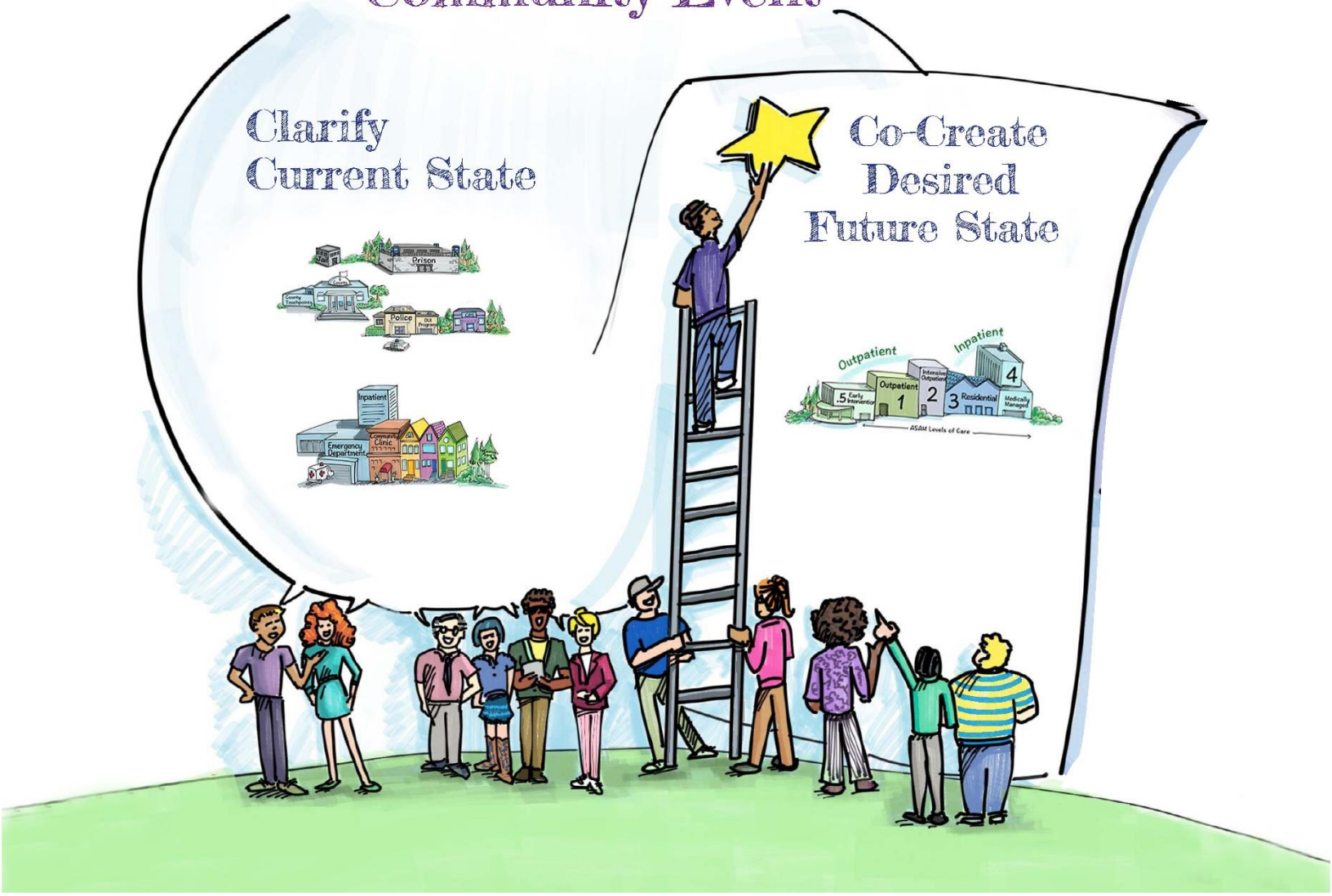
Collaborative Provider Community Event



BUILDING SUSTAINABLE TRANSITIONS OF CARE FOR PEOPLE WITH ADDICTIONS

Mendocino County Community Process Improvement Event

November 13th and 14th , 2019

HEALTH MANAGEMENT ASSOCIATES

BUILDING SUSTAINABLE TRANSITIONS OF CARE FOR PEOPLE WITH ADDICTIONS

Mendocino County

November 13th and 14th, 2019

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Executive Summary

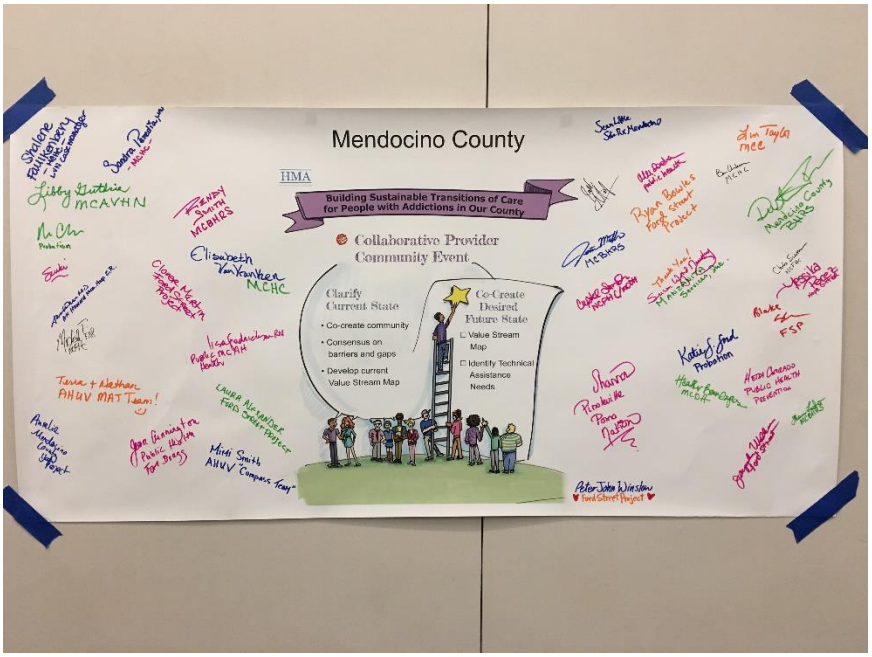
Overdose is the leading cause of accident-related death in the United States. The vast majority of these overdoses come from a combination of prescribed opioids and heroin. As we have watched the opioid crisis worsen over the last ten years, we have reached a point where the treatment system, in its current state, can no longer handle the volume of patients needing care. Opioid use and overdose have been increasing in California, though the rates of use and overdose are lower than in many states.

Understanding this reality, the federal government has allocated billions of dollars to states to build appropriate systems of care for patients with opioid use disorder (OUD) and other addictions; including the State Treatment Response (STR) and State Opioid Response (SOR) grants. The California Department of Health Care Services (DHCS) received STR and SOR grants which support project funding for the California Medication Assisted Treatment (MAT) Expansion Project. This initiative aims to serve an estimated 290,000 individuals with Opioid Use Disorders (OUD), prevent drug overdoses, and treat OUD as a chronic disease. Health Management Associates (HMA) received SOR funding from DHCS to focus on developing predictable and consistent transitions of care to sustain addiction treatment as individuals transition from locations such as emergency departments, jails, primary care clinics, the community at large and/or inpatient hospital settings. Ten counties across California were selected to participate in the Transitions of Care project based on need and capacity within the county. The Transitions of Care project: 1) engages stakeholders in each selected county in a two-day countrywide process improvement event and; 2) subsequently provides ongoing technical assistance through September 2020 to support the county in achieving their ideal future state for addiction treatment. Mendocino County, one of the ten counties selected, participated in a large-scale process improvement event on November 13th and 14th, 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 Mendocino County residents in need of addiction treatment and support services.

The Mendocino 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 Mendocino County, CA.

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

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



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 Mendocino County as being an optimal location to build and stabilize such transitions of care to decrease the risk of overdose and death amongst residents with opioid use disorder. In addition to Mendocino 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 or 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 Mendocino County Health and Human Services Agency Behavioral Health & Recovery Services Division, the Mendocino Community Health Center (MCHC), SafeRX Mendocino County, Partnership Health Plan, SUD treatment providers and community stakeholders in each selected county in a two-day countrywide process improvement event. A Process Improvement Event final report, this report, is issued to all participants and made available publicly through the Transitions project website, (www.AddictionfreeCA.org). Upon issuance of the Process Improvement Event final report, the project will officially pivot to the Technical Assistance (TA) phase. The TA phase of the project will run through September 30, 2020, and assist the county in achieving the community-defined "ideal future state value stream map." Those who are directly involved with the development of the Transitions project plan for the County will be eligible to receive ongoing individualized TA 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 Jenine Miller, Mendocino County's Behavioral Health Recovery Services (BHRS) Director; Dustin Thompson, BHRS Staff Services Administrator; and Heidi Corrado, Mendocino County's Safe RX Program Administrator. This group participated in weekly planning meetings to engage community stakeholders and plan for the activities of the two-day process improvement event.

In addition to the Mendocino County Health and Human Services Agency, HMA also coordinated with Ben Anderson, Behavioral Health Director at the Mendocino Community Health Centers, (MCHC) and leaders from the Partnership Health Plan. These lead organizations assisted our team in understanding the work already underway in Mendocino County. The Partnership Health Plan is engaged is standing up the Drug Medi-Cal Organized Delivery System Regional Model in Mendocino County. They provided us with an understanding of their community preparedness work related to developing their SUD and addiction treatment services within the County. Collectively, the County, MCHC and Partnership Health Plan staff assisted our team in launching the process improvement event and subsequent ongoing technical assistance program. Together, the County, MCHC and the 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

Mendocino County Health and Human Services Agency

- Tammy Moss-Chandler, Mendocino County Health and Human Services Agency Director

Mendocino County Behavioral Health Services Division Services Division

- Jenine Miller, Behavioral Health Director, Mendocino County Behavioral Health & Recovery Services (BHRS)
- Dustin Thompson, Staff Services Administrator, Mendocino County Behavioral Health & Recovery Services

Partnership Health Plan

- Liz Leslie, Program Manager, Wellness and Recovery Program
- Laurel McCarthy, Wellness and Recovery Program

Who Was Involved:

- Adventist Health-Howard Memorial Hospital
- Adventist Health-Memorial Hospital ER Bridge Program
- Bridge to Treatment
- Consolidated Tribe Project
- County of Mendocino Behavioral Health & Recovery Services
- County of Mendocino-Health Officer
- County of Mendocino-Health and Human Services Agency-Public Health
- Creative Change Productions
- Recovery
- Hopland Band of Pomo Indians
- Hospitality Center of Fort Bragg
- Howard Memorial Clinic
- KZYX Mendocino County Public Broadcasting
- Manzanita Services
- MCAVHN
- MCDH/NCFHC
- Mendocino Community Health Center (MCHC)
- Mendocino Coast District Hospitals
- Mendocino Coast Clinics
- Mendocino County Department of Public Health-MCAH
- No RX Abuse-Mendocino County
- Mendocino County Health and Human Services Agency
- Mendocino County Probation
- Mendocino County Public Defender's Office
- Partnership Health Plan
- Pinoleville Pomo Nation
- Redwood Community Services
- Redwood Quality Management Company
- Ukiah Recovery Center - Ford Street Project
- 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 Mendocino 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 Mendocino 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 Mendocino 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, discussion and guidance around the release of information 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

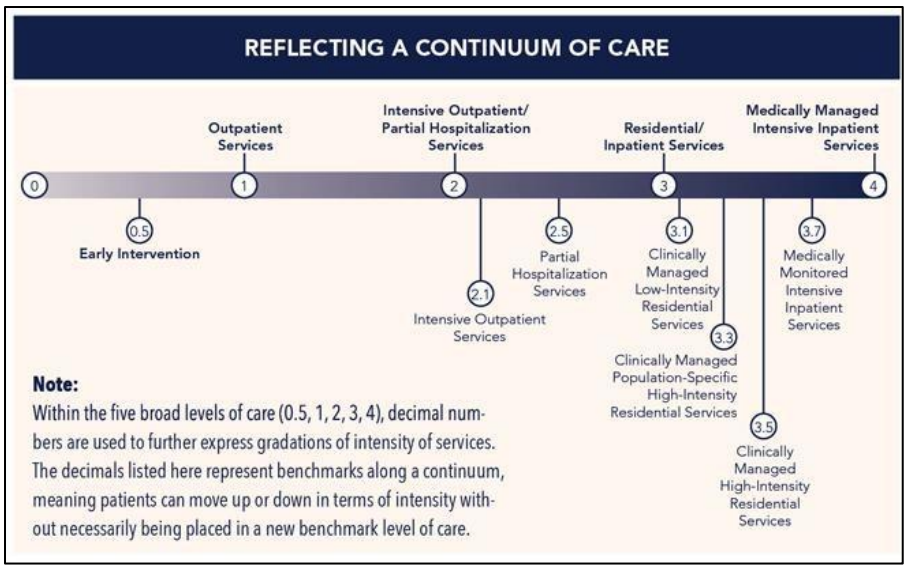
ASAM's criteria, formerly known as the ASAM patient placement criteria, is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. Today the criteria have become the most widely used 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 adequately serves and supports medical professionals, employers, purchasers, and providers of care in both the public and private sectors.

[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.*

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)

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Section 2: Event Results

A. Goals of the Participants

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

- Create a 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 Mendocino County, under which all the goals named above can be placed.

THE OVERARCHING GOAL:

ELIMINATE ADDICTION-RELATED DEATHS IN MENDOCINO COUNTY

B. Current State Value Stream Maps (VSM)

Tribal Health

Tribal Health

The three pathways by which people engage in services with Tribal Health in Mendocino County, include: self-referral, outside referral, and council referral. Some of the barriers encountered when a person self-refers include internal motivation, difficulty engaging the person in services, and the amount of time it takes to get ther person connected to appropriate services. A barrier related to outside referrals is that there is a lack of working-relationships with non-tribal entities in the area. Barriers related to internal or council referrals are personal buy-in from the person referred, and sanctions from the referring agency. Once a person is successfully referred, tribal health decides if the individual needs rehab or case management. If the individual enters case management, there are a lack of incentives to keep them engaged. If the individual is recommended for rehab services, tribal services within the county are limited, and other services can be up to three hours or more away. Other barriers related to rehab include a lack of transportation and childcare services, as well as case management if the individual is in rehab outside of tribal health. A barrier related to getting individuals into the most appropriate level of care is a lack of partnerships with outside agencies, which makes it difficult to make referrals. Barriers that flow throughout this value stream map include lack of insurance coverage, lack of tribal and culturally appropriate services within the county, and stigma.

Residential Treatment

Residential Treatment (includes Ford Street)

The pathways by which clients enter residential treatment in Mendocino county include agency referral or client self-referral. A barrier related to agency referral is a lack of community awareness about what residential treatment does. A barrier related to client self-referral is capacity. After a client is referred, they are screened. Barriers associated with screening include funding, breakdown of continuity of care, language, history of client with residential treatment facility, serious mental illness as it relates to the treatment facility's scope of practice, client criminal history, negative talk from other agencies about the treatment facility, lack of knowledge about processes and court-ordered level of care (i.e. a judge determines the level of care for client without doing the appropriate screening, assessment and level of care determination). After screening, the next step is to determine if residential treatment is appropriate for the client. If it is, the client is referred to primary care or the emergency department for clearance.

Next, the client goes through the intake process. Barriers associated with the decision to admit a client include not having the appropriate detox medications, lack of respect from doctors about the treatment facility's knowledge, lack of transportation for the client, and the client wanting a "last hurrah" before going into treatment.

After the decision has been made for a client to enter residential treatment, a date and time for intake is set. Barriers to intake include issues with technology, and a lack of resources to get the client things they need while in treatment, like medications and clothing. After the intake, the client goes through orientation. Barriers during orientation include keeping clients engaged and having gender specific requests from clients, and not having sufficient staff to fulfill those requests. After a client goes through orientation, an assessment, and treatment planning are conducted. It is possible at this point that the client will be referred to another agency. Barriers at this point include staffing, mental health issues arising, and appointment turnaround with referral agencies. If it is determined the client should remain in residential treatment, the next step is for them to enter either group and/or individual therapy. The final step is exit planning. Barriers to exit planning include the recovery environment, funding, aftercare and housing.

Prevention


Provide upstream direct service
Educate
Receive referrals
Staffing – mistrust
Poor communication /silos
Mild/ moderate vs. severe funding bifurcation
Regional silos
Geographic
Lack of cultural relevance
Capacity building
Assess and mitigate ACES
Referral to social support services
Narcan distribution
Educate
Receive referrals
Perceived restriction at county level
Availability
Cost
Stigma
Support economic wellness
Educate physicians, pharmacists
Capacity building
Department policy decision
Counseling
Lack of providers
Transportation
Child care
Linkage
No master map to providers, services
Funding
Continuity of service
Program provider mapping
Effective collaboration across agencies
Decrease stigma
Distrust of agencies
Misperception of services
Promote via social media, PSAs, school announcement
Education
Stigma, no data to show a group has an issue
Advertising opportunities limited
Access to schools
Limited time
Cross agency collaboration $$$
Braided grant funding
Grant admin
Staffing
Time needed for action
No overview of available resources

Prevention (Public Health)

Prevention is focused on upstream factors, which primarily includes education and receiving referrals. Barriers encountered include mistrust among staff, poor communication, silos, and bifurcated funding. The prevention community would like to have greater focus on assessing and mitigating adverse childhood experiences and referral to social support services. Barriers related to doing this include navigating regional silos, geographic barriers, and cultural relevance. Another area in which prevention works is Narcan distribution, education and referrals. Barriers encountered in this area include perceived restriction at the county level, availability of Narcan, cost and stigma. Those working in prevention would like to educate physicians, pharmacists and others about Narcan, build capacity and support economic wellness to reduce these barriers. Prevention also works in the area of counseling. Barriers encountered include lack of providers, transportation and childcare. Prevention works to support linkages to care. However, there is no master map of services or providers in the community, and there is a lack of funding, and continuity of services. Those working in prevention would like to work to improve collaboration across agencies and create a map of providers in the county. Additional areas in which prevention works include decreasing stigma, education and grant administration. Barriers include mistrust of agencies, misunderstanding of services provided, stigma, limited advertising opportunities for educational campaigns (due to stigma), limited access to schools to share information, staffing, time needed for action, and again, the lack of map or overview of existing resources. Those working in prevention would like to work toward braided funding streams, and cross agency collaboration to alleviate some of these barriers.

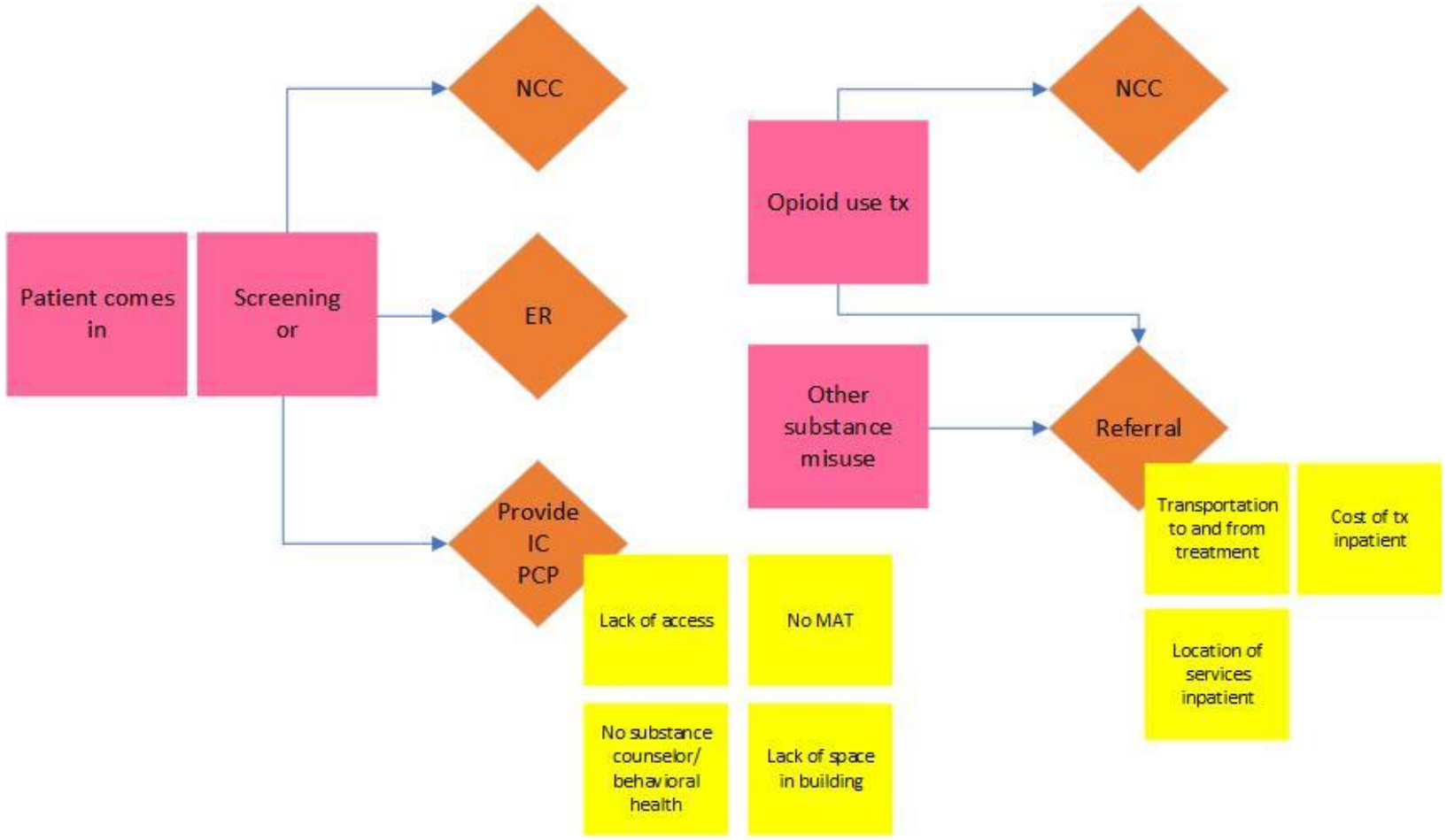
Hospitals (Adventist Health-Howard Memorial Hospital)

Hospitals

This process map represents the flow beginning when a patient enters the emergency department. First, the patient comes to the hospital and is triaged. One barrier is that the person doing the triage may not know if the patient is already in treatment for an OUD. After the patient is triaged, hospital staff determines if the patient needs detox or further medical intervention. If they only need detox, the patient is then connected with the Substance Use Navigator (SUN) and provided with appropriate medication. Then, the patient is discharged (d/c) with necessary prescriptions. Potential barriers include difficulty with follow up (i.e. communication with patient) and staff remembering to give them naloxone to-go.

If the patient has a medical need, they are evaluated and given medical or psychiatric treatment as is indicated. Barriers include the provider not recognizing the patient's substance use disorder, the patient being given narcotics before buprenorphine, and psychiatric inpatient not accepting patients who are on buprenorphine, or patients with substance use disorders in general because of the misperception that their SUD is the extent of their mental health challenges, which is not always the case. Depending on the patient's disposition and determination of need, they may either be discharged with a prescription, enter into outpatient treatment, or be admitted and treated. Barriers associated with being admitted include inpatient providers not being comfortable with buprenorphine, or not having their X wavier, and facilities to which patients are transferred not continuing MAT.

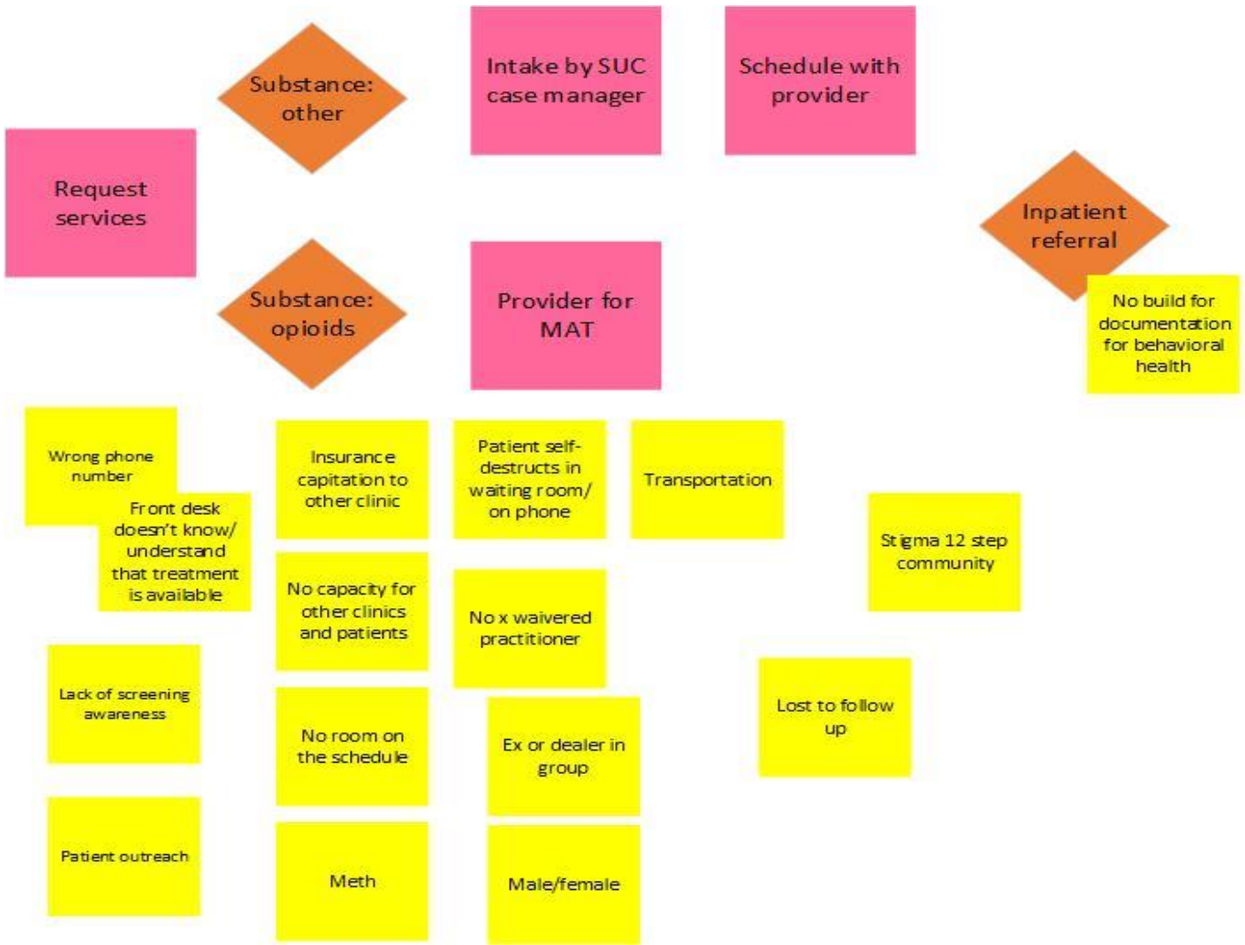
Rural Health Center – North Coast County Clinic (NCC)



Rural Health Center (includes Northwoods County Health Center)

Northwoods County Health Center (NCC) does not have a MAT program. Upon arrival the client is screened by a nurse. If they need a prescription refill, they are triaged to their primary care provider. If the client is in crisis, they are sent to the emergency department, and if their needs can be met in-house, they are taken care of at NCC. Barriers related to referring to primary care include lack of access to trained providers, no MAT, no substance counselor or behavioral health providers on staff, and a lack of physical space in the building. A barrier to referring to the emergency department is the limited availability of beds. Depending on the needs of the patient, they will either be given opioid treatment at NCC or referred out for other substance use treatment. Barriers related to referral include transportation to and from treatment, cost and location of treatment.

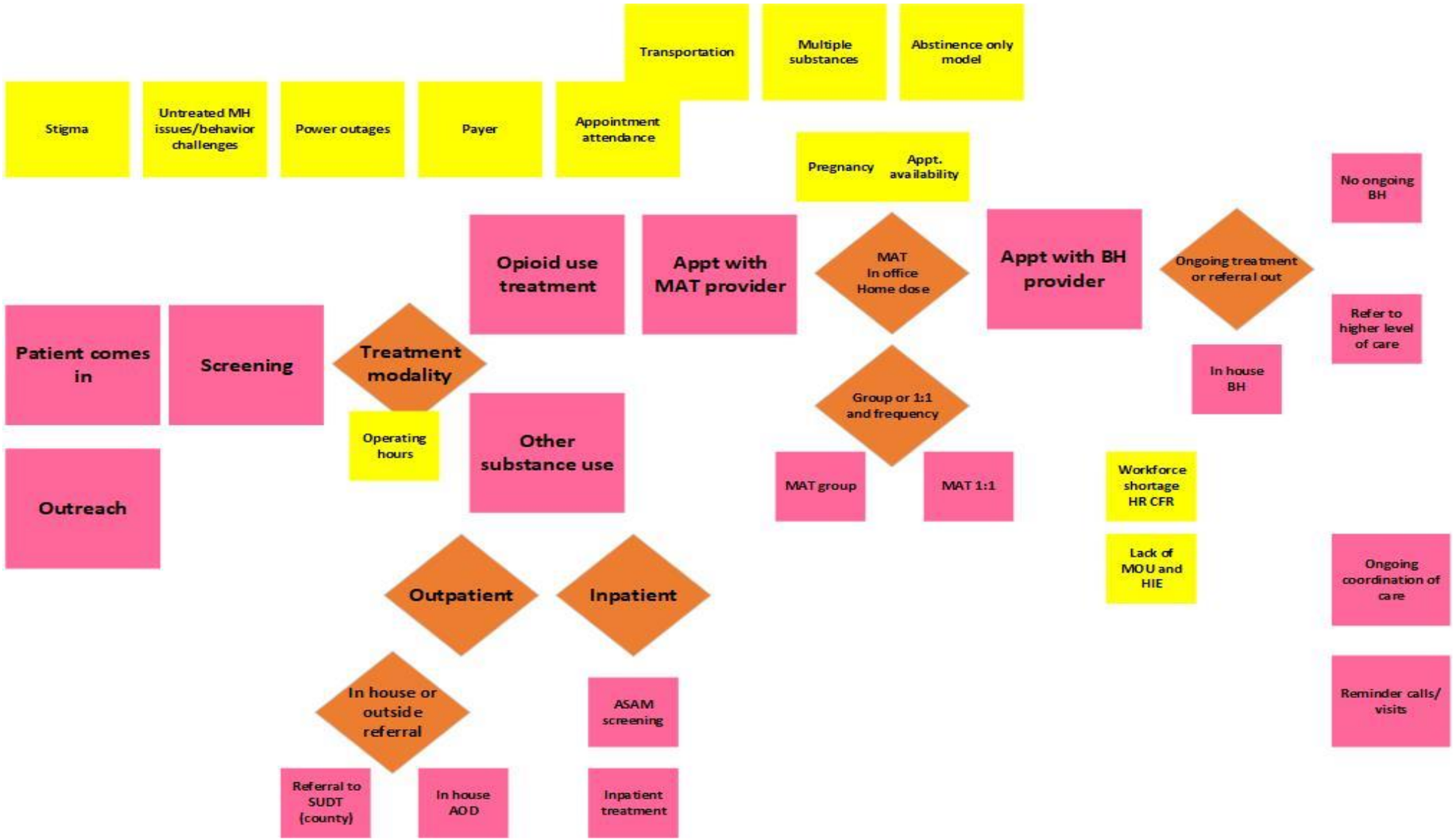
Rural Health Center – with MAT



Rural Health Centers
(Little Lake Health Center in Willits & Mendocino Coast in Ft. Bragg)

A patient typically begins by requesting services. Then the staff determines if the patients' needs are related to opioids or another substance. If it is another substance, then a case manager conducts and intake, and schedules them with an appropriate provider. If their needs are related to opioids, they are scheduled with a MAT provider. Cross-cutting barriers include having incorrect contact information for a client; front desk staff not having all the information about treatment available in the clinic; lack of screening awareness; clients using other substances like meth; knowing people who are in group therapy sessions; insufficient capacity; insurance capitation; challenging behaviors displayed by the client in the waiting room or on the phone; not enough DEA X-Waivered providers; transportation; stigma in the 12-step community about MAT; and loss to follow up.

Mendocino Community Health Center (MCHC)



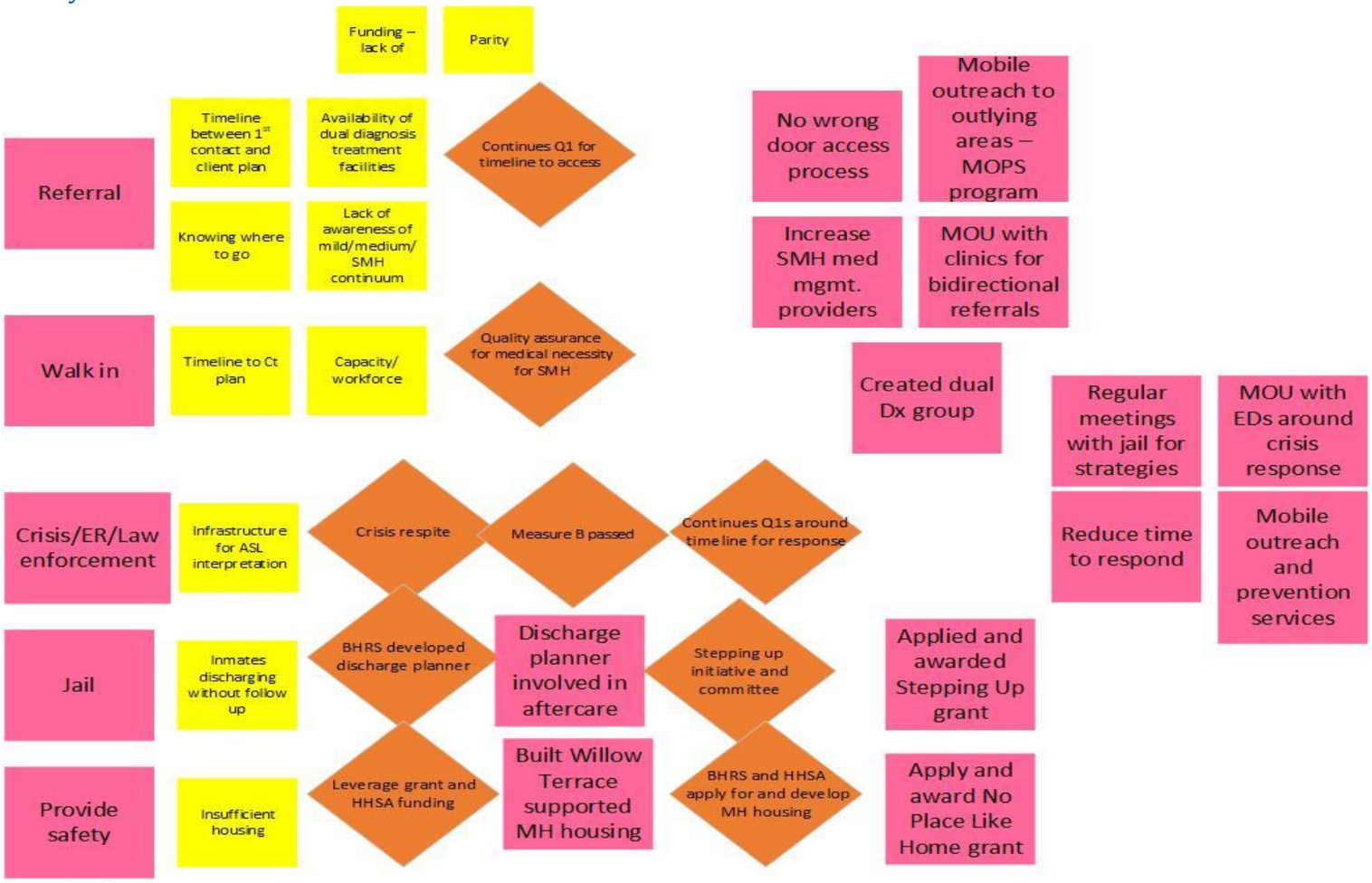
Mendocino Community Health Center (MCHC)

Clients come to MCHC either through a referral, on their own, or because they received some kind of outreach from MCHC. Once they arrive, they are screened to better understand their needs. Based the result of the screening, the provider decides what kind of treatment the patient needs. One barrier is the hours of operations for MCHC. If the patient needs OUD treatment, they are given an appointment time with a MAT provider. The MAT provider determines if they have an in-office induction, or home induction. Barriers related to MAT include pregnancy and appointment availability. The MAT provider will also determine if the patient should enter group or 1 on 1 therapy, and the frequency of therapy. Next, the client will have an appointment with a behavioral health provider. The behavioral health provider will determine if the patient should receive ongoing treatment at MCHC or if they need to be referred out to a higher level of care.

When a patient first arrives at MCHC it is determined that need care for substances other than opioids, the process is more complicated and not currently structured in a way they would like. For example, after it has been determined that the patient needs care for substances other than opioids, a staff member will find out if they are more interested in inpatient or outpatient services. If they are interested in inpatient services, a staff member will conduct an ASAM assessment. It is currently structured in this way because the ASAM assessment takes a long time and they do not have capacity to do the assessment on everyone who falls into this category. If the patient qualifies based on their assessment, and there is funding available, staff will refer them to an inpatient facility. If the patient prefers outpatient services, they will either be taken care of in house at MCHC or referred to county substance use disorder treatment services.

Cross cutting barriers include stigma, untreated mental health issues, power outages, reimbursement/payers (i.e. capitation), appointment attendance, transportation, use of multiple substances, abstinence only models, information sharing, funding, and having correct contact information for patients.

County Behavioral Health – Mental Health



County Behavioral Health – Mental Health

Clients come to the mental health side of county behavioral health by way of referrals, walk-in, crisis that include ED or law enforcement, jail, or seeking safety/shelter. Some barriers related to referrals include the time that passes between the first contact with a client and the development of a treatment plan, the availability of dual diagnosis treatment facilities, clients not knowing where to go or who to contact for help, and capacity and workforce. Barriers related to walk-ins include the timeline for client treatment, capacity, and workforce. To address some of the barriers encountered by clients who come by way of referral or walk-in, County Behavioral Health is conducting continuous quality improvement related to timeliness of services and access. They hope to improve services to those who are referred or walk-in by working on processes related to no-wrong-door access to services, mobile outreach, increasing medication management services for those with serious mental illness; creation of MOUs with clinics for bidirectional referrals; and the creation of a dual diagnosis group.

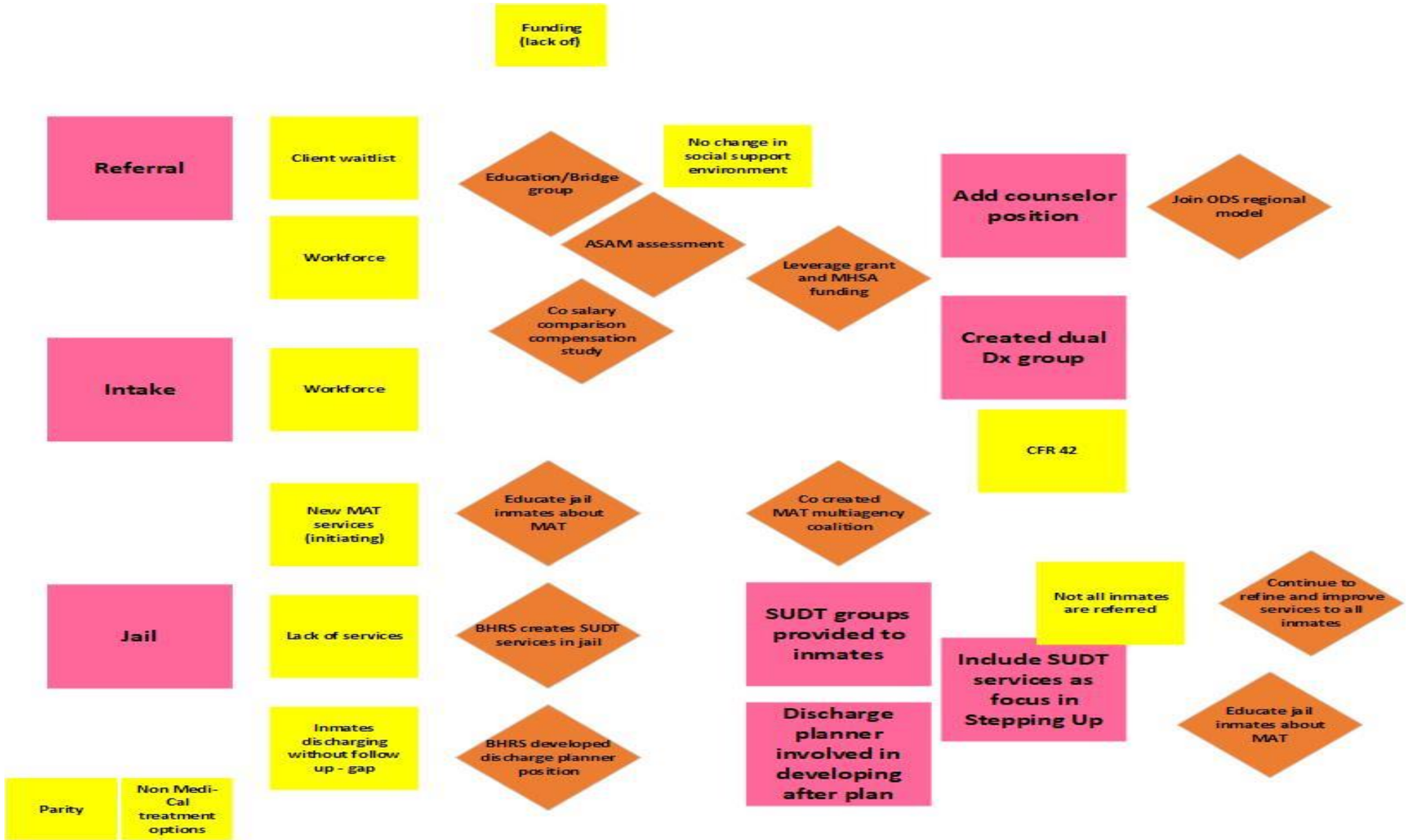
A barrier encountered by those who come to county behavioral health because of a crisis is the lack of infrastructure for ASL interpretation. Decisions that need to be made are related to crisis respite, Measure B being passed, and appropriate continuous quality improvement for timeliness of services and access. To better serve this population, County Behavioral Health staff hold regular strategy meetings with jail staff, they have established MOUs with emergency departments related to crisis response, they have reduced their response time, and have established some mobile outreach and prevention services.

A barrier encountered by those leaving jail in need of services is that they are sometimes discharged without any follow up. To address this issue, County Behavioral Health developed a discharge planner.

A barrier encountered by those who come to County Behavioral Health seeking safety is insufficient housing. County Behavioral Health is leveraging grant and HHSA funding to build Willow Terrace, which is supported mental health housing. Behavioral Health and HHSA are jointing applying for additional funding to support housing needs.

Cross cutting barriers include funding, and parity between insurance funding sources.

County Behavioral Health –Substance Use Disorder Services



County Behavioral Health – Substance Use Disorder Services

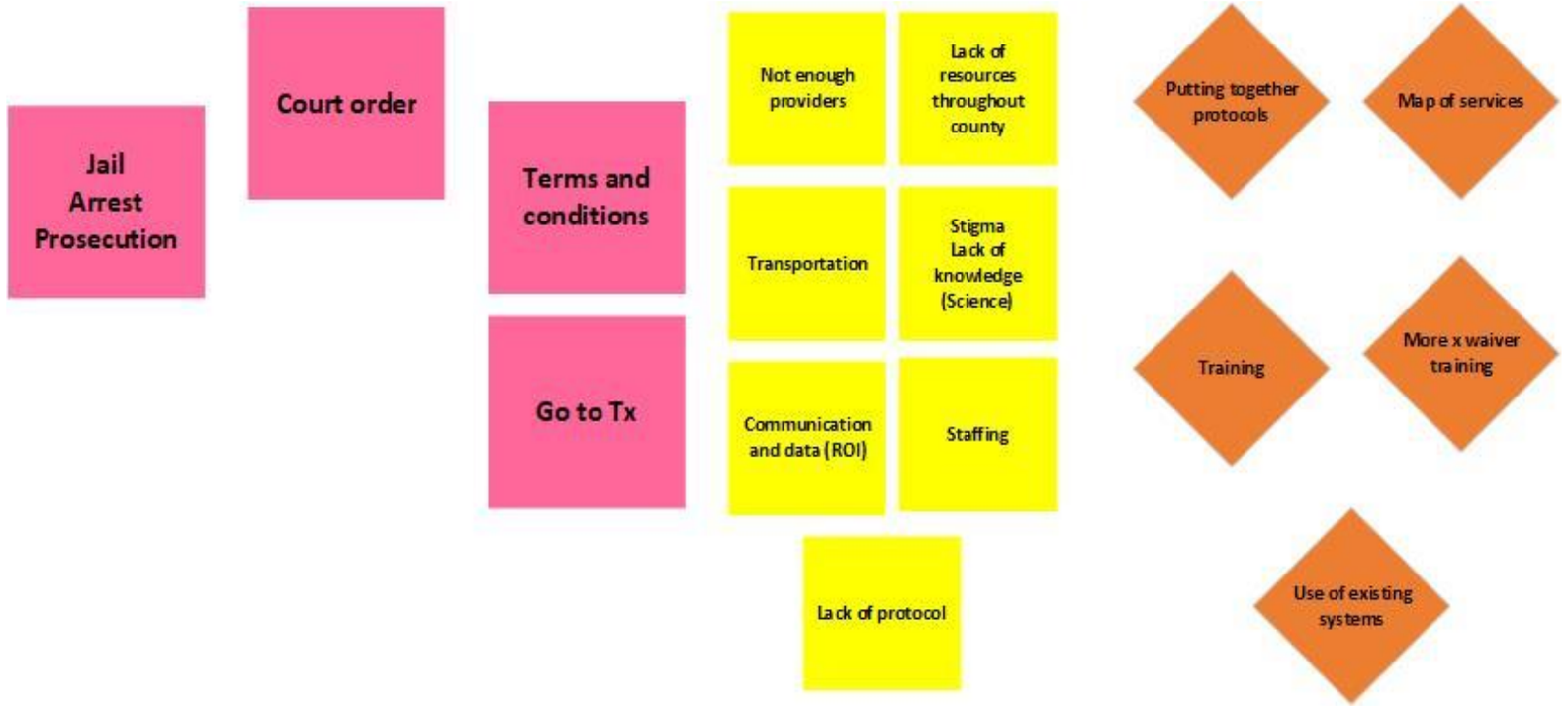
Clients come to substance use disorder services of the County Behavioral Health system by way of referral, intake, or jail. If a client comes via referral, some of the barriers encountered are a waitlist and an insufficient workforce. County Behavioral Health staff then decide if the client needs education by way of a Bridge Group and/or an Assessment (ASAM).

Barriers encountered by clients who come via intake include, again, workforce. Since the workforce is a common barrier, County Behavioral Health is working on a salary comparison compensation study. Additionally, they are leveraging HHSA funding to address this and other common barriers. When successful, they plan to hire an additional counselor position, create a dual diagnosis group, and join the DMC-ODS regional model.

Barriers encountered by those who come to SUD services at County Behavioral Health by way of a jail include the initiation of new MAT services, a lack of services. Some inmates are discharged from jail without any follow up at all. County Behavioral Health is working to address some of these barriers by educating jail inmates about MAT, creating SUD services in jails, and creating a discharging planner position at the jail.

Some cross-cutting barriers include a lack of funding, parity between insurance funding sources, and non-Medi-Cal treatment options.

Probation


Jail
Arrest
Prosecution
Court order
Terms and conditions
Go to Tx
Not enough providers
Lack of resources throughout county
Transportation
Stigma
Lack of knowledge (Science)
Communication and data (ROI)
Staffing
Lack of protocol
Putting together protocols
Map of services
Training
More x waiver training
Use of existing systems

Probation

People enter probation by way of jail, arrest, prosecution, or court order. Typically, people enter formal probation with the terms and conditions as determined by a judge. When they come to probation, they are screened and assessed, and then enter treatment with what is usually a three-year treatment plan. Barriers encountered include an insufficient number of providers, transportation, communication and data sharing, lack of resources throughout the county, stigma, lack of understanding of the science of addiction, staffing, and lack of protocol. The next steps for probation include putting together protocols, trainings, creating a map of existing services, offering more X-waiver training, and better utilizing existing systems.

C. 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 Mendocino 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

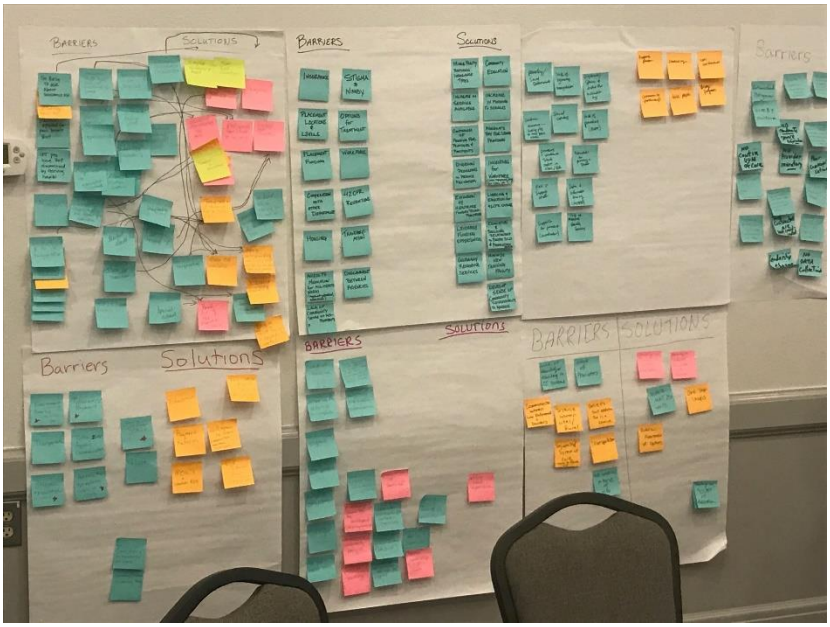
During the current state value stream mapping session described in the previous section of this report, Mendocino County Stakeholders were asked to identify the barriers they encounter in their current workstream. A summary of the gaps and barriers identified during that session are summarized in the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

	Structural Barriers	Structural Inefficiencies	Structural Gaps	Capacity	Knowledge/ Training	Inconsistency	Stigma/ Criminalization	Social Correlates	Funding	Insurance	Cultural Competency
Tribal Health	3						1			1	1
Residential Treatment	4	6	3	2	4			6	2		
Prevention	6	2	1	3			5		3		1
Hospitals	2	1	1	1	4						
Rural Health Center – NCC, no MAT	3		2	1					1		
Rural Health Center – BH services	1	1	2	1	2		1	7		1	
MCHC	4	1	1	1	1		1	4		1	
County BH – Mental Health	2	2	3	1	1				1	1	
County BH – SUD		1	3	2	2			1	1	2	
Probation	1		2	2	2		1				

Group Barrier Discussion Summary

Mendocino 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 the 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:

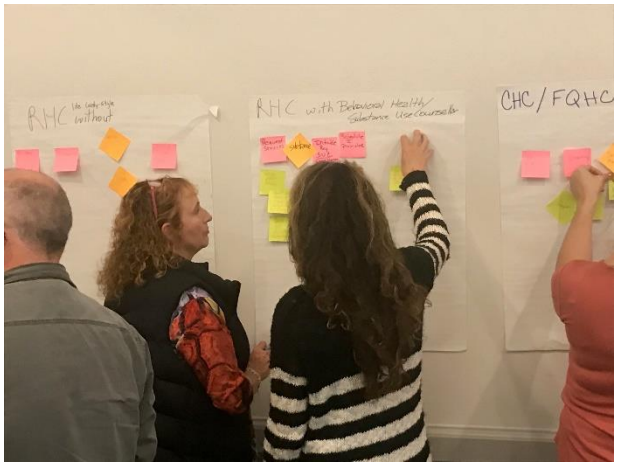
- Lack of resources (ex: funding for MAT or prevention programs; Insufficient physical space to provide MAT)
- Lack of coordination between agencies – willingness to cooperate between agencies; community partnerships; development of a communication protocol; agency ownership of clients
- Social determinants affecting clients (transportation, etc.)
- Insufficient insurance reimbursement for SUD services - payment reform
- The economy and culture of the community (ex: People selling drugs to meet their basic needs; Lack of sense of responsibility in the community; Stigma related to SUD) – develop a sense of community responsibility through education and outreach; start with higher-level officials to set an example
- Workforce - Insufficient number of providers to provide MAT -incentives for the workforce (i.e., higher pay)
- Lack of service availability (ex: behavioral health services) – telepsychiatry, mobile MAT and treatment unit
- Knowledgebase of staff and in the community – create public awareness/education options
- Disjointed and difficult to understand rules, regulations and funding streams – a centralized hub of information, information clearinghouse
- Information sharing between agencies and physical and behavioral health providers – lobbying and education around 42 CFR Part 2; cross-sector data sharing agreements

D. 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 Mendocino 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 Mendocino 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. Mendocino 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. Mendocino 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 SAPT funds. These services include outpatient treatment services and limited withdrawal management services. Mendocino County is a Partnership Health Plan County and will participate in the Partnership Health Plan Regional Model for SUD Services upon implementation mid spring 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 the appropriate level of services. Since the Partnership Health Plan serves Mendocino County, there is an 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. The implementation of the Regional SUD Model through Partnership will extend transportation assistance to Medi-Cal eligible clients who are receiving SUD treatment services through Partnership's network of providers.

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. Mendocino 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 no methadone treatment program operating within Mendocino County. Methadone treatment is not available in Mendocino County. Residents access methadone treatment in the city of Santa Rosa, located in the south in the neighboring Sonoma County. There are two Methadone Treatment programs in Santa Rosa, Santa Rosa Treatment Program (SRTP), and Redwood Empire Addictions Program. The distance to a methadone treatment provider can vary depending on the proximity of a client's residence to the Santa Rosa NTP treatment provider site.

There are six California Bridge contracted sites that provide MAT treatment through a network of providers within Mendocino County along the Highway 101 and State Route 20 corridor. Access to MAT treatment is complicated by the small number of providers and the vast geographic characteristics of mountains and rivers within Mendocino County. The distance to a methadone treatment provider can vary depending on the 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. The availability of MAT treatment sites on the CA Bridge program's service directory map for Mendocino County.
https://www.google.com/maps/d/viewer?mid=1OvkCsODLNjAEbmveELpO70n4UaEUt9FO&hl=en&ll=39.33225109624017%2C-123.43583217913726&z=10

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, thirteen applications for ongoing technical assistance (TA) were received from provider organizations that participated in the process improvement event. Four of the thirteen organizations expressed interest in either expanding or developing new MAT capacity. The four provider sites include Mendocino Community Health Clinics, Inc., Mendocino Coast District Hospital, Pinoville Pomo Nation, and Adventist Health Ukiah Valley (AHUV)/Howard Memorial. HMA has assigned TA coaches to assist these 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.

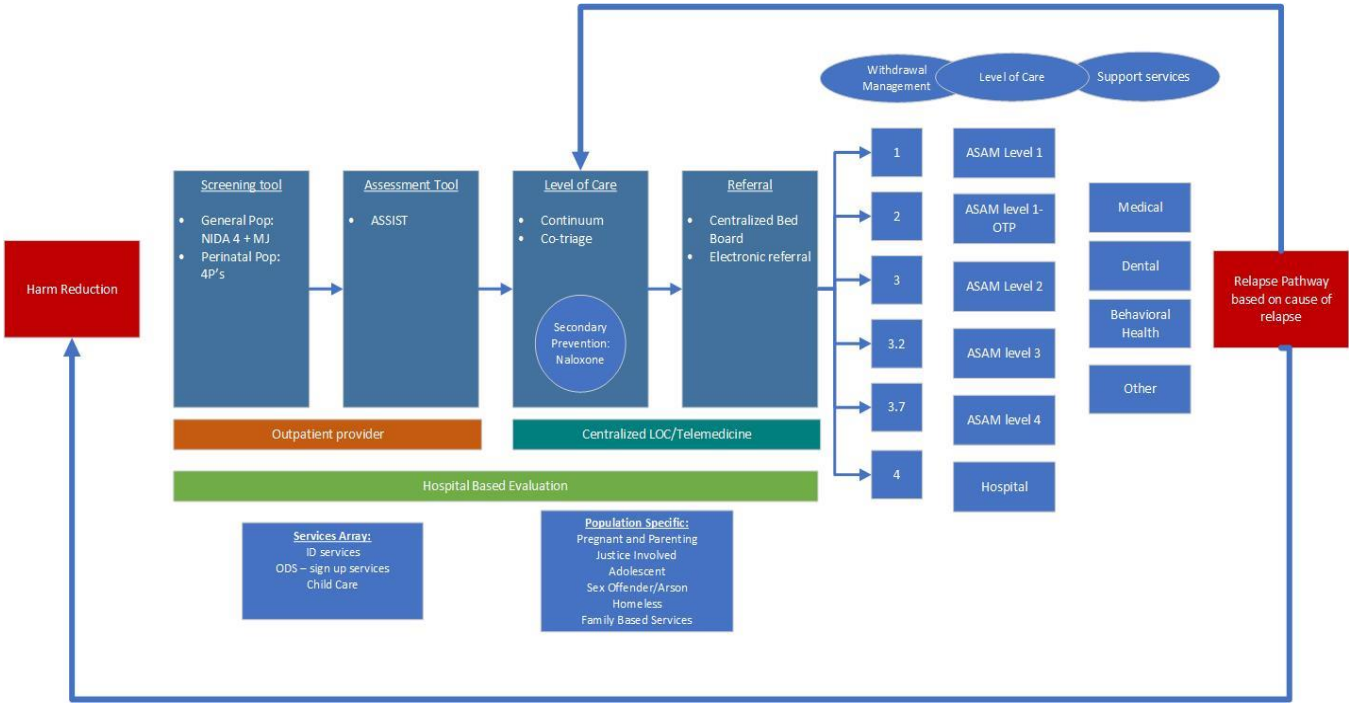
E. Triggers

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

F. 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 Mendocino 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 a 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 identifying a countywide, specific screening tool and more focus on ensuring that providers are using a standardized and evidenced-based tool. The focus was on the use of the county selected standardized, evidence-based assessment tool that would result in patients getting into needed 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. Mendocino 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.

Dr. Corey Waller 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 will trigger a set of 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 assessed and referred to supportive services.

Assessment

Considerable discussion surrounded the selection of an appropriate tool for SUD assessment for Mendocino 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 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. The determination is 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 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. A Face-to-face assessment at the provider site involves a biopsychosocial assessment to determine if the client meets the medical necessity criteria based on the Diagnostic Statistical Manual (DSM). The ASAM criteria will then be applied to make the appropriate level of care recommendation(s).

The county has expressed interest in adapting 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 Mendocino County, there are many levels of services available for both withdrawal management and treatment of the SUD. Mendocino 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 complete, the eco-system can overlay the needed support services.

Transportation was also mentioned more than once as a significant need and needs to 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 assistance can include assisting clients with obtaining an ID, getting housing, and having appropriate food availability. All of these needs should be coordinated through a central "hub" for information and referral.

Relapse

Early relapse detection and intervention will decrease the risk of 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 provided and the continued hard work of the community partners, there is no doubt that it will be realized.

03 Section 3: Implementation Strategy

A. Next Steps

In a matter of two days stakeholders from across Mendocino 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 came from the generous participation of individuals and institutions who deliver care or are otherwise vested in addiction treatment in Mendocino County. Given this effort, 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

Before the process improvement event, we collaborated with the Mendocino County Health and Human Services Agency, Behavioral Health Services department, the Mendocino Community Health Center, and the Partnership Health Plan to develop an attendee list and conduct outreach to invitees to encourage attendance. Also, before the event, the Behavioral Health Services department completed a survey to document existing substance use disorder (SUD) capacity and resources in Mendocino 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 checked 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 placed into one of two TA tracks:

1. Generalized TA: Sites that are unlikely to provide MAT but are seeking general TA
2. MAT 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 are placed into the General TA track, and those that checked options 4 or 5 are placed into the TA MAT Coaching group. The TA MAT Coaching group provides more hands-on coaching to begin providing MAT services or scale-up existing services. This scoring is methodology reinforces the focus of the Transitions of Care Project which is to increase the availability of new or expansion of existing 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 12 organizations applied for TA:

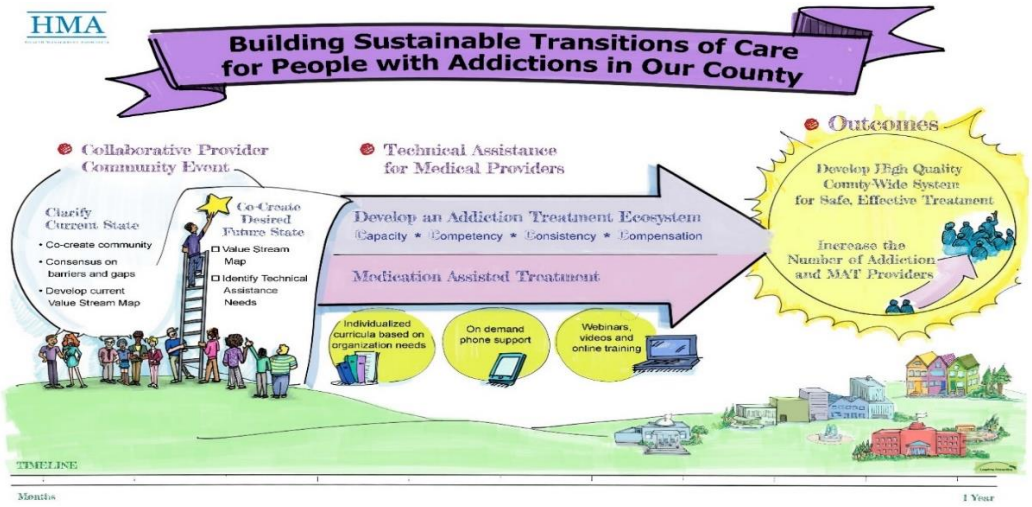
+ Adventist Health Ukiah Valley
+ Adventist Health Ukiah Valley/Howard Memorial
+ Ford Street Project
+ Manzanita Services, Inc.
+ MCAVHN Care and Prevention Network
+ Mendocino Coast District Hospital
+ Mendocino Community Health Clinics. Inc.
+ Mendocino County Behavioral Health and Recovery Services
+ Mendocino County Probation
+ North Coast Family Health Center/Mendocino Coast District Hospital
+ Pinoleville Pomo Nation
+ Ukiah Recovery Center

The ten 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.*	11
2	*Learn more about how our organization can participate in a community-wide solution to the opioid epidemic.*	9
3	*Improve our role in managing the transitions of care as residents in our community move within the addiction system of care.*	9
4	*Scale-up our current MAT program by increasing the number of patients treated.*	4
5	*Start providing MAT services at our organization.*	4
6	*Learn how to provide or improve addiction treatment to pregnant and parenting women.*	4

C. Conclusion

In conclusion, HMA thanks the Mendocino 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 Mendocino 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 Mendocino County Health and Human Services Agency and their Behavioral Health Services Department, along with Mendocino Community Health Centers, 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. Mendocino County Data

MENDOCINO COUNTY: POPULATION 87,841

STATISTICS

- OUD Death Rate
  - 2017: 19.3, Rank 3/41
  - 2016: 17.3, Rank 5/41
- All Drug Death Rate
  - 2017: 29.8, Rank 4/41
  - 2016: 29.3, Rank 9/41
- ED Opioid Rate
  - 2017: 38.3, Rank 9/41
  - 2016: 40.0, Rank 10/41
- 3 Hospitals

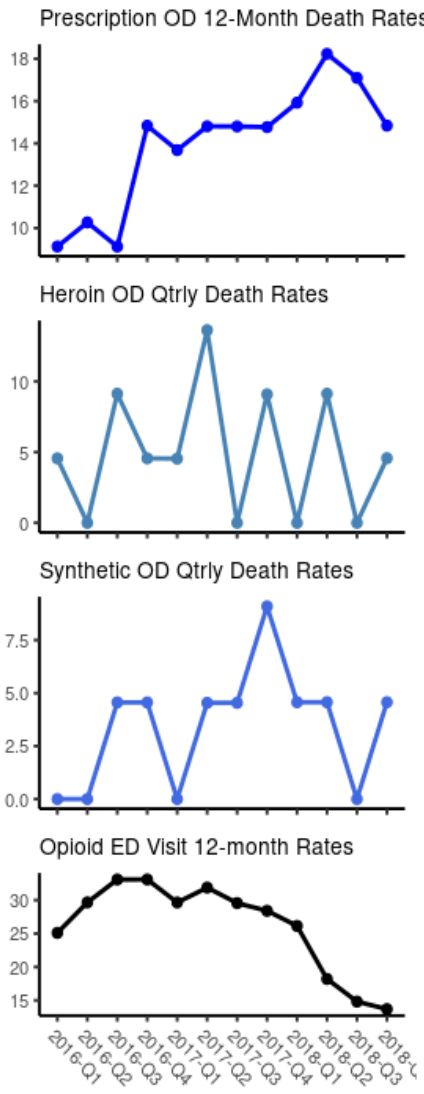
ADDITIONAL FACTORS

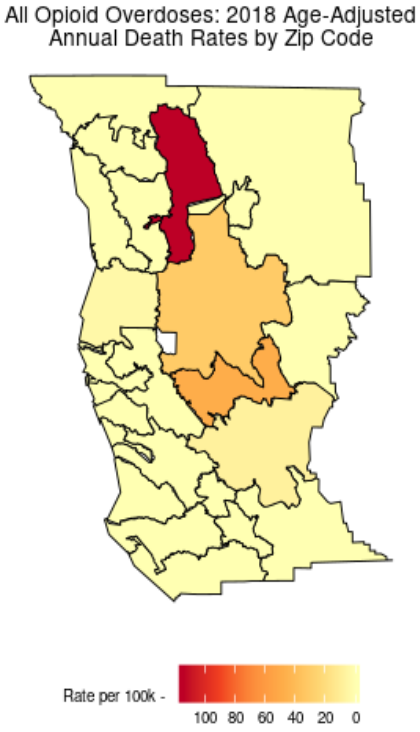
- Coalition: SafeRx Mendocino
- SAMHSA Funds: $1,518,250
- Drug Medi-Cal Organized Delivery System? Yes
- Presence of CA Bridge: Yes

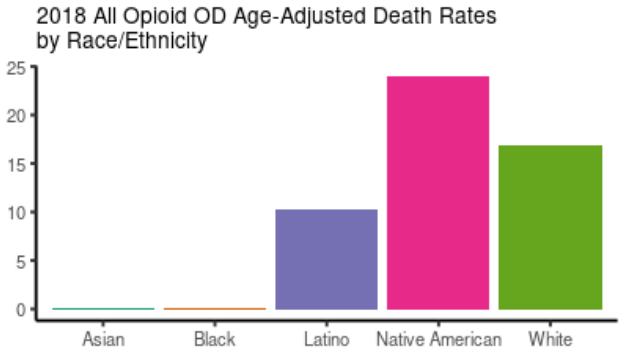
Prescription Drug Overdose Prevention Initiative Mendocino Opioid Overdose Snapshot: 2016-Q1 to 2018-Q4

Report downloaded 11-26-2019

Mendocino experienced 14 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 16 per 100k residents. This represents a 18% 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.

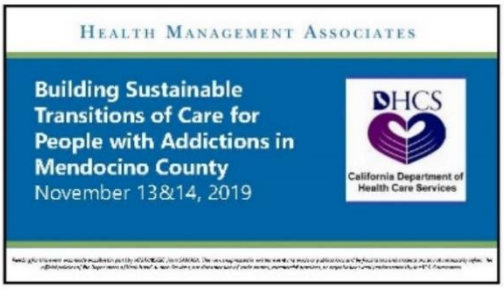


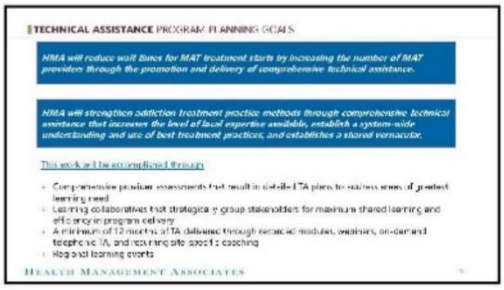




B. Process Improvement Event Slides

11/20/2019





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COUNTY SELECTION DATA POINTS CONSIDERED

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

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

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

HEALTH MANAGEMENT ASSOCIATES 7

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

HEALTH MANAGEMENT ASSOCIATES 10

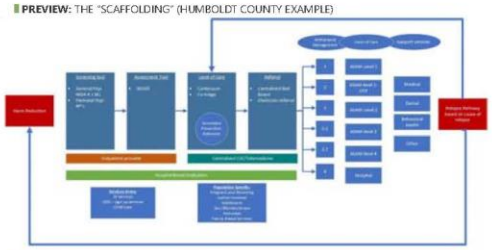
Mendocino County: POPULATION 87,841

STATISTICS
- OUD Death Rate (2017) 19.3; Rank 5/41
- ED Opioid Rate (2017) 38.1; Rank 9/41
- 3 Hospitals
- 39 Pharmacies
- 5 FQHCs
- Methadone Pt Rate 0; Rank n/a

ADDITIONAL FACTORS
- SAMHSA Funds: $1,518,250
- Coalition: SafeRx Mendocino
- Presence of CA Bridge: Yes
- Drug Medi-Cal Organized Delivery System?: Yes

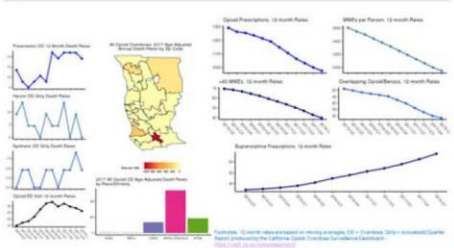
HEALTH MANAGEMENT ASSOCIATES 8

PREVIEW: THE "SCAFFOLDING" (HUMBOLDT COUNTY EXAMPLE)



HEALTH MANAGEMENT ASSOCIATES 11

Mendocino County Continued



9

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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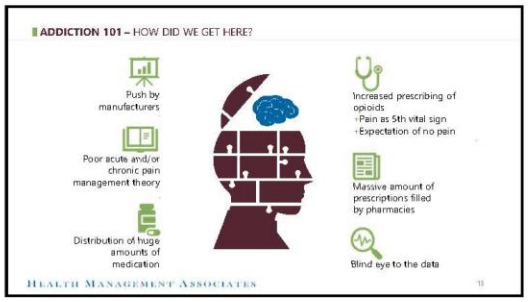
ADDICTION 101 – HOW DID WE GET HERE?
Push by manufacturers
Poor acute and/or chronic pain management theory
Distribution of huge amounts of medication
Increased prescribing of opioids
•Pain as 5th vital sign
•Expectation of no pain
Massive amount of prescriptions filled by pharmacies
Blind eye to the data
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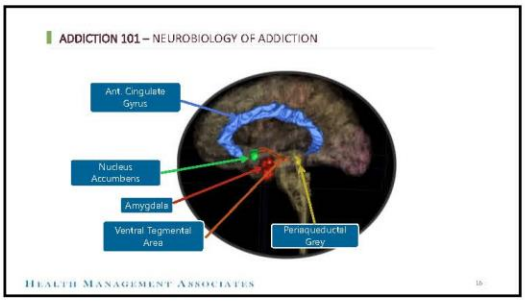
ADDICTION 101 – NEUROBIOLOGY OF ADDICTION
Ant. Cingulate Gyrus
Nucleus Accumbens
Amygdala
Ventral Tegmental Area
Periaqueductal Grey
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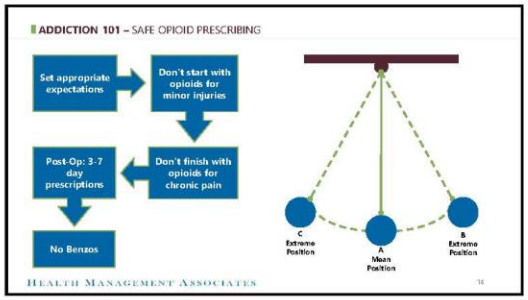
ADDICTION 101 – SAFE OPIOID PRESCRIBING
Set appropriate expectations
Don't start with opioids for minor injuries
Don't finish with opioids for chronic pain
Post-Op: 3-7 day prescriptions
No Benzos
C Extreme Position
A Mean Position
B Extreme Position
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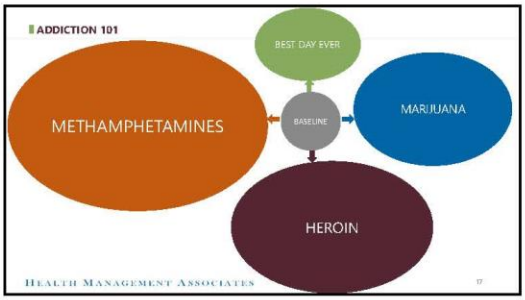
ADDICTION 101
BEST DAY EVER
METHAMPHETAMINES
BASELINE
MARIJUANA
HEROIN
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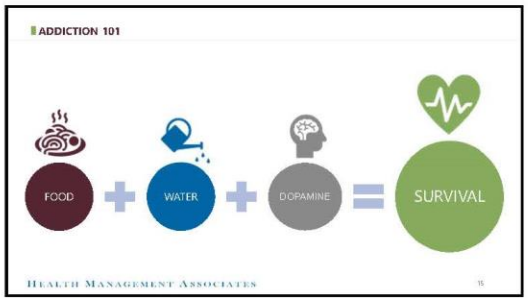
ADDICTION 101
FOOD
WATER
DOPAMINE
SURVIVAL
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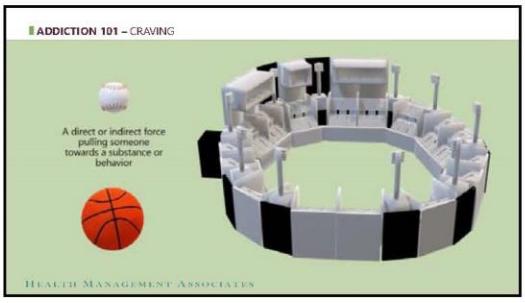
ADDICTION 101 – CRAVING
A direct or indirect force pulling someone towards a substance or behavior
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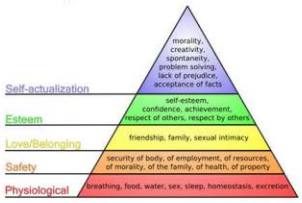
Hierarchy of Needs



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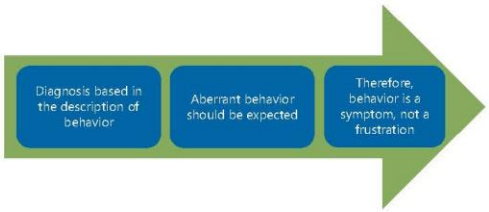
ADDICTION 101 – BEHAVIOR



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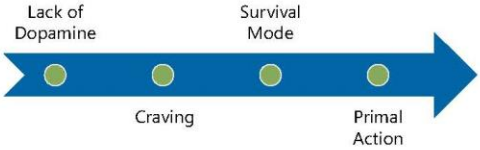
ADDICTION 101 – BEHAVIOR



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ADDICTION 101 – RELAPSE

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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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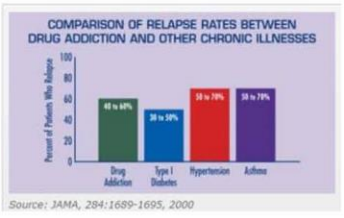
ADDICTION AS A CHRONIC DISEASE



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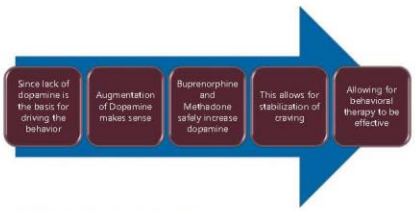
ADDICTION 101 – TREATMENTS



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ADDICTION TREATMENT ECOSYSTEM CLINIC STRUCTURES

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THE ECOSYSTEM OF CARDIAC CARE

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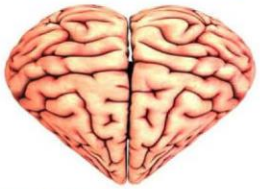
ADDICTION TREATMENT ECOSYSTEM CHANGING HEARTS AND MINDS

ADAPTIVE vs. TECHNICAL



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THE ECOSYSTEM OF ADDICTION CARE

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ADDICTION TREATMENT ECOSYSTEM IMPLEMENTATION

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

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ADDICTION TREAMENT ECOSYSTEM CAPACITY

- Access to all levels of care
- Bed and appointment capacity within each level
- Appropriate and smooth transitions between the levels of care

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ADDICTION TREAMENT ECOSYSTEM COMPENSATION

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

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ADDICTION TREAMENT ECOSYSTEM COMPETENCY

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

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ADDICTION TREAMENT ECOSYSTEM COMMUNITY

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

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ADDICTION TREAMENT ECOSYSTEM CONSISTENCY

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

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SCREENING, ASSESSMENT & LEVEL OF CARE DETERMINATION

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

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

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

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LEVEL OF CARE DETERMINATION

Evaluating for placement

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

ADDICTION TREAMENT ECOSYSTEM PHASES OF PROCESS

Phase 3

Structure	Tools	Knowledge
• Hospital-based intervention • Outpatient-based intervention • Community intervention • ASAM levels of care	• Guidelines • Site Dashboard • Site plans • PM granular tools • Patient facing tools	• Didactics • Guidelines • Asynchronous content • Coaching calls • Echo

ADDICTION TREAMENT ECOSYSTEM PHASES OF PROCESS

PHASE 1

Observation/Evaluation Phase	Leadership Alignment (corporate and local)
• ID current cultural state of institution or community • Identify patients/clients/ members receiving care in that institution or Community • Deep dive evaluation of current state • Determine alignment	• C-suite of Institution • Informal Community Leaders • Community Leaders • Business Leaders

TABLE DISCUSSION

WHAT ARE THE BARRIERS AND GAPS IN YOUR CURRENT SYSTEM?

ADDICTION TREAMENT ECOSYSTEM PHASES OF PROCESS

Phase 2

Cultural Alignment	Goals & Scope	Data
• Listen to all sides • Teaming • Direct patient input	• Utilization • Cost • Expansion of Service • Develop new service line • Population	• Payer • Hospital • HIE • PDMP

GOAL

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

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

POTENTIAL SOLUTIONS:

DISCUSS WITH YOUR GROUP AND WRITE DOWN POTENTIAL IDEAS/SOLUTIONS TO THE BARRIERS AND GAPS-CAPTURE THESE IDEAS ON STICKY NOTES AND ADD THEM TO THE BARRIERS AND GAPS

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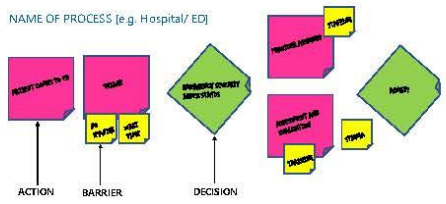
CURRENT STATE VALUE STREAM MAP EXAMPLE

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



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GROUP DISCUSSION: BARRIERS AND SOLUTIONS

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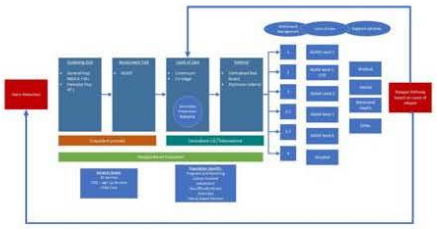
Preview: THE "SCAFFOLDING" (HUMBOLDT COUNTY EXAMPLE)



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FUTURE STATE MAPPING ON DAY 2

IN A PERFECT WORLD...

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FIELD NOTES

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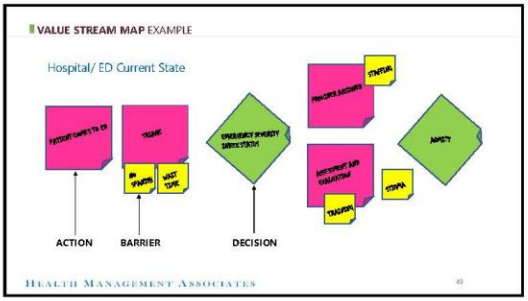
VALUE STREAM MAP EXAMPLE
Hospital/ ED Current State
ACTION
BARRIER
DECISION
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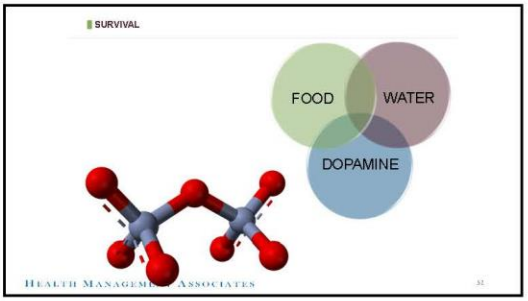
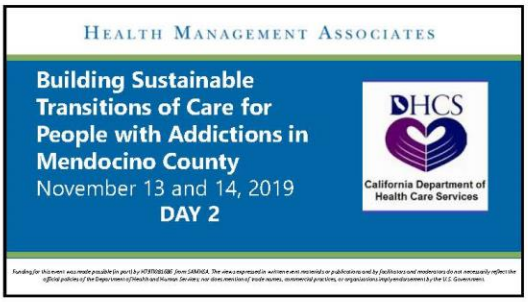

SURVIVAL
FOOD
WATER
DOPAMINE
HEALTH MANAGEMENT ASSOCIATES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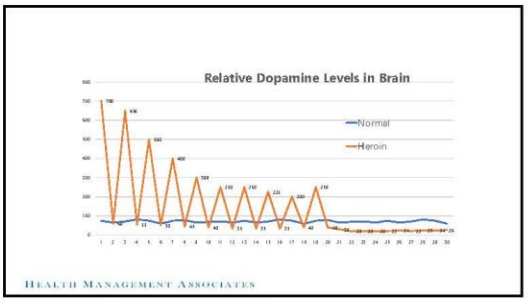
Building Sustainable Transitions of Care for People with Addictions in Mendocino County
November 13 and 14, 2019
DAY 2
DHCS
California Department of Health Care Services


Relative Dopamine Levels in Brain
Normal
Heroin
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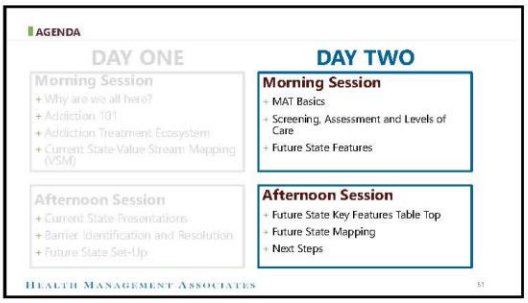
AGENDA
DAY ONE
Morning Session
+ Why are we all here?
+ Addiction 101
+ Addiction Treatment Ecosystem
+ Current State Value Stream Mapping (VSM)
Afternoon Session
+ Current State Presentations
+ Barrier Identification and Resolution
+ Future State Set-Up
DAY TWO
Morning Session
+ MAT Basics
+ Screening, Assessment and Levels of Care
+ Future State Features
Afternoon Session
+ Future State Key Features Table Top
+ Future State Mapping
+ Next Steps
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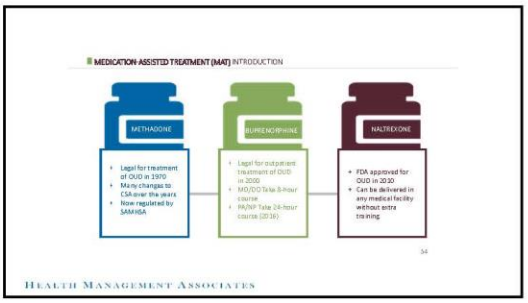
MEDICATION-ASSISTED TREATMENT (MAT) INTRODUCTION
METHADONE
BUPRENORPHINE
NALTREXONE
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CATEGORIES OF MAT FOR OUD

METHADONE	BUPRENORPHINE	NALTREXONE
full agonist activates opioid receptors which eliminates craving for other opioids	***partial agonist*** activates opioid receptors in the brain, but to a much lesser degree, which reduces craving for other opioids	***antagonist*** blocks opioid receptor without activating it, which eliminates opioid effect if opioids are taken

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METHADONE GENERAL REGULATIONS

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

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METHADONE
FULL AGONIST

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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 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 OUTCOMES

- The most studied of the three medications
- Retention in treatment is the main outcome and has ranged between 60 and 80% among RCTs
- Possibly due to combination of high intensity treatment and medication
- Still standard of care for patients with Severe Opioid Use Disorder

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RETENTION IN METHADONE TREATMENT IS ASSOCIATED WITH:

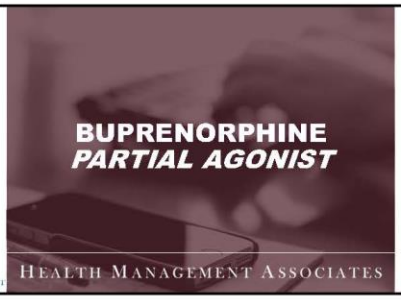
- ☑ Reduction in the use of illicit drugs
- ☑ Reduction in criminal activity
- ☑ Reduction in needle sharing
- ☑ Reduction in HIV infection rates and transmission
- ☑ Cost-effectiveness
- ☑ Reduction in commercial sex work
- ☑ Reduction in the number of reports of multiple sex partners
- ☑ Improvements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

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

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

BUPRENORPHINE WHO IS APPROPRIATE?

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

BUPRENORPHINE GENERAL REGULATIONS

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 TRAINING REQUIRED

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

BUPRENORPHINE 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 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 INDUCTION

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

Induction/Starting Buprenorphine

The science and art of avoiding precipitated withdrawal

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NALTREXONE WHO IS APPROPRIATE?

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

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BUPRENORPHINE CAVEATS

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

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NALTREXONE GENERAL REGULATIONS

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

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NALTREXONE MEDICATION FORMS

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

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NALTREXONE PROPERTIES

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

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MAT CONCLUSIONS

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

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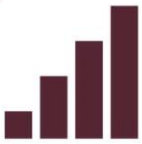
NALTREXONE OUTCOMES

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



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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

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NALTREXONE CAVEATS

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

HEALTH MANAGEMENT ASSOCIATES 81

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)

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SCREENING, ASSESSMENT AND LEVEL OF CARE DETERMINATION

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, 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).

SCREENING TOOLS

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

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).

The NIDA 4 +1 (MJ for CA)

❑In the last 1 year have you...
- ❑Smoked tobacco or vaped?
- ❑Had more than 4(women)/5(men) drinks of alcohol in one day or more than 10 in one week
- ❑Used a prescription for something other than prescribed
- ❑Used an illegal or illicit drug
- ❑Used marijuana*

❑If the answer is yes to any of the above questions then the screen is positive and an assessment should be done

*Added due to legalization of MJ in CA

ASSESSMENT TOOLS

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

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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.

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ASSESSMENT TOOLS

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

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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)

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

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

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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)

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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 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 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 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.

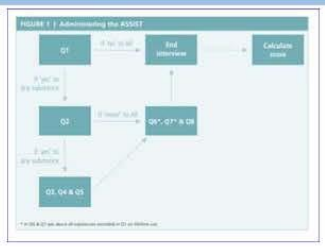
Question 6: External concern

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)

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.***

LEVEL OF CARE DETERMINATION

Evaluating for placement

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

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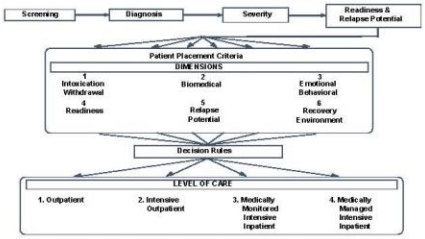
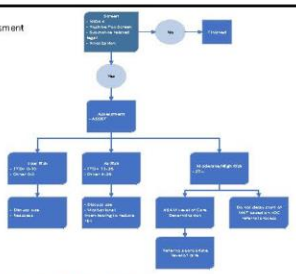
The ASAM Criteria Decision Process



Screening and Assessment



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ASAM CRITERIA METHODS OF DELIVERY

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

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CONSTRUCTING THE FUTURE STATE

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CURRENT STATE VALUE STREAM MAP RESIDENTIAL TREATMENT (FORD ST.)

REVIEW OF THE CURRENT STATE

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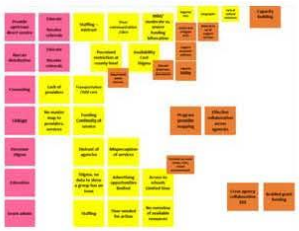
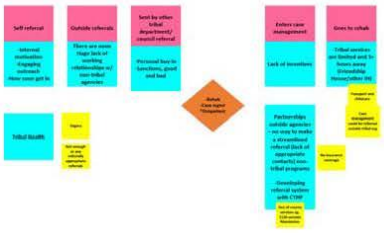
CURRENT STATE VALUE STREAM MAP PREVENTION



CURRENT STATE VALUE STREAM MAP TRIBAL HEALTH



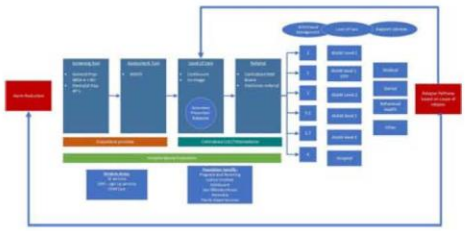
CURRENT STATE VALUE STREAM MAP PATIENT/CONSUMER/ADVOCATE

CURRENT STATE VALUE STREAM MAP HOSPITAL

SOLUTIONS FOR THE MENDOCINO COUNTY FUTURE STATE

FUTURE STATE OF ADDICTION TREATMENT IN MENDOCINO COUNTY

MENDOCINO COUNTY: Future State Treatment and Recovery Ecosystem



IN A PERFECT WORLD...

FUTURE STATE FEATURES:
- **TABLE TOP**
- **GALLERY WALK**
- **DISCUSSION**

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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

TECHNICAL ASSISTANCE (TA) PROGRAM TRACKS:
GENERAL TA VS. COACHING

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HEALTH M

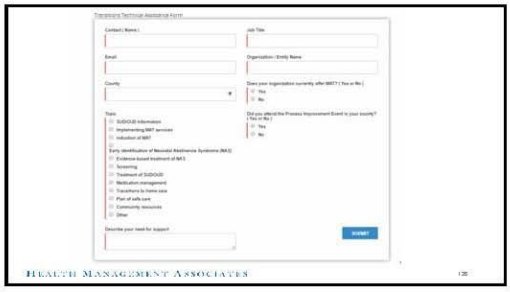
QUARTERLY CALLS

HEALTH MANAGEMENT ASSOCIATES

HEALTH MANAGEMENT ASSOCIATES

ADDICTIONFREECA.ORG

HEALTH MANAGEMENT ASSOCIATES



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NOW WHAT DO WE DO?

C. Summary of Evaluation Results

- What did you like MOST about this forum?
  - Interfacing with providers and others in the community and hearing their thoughts on the current and future states
  - Understanding that challenging behaviors are a symptom of addiction
  - ASAM criteria
  - The gathering of community resources to better serve clients
  - Collaboration between agencies
  - Presenters were very knowledgeable
  - Learning about MAT and the efficacy of the medications
  - Extremely informative presentation for non-medical professional
  - Learning the science of addiction
  - Discussion about barriers faced by providers and clients and how to overcome them
  - Shared experience with other organizations
  - Corey's straight forward, evidence based, no-nonsense approach
  - Networking
  - Learning about resources in the community
  - Ideas about how to change and improve practices

- What changes would you recommend?
  - Activities out of comfort zone
  - Greater participation from some stakeholder groups
  - Acronyms
  - Shorter breakout sessions (30 minutes rather than 1 hour)
  - Would have liked more conversation about what we do now, and how to improve services
  - There is a disconnect between treatment availability in rural areas and lack of funding
  - Resistance in the groups
  - Less group time, more presentations

- Give an example of something new you learned about addiction:
  - The depth of which dopamine plays in substance use disorder
  - Relationship between dopamine and addiction
  - Medications – MAT
  - Can't overdose on suboxone
  - The impact of MAT
  - Co-triage, ASSIST, Continuum
  - New technology for assessment and evaluation
  - The many ways in which our society stigmatizes addiction
  - Barriers faced by providers and clients
  - The way we currently treat patients is inadequate
  - The use of new medications to facilitate recovery
  - The multigenerational effect of addiction

- What topics would you like to learn more about?
  - Stories of those with lived experience
  - How treatment differs among different cultures
  - How to fund components of the addiction treatment system
  - How to gain buy in among staff
  - ASAM
  - Continuum of care
  - Setting up a residential treatment program
  - Technology
  - ASSIST and co-triage tools
  - How to implement the future state
  - How to get agencies to work together
  - How to support social needs of MAT patients (transportation, school, jobs etc.)
  - How to improve existing systems
  - The availability of funds to attract new providers, and encourage existing providers to get X waiver
  - Deep dive into psychotherapy
  - Resilience in substance use disorder
  - Other supportive medications for substances other than opiates
  - Bridge program
  - Telepsychiatry
  - Continuum assessment

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