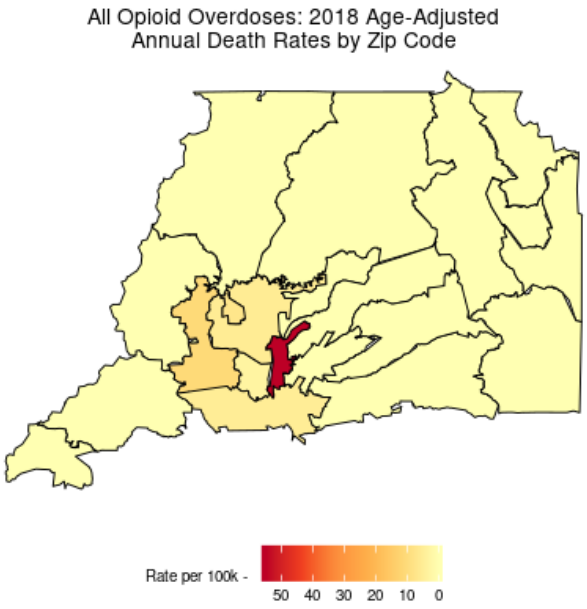
Shasta experienced 11 deaths due to all opioid-related overdoses in 2018, the most recent calendar year of data available. The annual crude mortality rate during that period was 6.1 per 100k residents. This represents a 35% decrease from 2016. The following charts present 12-month moving averages and 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.

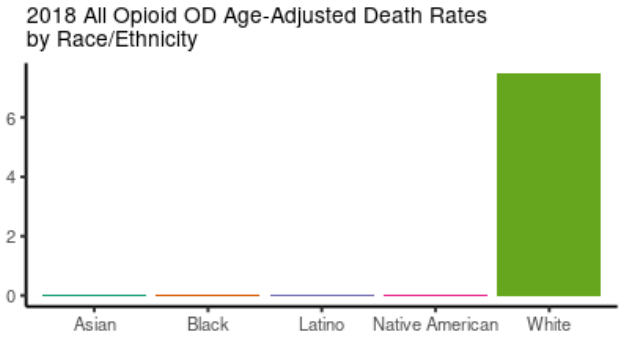




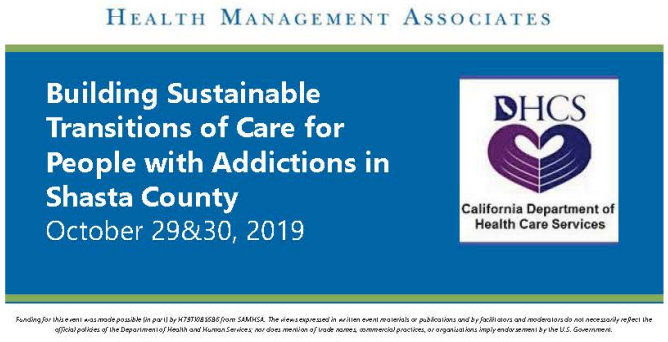


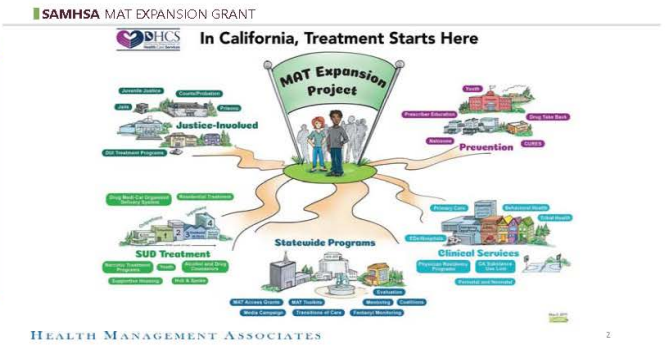


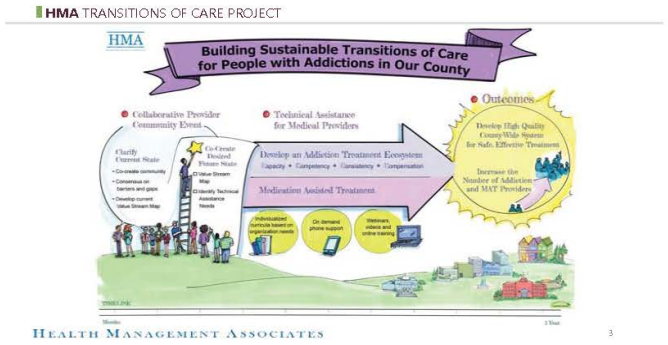


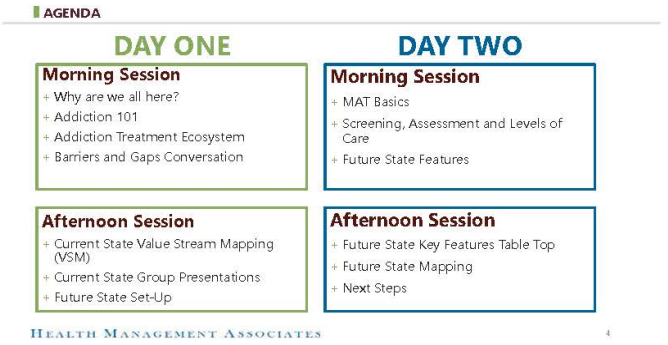


B. Process Improvement Event Slides









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

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SHASTA COUNTY: POPULATION 177,223

STATISTICS

- OUD Death Rate 14.1: Rank 5/58
- ED Opioid Rate 99.83: Rank 3/58
- 5 Hospitals: Rank 21/58
- 1 Pharmacy: Rank 58/58
- 6 FQHCs: Rank 5/58
- Methadone Pt Rate 0: Rank n/a

ADDITIONAL FACTORS

- SAMHSA Funds: $887,500
- 1 Hub and 9 Spoke sites
- Presence of CA Bridge: Y
- Drug MediCal Organized Delivery System?: Y

HEALTH MANAGEMENT ASSOCIATES 8

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

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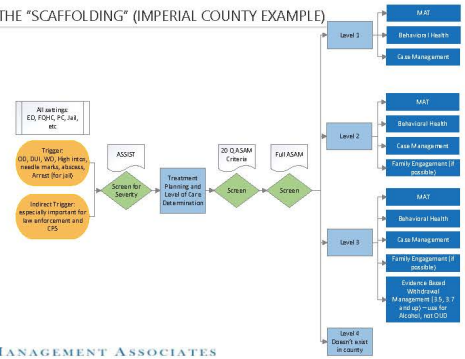
PREVIEW: THE "SCAFFOLDING" (IMPERIAL COUNTY EXAMPLE)



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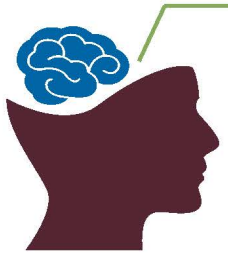
ADDICTION 101 – THE PROBLEM



What is Addiction?

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

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ADDICTION 101 – HOW DID WE GET HERE?

Push by manufacturers

Poor acute and/or chronic pain management theory

Distribution of huge amounts of medication

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

Massive amount of prescriptions filled by pharmacies

Blind eye to the data

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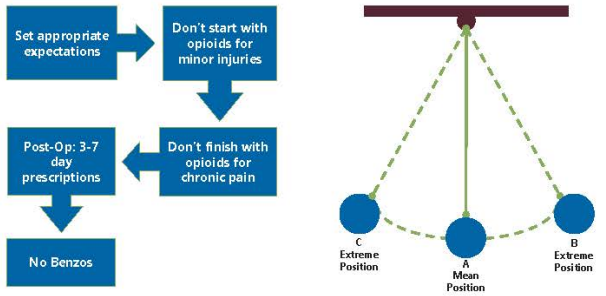
ADDICTION 101 – SAFE OPIOID PRESCRIBING



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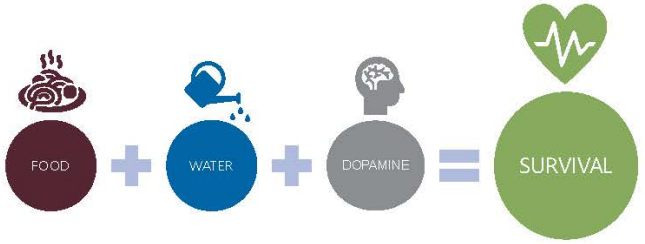
ADDICTION 101



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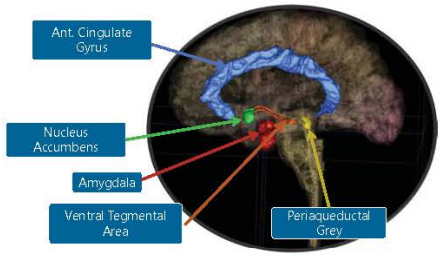
ADDICTION 101 – NEUROBIOLOGY OF ADDICTION



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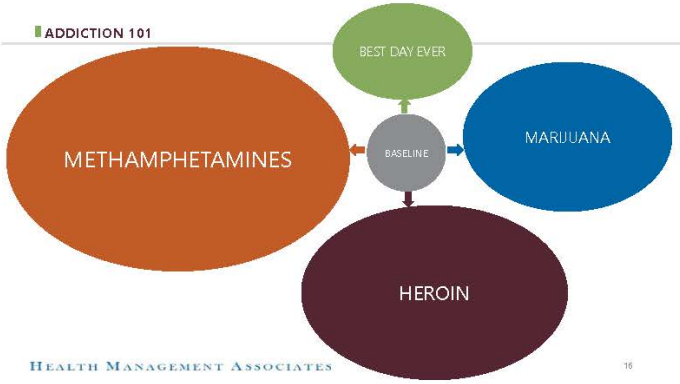
ADDICTION 101



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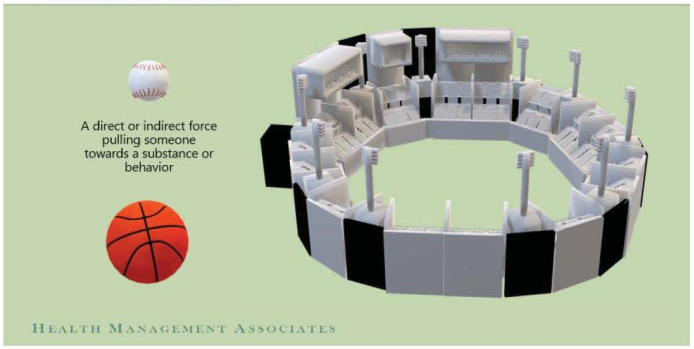
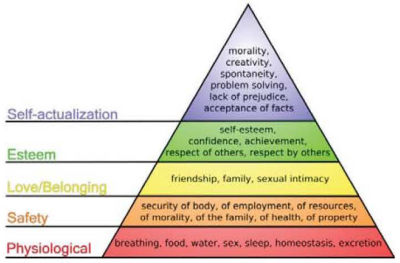
ADDICTION 101 – CRAVING



Hierarchy of Needs



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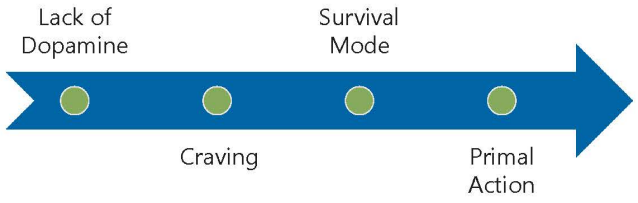
ADDICTION 101 – BEHAVIOR



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DSM-5 DIAGNOSIS OF OUD

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

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

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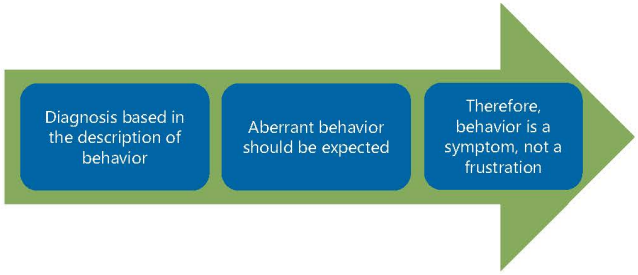
ADDICTION 101 – BEHAVIOR



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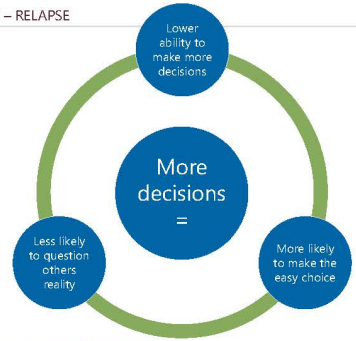
ADDICTION 101 – RELAPSE



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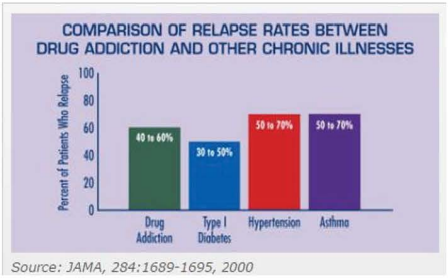
ADDICTION AS A CHRONIC DISEASE



Source: JAMA, 284:1689-1695, 2000

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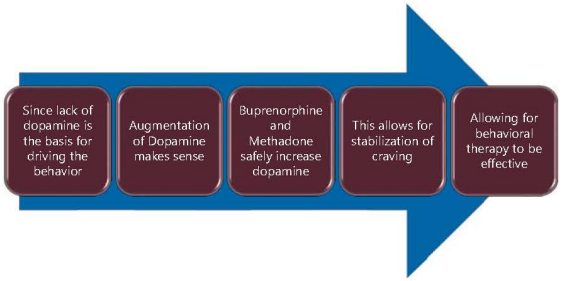
ADDICTION 101 – TREATMENTS



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THE ECOSYSTEM OF CARDIAC CARE

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THE ECOSYSTEM OF ADDICTION CARE

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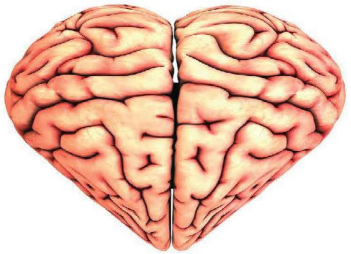
ADDICTION TREATMENT ECOSYSTEM CLINIC STRUCTURES

HEALTH MANAGEMENT ASSOCIATES 27

ADDICTION TREATMENT ECOSYSTEM CHANGING HEARTS AND MINDS

ADAPTIVE vs. TECHNICAL



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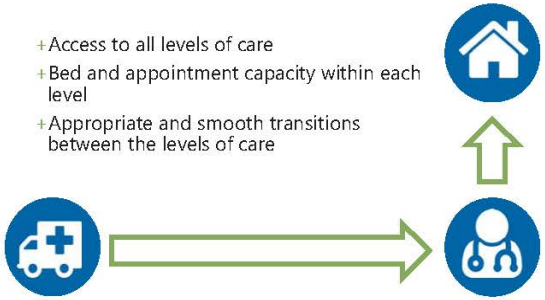
ADDICTION TREATMENT ECOSYSTEM IMPLEMENTATION

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

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



ADDICTION TREAMENT ECOSYSTEM COMPETENCY

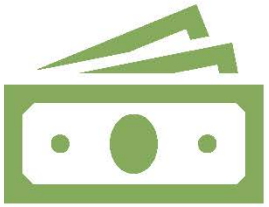
- BH personnel working at appropriate level of training
- Addiction specific training of BH and care coordinators
- Standardized peer support training
- PCPs who are waivered and trained with ongoing TA
- Board Certified Specialists with up to date MOC
  - Includes need for increased fellowships
- Academic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

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

ADDICTION TREAMENT ECOSYSTEM COMPENSATION

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



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

SCREENING, ASSESSMENT & LEVEL OF CARE DETERMINATION

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

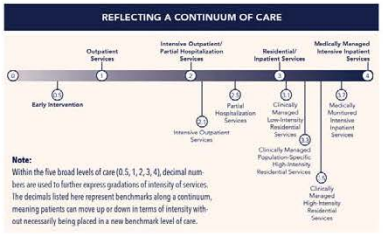
❑ **Assessment:**
A deep evaluation meant to solidify the presence and severity of a disease (lower sensitivity, high specificity)

❑ **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).

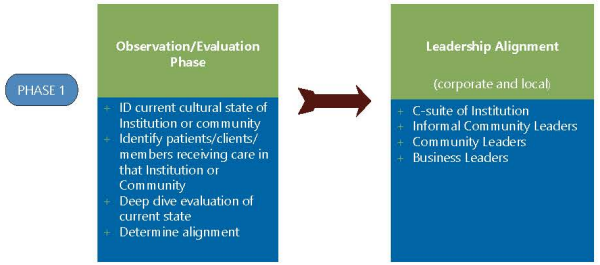
LEVEL OF CARE DETERMINATION

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



ADDICTION TREAMENT ECOSYSTEM PHASES OF PROCESS

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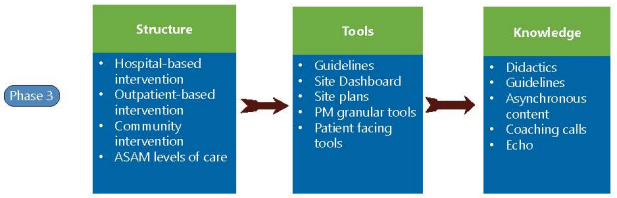


TABLE DISCUSSION

WHAT ARE THE BARRIERS AND GAPS IN YOUR CURRENT SYSTEM?

GOAL

THE THING THAT KEEPS ME FROM EFFECTIVELY TREATING IS….

IN A PERFECT WORLD WE WOULD LIKE TO….

ROVING BRAINSTORM

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

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

GALLERY WALK

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

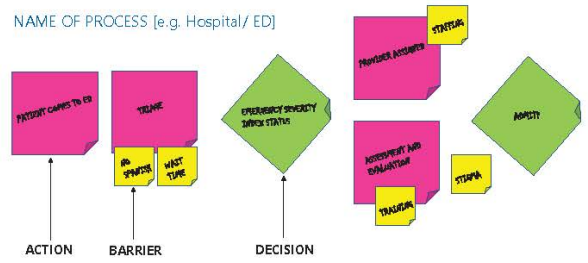
SOLUTIONS

GROUP DISCUSSION: BARRIERS AND SOLUTIONS

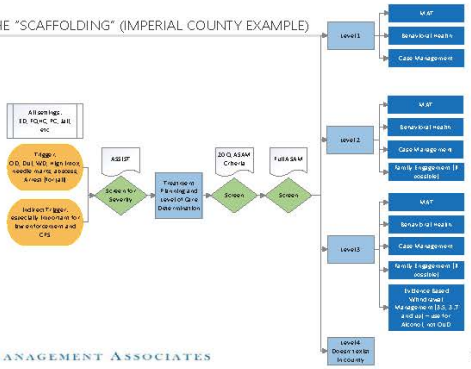
FUTURE STATE MAPPING ON DAY 2

IN A PERFECT WORLD…

CURRENT STATE VALUE STREAM MAP EXAMPLE



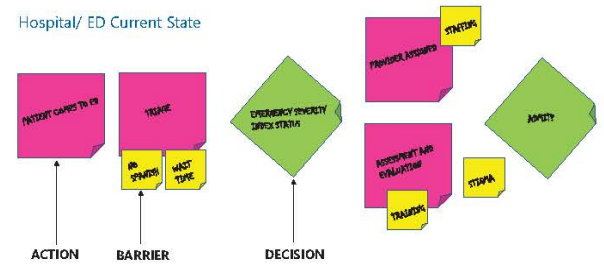
Preview: THE "SCAFFOLDING" (IMPERIAL COUNTY EXAMPLE)



FIELD NOTES

VALUE STREAM MAP EXAMPLE

Hospital/ ED Current State



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

October 29&30, 2019

DAY 2

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.

AGENDA

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

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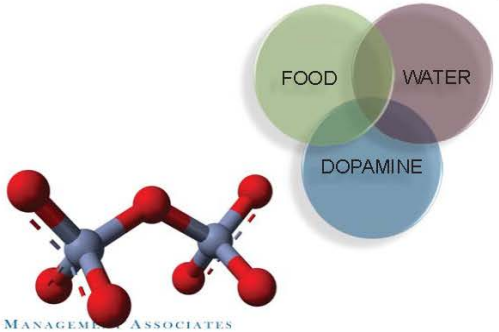
SURVIVAL



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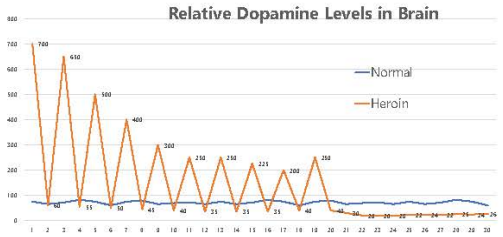

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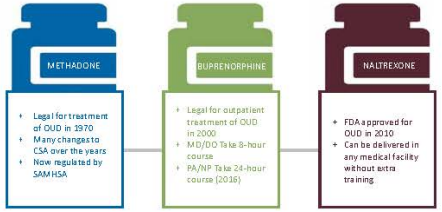
MEDICATION-ASSISTED TREATMENT (MAT) INTRODUCTION



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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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HEALT

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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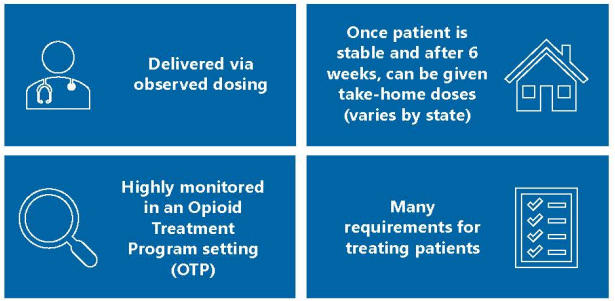
METHADONE GENERAL REGULATIONS



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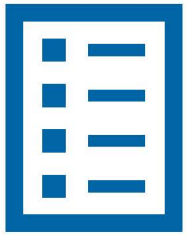
METHADONE CLINIC REQUIREMENTS

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



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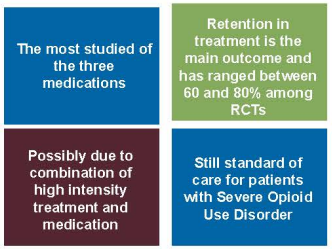
METHADONE OUTCOMES



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RETENTION IN METHADONE TREATMENT IS ASSOCIATED WITH:

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

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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

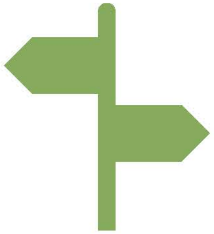
+ Retention in treatment at 1 year have ranged from 55% to 65% using the sublingual medication
+ High degree of variability in the delivery models and patient severity
+ Most rapid stabilization of dopamine

BUPRENORPHINE PROPERTIES

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

BUPRENORPHINE CAVEATS

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



BUPRENORPHINE INDUCTION

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

BUPRENORPHINE CAVEATS

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

NALTREXONE WHO IS APPROPRIATE?

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

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

NALTREXONE MEDICATION FORMS

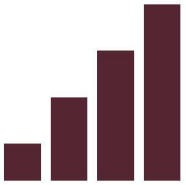
- Pills at 25mg and 50 mg
- Long acting injectable 380mg (28-30 days)
  - Vivitrol
- Implantable beads
  - 6 months of coverage of 0.9 ng/ml naltrexone
  - 3.5 ng/nl of 6-beta-Naltrexol)

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)

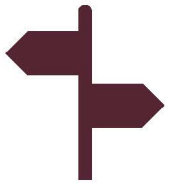
NALTREXONE OUTCOMES

- 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



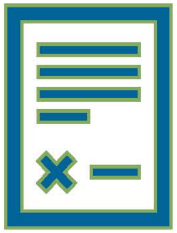
NALTREXONE CAVEATS

- 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



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.

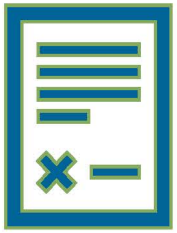


WHAT TO DO WHEN PATIENT ON MAT TEST POSTIVE FOR OTHER DRUGS?

+ 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).

LET'S TRY THIS OUT....

❑ **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

❑AUDIT-C
❑DAST
❑NIDA Quick Screen/NIDA 4
❑CRAFFT
❑4P's/4P's Plus

The NIDA 4 +1 (MJ for CA)

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

*Added due to legalization of MJ in CA

HEALTH MANAGEMENT ASSOCIATES

ASSESSMENT TOOLS

- If a patient screens positive, then need to assess for the presence of the disorder
- If the disorder is present, we can determine the severity
- Many validated tools exist

HEALTH MANAGEMENT ASSOCIATES

ASSESSMENT TOOLS

- Addiction Severity Index (ASI)
- Tobacco, Alcohol, Prescription medication, and other Substance use Tool (TAPS2)
- ASSIST

HEALTH MANAGEMENT ASSOCIATES

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

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

HEALTH MANAGEMENT ASSOCIATES

Question 1: Lifetime use

- ❑In your life, which of the following substances have you ever tried? *(non-medical use only)*
  - ❑No
  - ❑Yes
- ❑Ask for all substances
- ❑Record any use (even if only tried once)
- ❑Probe: *Not even at a party?*
- ❑If "No" to all substances, end the interview.

Question 2: Recent Use

Frequency of use over past 3 months.

During the past 3 months, how often have you used the substances you mentioned *(first drug, second drug, etc.)?*

- ❑ Never (0)
- ❑ Once or twice (2)
- ❑ Monthly (3)
- ❑ Weekly (4)
- ❑ Daily or almost daily (6)

Question 3: Strong urge to use

Frequency of experiencing a strong desire or urge to use each substance in the past 3 months.

During the past 3 months, how often have you had a strong desire or urge to use *(first drug, second drug, etc.)?*

- ❑ Never (0)
- ❑ Once or twice (3)
- ❑ Monthly (4)
- ❑ Weekly (5)
- ❑ Daily or almost daily (6)

Question 4: Health, social, legal, or financial problems

Frequency of experiencing health, social, legal or financial problems related to substance use, in the past 3 months.

During the past 3 months, how often has your use of *(first drug, second drug, etc.)* led to health, social, legal, or financial problems?

- ❑ Never (0)
- ❑ Once or twice (4)
- ❑ Monthly (5)
- ❑ Weekly (6)
- ❑ Daily or almost daily (7)

Question 5: Failure to fulfill major role responsibilities

Frequency of experiencing a strong desire or urge to use each substance in the past 3 months.

During the past 3 months, how often have you failed to do what was normally expected of you because of your use of *(first drug, second drug, etc.)*?

- ❑ Never (0)
- ❑ Once or twice (5)
- ❑ Monthly (6)
- ❑ Weekly (7)
- ❑ Daily or almost daily (8)

Question 6: External concern

Evaluation of someone else's concern about the patient's substance use.

Has a friend or relative or anyone else ever expressed concern about your use of *(first drug, second drug, etc.)*?

- ❑ No, Never (0)
- ❑ Yes, in the past 3 months (6)
- ❑ Yes, but not in the past 3 months (3)

Question 7: Failed attempts to control substance use

Evaluation of the patient's failed attempts to control use.

Have you ever tried and failed to control, cut down, or stop using *(first drug, second drug, etc.)*?

- ❑ No, Never (0)
- ❑ Yes, in the past 3 months (6)
- ❑ Yes, but not in the past 3 months (3)

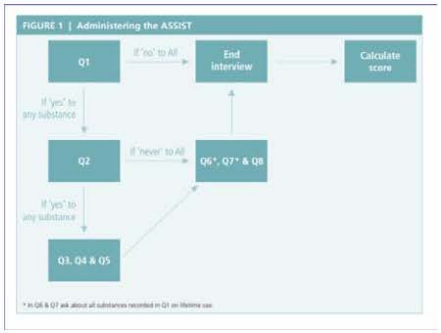
Question 8: Injecting drug use

Have you ever used any drug by injection?
(non-medical use only)

- ❑ No, Never (0)
- ❑ Yes, in the past 3 months (2)
- ❑ Yes, but not in the past 3 months (1)

If yes, query about pattern of injecting, as follows.

ASSIST



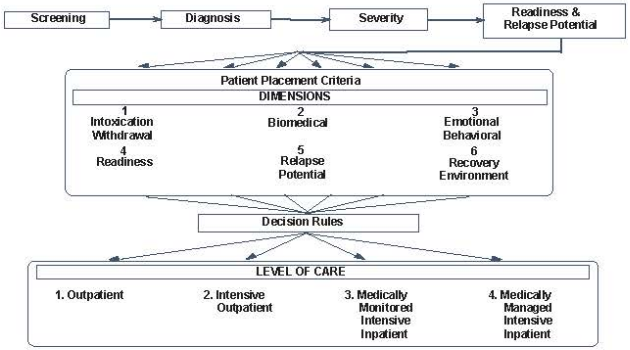
Scoring the ASSIST

What do the Specific Substance Involvement Scores Mean?

- **Alcohol**
  - 0-10 Low Risk
  - 11-26 Moderate Risk
  - 27+ High Risk
- **All other substances**
  - 0-3 Low Risk
  - 4-26 Moderate Risk
  - 27+ High Risk

For each substance (labelled a. to j.), add up the scores received for questions 2 through 7 inclusive. *Do not include the results from either Q1 or Q8 in this score.*

The ASAM Criteria Decision Process



ASAM CRITERIA METHODS OF DELIVERY

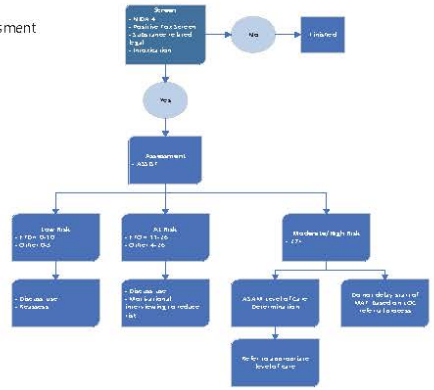
- Structured interview
  - High variability
  - Not always accepted
  - Write-up's vary in sophistication
- On-line Continuum
  - Asymmetrical Branching
  - Improves interrater reliability
  - Has a dashboard
  - Information is transmittable
- Co-triage
  - 20 questions (about 10-15 min)
  - Provisional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

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

Screening and Assessment

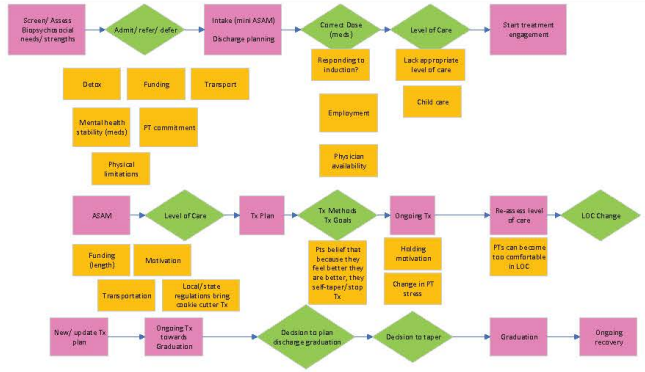


CONSTRUCTING THE FUTURE STATE

REVIEW OF THE CURRENT STATE

HEALTH MANAGEMENT ASSOCIATES

CURRENT STATE VALUE STREAM MAP SUD TREATMENT PROVIDER



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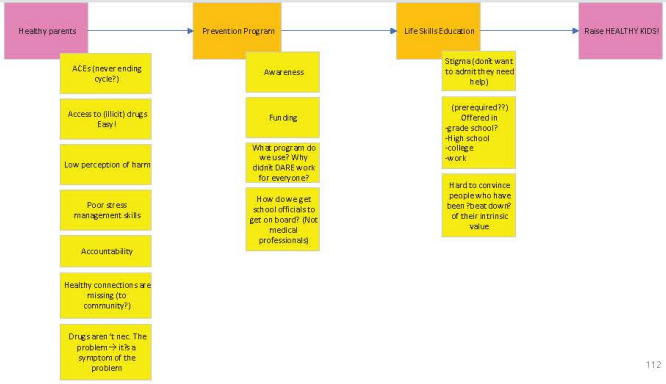
CURRENT STATE VALUE STREAM MAP PREVENTION



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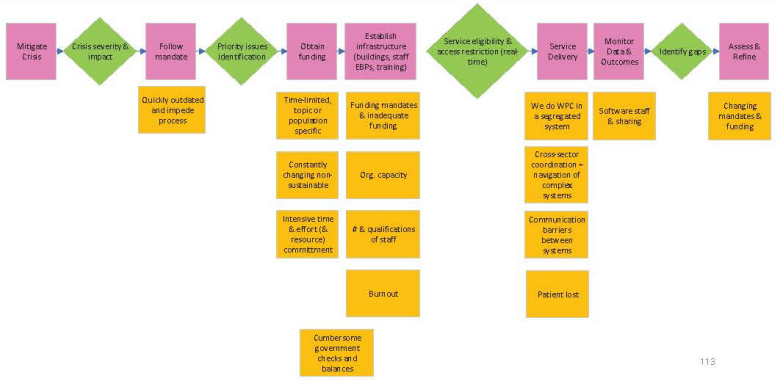
CURRENT STATE VALUE STREAM MAP SYSTEMS ADMINISTRATION



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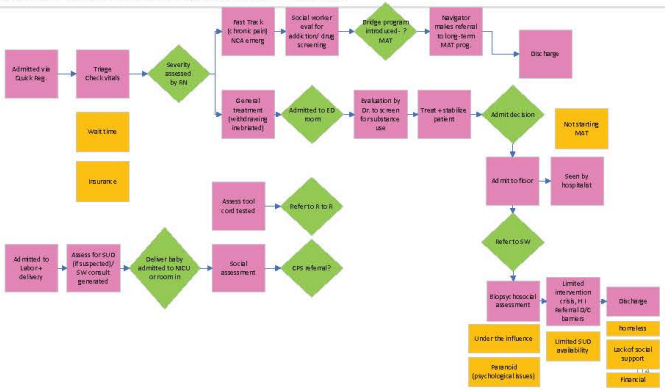
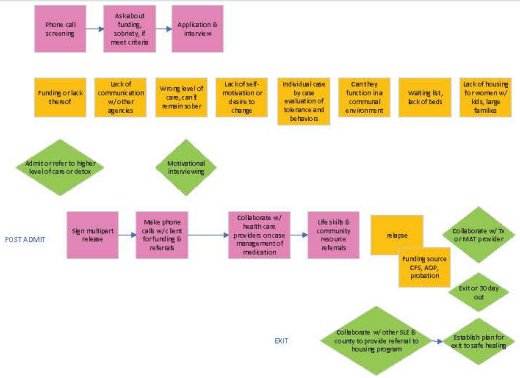
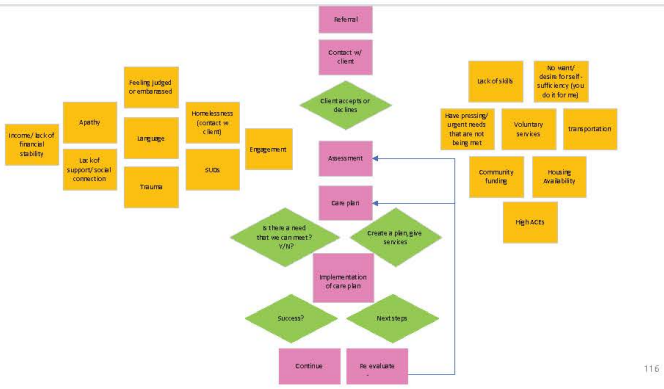
CURRENT STATE VALUE STREAM MAP HOSPITAL



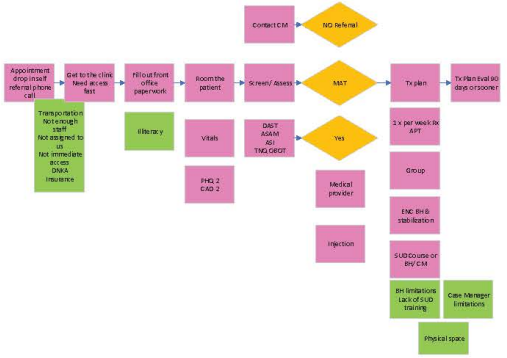
CURRENT STATE VALUE STREAM MAP SOBER LIVING



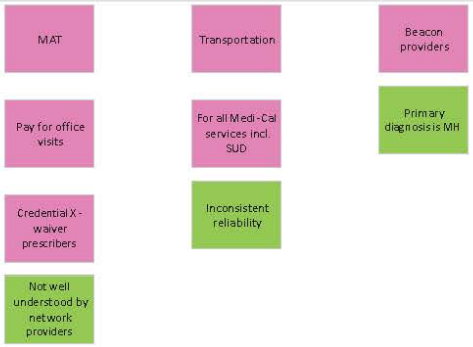
CURRENT STATE VALUE STREAM MAP COMPLEX CARE MANAGEMENT



CURRENT STATE VALUE STREAM MAP FQHC



CURRENT STATE VALUE STREAM MAP PARTNERSHIP HEALTH PLAN



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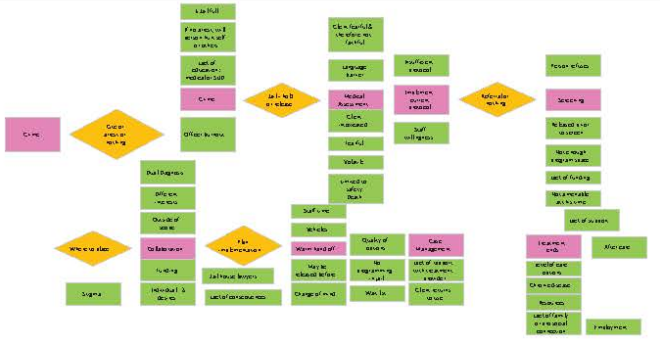
CURRENT STATE VALUE STREAM MAP CRIMINAL JUSTICE



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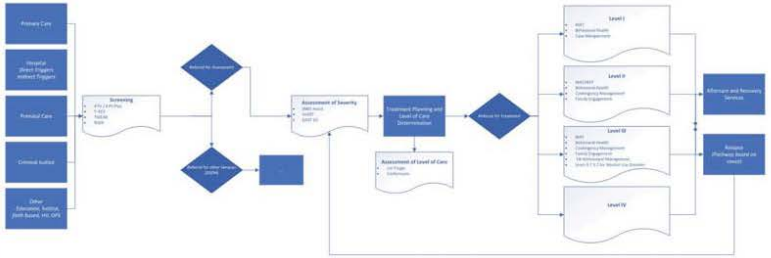
IN A PERFECT WORLD...

FUTURE STATE FEATURES:

- TABLE TOP
- GALLERY WALK
- DISCUSSION

SHASTA COUNTY: Future State Treatment and Recovery Ecosystem



FUTURE STATE MAPPING: Key Features of the Future State

You will have 40 minutes to Identify Key Features

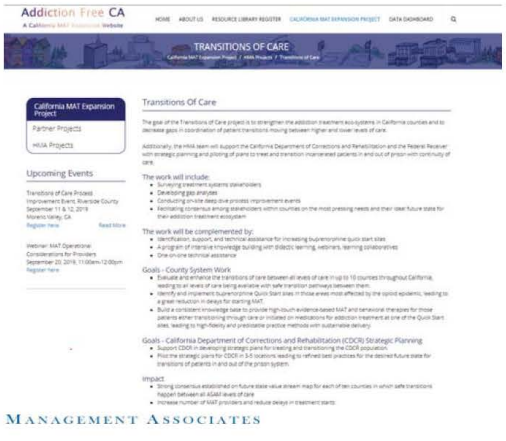
- Brainstorm the key features you would want to see in the future state treatment and recovery ecosystem (e.g., centralized bed or appointment locator, uniform screening at every entry node). Keep notes
- Select your top two key features and note them on your tracking document
- Select someone to report out your key features

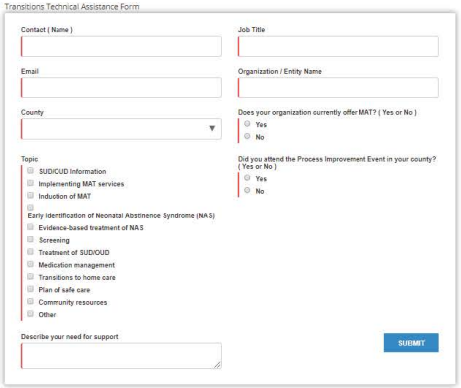
Report Out and Group Discussion on Key Features (after lunch)

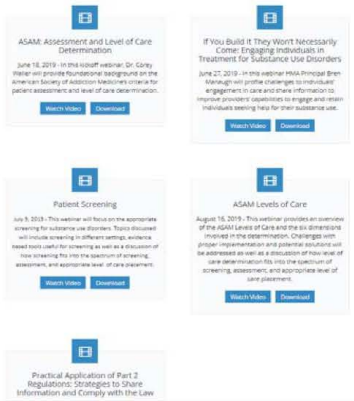
- Report out on key features of the future state
- Write the final two key features from your group on a yellow post-it note – **USE THE SHARPIE, please.**
- Post key features identified on future state map as directed

ADDICTIONFREECA.ORG


Addiction Free CA
In California, Treatment Starts Here
DATA DASHBOARD
RESOURCE LIBRARY
CHOOSEMAT TREATMENT LOCATOR
SAMHSA TREATMENT LOCATOR
Upcoming Events And Announcements
About Site


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


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/CUD Information
Implementing MAT services
Induction of MAT
Early identification of Neonatal Abstinence Syndrome (NAS)
Evidence-based treatment of NAS
Screening
Treatment of SUD/OUD
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


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

NOW WHAT DO WE DO?

C. Summary of Evaluation Results

- What did you like MOST about this forum?
  - Very interactive
  - Opportunities for collaboration and networking
  - Meeting and hearing from other providers
  - Broad representation from the community
  - Presentations very informative and easy to understand
  - Information on MAT including mechanics, medications, etc.
- What changes would you recommend?
  - Provider copies of the slides for participants to follow along
  - Include information about treatment beyond MAT (CBT, etc.)
  - Give participants better warning that they will be asked to report out, and that presentations will be recorded (note: presentations only recorded for note taking purposes. They will not be used for promotional materials.)
  - Include MAT in first day 1 combined with Addiction 101 presentation
  - Provide greater direction for current state mapping process
  - Allow more time for report outs (CSVSMs)
  - Use less clinical terminology
  - Be more inclusive for non-clinical staff
- Give an example of something new you learned about addiction:
  - Dopamine and its effects on the brain
  - Medications used for MAT
  - Assessment tools
  - There are many barriers for those working in SUD treatment
  - Process mapping
- What topics would you like to learn more about?
  - Interagency accessibility
  - How to advocate for incarcerated individuals
  - ASAM Continuum - brief screeners
  - Multi-dimensional assessment (ASAM criteria- based) process for determining level of care
  - Therapies to supplement MAT combined with CBT etc.
  - Assessment tool options
  - Culture of opioid users
  - Breakdown of differences related to prescription and treatment for OUD
  - Services in the community
  - Next steps and how to get started
  - Smooth transitions between services
  - Navigating 42 CFR part 2 in the context of integrated care
  - MAT 201 – more advanced version
  - Value based care
  - Sustainability for intensive case management and support staff in FQHC

- SUD in pregnancy
- MAT in jails – what is happening in our community?

D. Citations

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