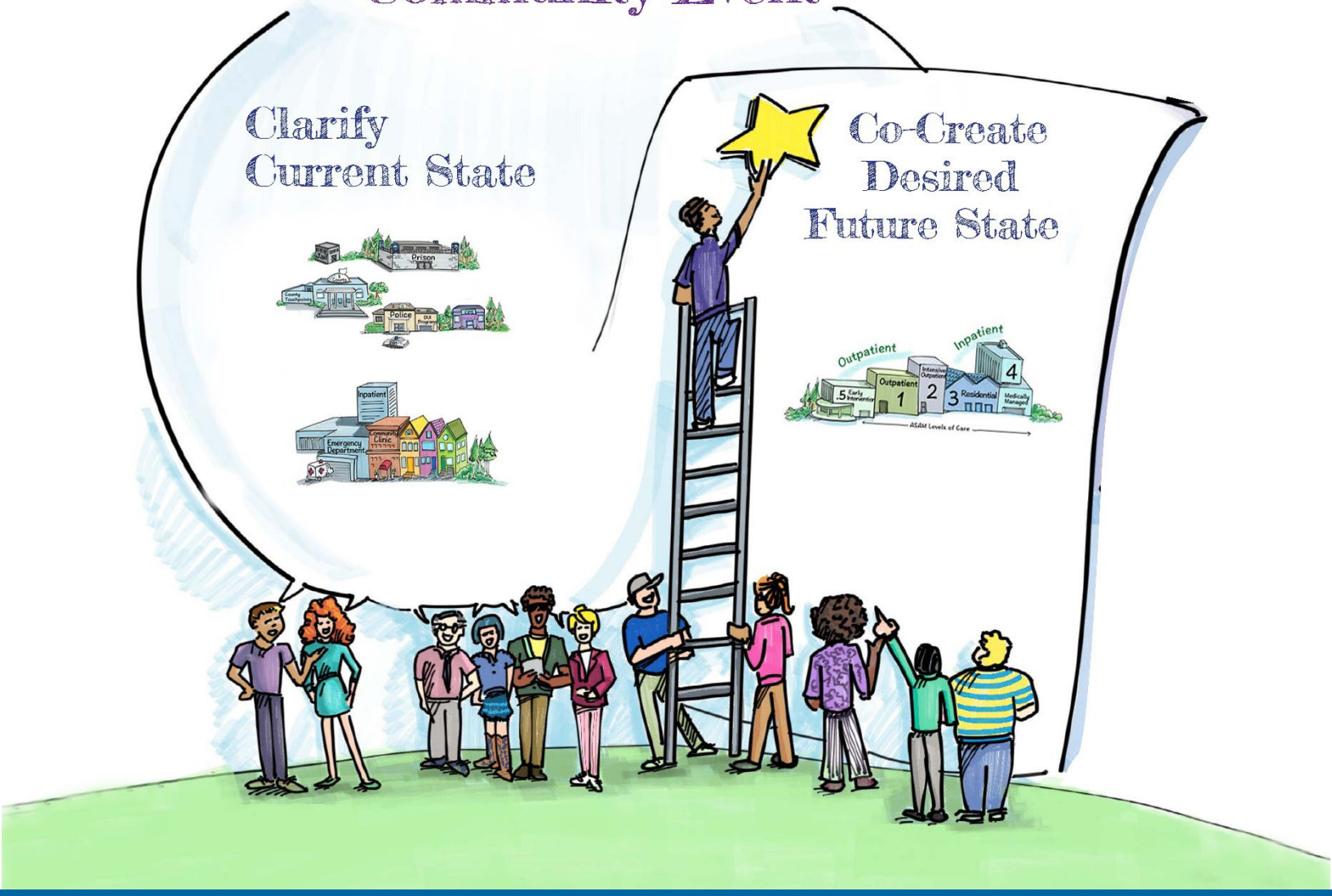
Collaborative Provider Community Event



STRENGTHENING THE SUBSTANCE USE DISORDER TREATMENT AND RECOVERY ECOSYSTEM

San Bernardino County

Process Improvement Event

May 11 & 12, 2021

HEALTH MANAGEMENT ASSOCIATES

STRENGTHENING THE SUBSTANCE USE DISORDER TREATMENT AND RECOVERY ECOSYSTEM

San Bernardino County

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Department of Health Care Services

HMA
HEALTH MANAGEMENT ASSOCIATES

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Executive Summary

Overdose is the leading cause of accident-related death in the United States. In recent years, the vast majority of these overdoses came from a combination of prescribed opioids and heroin. More recently, synthetic opioids, such as fentanyl, account for over 2/3 of these overdose deaths (although methadone is technically a synthetic opioid, it is reported separately and accounts for nearly 5% of OD deaths). As the opioid crisis has worsened over the last ten years, we have reached a point where the treatment system, in its current state, can no longer handle the volume of patients needing care. Moreover, the pandemic has exacerbated the problem as recent CDC data indicates overdose deaths are up 36.7% between August 2019 and August 2020.[1] Overdose deaths attributed to synthetics such as fentanyl, but excluding methadone, are up as well (since 2019).[2] 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 Systems 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. Seven counties across California were selected to participate in the Systems of Care project based on need and capacity within the County. The Systems of Care project: 1) engages stakeholders in each selected County in a two-day county-wide process improvement event and 2) subsequently provides 12 months of ongoing technical assistance to support the County in achieving their ideal future state for addiction treatment. San Bernardino County, one of the seven counties selected, participated in a large-scale process improvement event on May 11 & 12, 2021 that included members from local governmental agencies, health care organizations, addiction treatment providers, and law enforcement agencies. 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 systems of care for San Bernardino County residents in need of addiction treatment and support services.

San Bernardino County Department of Behavioral Health, San Bernardino Public Health, Arrowhead Medical Regional Center, Inland Valley Recovery Services , and Inland Empire Opioid Coalition, 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 San Bernardino County, California.

[1] Ahmad FB, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2021.

[2] National Center for Health Statistics (NCHS). Multiple Cause of Death 1999-2019 on CDC WONDER Online Database, released 2020, http://wonder.cdc.gov/mcd-icd10.html

The two-day virtual event was attended by more than 60 individuals. The event set the stage for improved coordination of transitions of care and adopting universal evidence-based tools for screening, assessment, and level of care determination. It is expected that this event 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.

Section 1: Introduction and Background

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 opioid-related emergency department visits in California more than tripled between 2006 and 2019 and increased 38.3% between 2019 and 2020 alone. Death rates from heroin overdose have remained flat since 2014, after annual increases from 2011 to 2014. Deaths resulting from synthetic (other than methadone), such as fentanyl, increased by more than 50% between 2016 and 2017. In 2019, 1,675 of the 2,802 deaths from opioid overdose in California involved synthetic opioids.

In an effort to address the opioid epidemic throughout the state, the California Department of Health Care Services (DHCS) is implementing the California Medication Assisted Treatment (MAT) Expansion Project. The project is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) State Targeted Response (O-STR) grant and State Opioid Response (SOR) I and II grants. The DHCS has, in turn, issued a number of grants collectively referred to as the California MAT Expansion Project, with the aims of increasing access to MAT, reducing unmet treatment need, and reducing opioid overdose deaths through prevention, treatment, harm reduction, and recovery activities. The statewide project has a special focus on populations with limited MAT access, including youth, those living in rural areas, American Indian & Alaska Native tribal communities, and people experiencing homelessness.

In earlier rounds of funding, DHCS applied for and received over $176 million from SAMHSA to build appropriate systems of care for patients with opioid use disorder and other co-occurring disorders. In the most recent round of SOR funding through the SOR II grant, DHCS is administering over $210 million in grants to over 30 projects in the state. To date, the effort has expanded access to MAT by supporting more than 650 access points, including hospitals, primary care sites, county jail systems, Indian Health Programs, mental health clinics, substance use disorder (SUD) clinics, and more. The overdose prevention efforts have resulted in the prevention of over 28,000 overdoses through direct naloxone administration.

HMA received SOR funding from DHCS to focus on building and enhancing treatment and recovery ecosystems to sustain addiction treatment and ensure consistent and predictable transitions as an individual moves from locations such as emergency departments, jails, primary care clinics, the community at large and/or inpatient hospital settings to the appropriate level of care in the community for initiation of or ongoing treatment. Through rigorous assessment of all 58 counties in California, HMA identified San Bernardino County as being an optimal location to build and stabilize such Systems of Care to decrease the risk of overdose and death amongst citizens with opioid use disorder. In addition to San Bernardino County, five other counties were identified as key locations on which to focus these efforts.

Systems of Care Project Goals

Make treatment more accessible and equitable for people with SUD/OUD/StUD

Improve the safety of transitions between levels of care

Strengthen links and communication among all stakeholders in the ecosystem

Support all stakeholders' achievement of shared county-level SMART goals

Increase the number, activity and cultural concordance of MAT prescribers in the county

Level Setting: Why Are We Here?

The Systems of Care project engages stakeholders in each selected County in an 18 months process aimed at supporting the County to move toward community-defined goals and the ideal future state treatment and recovery ecosystem. This is accomplished through collaboration with a county leadership team tasked to co-design and conduct a virtual two-day countywide process improvement event, followed by 12-months of ongoing coaching and technical assistance. Those stakeholders who are actively involved with the ecosystem enhancement/development for the County will be eligible to receive ongoing individualized technical assistance from a team of national experts covering all aspects of knowledge required to build and sustain an evidence-based addiction treatment ecosystem.

HMA worked with Dr. Bill Oglesby, Deputy Director, CJSUDRS, Dr. Jon Avalos, Addiction Medicine Physician, Michael Sweitzer, PM II, SUDRS and Jennifer Alsina, PM II, SUDRS County of San Bernardino Department of Behavioral Health program leadership. Specifically, we identified key stakeholders and organizations who should be included in the process improvement event and to whom coaches should outreach in advance of the event to ascertain their level of need for and interest in coaching and TA Assistance. The HMA team also held meetings with a planning team who are represented below.

Collectively, County staff and the planning team assisted HMA in launching the process improvement event and subsequent ongoing coaching and technical assistance program. County staff helped identify and engage the audience for the process improvement events, sent out invitations and took an active role during the events using their leadership to set a strong tone of collaboration for the event and the ensuing work toward county-level goals.

Planning Team/Key Change Agents

- Dr. Jon Avalos, Addiction Medicine Physician
- Dr. Bill Oglesby, Deputy Director, CJSUDRS
- Michael Sweitzer, PM II, SUDRS
- Jennifer Alsina, PM II, SUDRS
- Dr. Hobart Lee, LLU Family Medicine
- Dr. David Lanum, ARMC
- Dr. Edward Pillar, ARMC
- Dr. Mike Sequeira, San Bernardino County Department of Public Health
- Dr. Christopher Berger, San Bernardino County Department of Public Health
- Tina Hughes, Inland Valley Recovery Services Upland Recovery Center

Process Improvement Event Participants: Agencies and Organizations

- Aegis Treatment
- Arrowhead Regional Medical Center San Bernardino County
- Cedar House
- Dignity Health
- Inland Valley Recovery Services
- Inland Behavioral and Health Services
- LSSC
- Mental Health Systems Inc
- Molina Health Care
- Rim Family Services
- Riverside San Bernardino County Indian Health Inc.
- San Bernardino County Board of Supersvisors
- San Bernardino County Public Health Department
- San Bernardino County Police Department
- San Bernardino County Courts
- San Bernardino County Department of Behavioral Health
- Western University
- Vituity

Process Improvement Methodology

In advance of the event, the HMA team, consisting of a team lead (Charles Robbins), two coaches (Rich VandenHeuvel and Scott Haga), and a technical assistance coordinator (Nayely Chavez), worked with the County to gather high-level information on addiction treatment resources and capacity in San Bernardino County and to identify stakeholders who constitute or should be part of the current treatment and recovery ecosystem. That information gathering along with the considerable efforts of a county-level planning group, laid the groundwork for outreach to stakeholders, pre-work, and collaborative planning in anticipation of an intensive, virtual Process Improvement Event (PIE) characterized by client-focused testimonials, process mapping, presentation, and discussion.

Most healthcare professionals are familiar with LEAN processing (i.e. Six-Sigma, etc.) 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 those tools can play in developing and managing an entirely new process. The field of addiction medicine, however, is neither fully built nor just born. Recognizing this, HMA facilitated a hybrid method to map and understand the current state structure and build the new pathways toward an enhanced future state.

The process improvement event engaged a variety of stakeholders, covered significant topics in addiction medicine, and facilitated important deliberations about the treatment and recovery ecosystem. Participants represented different aspects of the addiction space in San Bernardino County: SUD treatment, residential providers, hospital, probation department, behavioral health, public health, people with lived experience, and many others. HMA used the early parts of the agenda to provide an overview of the project and build a shared knowledge base about the neurobiological basis of addiction.

Participants were welcomed by County Board of Supervisors Chairman, Curt Hagman, who provided context of opioid and substance use disorder in the County and the County's commitment to strengthening and enhancing supports and services. The early agenda also included a panel presentation entitled "What's Working in San Bernardino County" to accentuate the existing efforts in the county. Panelists included representatives of behavioral health, public health, hospitals, and persons with lived experience. Of particular note, Jeanine Lorazno, a community member, shared her experience of heroin usage, the stigma of MAT by abstinence only recovery programs, and eventual success of her recovery journey.

> *My advice to providers is to "treat patients with dignity and like a whole human being".*
> -Jeanine Lozano, Community Member

Participants discussed specific gaps and barriers in randomly assigned breakout groups. During the breakouts, participants prioritized their list, sharing the most salient ones in a report out that resulted in a compilation representing the most significant gaps and barriers in San Bernardino County. This exercise allowed for a discussion of how barriers are experienced within the larger system of care. That discussion served as a lead into the remainder of the activities on Day 1 and, importantly, to the discussion of potential solutions and future goals.

A number of agencies completed process maps of their key SUD services in advance of the PIE, and those process maps were presented and discussed in the second half of Day 1. Process mapping is an adaptation of an evidence-based performance improvement tool incorporated into system improvement models like Lean, Six Sigma, and Total Quality Management. The purpose of this kind of mapping exercise is to analyze and improve the flow of SUD treatment processes (or any processes for that matter) by identifying unnecessary variation, gaps, and barriers, duplication, or other factors that create friction for the customer. For some agencies, this was a new exercise and a valuable skill developed with the assistance of the HMA coach and technical assistance coordinator.

Each program gave an oral description to the group, including all interventions and decision points in their process flows and identifying both intervention-specific and global barriers and gaps. This reporting out on current state processes allowed everyone in the room to understand how others were serving

those with addiction and the struggles involved in doing so. 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, assessment, and level of care placement for treatment in San Bernardino County. In a more traditional process improvement event, any one of the providers might have taken a full week to develop the same amount of work produced in only a few hours before this event. After each provider group presented their map to the rest of the participants we engaged in discussion about the revelations from that process and refined the compilation of significant gaps and barriers from our earlier exercise.

On the morning of day two, the participants received inspiration from Vince Parker, a community member. Vince shared his personal story and provided insights about his addiction to pain medicine, lack of awareness of MAT, the serendipitous referral to Arrowhead Regional Medical Center, his recovery journey, and his advice to post signage in clinical settings about opioid use and how to obtain support.

"Thank you for sharing your powerful journey Vince! Your story is absolutely pertinent!!!" – A participant in Chat

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Afterward, the group returned to review the science of Medication-Assisted Treatment (MAT), screening, assessment, and level of care determination; learn about the power of stigma as an obstacle to recovery; and hear information about telehealth, sharing Protected Health Information , and the status of recent regulatory changes influencing the treatment of SUD. These presentations resulted in further discussion and clarification around how some of these matters influence potential recovery pathways in San Bernardino County.

After reviewing the gaps and barriers compiled during the first session, participants engaged in more breakout work. This time the breakout groups were tasked with identifying key features they wanted to add to or improve to get closer to their ideal treatment and recovery ecosystem and to other solutions aimed at addressing the identified gaps and barriers. Once again, participants were asked to prioritize future state features and solutions, and those prioritized solutions were reconciled into a consolidated list during the report out. The items on that consolidated list were then arrayed on the ideal ecosystem "scaffolding" to underscore where the greatest improvement opportunities exist withthe ecosystem.

The PIE closed with a detailed discussion about how San Bernardino County will move forward with the work of this PIE and toward an enhanced treatment and recovery ecosystem for individuals affected by OUD/SUD. Prior to the event, the planning committee developed a few sample goals based on the discussions about the current state and information gathered during stakeholder interviews. The draft sample goals were presented on a slide, and the County provided context to each of them. Afterward, feedback was obtained through a poll. HMA staff closed with a discussion about the availability of technical assistance and coaching for San Bernardino County and the identified agencies interested in promoting those county goals.

It is worth mentioning that the participants in attendance were a particularly engaged group representing a broad cross-section of organizations, departments, decision-makers, doers, and people

with lived experience. The future state map was developed based on the previously gathered information from in-person meetings, electronic surveys, and the real-time input of the groups that had developed the current state maps and prioritized the key features for the future state. While not every treatment organization was present, the buy-in from the different groups was significant, and it was their voices that created the product.

Basic Principles of SUD Treatment

This section addresses a number of basic principles embraced by the broader recovery community and by the Systems of Care initiative, in particular. These principles reflect widely accepted standards for care for the treatment of OUD/SUD and the care management of general populations with chronic conditions.

As is the case with most counties in the state, San Bernardino County is contracted with the state Department of Healthcare Services (DHCS) as a Drug Medi-Cal, Organized Delivery System (DMC-ODS). DMC-ODS is the nation's first SUD pilot under a Medicaid section 1115 waiver, and is intended to address the unevenness of access, quality, and inadequate breadth of SUD care currently available under the Medi-Cal program by essentially positioning the counties as an SUD managed care plan over a network that must[3]:

- Build a benefit package consistent with the American Society for Addiction Medicine (ASAM) criteria and ensuring coverage across a broad continuum of SUD treatment and support services

[3] Adapted from Brassil M, Backstrom C, Jones E. "Medi-Cal Moves Addiction treatment into the Mainstream: Early Lessons from the Drug Medi-Cal Organized Delivery System Pilots. An Issue Brief developed for the California Healthcare Foundation, 2018.

- Specify standards for quality and access
- Require providers to deliver evidence-based care
- Coordinate with physical and mental health services
- Act as a managed care plan for SUD treatment services

The San Bernardino DMC-ODS Implementation Plan was approved by DHCS in May of 2017 and services began in March 2018. San Bernardino had a robust SUD treatment ecosystem and successfully transitions a majority of stakeholders to the DMC-ODS system. Since implementation, DMC -ODS services have been expanded. Services are offered at the following ASAM levels: .5, 1, 2.1, 3.1, 3.3, and 3.5. Residential treatment with withdrawal management (3.2WM) is also offered, and medical detox services (3.7) are available through a contracted provider in Riverside County. Applications to provide levels WM1 and WM2 are currently being processed to add these services to the DMC-ODS system in San Bernardino County.

While the implementation of DMC-ODS has made significant contributions to the ecosystem in San Bernardino County, elements of the waiver design and the complexities of recovery pathways underscore the importance of continuing to think expansively about the kind of networks required to meet the needs of the entire population struggling with OUD/SUD including but not limited to those on Medi-Cal or financially disadvantaged. Contracting requirements effectively exclude Federally Qualified Health Centers (FQHCs) and other safety-net providers from DMC-ODS contracts even though these providers constitute a significant portion of the SUD treatment and behavioral health providers. Additionally, there are tremendous complexities addressing the needs of special populations, such as those interfacing with the criminal justice system (over two-thirds of whom suffer from SUD), youth (whose SUD treatment needs are imperfectly covered under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits package), persons experiencing homelessness and those in tribal communities.

In addition to considerations about the ecosystem network there are basic principles of SUD treatment that must be acknowledged, understood and addressed by counties as they assume responsibility for this population. Those principles begin with a shared understanding of SUD as a chronic illness characterized by dysregulation of the midbrain centers that control motivation, reward, emotion and addiction. As discussed during the PIE, that dysregulation results in abnormal release and ultimately depletion of dopamine in the brain, triggering a cascade of symptoms often experienced by society as aberrant if not criminal behaviors. As the understanding and acceptance of SUDs as chronic neurobiological diseases has increased, engaging and sustaining affected individuals in treatment has improved and will continue to do so.

The Importance of Screening and Level of Care Determination

Understanding the distinction among screening, assessment and level of care determination is important as we contemplate the features of an ideal treatment and recovery ecosystem. During the PIE, participants came to understand that screening is the use of formal tools or questionnaires validated for use in target populations to identify someone at risk for a disease such as SUD. Research has indicated that standardized screening should be implemented for all populations and across all potential entry nodes into the broader health and human services system to ensure that those in need are identified and referred. Assessment is a deeper evaluation, also using validated tools, to confirm the

presence of a disease and trigger additional assessments. The level of care determination assesses the individual's needs across a number of domains to enable decision-making about and referral to the appropriate level of care.

The American Society of Addiction Medicine (ASAM) Criteria

The American Society of Addiction Medicine (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, duration of treatment, and transfer/discharge of patients with addiction and co-occurring conditions. Use of the ASAM Criteria is required in over 30 states, including in California for DMC-ODS contracted counties.

San Bernardino County uses screening and assessment tools based on the ASAM criteria. Individuals are assessed using age appropriate tools as well as having an assessment using ASAM's Immediate Need Profile tool.

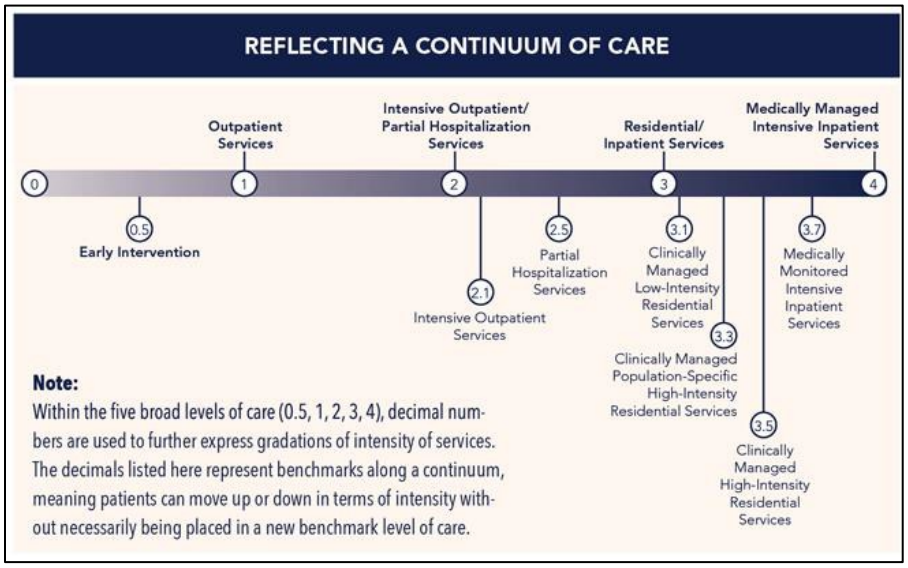
At present, the County operates a centralized screening and assessment servicethrough the San Bernardino Screening, Assessmenand Referral Center (SARC) to ensure consistent data collection and uniformity of screening and assessment criteria for DMC-ODS services. Centralized assessment was identified as a barrier during the PIE, and there is potential to explore de-centralized models using consistent screening and assessment criteria across county providers. This approach would require providers to conduct assessments using consistent evidence-based and validated criteria and necessitating training and process development to assure the County can still meet their DMC-ODS data and reporting responsibilities. This approach would align with emerging practices to facilitate improved access to services. Minnesota, for instance, is moving to "Direct Access" via providers for state-funded SUD services as of July 1, 2022[4].

Currently there are two validated methods for determining appropriate level of care using the ASAM Criteria. The first is having a behavioral health clinician conduct an assessment and applying The ASAM

[4] Minnesota Department of Human Services. Online Provider Manual, Substance User Disorder (SUD) Services, accessed May 5, 2021, https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ID_008949

Criteria as published , including referencing the published crosswalks within the criteria to determine the assigned level of care. The second is completion of an assessment using the software ASAM Continuum. ASAM CONTINUUM is an electronic assessment used to assess individuals with addictive, substance-relatedand co-occurring conditions using a branching algorithm guided set of validated questions. Assessment with ASAM CONTINUUM can be completed by clinical or non-clinical staff and produces validated assessment report for Level of Care, Addiction Severity Index (ASI) and a comprehensive biopsychosocial assessment narrative.

Both of these methods have implementation challenges. ASAM CONTINUUM is a cloud-based subscription software solution with initial and ongoing per-user costs. These costs have often been seen as prohibitive of widespread implementation. Use of the printed ASAM Criteria requires considerable training and involves significant complexity in application of multiple dimensional crosswalks. This high level of complexity, as well as an extended period to develop competency, has resulted in many counties in California developing internal tools for ASAM Level of Care assessment. While these tools simplify the process, they are not validated and do not result in a validated assessment using the ASAM Criteria. In light of these challenges, many DMC-ODS counties have created their own tools based on the ASAM criteria, with approval of DHCS. This has resulted in a situation where consistent assessments with fidelity to the validated methods has been difficult to document.



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

Evidence-Based Treatments for OUD and Other SUD: MAT and Contingency Management

Medication for Addiction Treatment (formerly known as Medication Assisted Treatment), or MAT, has now been established as the gold standard for the treatment of OUD. The therapeutics currently licensed by the Federal Drug Administration (FDA) for the treatment of SUD were discussed in detail during the PIE and include methadone, buprenorphine, and naltrexone extended release injection. Despite the indisputable evidence about the effectiveness of MAT for OUD, there continue to be substantial barriers to the broad implementation of these treatments. Common barriers include inadequate numbers of X-Waivered providers who are actively prescribing buprenorphine, deep social model treatment culture in significant elements within the treatment community (i.e., treatment

providers resistant to the use of any pharmaceuticals to manage SUD), stigma, fears about diversion potential, and general reluctance to embrace change. Most of these barriers exist because of ignorance and incomplete exposure to the evidence demonstrating the effectiveness of these medications in the treatment of OUD and a failure to understand how difficult it is to ready those with OUD/SUD to embark on any kind of recovery pathway without addressing dopamine depletion.

During the Process Improvement Event, San Bernardino County stakeholders shared insight on current barriers to MAT in their county. One highlighted challenge was the lack of availability of X-waivered providers as well as the hesitancy of X-waivered providers to prescribe. Similar challenges around limited the availability of other staff roles, such as care coordinators, substance use navigators and case managers, were also highlighted as directly impacting the ability to engage patients on MAT services. The group also drew attention to challenges of care coordination among the different providers a person with OUD/SUD may interact with. This called attention to the need to focus on transitions of care as well as intentional discharging from provider to provider. Lack of access to integrated care as well as timely referral follow through were also deemed significant barriers. In regard to special populations, the group highlighted the lack of adequate discharge coordination for criminal justice involved individuals. The need for culturally and linguistically competent providers and services for patients whose primary language is not English was also highlighted. The group also highlighted the administrative challenges around Medi-Cal services. At the intersection of many of the barriers stood the need of further understand MAT and harm reduction strategies.

In addition to a focus on the treatment of OUD, California is also reeling from an epidemic of methamphetamine and other stimulants. In most counties, methamphetamines and other stimulants are now the most prevalent drugs reported among those seeking treatment. And although opioids are still the most common source of drug overdoses, methamphetamines and other stimulants are increasing as a cause of overdose. Recognizing these shifts, the California DHCS is encouraging SOR grantees to address methamphetamines as well as OUD in their projects.

At present there are no FDA approved medications for the treatment of methamphetamine and other stimulant use disorder (StUD). The only evidence-based treatment specifically indicated for StUD is contingency management. There are recent and ongoing studies evaluating the promising combination of long-acting naltrexone and the antidepressant bupropion, although the treatment effect documented to date would be considered modest at best. These studies, several of which are being conducted as part of the National Institutes of Drug Abuse (NIDA) Clinical Trials Network (NIDA-CTN), should be monitored. It is worth acknowledging that psychosocial treatments, such as cognitive-behavioral therapy (CBT), and the treatment of co-occurring disorders, such as depression, are considered the standard of care and best practice for the treatment of SUD regardless of the main drug of choice. Consequently, the use of antidepressants and CBT are entirely justifiable for anyone with SUD (NB: studies demonstrate no significant effect of either antidepressants or naltrexone when used alone for the treatment of StUD). In the interim, treatment providers should be prepared to administer contingency management programs and do so while operating within the federal monetary value incentives limit imposed by the Center for Medicare and Medicaid Services (CMS) of $75/year.[5]

[5] Trivedi MH et al, Naltrexone and Bupropion in Methamphetamine Use Disorder. N Engl J Med 2021; 384:140-153

The Role of Stigma (i.e., the role of stigma abatement)

Stigma is a dynamic multidimensional phenomenon that occurs at multiple levels and constitutes one of the most powerful barriers to SUD treatment initiation and maintenance. Stigma occurs at three levels, each of which operates as a barrier. Self-stigma is characterized by internalized negative stereotypes that burden individuals with feelings of guilt and worthlessness, making it difficult for them to seek or feel confident about their ability to initiate treatment much less succeed on a recovery pathway. Public or social stigma is defined as attitudes, beliefs, and behaviors about individuals or groups in the absence of evidence. Long-held erroneous stereotypes and beliefs about the motivations behind the behaviors of individuals with SUD and the inappropriateness of treating OUD with other medications are examples of the social stigma evident in San Bernardino County. Structural stigma includes laws, regulations, policies and administrative practices that inappropriately and unfairly reduce the likelihood of identification, referral and treatment for individuals with SUD.

PIE participants specifically noted the need for continuing county-wide educations regarding addiction as a chronic brain disease. Providing information, including objective data as well as perspectives from individuals with lived experience, was identified as necessary and impactful. It was noted that this education is needed for the community at large, patients and providers, as well as other community services such as Child Welfare. This included a need to offer MAT to all individuals with OUD while also honoring other treatment options and choices (medical and social models of recovery). Progress was noted, but there was recognition that this needed to be ongoing and continuous, including education regarding harm reduction and naloxone.

The Importance of Transitions

Efforts should always be made to address transitions from one location or level of care to another for individuals with OUD or SUD in the same way transitions are important in a system of care for individuals with any other type of medical disease. That is particularly the case for certain populations such as individuals re-entering society after being in the criminal justice system, pregnant and parenting women with OUD entering or leaving the hospital setting, and persons experiencing homelessness. Planning transitions is best accomplished by ensuring that critical information passes from one provider to the next. Coordination of care and transitions are facilitated when clients have copies of their recent treatment plan and goals, or by having standardized consent forms that meet 42 CFR Part 2 requirements to allow direct sharing of appropriate treatment and clinical information.

Participants specifically noted the need to support transitions for those with the most complex needs (co-occurring medical and mental health needs, justice involved, etc.). This was prioritized as a goal area, with potential for pilot approaches with designated “responsible care managers” supporting development and monitoring implementation of individualized treatment plans across providers; with emphasis on the justice involved population across all points of the Sequential Intercept Model. This would require coordination across providers and with law enforcement, including the various co-response teams (SBSD, SBPD and SRPD) to address opportunities to coordinate services from first contact, through diversion and adjudication, incarceration and re-entry, if necessary. For the non-justice involved population, participants discussed the importance of direct supports for referrals and transitions of care; up to and including navigators and peer supports accompanying and supporting individuals and supporting access to transportation.

Embrace Diversity, Equity and Inclusion and Low Barrier Treatment

In many communities throughout California, individuals with OUD/SUD face additional barriers beyond stigma because of their race/ethnicity, gender, sexual orientation, or other characteristics. Those barriers may include inadequate access to treatment providers, especially those whose cultures, language, and traditions are very different from their own. The diversity in our state demands that these challenges be acknowledged and addressed. Conversations with individuals about OUD/SUD should utilize non-judgmental, non-stigmatizing, compassionate, -informed, and motivational interviewing techniques. Effective recovery systems also work to address diversity, equity and inclusion by acknowledging disparities and requiring access to quality treatment for those disproportionately impacted, including persons of color and others who have been stigmatized and marginalized. Staff should always, but especially at the time of initial contact, approach individuals seeking treatment with compassion and cultural humility as you seek to meet their needs. Moreover, intentional workforce development must recognize the lack of diversity among management and provider staff, in particular, and enhance cultural intelligence in patient care. A just recovery community must include cultural humility, a commitment to introspection, value health equity, and elevate the voices of persons with lived experience.

Additionally, conventional treatment programs often condition the induction or maintenance of MAT and other therapies on well-intentioned, but rigid requirements, such as abstinence from other drug use, toxicology testing, lengthy assessments, and participation in social and psychological services. Those requirements can be significant barriers to life-saving treatment. The goal of low barrier care is to reduce overdose deaths and improve overall health and well-being by creating client-centered treatment programs and services that are easy to access, high quality, and minimize obstacles to care. Evidence indicates that low barrier programs for adults with OUD/SUD, especially persons experiencing homelessness and others who are ambivalent about continued drug use do, in fact, reduce overdose deaths and other complications related to OUD/SUD.

Section 2: Event Outcomes

Goals of the Participants

Day one of the process improvement event began with a discussion of why we are all gathered at this event. Among the potential goals of the process improvement event are the following:

- Make treatment more accessible and equitable for people with SUD/OUD/StUD
- Strengthen links and communication among all stakeholders in the ecosystem
- Increase the number, activity, and cultural concordance of MAT prescribers in the County
- Reduce overdose deaths
- Understand all stakeholders' role and needs in the ecosystem and support the achievement of their goals, especially those that advance shared county-level SMART goals

What Is Working in San Bernardino County?

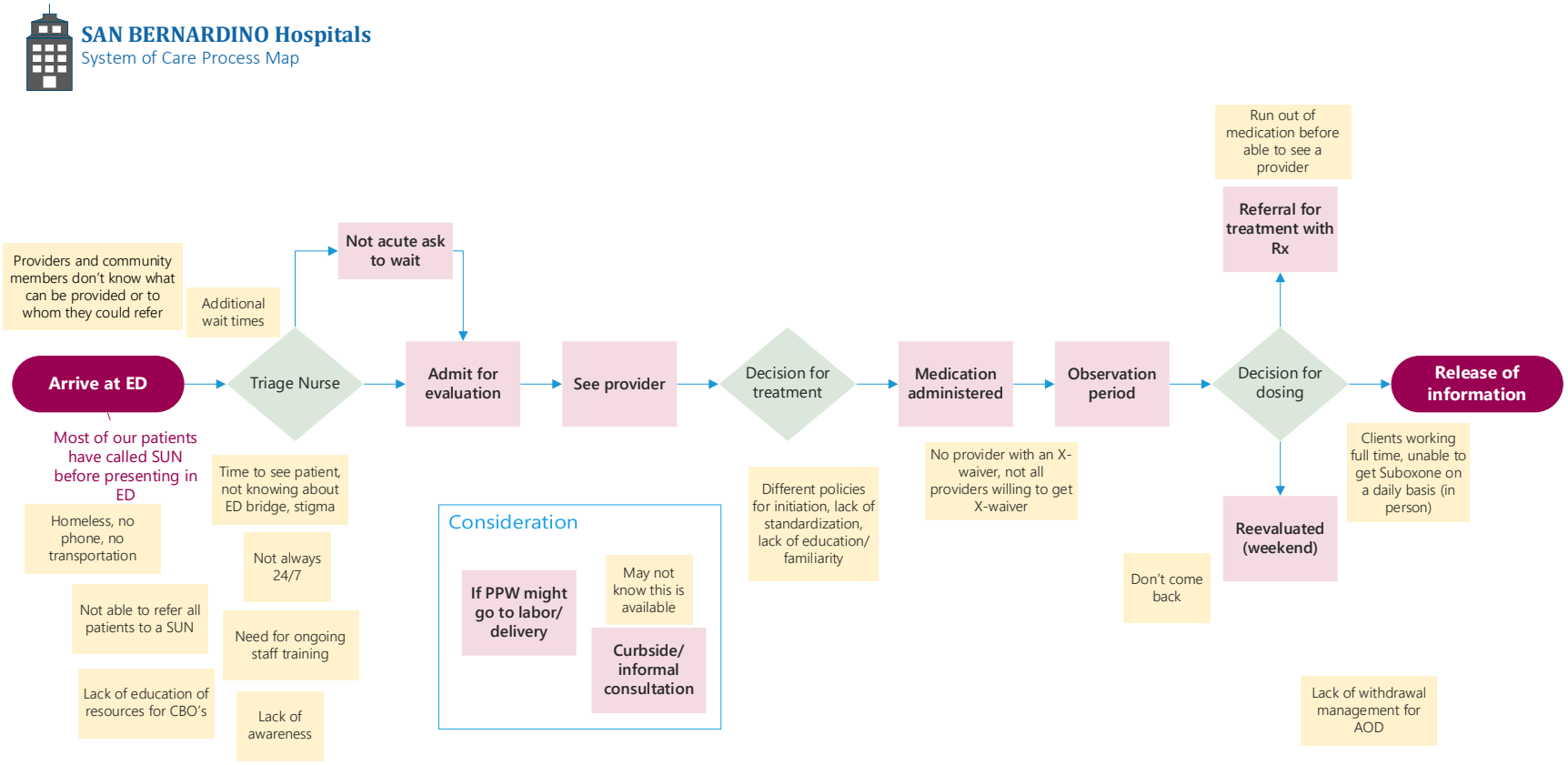
The PIE planning group in San Bernardino County organized a stimulating panel to provide an overview of effective programs and features in the overall treatment and recovery ecosystem in San Bernardino County. Panel participants included Eric Alvarez, Substance Use Navigator from Arrowhead Regional Medical Center, Jeanine Lozano, Community Member, Crystal Horn, Director of Marketing and Fund development for Inland Valley Recovery Services, Dr. Jonathan Avalos, Addiction Medicine Physician and Dr. Edward Pillar from Arrowhead Regional Medical. Panelists emphasized the amount of progress in San Bernardino County, citing advances building relationships with patients using staff such as substance use navigators. Specific education and anti-stigma efforts were noted with across sectors, including providers and hospitals. Jeanine Lozano emphasized the importance of treating patients with dignity. Crystal Horn also identified her organization's focus on maintaining a continuum of care and its leverage of technology to support accessibility. Dr. Pillar also highlighted the success of the ED Bridge program, allowing for linkage to treatment in the ED.

Pre-Work: Agency-Level Process Mapping of the Recovery Path

Each of the counties participating in the Systems of Care initiative engaged in flow mapping of the key processes used by various provider or stakeholders. Mapping out relevant work processes – in this case related to services provided for individuals with OUD/SUD – is an adaptation of an evidence-based quality improvement tool incorporated into models like Lean, Six Sigma and Total Quality Management. It can be tremendous helpful in analyzing and improving the flow of SUD treatment processes by identifying unnecessary variation, gaps and barriers, duplication or other factors that create friction for the customer (and sometimes for workers as well). In San Bernardino County the PIE planning group identified several providers from different sectors to map key processes in the ecosystem. What follows are diagrams and narrative descriptions of the process maps presented by a number of agencies and stakeholders during the PIE.

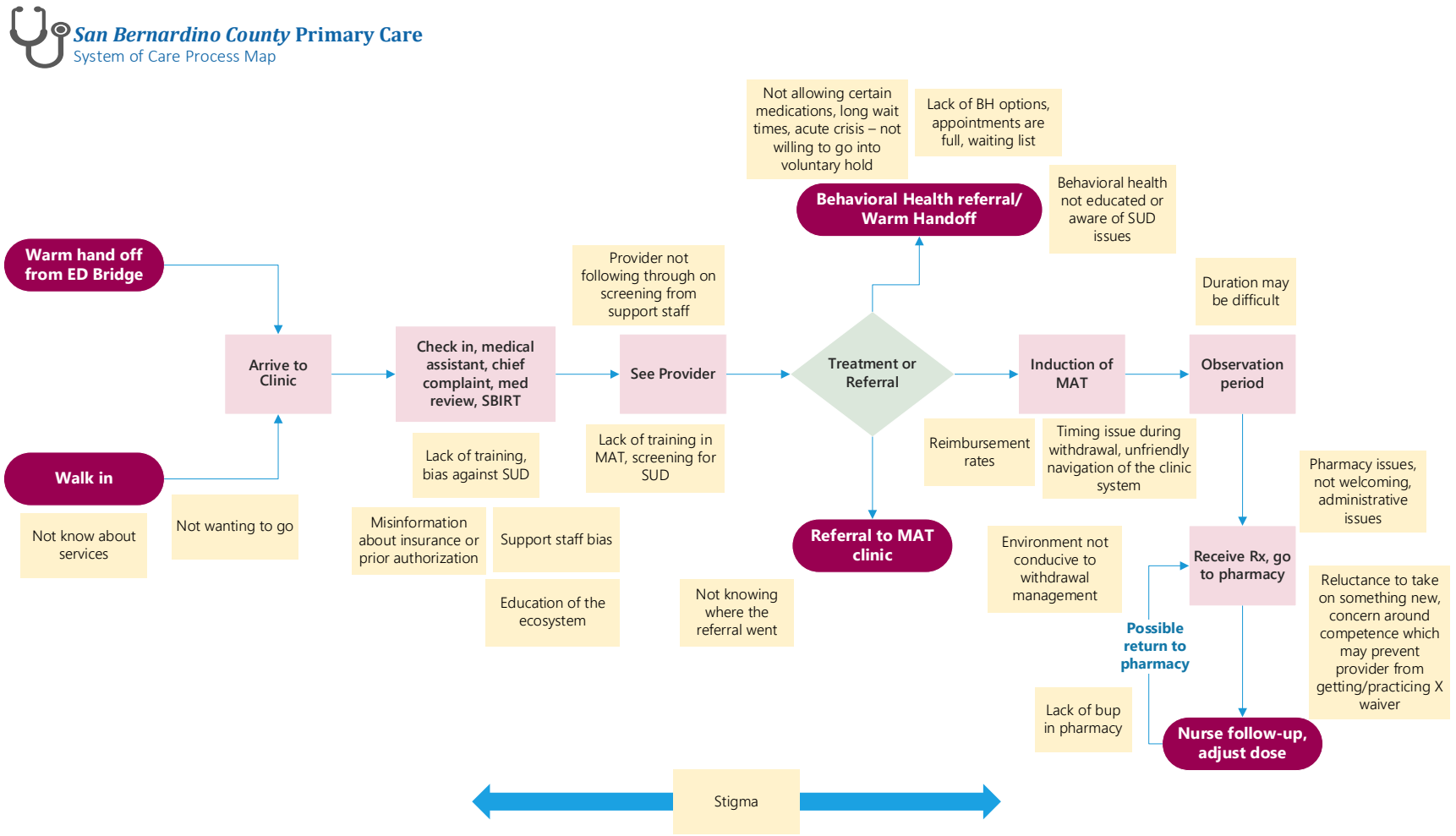
San Bernardino County Hospitals

On March 29, representatives from San Bernardino hospitals together with San Bernardino County staff gathered to map out the hospital workflow. As shown in the map, the process begins with the patient entering the hospital through the emergency department and moves through a series of process steps (pink), decision points (green), and next steps all the way to discharge. Barriers that exist are represented by yellow.



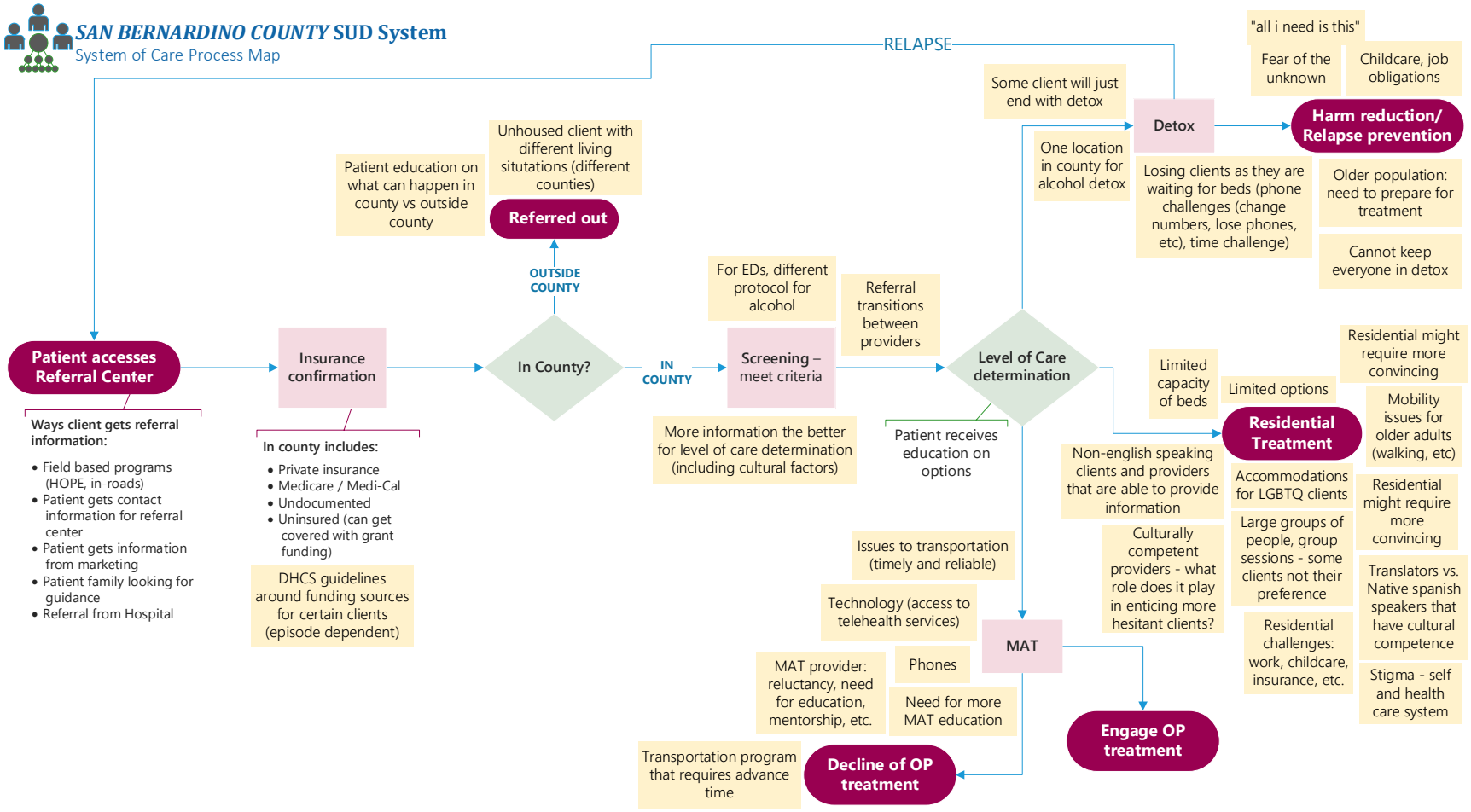
San Bernardino County Primary Care/Public Health:

On March 18, representatives from San Bernardino primary care clinics together with San Bernardino County staff gathered to map out the primary care clinic workflow. As shown in the map, the process begins with the patient entering the clinic and moves through a series of process steps (pink), decision points (green), and next steps all the way to treatment and/or referral. Barriers that exist are represented by yellow.



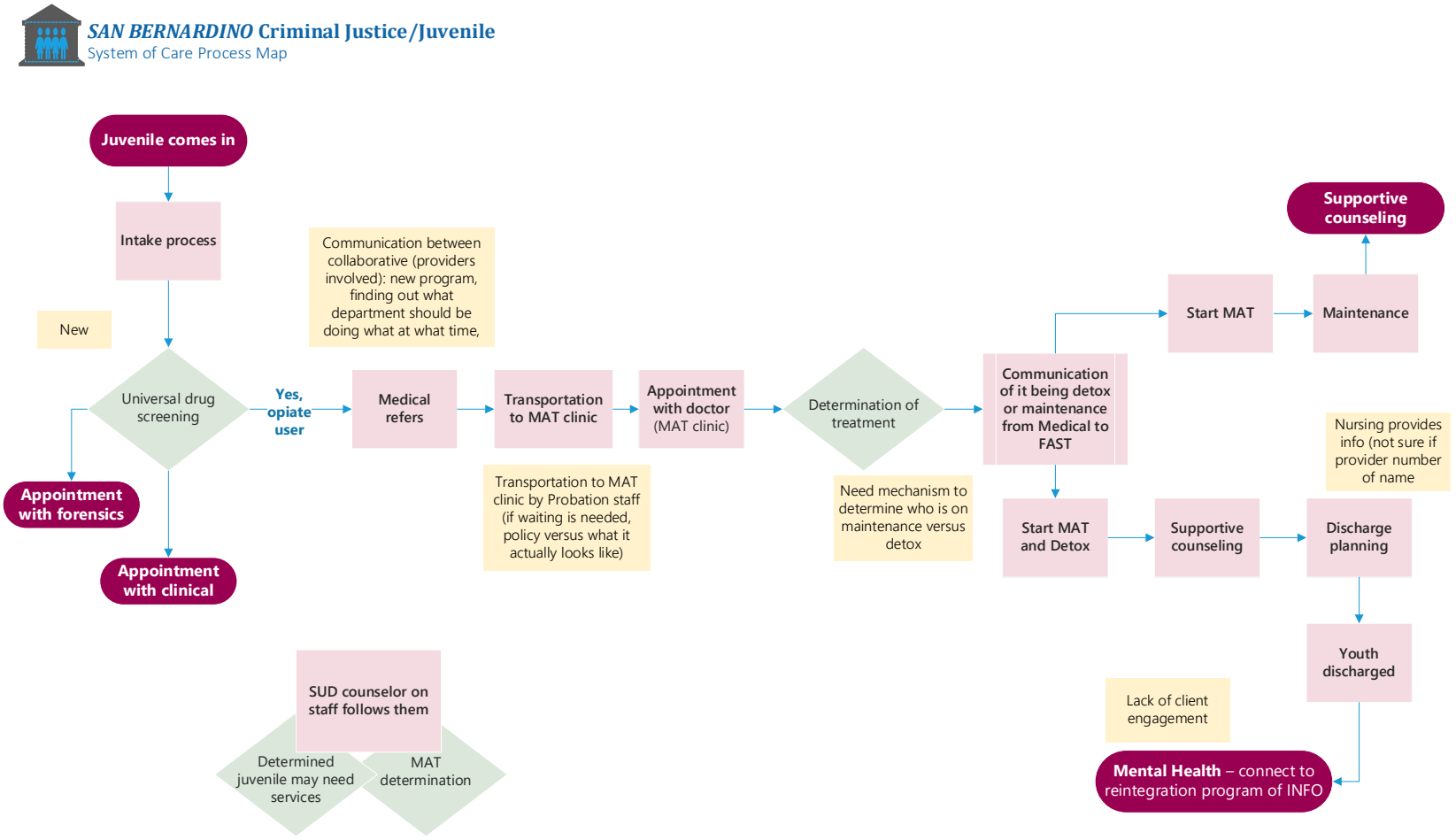
San Bernardino County SUD Treatment:

On March 31, representatives from San Bernardino SUD treatment facilities together with San Bernardino County staff gathered to map out the SUD treatment workflow. As shown in the map, the process begins with the patient entering the clinic and moves through a series of process steps (pink), decision points (green), and next steps all the way to treatment and/or referral. Barriers that exist are represented by yellow.



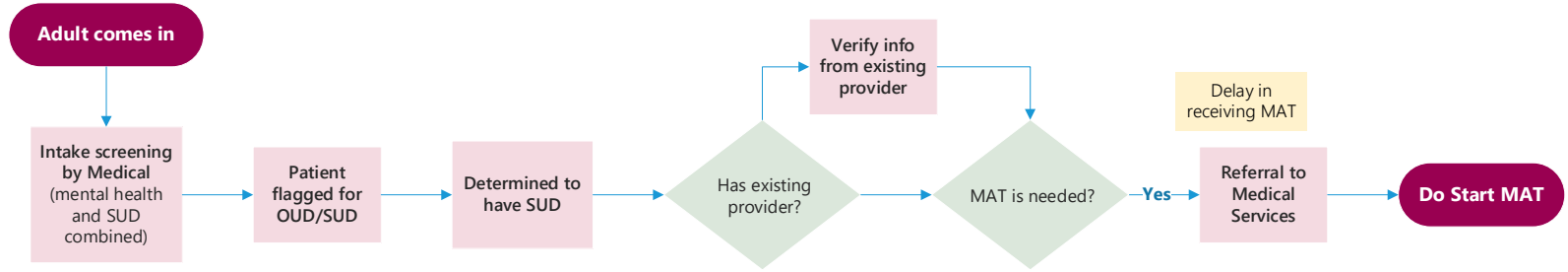
San Bernardino County Criminal Justice:

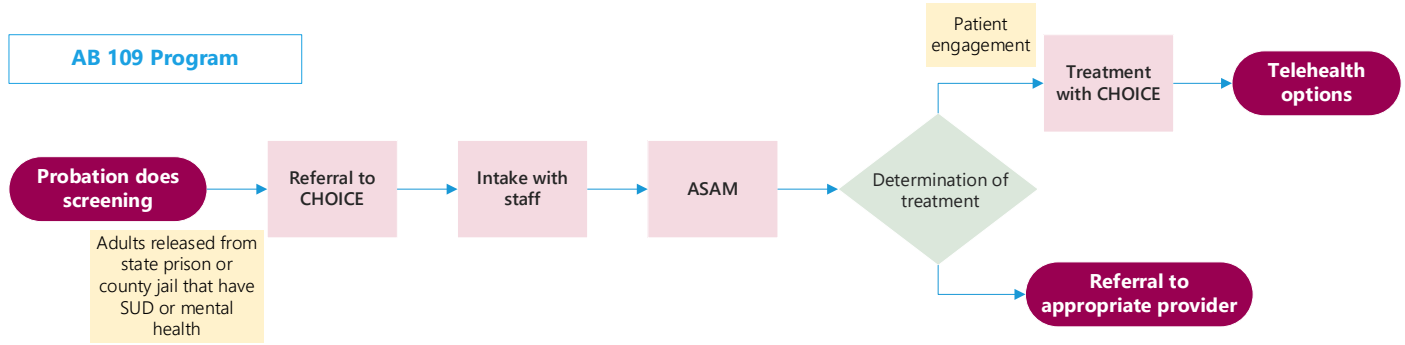
On March 30, representatives from San Bernardino criminal justice together with San Bernardino County staff gathered to map out the criminal justice workflow. As shown in the map, the process begins with the detainee entering the system and moves through a series of process steps (pink), decision points (green), and next steps all the way to discharge and referral for treatment. Barriers that exist are represented by yellow.



SAN BERNARDINO COUNTY Criminal Justice / Adult

System of Care Process Map

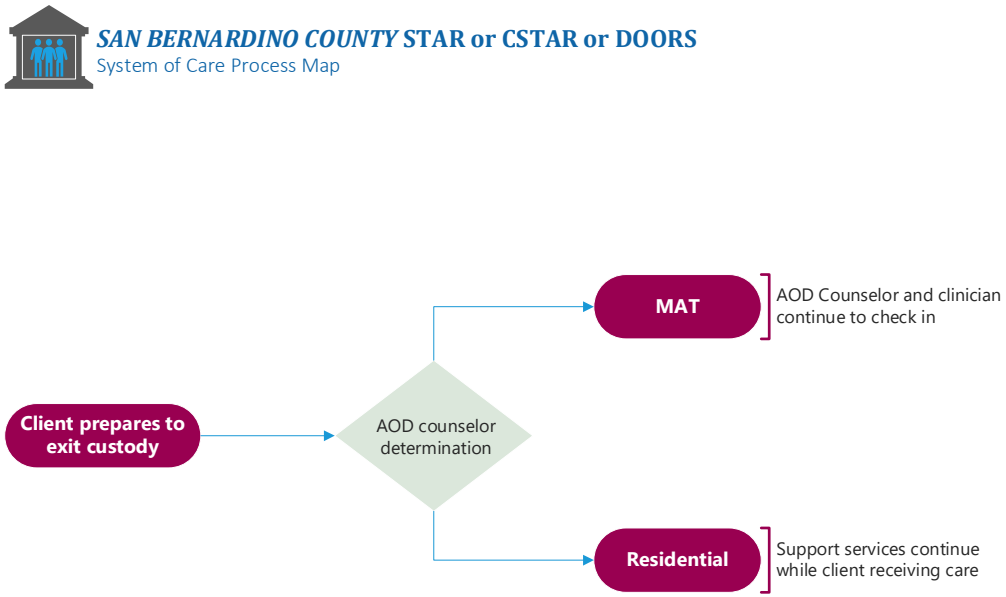




Communication and collaboration

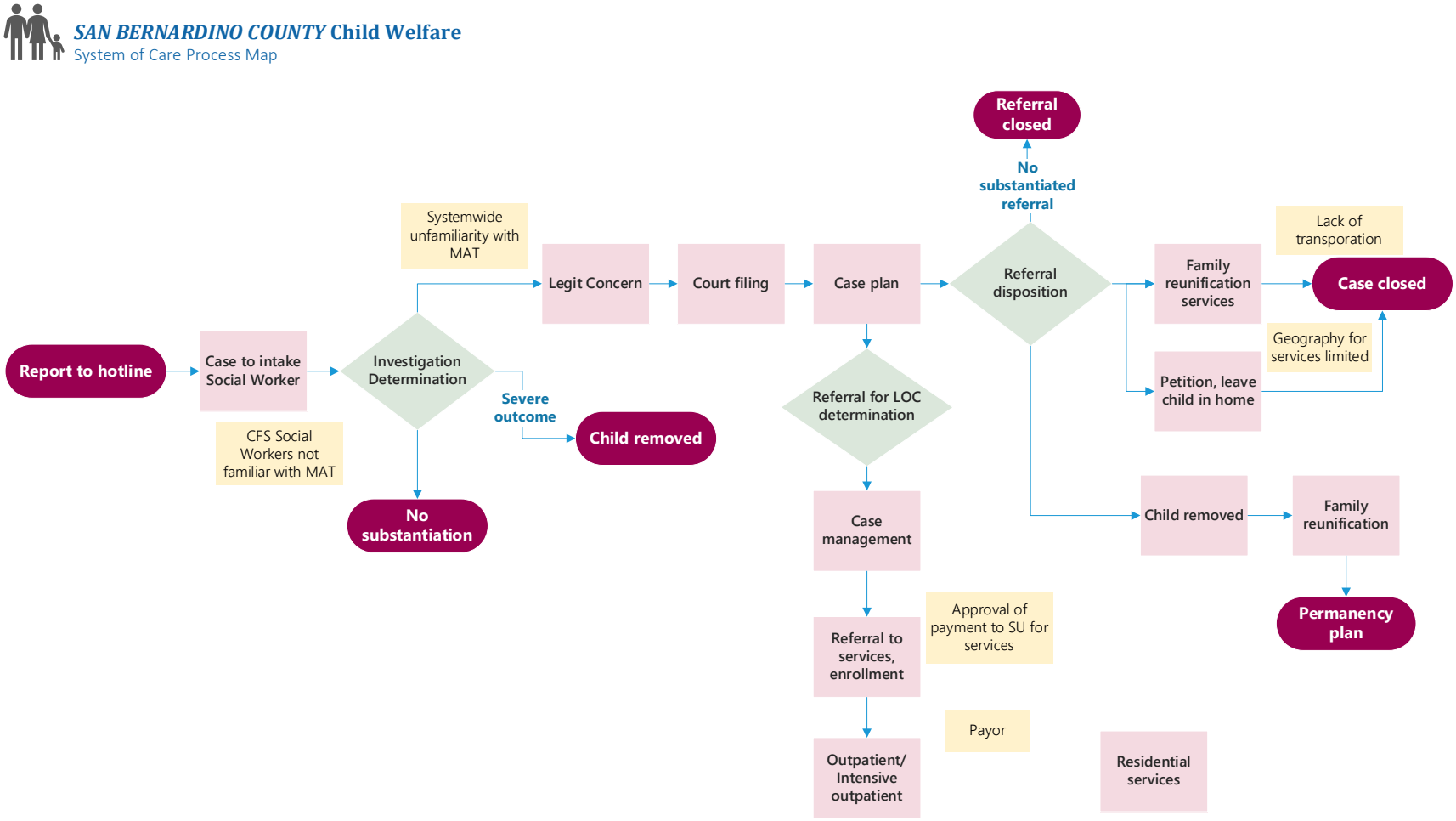
San Bernardino County STAR:

On March 30, representatives from San Bernardino STAR together with San Bernardino County staff gathered to map out the criminal justice workflow. As shown in the map, the process begins with the detainee entering the system and moves through a series of process steps (pink), decision points (green), and next steps all the way to discharge and referral for treatment. Barriers that exist are represented by yellow.



San Bernardino County Social Services:

On March 24, representatives from San Bernardino Social Services together with San Bernardino County staff gathered to map out the child welfare workflow. As shown in the map, the process begins with a parent/child SUD case entering the system and moves through a series of process steps (pink), decision points (green), and next steps all the way to closing the case. Barriers that exist are represented by yellow.



Gaps and Barriers: Inventory and Discussions

Community-wide transformation of any sort is always a complicated undertaking the requires comprehensive and multi-sector assessment and commitment. In this case, identifying the current state of what is being enhanced or transformed, in this instance, the treatment and recovery ecosystem, often begins with the powerful and important exercise of identifying the gaps and barriers in a system. This aids in clearly defining the problem(s) to be solved. While there is much good work and effort happening in San Bernardino County to address OUD/SUD, stakeholders at the PIE agreed there were many challenges, particularly around stigma, lack of understanding of MAT, coordination of transitions from jail to the community, and case management.

Group Barrier Discussion Summary

On Day 1, stakeholders participating in the PIE engaged in animated discussions in breakout groups to identify gaps and barriers in the San Bernardino County ecosystem. The following represents and comprehensive list of gaps and barriers across the 9 breakout groups.

Group 1:

- Lack of communication among partners about 1) services offered in the community and 2) how to access the resources
- Stigma on the provider and client side– utilizing MAT, how to refer to MAT providers, admitting that you have a SUD and that it's ok to access services
- A lot of moving parts for the client to access services (e.g. childcare, transportation, limited tech knowledge to access telehealth)

Group 2:

- Funding
- Transportation (especially in rural areas)
- Engagement and care coordination to levels of care, between systems, navigate payment, social support etc

Group 3:

- Connecting clients (not just making a referral, but actually making sure that the client makes it to the next level of care)
- Lack of warm handoff
- Need for adolescent treatment at ALL levels of care
- No 3.7 level of care in San Bernardino

Group 4:

- Housing for homeless population
- Not enough case managers in rural areas to provide support
- Limited number of MAT providers

Group 5:

- We need all the level of services, MH issues, getting clients into higher level of care, need psychiatrist on staff
- Lack of understanding of what MAT is; lack of acceptance due to cultural bias
    - More cultural competency education
- Lack of filled position, peer support specialists, SUD studies for certification
    - Workforce issue

Group 6:

- Acknowledgement that success is not equally accessible
- Lack of residential beds

Group 7:

- Having treatment available in a timely manner when the individual is ready for care
- Lack of understanding of what resources are available – no centralized source of truth
- Housing

Group 8:

- Lack of emphasis on prevention and early intervention
- Access to integrated whole person care
- Lack of capacity across all levels of care, including for high need high risk individuals
- Lack of no wrong door policy

Group 9:

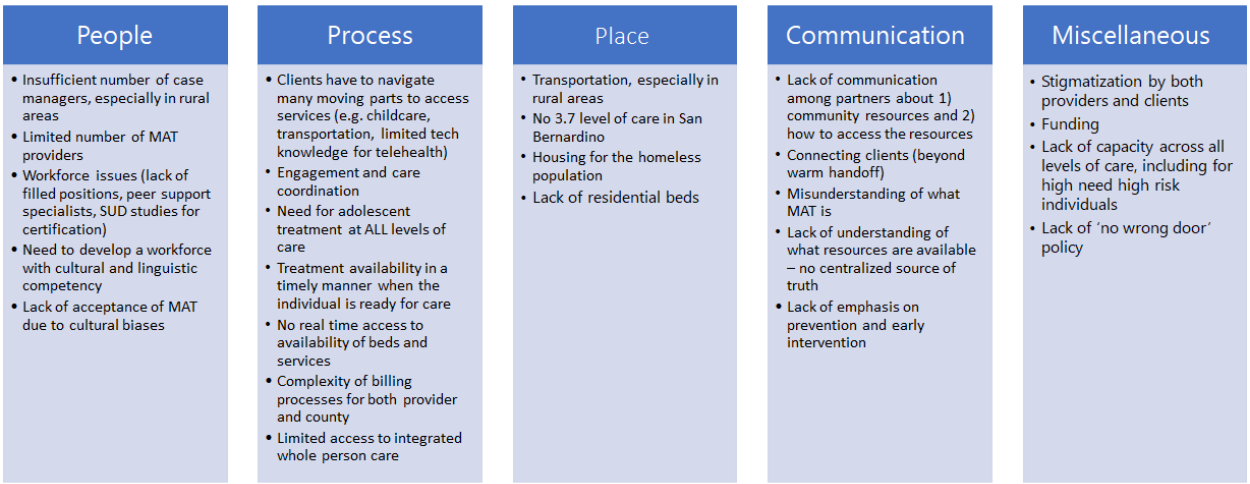
- Complexity of billing processes for both provider and county
- Workforce with cultural and linguistic competency
- Real time access to availability of beds and services

"It's important to remember that harm reduction and abstinence are not at odds of one another necessarily, recovery is a continuum and there are a variety of ways to address it on that spectrum". – A participant in Chat

---

Most Significant Gaps and Barriers

The gaps and barriers listed above were further discussed and culled into a prioritized set of gaps and barriers. That prioritization was initially done in the breakout groups as each was asked to identify the three most significant gaps/barriers in San Bernardino County. Once the breakout groups rejoined the main virtual assembly, there was a round-robin discussion to identify the top two gaps and barriers. This exercise had implications for the work to be done on Day 2 when stakeholders identified key solutions or features to address those gaps and barriers.



The most significant gaps/barriers are listed below.

- Insufficient number of case managers, especially in rural areas.
- Limited number of MAT Providers.
- Workforce issues (e.g. lack of filled positions, peer support specialists, SUD studies for certification)
- Need to develop a workforce with cultural and linguistic competency.
- Lack of acceptance of MAT due to cultural biases.
- Clients must navigate many moving parts.

- Clients must navigate many moving parts to access services (e.g. childcare, transportation, limited tech knowledge for telehealth)
- Engagement and care coordination
- Need for adolescent treatment at ALL levels of care.
- Treatment availability in a timely manner when the individual is ready for care.
- No real-time access to availability of beds and services
- Complexity of billing processes for both provider and county
- Limited access to integrated whole person care
- Transportation, especially in rural areas
- No 3.7 level of care in San Bernardino
- Housing for the homeless population
- Lack of residential beds
- Lack of communication among partners about 1) community resources and 2) how to access the resources.
- Connecting clients (beyond warm handoff)
- Misunderstanding of what MAT is
- Lack of understanding of what resources are available – no centralized source of truth.
- Lack of emphasis on prevention and early intervention
- Stigmatization by both providers and clients
- Funding
- Lack of capacity across all levels of care, including for high need high risk individuals.
- Lack of 'no wrong door' policy

Future System Features and Solutions

During Day 2, stakeholders were exposed a second time to a scaffold of a version of the ideal treatment and recovery ecosystem. Revisiting the scaffolding created a context for the important work of Day 2, which was to identify key features and solutions that can pave the way for realizing the ideal treatment and recovery ecosystem for San Bernardino County.

Group Key Features/Solutions Discussion Summary

With that scaffold in mind and after reviewing the prioritized gaps and barriers identified during Day 1, participating stakeholders were engaged a second time in random breakout groups – this time for the purpose of identifying solutions and key features to facilitate moving from their current state to an improved future state of OUD/SUD treatment. The term 'features' was defined as the characteristics, attributes or substructures of the key components of the treatment and recovery ecosystem (e.g., an example of a key feature might be to have a centralized appointment slot/bed locator for the referrals process). A comprehensive list of the solutions and key features is included below.

Most Significant Key Features/Solutions

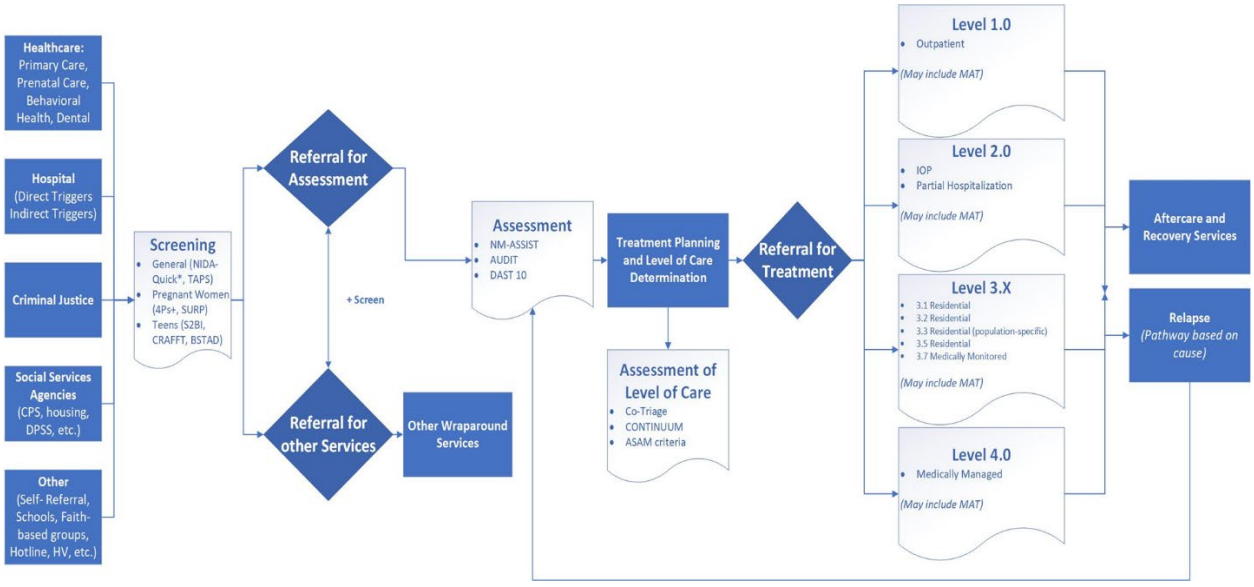
As was the case with group work on gaps and barriers, when the smaller groups rejoined the main gallery, the ensuing discussion identified a list of prioritized solutions and key features that were then arrayed on the scaffolding to make clear what aspects of the ecosystem were to be affected by the solutions.

Key features and solutions prioritized included:

- More accessible telehealth equipment
- Improved recruitment strategies
- Pharmacist stigma abatement training
- Stigma abatement training in recovery community
- County-wide ROI form and training
- Training for health care professionals for SUD treatment
- Streamline documentation for treatment and billing for SUD treatment
- Outreach and training for SUDRS
- Expand ED Bridge to all hospitals in the county
- Build training curriculum with client testimony and lived experience in mind
- Outreach and training on MAT for professionals in other fields (including sober living)
- Outreach materials (print/online/tv/radio) for SUD treatment and MAT services
- Media campaigns with an age-based approach
- Develop interdisciplinary MAT education and outreach teams
- Culturally competent training and education for MAT/SUD treatment
- Adding a 3.7 level of care facility in the county
- No wrong door approach
- Higher compensation for rural providers
- Field based or mobile MAT and SUD treatment unit

The "Scaffolding" of the Future State

After prioritizing the initial set of key features as a group, stakeholders moved into actually mapping out the process and structure of an ideal future state treatment and recovery ecosystem by posting the solutions and key features onto the scaffolding. With the understanding that there is some variation in process based on stakeholder type, Charles Robbins guided the full group through that mapping process, the final product of which is shown in the figure below.



Section 3: County-Level Goals and Implementation Strategy

County-Level Goals

Prior to the event, the planning committee developed a few sample goals based on the discussions about the current state and information gathered during stakeholder interviews. The draft sample goals were presented on a slide and the County provided context to each of them.

Sample County Goals:

County Eco-System

By *[date]*, develop a county eco-system map of all SUD treatment providers, ED Bridge, NTP/OTP, Pharmacies, MAT expansion projects, and related support services to increase and systematize information sharing and coordination across other SUD initiatives/funding steams and partners.

Provider network

- By *[date]* establish reasonable benchmarks to build MAT provider capacity to ensure network adequacy.

Data

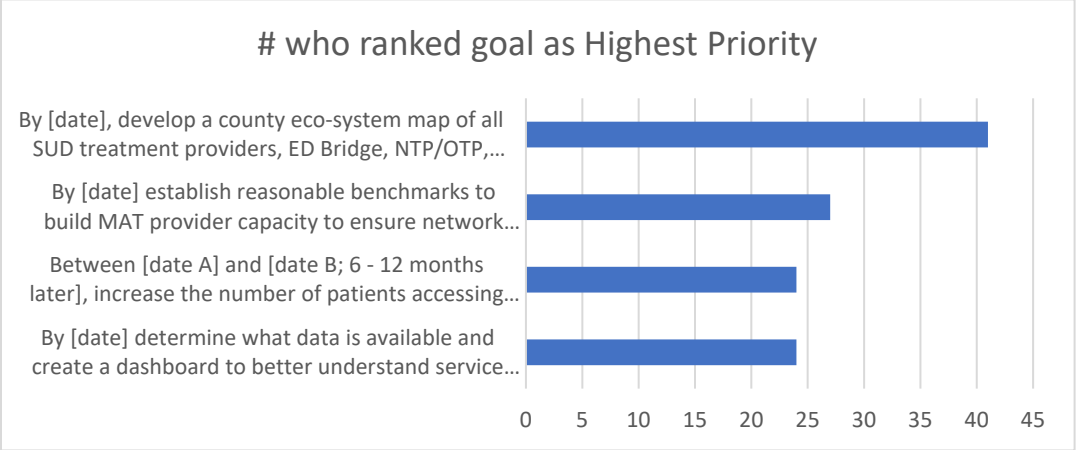
- By *[date]* determine what data is available and create a dashboard to better understand service utilization, to identify potential areas for increased focus and to establish annual benchmarks.

Access to Evidence-Based Care

- Between *[date A]* and *[date B; 6 - 12 months later],* increase the number of patients accessing MAT in county operated facilities by XX% per quarter.

After the presentation, participants were asked to answer a poll question to rank each goal.

The results were:



Implementation Strategy

In a matter of two days stakeholders from across San Bernardino County were able to identify major aspects of the systems that touch patients with addiction, determine what the major gaps and barriers

are, and develop a viable future state "scaffolding". The ideal future state treatment and recovery ecosystem in San Bernardino County would include:

- Assuring access to MAT friendly/MAT welcoming residential treatment/sober living/recovery residences – including transition support after residential
- Increased care coordination/discharge planning capacity in jail, and care coordination transition support upon re-entry from jail
- Increased awareness, education and buy-in for all community providers (all sectors) through a community wide education and anti-stigma events (including neuroscience of addiction 101)
- Universal database or "bedboard" to identify residential treatment bed capacity – streamlining handoffs and transitions
- Communication and information exchange across providers (including single b/w providers: one standardized screening tool)

Based on the feedback from the presentations, breakout discussions, chats, and polls, HMA recommends that the County Department of Behavioral Health host a quarterly "All County SUD Treatment Ecosystem" video teleconference. This reoccurring activity would provide a communication mechanism to promote transparency, provider engagement, and quality of services.

Next Steps

1. Convene a workgroup to develop the county-wide goals so that they are specific, measurable, achievable, relevant, and timely (SMART).
2. Host a quarterly "All County SUD Treatment Ecosystem" video teleconference and report on the progress of the goals.
3. Encourage participation in HMA's technical assistance and coaching program.

Technical Assistance and Coaching Program

HMA offers 12-months of free technical assistance and coaching to SUD provider organizations.

Coaching Options Include:

- Most popular: 1:1 practice coach for up to 12 months
- Streamlined TA: 1:1 practice coach for limited time period
- Quick start TA: Brief TA encounter (1-2 sessions) to address specific questions/issue

Interested organizations can complete a TA application at https://addictionfreeca.org/

- Please complete only one application per agency process
- Coordinate with your leadership and colleagues

How do we do it:

- Complete online practice assessment (link will come from your TA Coordinator)
- TA coach will be assigned; first coaching call scheduled
- On 1st call Coach will review notable assessment responses and work with you on SMART goal development

Benefits:

- Ready access to experts in the field
- Shared learning and best practices
- Accelerates your goals for SUD treatment

Conclusion

In conclusion, HMA thanks the San Bernardino County community who turned out with their hearts and minds committed to this work. We hold the deep conviction that the San Bernardino County community and stakeholder coalition of substance use disorder treatment providers, medical professionals, hospitals, law enforcement, and the community-based organization sector has what it takes to rethink one of the most complex medical conundrums in modern history. The San Bernardino County treatment and recovery ecosystem is nestled on a strong foundation with the implementation of DMC-ODS. With resources mobilizing throughout the state and within the county, the strong leadership of San Bernardino County Behavioral Health have the vision, leadership and ability to fully implement the envisioned future state pathway within the next two to three years. Together, we have the power to normalize the disease of addiction, better care for the community members suffering from this disease and eliminate overdose related deaths in the County.

Appendix

- San Bernardino County SUD Data
- Process Improvement Event Slides
- Summary of Evaluation Results
- Citations

San Bernardino County Data

2020 DATA
JULY 2019 – JULY 2020

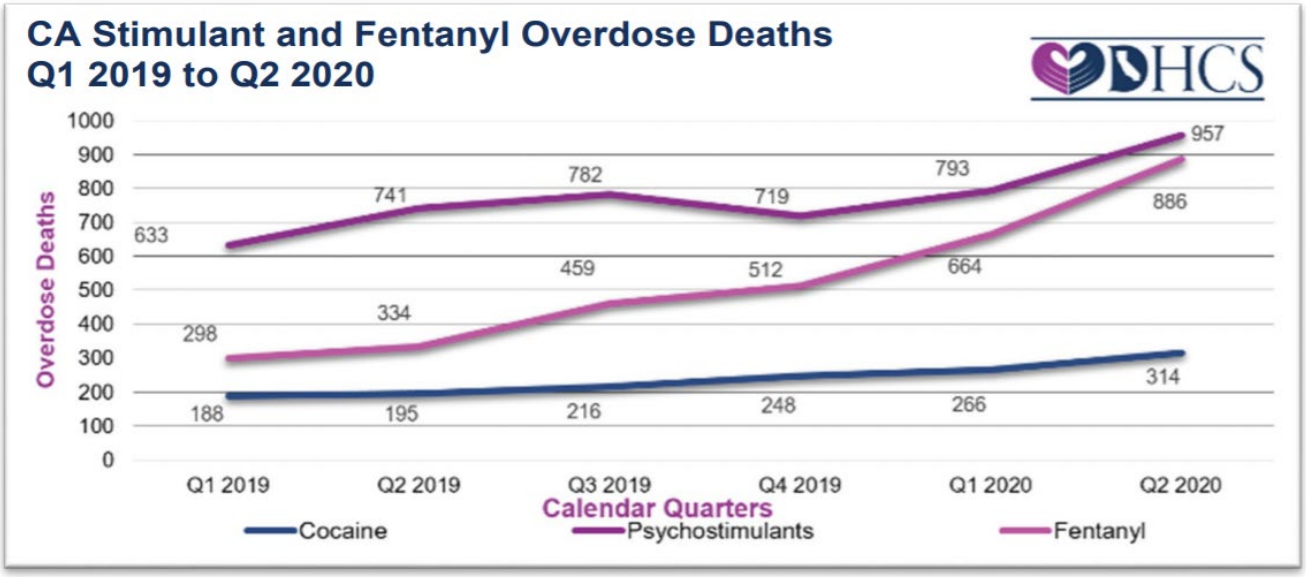
Nationally, all drug overdose deaths are predicted to increase by 24%, leading to 86,000 predicted deaths for the 12 months ending in July 2020.

National cocaine deaths increased by 30% and psychostimulant deaths excluding cocaine increased by 42%.

In California, all-drug related deaths increased by 20% to 6,954 over 12 months. Fentanyl accounted for 36% of these overdose deaths, an increase of 89% from the prior year. Psychostimulants deaths increased by 21% and cocaine by 49%.

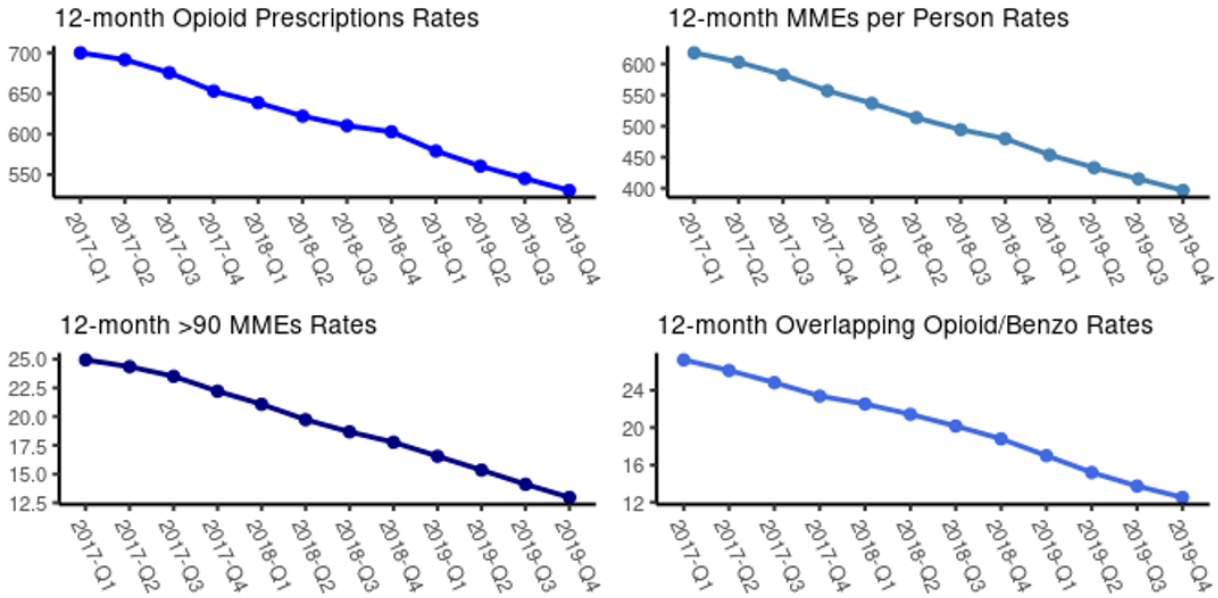
"One of the primary reasons why people are dying from overdoses is that they're using alone... they don't have people to call for help, to reverse the overdose."
- Darren Willett, Homeless Healthcare Los Angeles

"Everything fell apart all at one time. There is the financial stress, the mental stress… the social connections that are lost. And there's fentanyl everywhere."
- Tracey Helton, Harm Reduction Specialist



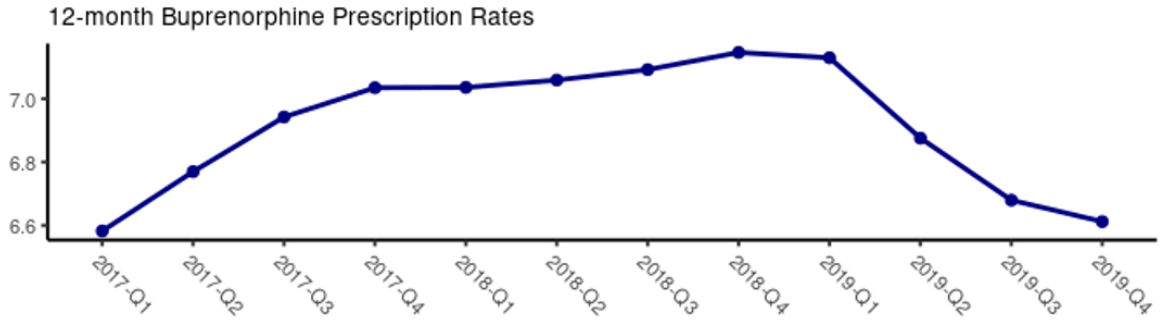
Prescribing

There were 1,156,400 prescriptions for opioids (excluding buprenorphine) in San Bernardino in 2019. The annual crude opioid prescribing rate for 2019 was 530.44 per 1,000 residents. This represents a 19% decrease in prescribing from 2017. The following charts present 12-month moving averages for crude opioid prescribing rates, the crude rate of MMEs (morphine milligram equivalents) per person, the crude high dosage rate (i.e. greater than 90 Daily MMEs in the quarter), and the crude opioid/benzodiazepine overlap crude rate from 2017 to 2019.

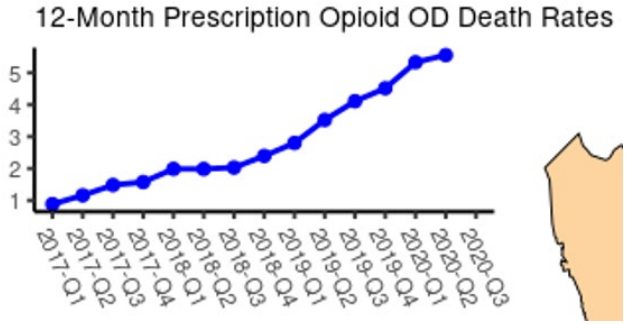


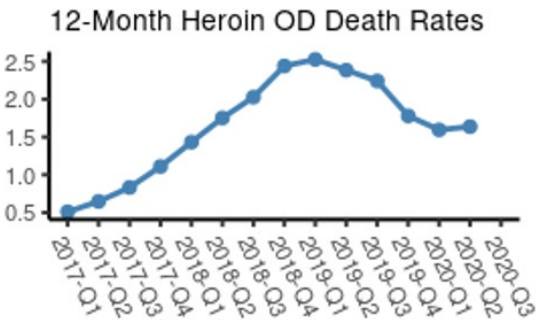
Treatment

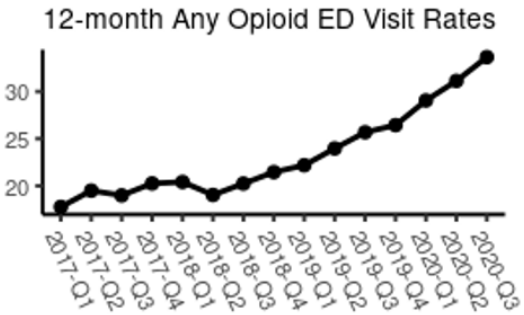
Buprenorphine prescriptions in the county are used to gauge the expansion of medication-assisted treatment (MAT). The annual crude buprenorphine prescribing rate for 2019 was 6.61 per 1,000 residents. This represents a 6% decrease in buprenorphine prescribing from 2017.

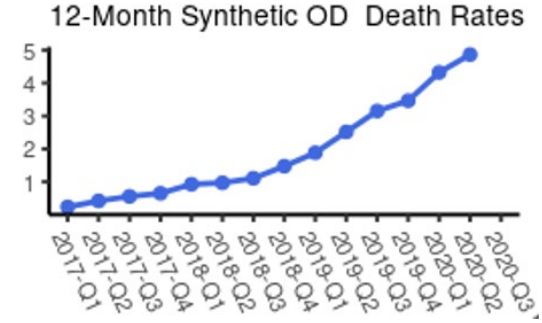


San Bernardino County Data









HEALTH MANAGEMENT ASSOCIATES

Building Sustainable Transitions of Care for People with Addictions in San Bernardino County

May 11, 2021
May 12, 2021

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

HOUSEKEEPING AND CME

- Please note we are recording our time together for internal purposes only.
- Please complete the evaluation that will be sent via email after the final session of this virtual event.
- Application for CME credit has been filed with the American Academy of Family Physicians. Determination of credit is pending
- A report of these proceedings will be produced within weeks and will include a copy of the presentation slide deck.
- Follow-up questions?
  - Contact Nayely Chavez
  - nchavez@healthmanagement.com

WELCOME

San Bernardino County Welcome

Dr. William Oglesby
Deputy Director of the Criminal Justice Substance Use Disorder and Recovery Based Services Division

SAN BERNARDINO COUNTY | Behavioral Health

*Please be sure to **mute** yourself by hovering your curser over the microphone (Mute) icon on the bottom left side of your screen and click. A red slash will appear.*

WELCOME

San Bernardino County Welcome

Chairman Curt Hagman
San Bernardino County Board of Supervisors

*Please be sure to **mute** yourself by hovering your curser over the microphone (Mute) icon on the bottom left side of your screen and click. A red slash will appear.*

WELCOME: SAN BERNARDINO COUNTY PLANNING GROUP

- Dr. Jon Avalos, Addiction Medicine Physician
- Dr. Bill Oglesby, Deputy Director, CJSUDRS
- Michael Sweitzer, PM II, SUDRS
- Jennifer Alsina, PM II, SUDRS
- Dr. Hobart Lee, LLU Family Medicine
- Dr. David Lanum, ARMC
- Dr. Edward Pillar, ARMC
- Dr. Mike Sequeira, San Bernardino County Department of Public Health
- Dr. Christopher Berger, San Bernardino County Department of Public Health
- Tina Hughes, Inland Valley Recovery Services Upland Recovery Center

SAN BERNARDINO COUNTY | Behavioral Health

*Please be sure to **mute** yourself by hovering your curser over the microphone (Mute) icon on the bottom left side of your screen and click. A red slash will appear.*

HEALTH MANAGEMENT ASSOCIATES

WELCOME

Health Management Associates Welcome

Presenter/Coach

Scott Haga, PA-C
Senior Consultant
HMA

Regional Lead

Charles Robbins, MBA
Principal
HMA

Coach

Rich VandenHeuvel, MSW
Principal
HMA

Southern California TA Coordinator

Nayely Chavez, MPH
Senior Associate
HMA

Coach

Bren Manuagh, LCSW-S
Principal
Coach for:

Optimizing Community Approaches to Challenging Populations with Opioid and/or Stimulant Use in the Justice System: Early Problem Substance Use

Expanding Access to MAT in County Criminal Justice Settings

HEALTH MANAGEMENT ASSOCIATES

SMALL BREAKOUT ROOM

HEALTH MANAGEMENT ASSOCIATES

AGENDA

DAY ONE

- **Welcome and Introduction**
- **Why Are We All Here?**
- **Addiction 101**
- **What's Working in San Bernardino County**
- **BREAK**
- **Introduction of the Future State Treatment and Recovery Ecosystem**
- **Presentation of Process Flow Maps**
- **Gaps and Barriers**
- **Getting Ready for Session 2**

DAY TWO

- Welcome
- Recap and Refocus from Day 1
- From the Front Lines – *Lived Experience*
- MAT Basics, Stigma, Regulatory Flexibility
- BREAK
- Other Important Concepts in SUD
- Revisiting the Future State Treatment and Recovery Ecosystem / Gaps and Barriers
- Key Features / Solutions
- Future State Mapping of Key Features / Solutions
- Goal Development and Next Steps

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

Healthcare in the US

Source: Photos by https://unsplash.com/@example"

OVERVIEW OF COUNTY PARTICIPANTS

- Regional distribution:
  - **Northern California**: Marin, Siskiyou, Yolo
  - **Central Valley**: Santa Cruz
  - **Southern California**: San Bernardino, Santa Barbara

NEED
- Opioid Use Disorder Death Rate (2018 and 2019)
- All Drugs Death Rate (2018 and 2019)
- Rate of ED Visits for Opioid (2018 and 2019)

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

SAN BERNARDINO COUNTY: DATA

2020 DATA
JULY 2019 – JULY 2020

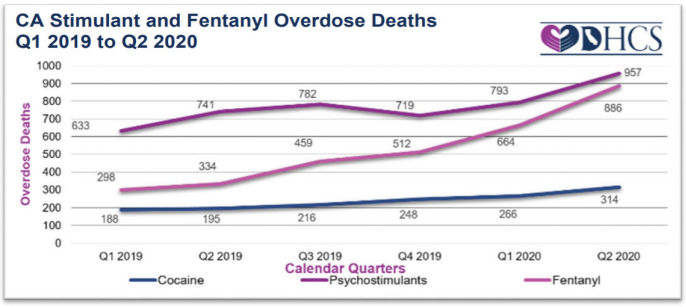
Nationally, all drug overdose deaths are predicted to increase by 24%, leading to 86,000 predicted deaths for the 12 months ending in July 2020.

National cocaine deaths increased by 30% and psychostimulant deaths excluding cocaine increased by 42%.

In California, all-drug related deaths increased by 20% to 6,954 over 12 months. Fentanyl accounted for 36% of these overdose deaths, an increase of 89% from the prior year. Psychostimulants deaths increased by 21% and cocaine by 49%.

"One of the primary reasons why people are dying from overdoses is that they're using alone... they don't have people to call for help, to reverse the overdose."
- Darren Willett, Homeless Healthcare Los Angeles

"Everything fell apart all at one time. There is the financial stress, the mental stress... the social connections that are lost. And there's fentanyl everywhere."
- Tracey Helton, Harm Reduction Specialist

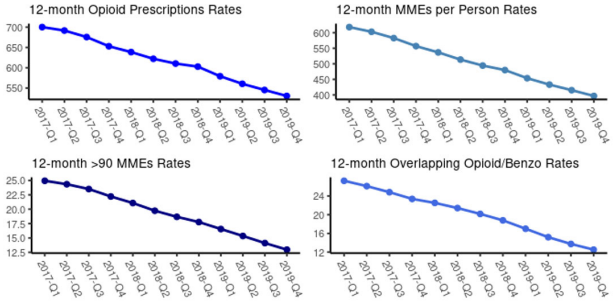


https://www.dhcs.ca.gov/services/Documents/CA-Overdose-Increases-2020.pdf

SAN BERNARDINO COUNTY: DATA

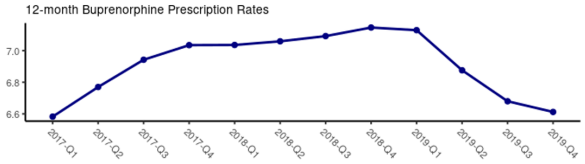
Prescribing

There were 1,156,400 prescriptions for opioids (excluding buprenorphine) in San Bernardino in 2019. The annual crude opioid prescribing rate for 2019 was 530.44 per 1,000 residents. This represents a 19% decrease in prescribing from 2017. The following charts present 12-month moving averages for crude opioid prescribing rates, the crude rate of MMEs (morphine milligram equivalents) per person, the crude high dosage rate (i.e. greater than 90 Daily MMEs in the quarter), and the crude opioid/benzodiazepine overlap crude rate from 2017 to 2019.



Treatment

Buprenorphine prescriptions in the county are used to gauge the expansion of medication-assisted treatment (MAT). The annual crude buprenorphine prescribing rate for 2019 was 6.61 per 1,000 residents. This represents a 6% decrease in buprenorphine prescribing from 2017.



https://skylab.cdph.ca.gov/ODdash/

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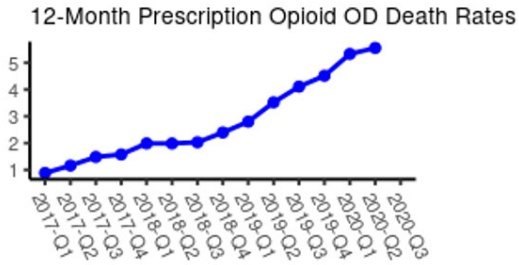
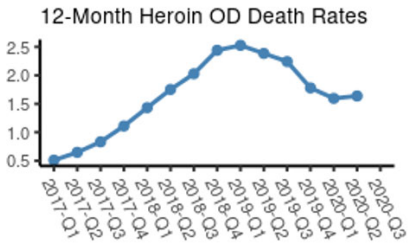
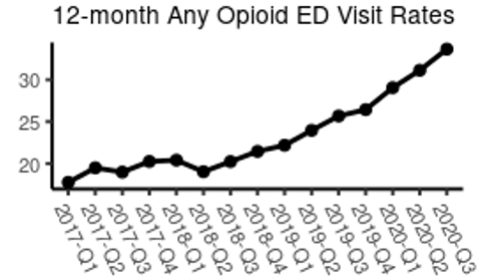
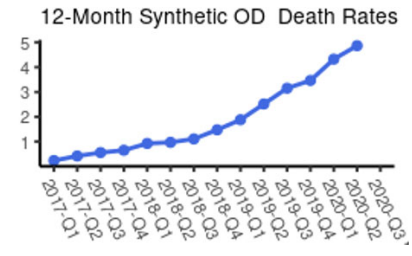
SAN BERNARDINO COUNTY: DATA









https://skylab.cdph.ca.gov/ODdash/

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SYSTEMS OF CARE: PROJECT BACKGROUND

Systems of Care

Charles Robbins – Regional Lead
Scott Haga – Coach
Rich VandenHeuvel – Coach
Nayely Chavez – TA Coordinator
Helen DuPlessis – Director of County Strategy

Expanding Access to MAT in County Criminal Justice Settings

Deb Werner

County Touchpoints

Optimizing Community Approaches to Challenging Populations with Opioid and/or Stimulant Use in the Justice System: Early Problem Substance Use

- **Champion:** Amber Carpenter, Mgr, County Dept of BH
- **TA Coach:** Bren Manaugh

SYSTEMS OF CARE PROJECT GOALS

Make treatment more accessible and equitable for people with SUD/OUD/StUD

Strengthen links and communication among all stakeholders in the ecosystem

Support all stakeholders' achievement of shared county-level SMART goals

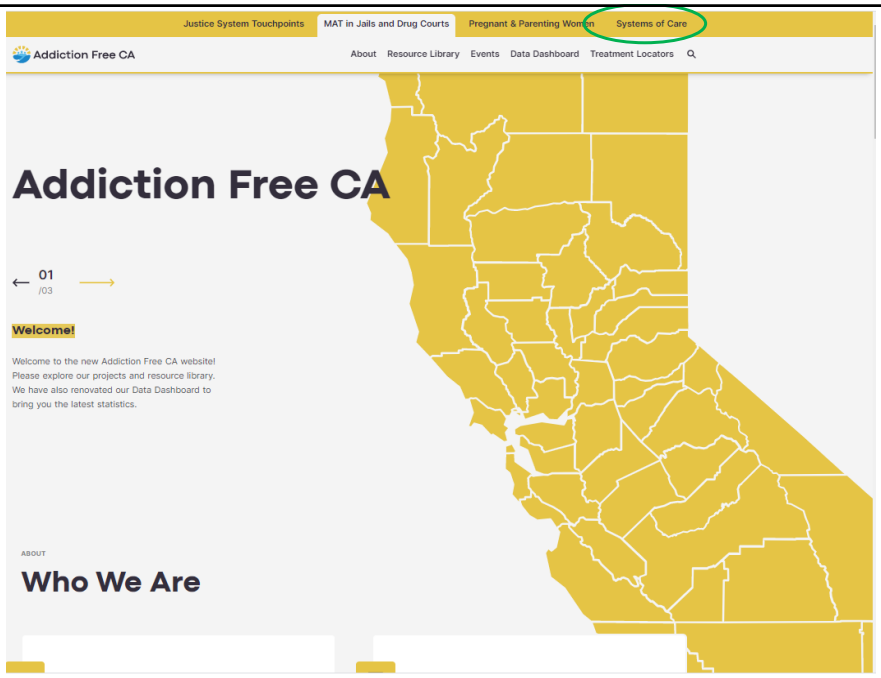
Improve the safety of transitions between levels of care

Increase the number, activity and cultural concordance of MAT prescribers in the county

SOR TECHNICAL ASSISTANCE (TA)

- The program offers TA, coaching and training.
  - Material is presented in various formats.
  - The content is created and delivered by HMA subject matter experts.
  - **Please review the attached TA overview and complete a TA Application on addictionfreeca.org under Systems of Care Program tab (1 application per agency)**
- All materials are available on the project website addictionfreeCA.org.
- Continuing educational credit is offered at no cost to attendees for many of the components.

HEALTH MANAGEMENT ASSOCIATES



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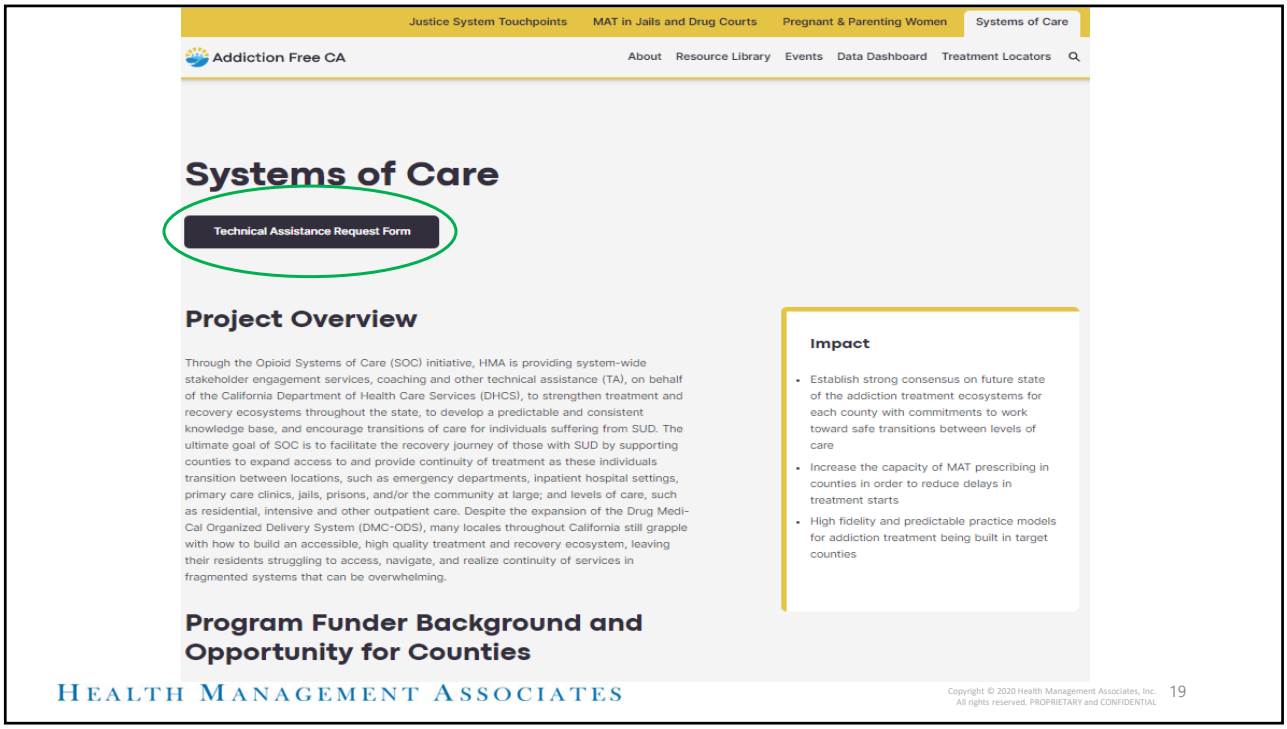
Justice System Touchpoints
MAT in Jails and Drug Courts
Pregnant & Parenting Women
Systems of Care
Addiction Free CA
About
Resource Library
Events
Data Dashboard
Treatment Locators
Systems of Care
Technical Assistance Request Form
Project Overview
Through the Opioid Systems of Care (SOC) initiative, HMA is providing system-wide stakeholder engagement services, coaching and other technical assistance (TA), on behalf of the California Department of Health Care Services (DHCS), to strengthen treatment and recovery ecosystems throughout the state, to develop a predictable and consistent knowledge base, and encourage transitions of care for individuals suffering from SUD. The ultimate goal of SOC is to facilitate the recovery journey of those with SUD by supporting counties to expand access to and provide continuity of treatment as these individuals transition between locations, such as emergency departments, inpatient hospital settings, primary care clinics, jails, prisons, and/or the community at large; and levels of care, such as residential, intensive and other outpatient care. Despite the expansion of the Drug Medi-Cal Organized Delivery System (DMC-ODS), many locales throughout California still grapple with how to build an accessible, high quality treatment and recovery ecosystem, leaving their residents struggling to access, navigate, and realize continuity of services in fragmented systems that can be overwhelming.
Impact
Establish strong consensus on future state of the addiction treatment ecosystems for each county with commitments to work toward safe transitions between levels of care
Increase the capacity of MAT prescribing in counties in order to reduce delays in treatment starts
High fidelity and predictable practice models for addiction treatment being built in target counties
Program Funder Background and Opportunity for Counties
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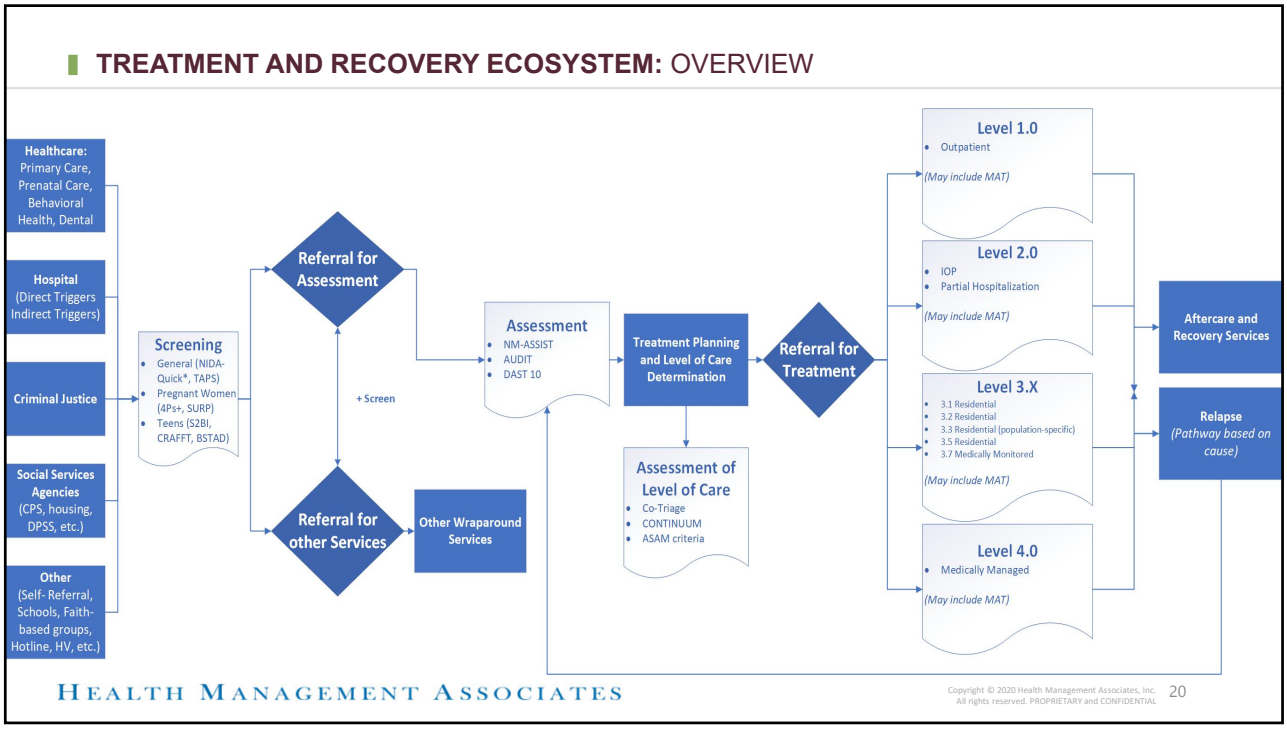
TREATMENT AND RECOVERY ECOSYSTEM: OVERVIEW
Healthcare: Primary Care, Prenatal Care, Behavioral Health, Dental
Hospital (Direct Triggers Indirect Triggers)
Criminal Justice
Social Services Agencies (CPS, housing, DPSS, etc.)
Other (Self- Referral, Schools, Faith-based groups, Hotline, HV, etc.)
Screening
General (NIDA-Quick*, TAPS)
Pregnant Women (4Ps+, SURP)
Teens (S2BI, CRAFFT, BSTAD)
Referral for Assessment
+ Screen
Referral for other Services
Other Wraparound Services
Assessment
NM-ASSIST
AUDIT
DAST 10
Treatment Planning and Level of Care Determination
Assessment of Level of Care
Co-Triage
CONTINUUM
ASAM criteria
Referral for Treatment
Level 1.0
Outpatient
(May include MAT)
Level 2.0
IOP
Partial Hospitalization
(May include MAT)
Level 3.X
3.1 Residential
3.2 Residential
3.3 Residential (population-specific)
3.5 Residential
3.7 Medically Monitored
(May include MAT)
Level 4.0
Medically Managed
(May include MAT)
Aftercare and Recovery Services
Relapse (Pathway based on cause)
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MESSAGES FOR
THE SYSTEMS OF CARE OPIOID USE DISORDER & SUBSTANCE USE DISORDER INITIATIVE

- Screening and Brief Assessment for OUD/SUD should be available at any health and social service point of entry
- Planning transitions between levels of care optimizes the recovery journey
- Everyone with OUD should be offered MAT
- Acknowledging disparities and cultural needs and offering low barrier treatment increases treatment initiation and retention
- Stigma reduction and motivational interviewing improve engagement of clients with OUD/SUD

ADDICTION 101: NEUROBIOLOGY OF ADDICTION

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ADDICTION 101: THE PROBLEM

What is Addiction?

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

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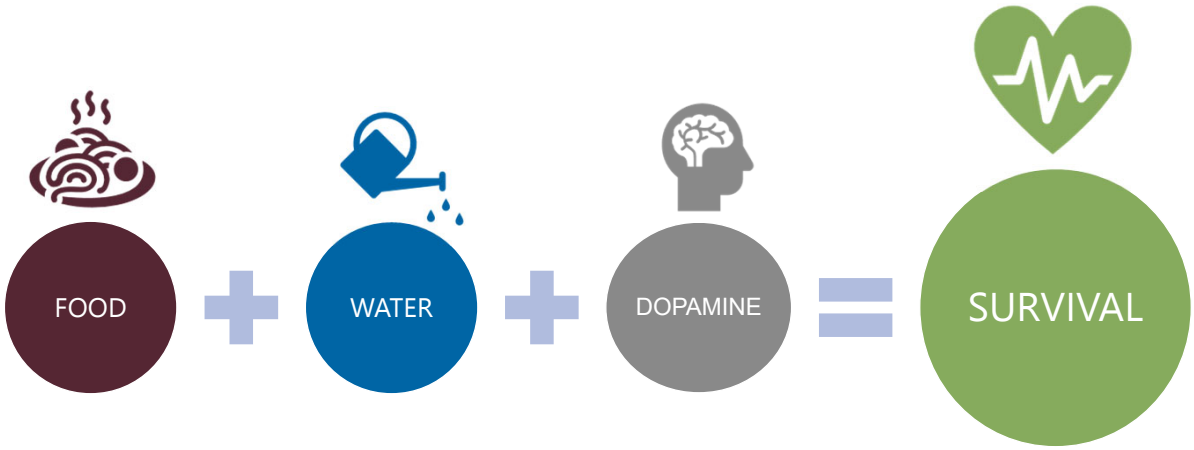
ADDICTION 101



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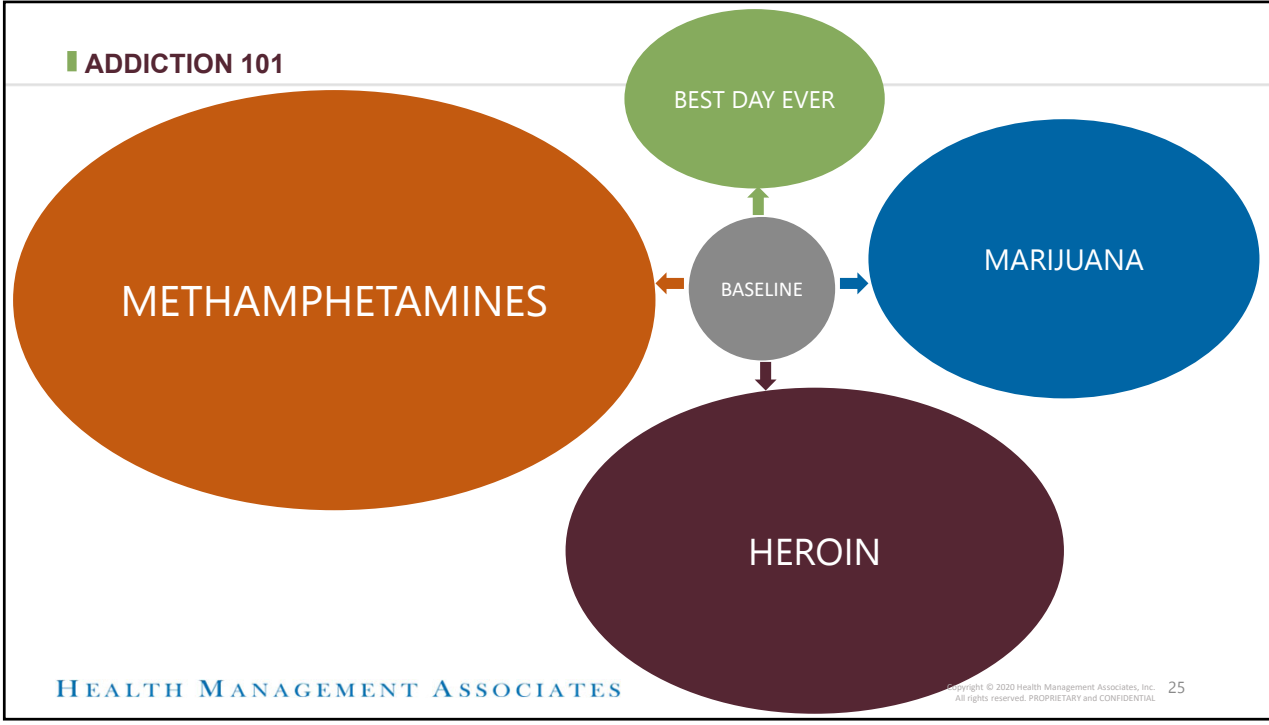
ADDICTION 101



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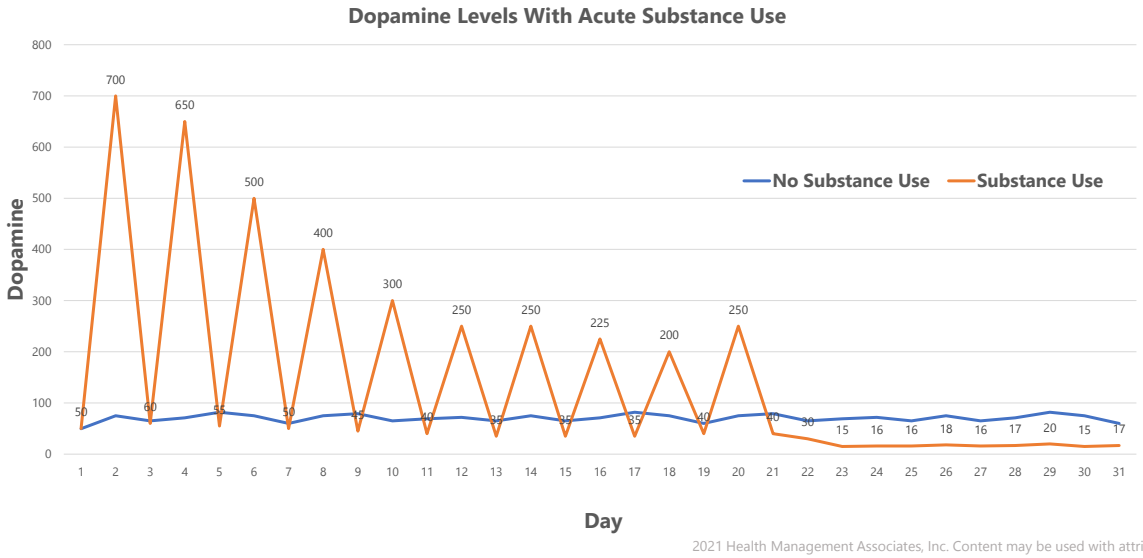
RELATIVE DOPAMINE LEVELS IN THE BRAIN



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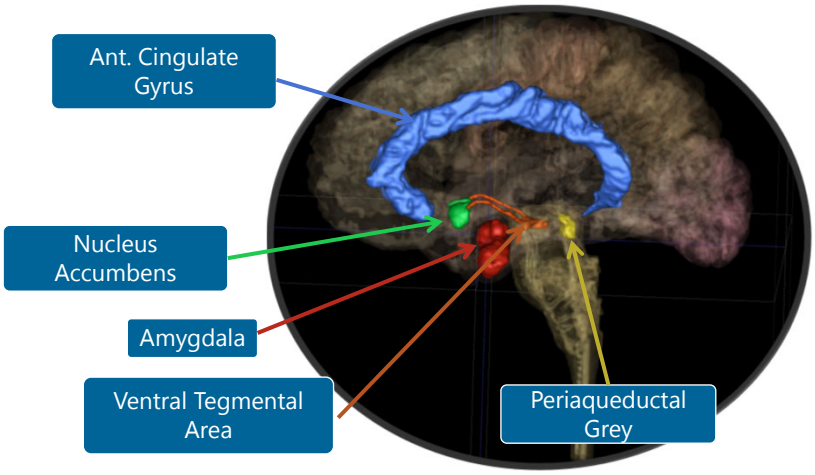
ADDICTION 101: NEUROBIOLOGY OF ADDICTION

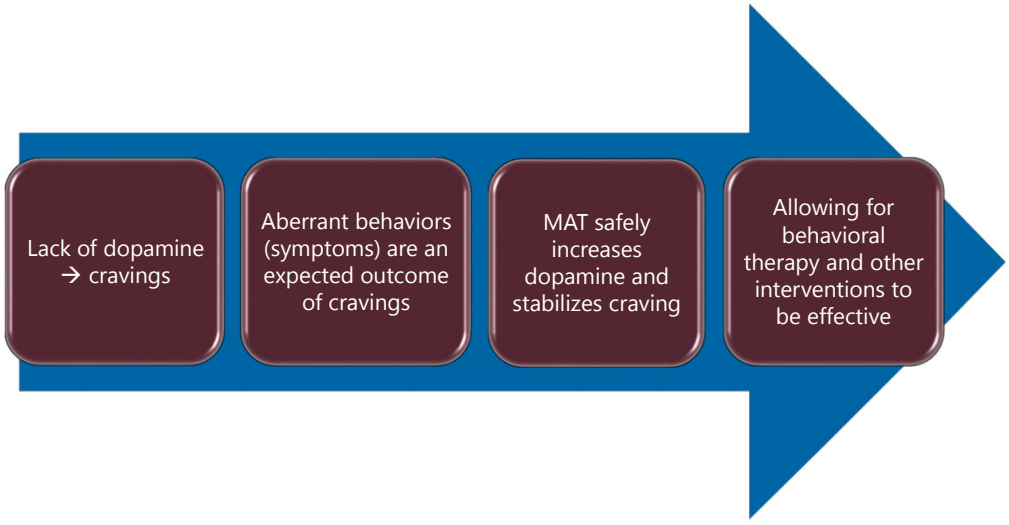


DSM-5: DIAGNOSIS OF OUD

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

ADDICTION 101: TREATMENTS



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WHAT'S WORKING IN SAN BERNARDINO COUNTY?

HEALTH MANAGEMENT ASSOCIATES

WHAT'S WORKING IN SAN BERNARDINO COUNTY: PANEL

- **Eric Alvarez,** Substance Use Navigator, ARMC
- **Jeanine Lozano,** Community Member
- **Crystal Horn,** Director of Marketing and
- Fund development, Inland Valley Recovery Services
- **Dr. Jonathan Avalos,** Addiction Medicine Physician
- **Dr. Edward Pillar,** ARMC

BREAK

INTRODUCTION TO THE FUTURE STATE TREATMENT AND RECOVERY ECOSYSTEM

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ADDICTION TREATMENT ECOSYSTEM: IMPLEMENTATION

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

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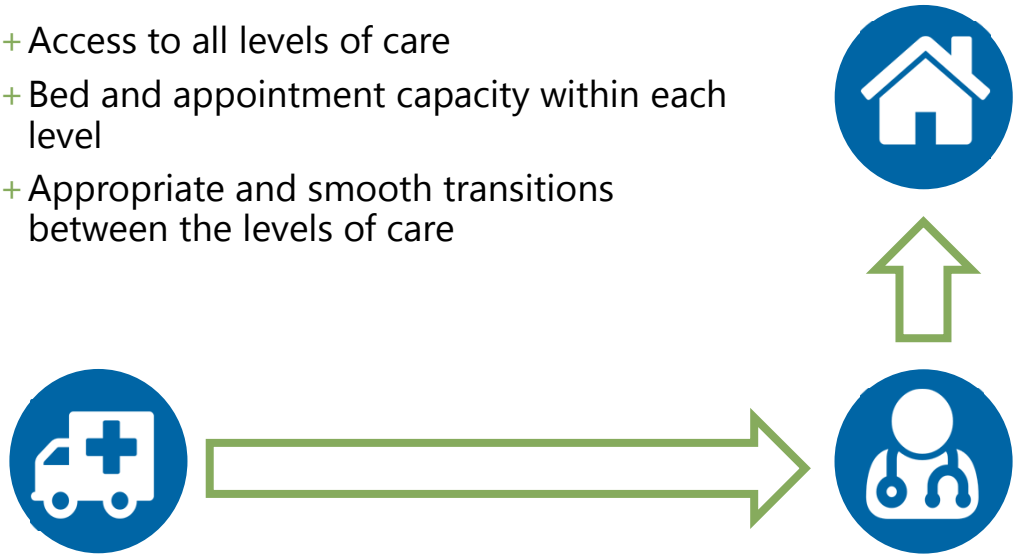
ADDICTION TREATMENT ECOSYSTEM: CAPACITY

- 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 TREATMENT ECOSYSTEM: COMPETENCY

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

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ADDICTION TREATMENT ECOSYSTEM: CONSISTENCY

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

ADDICTION TREATMENT ECOSYSTEM: COMPENSATION

- Payment parity for all clinicians
- CPT codes for bundled approaches
- Standard reporting to payers
- EMR expansion into addiction

ADDICTION TREAMENT ECOSYSTEM: COMMUNITY

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

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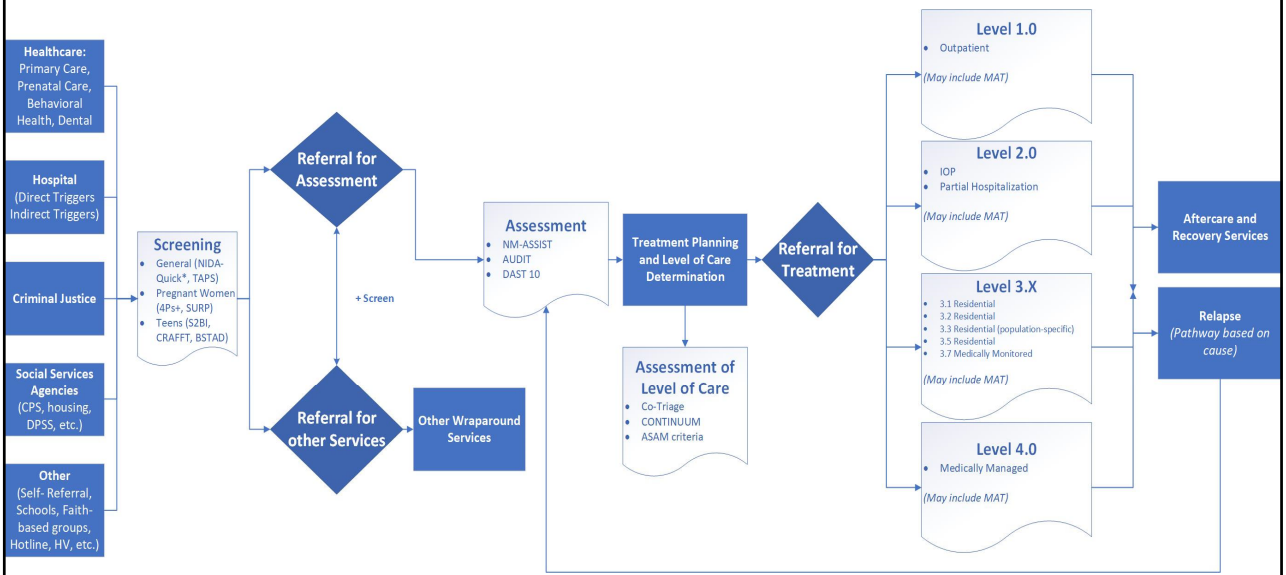
TREAMENT AND RECOVERY ECOSYSTEM: OVERVIEW



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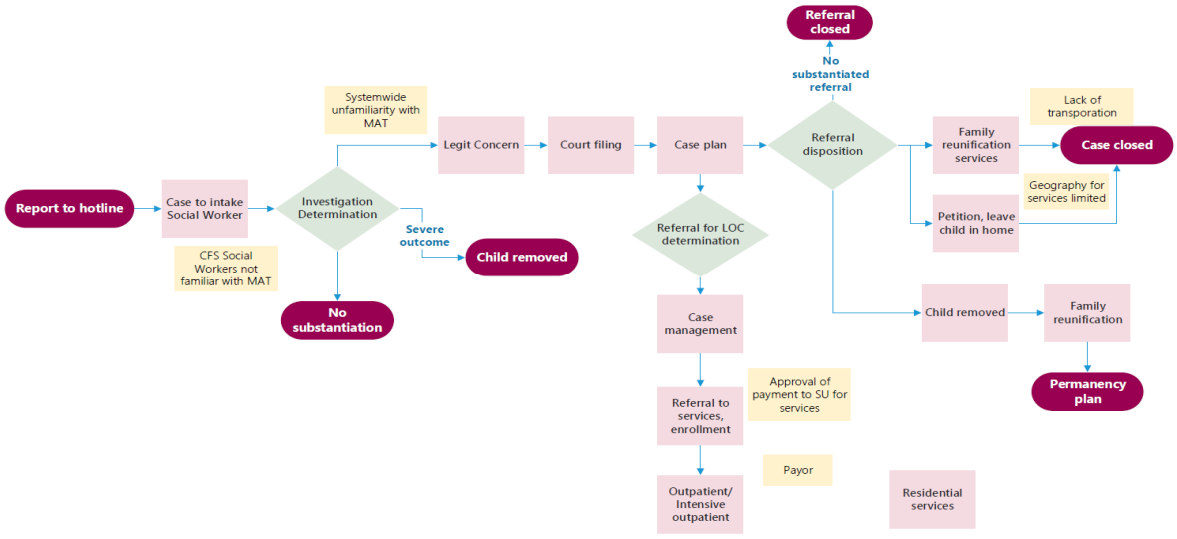
PROCESS FLOW MAPPING FROM AGENCIES IN SAN BERNARDINO COUNTY

8 MIN EACH

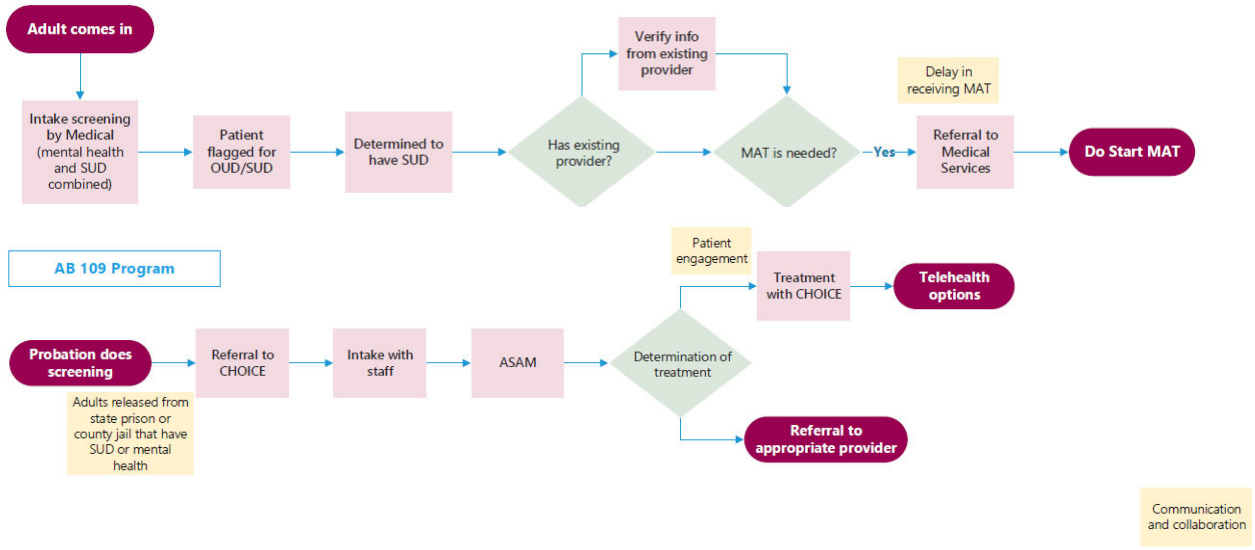
PROCESS MAP: SAN BERNARDINO COUNTY CHILD WELFARE

Presenter: Janette Herrera



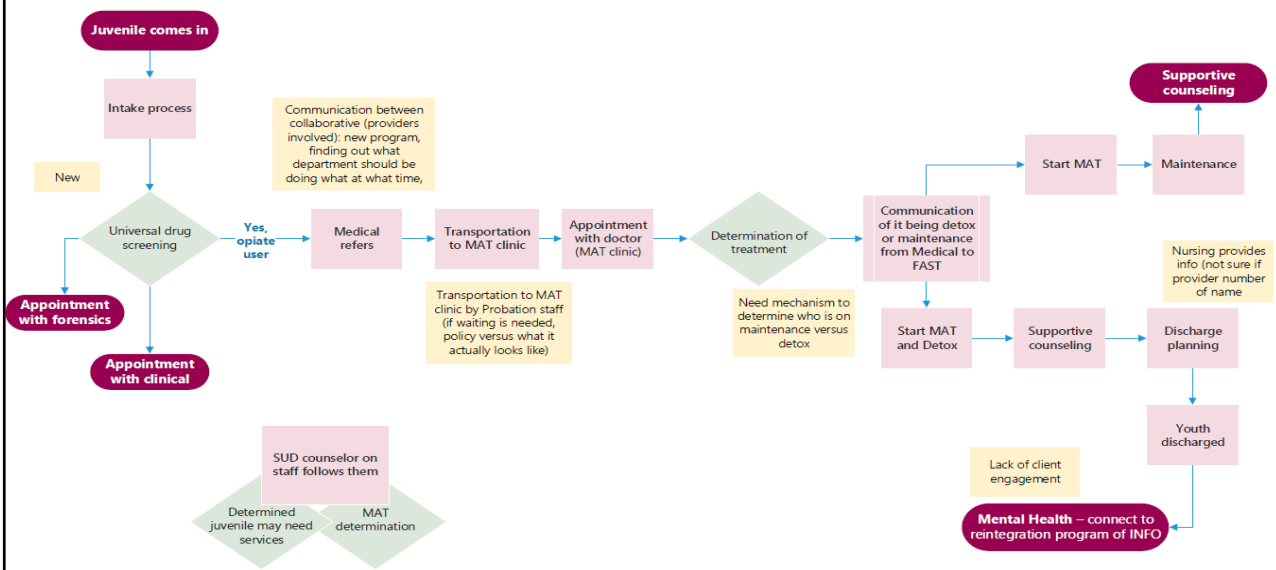
PROCESS MAP: SAN BERNARDINO COUNTY CRIMINAL JUSTICE ADULT

Presenter: Valerie Dunn



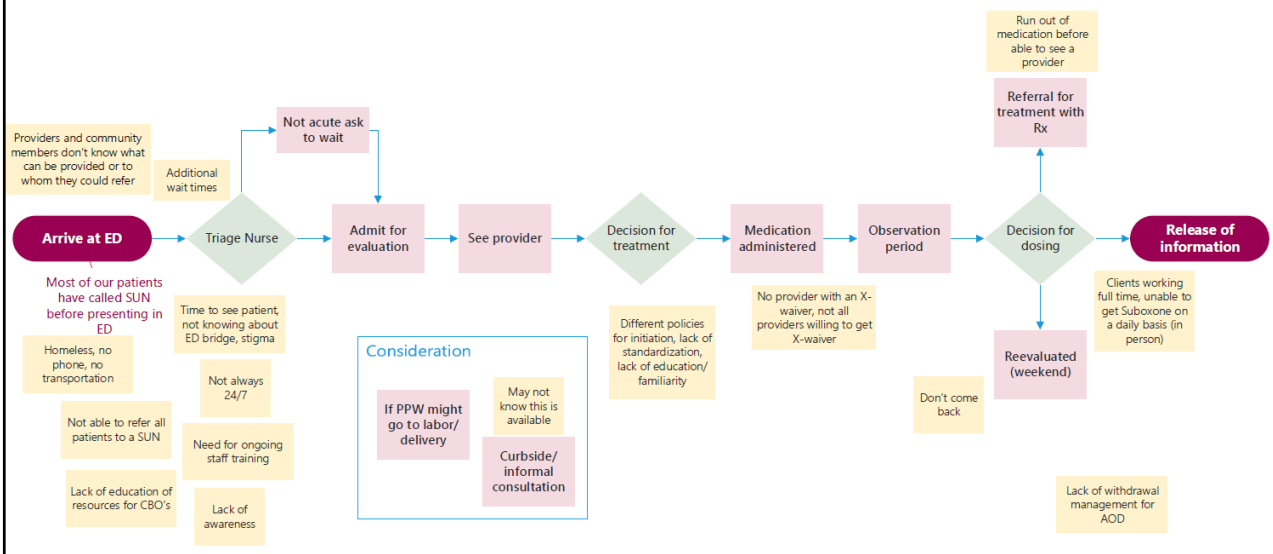
PROCESS MAP: SAN BERNARDINO COUNTY CRIMINAL JUSTICE JUVENILE

Presenter: Amber Carpenter



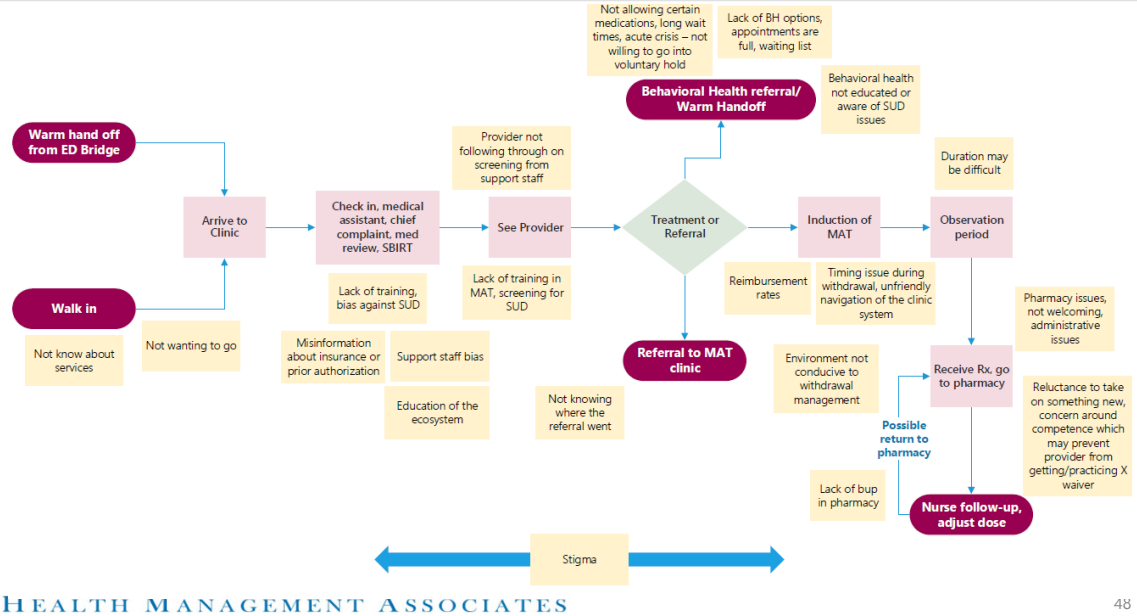
PROCESS MAP: SAN BERNARDINO COUNTY HOSPITALS

Presenter: Dr. Hobart Lee



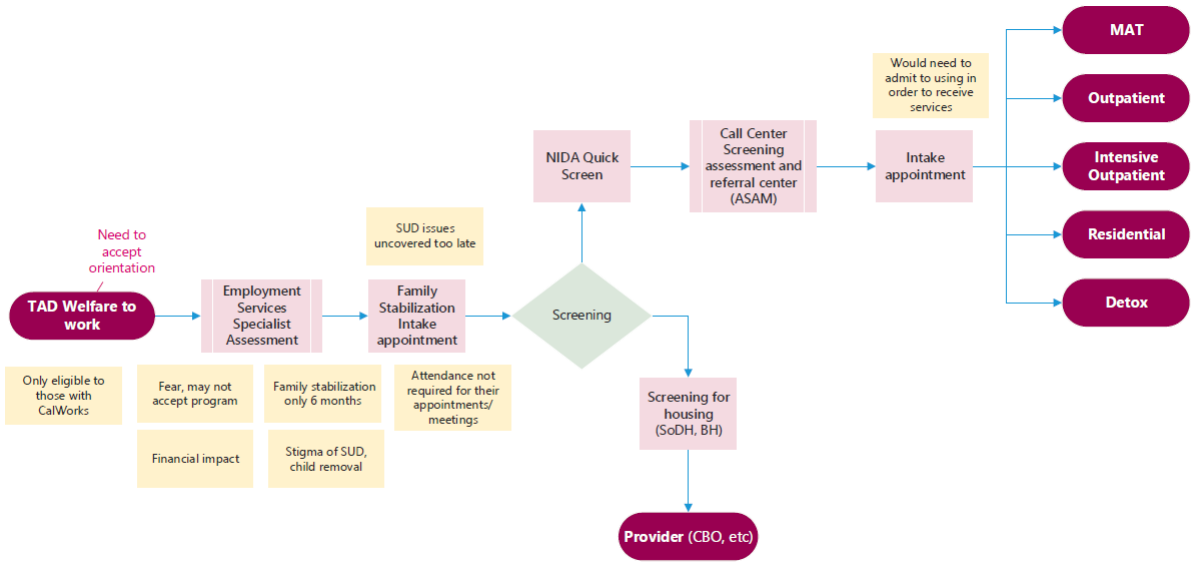
PROCESS MAP: SAN BERNARDINO COUNTY PRIMARY CARE

Presenter: Dr. Avalos



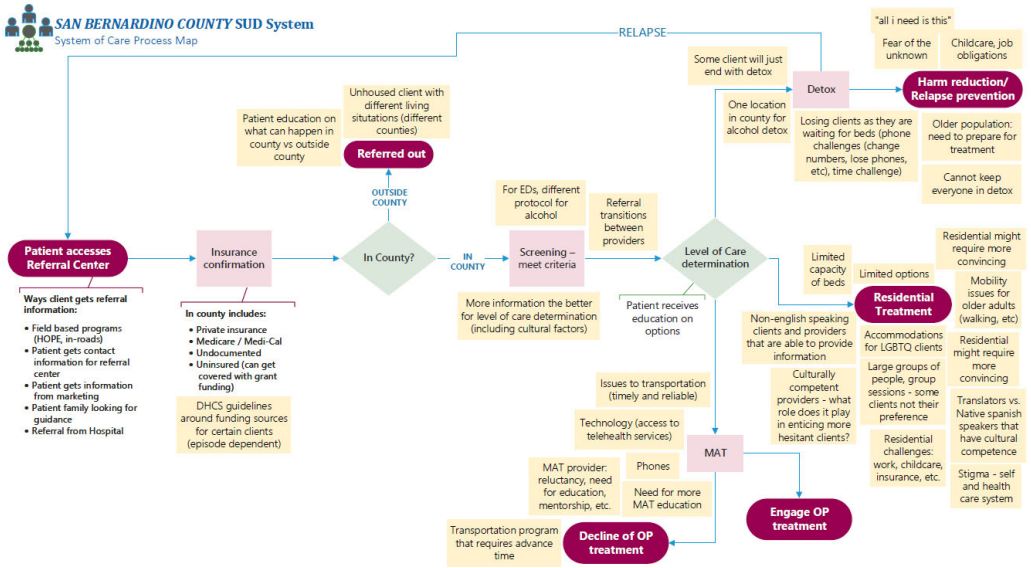
PROCESS MAP: SAN BERNARDINO COUNTY TRANSITIONAL ASSISTANCE

Presenter: Charisse Jones-Bruny



PROCESS MAP: SAN BERNARDINO COUNTY SUD TREATMENT

Presenter: Crystal Horn



WHAT ARE THE BARRIERS AND GAPS IN YOUR CURRENT SYSTEM?

CRITERIA TO CONSIDER WHEN IDENTIFYING GAPS AND BARRIERS

Implementation and County Goals	• Supports one or more of the County Goals • Within control of the team • Extent of resolution of problem (e.g., addresses root causes, gaps/barriers) • Ease of implementation (i.e., "low hanging fruit")
Acceptance and Buy-in	• Team interest or buy-in • Leadership or Management interest and support
Impact	• Influences a significant portion of the population with SUD/OUD • Potential effects on other systems • Urgency of problem
Cost	• Resources required to implement (e.g., people, money, time) • Return on investment expected (e.g., improved outcomes, less resources required) • Resources/cost to maintain (e.g., money and time)

GAPS AND BARRIERS
REFLECTION

GAPS AND BARRIERS: REFLECTION (5 MINUTES)

- Thinking about your county and the criteria for identifying gaps and barriers (Ease of implementation and concordance with county goals; Acceptance and buy-in; Significance of impact; Cost):
  - Think about the significant gaps and barriers applicable to your treatment and recovery ecosystem
  - Jot those down on scratch paper
  - Share those in the upcoming breakout session

GAPS AND BARRIERS
BREAKOUT

GAPS AND BARRIERS
REPORT OUT

REPORT OUT

HEALTH MANAGEMENT ASSOCIATES

GETTING READY FOR SESSION #2

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AGENDA

DAY ONE

- Welcome and Introduction
- Why Are We All Here
- Addiction 101
- What's Working in San Bernardino County
- BREAK
- Introduction of the Future State Treatment and Recovery Ecosystem
- Gaps and Barriers
- Getting Ready for Session 2

DAY TWO

- **Welcome**
- **Recap and Refocus from Day 1**
- **From the Front Lines**
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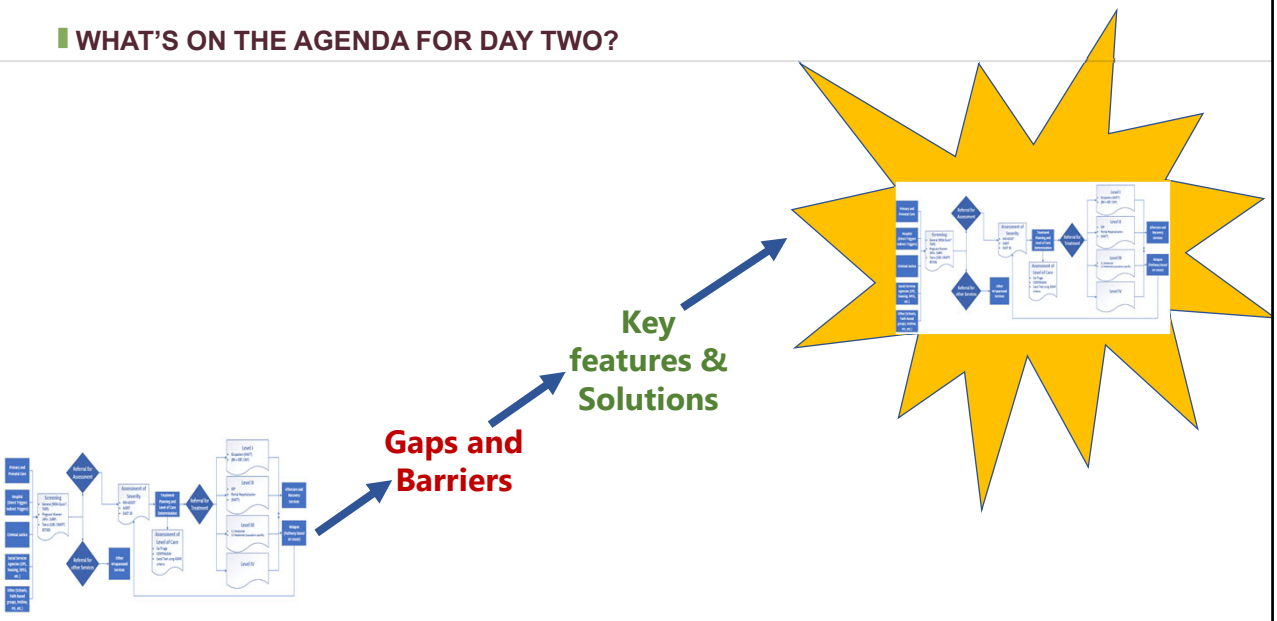
WHAT'S ON THE AGENDA FOR DAY TWO?



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THANK YOU!

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Building Sustainable Transitions of Care for People with Addictions in Santa Barbara County

May 11, 2021

May 12, 2021

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

HOUSEKEEPING AND CME

- Please note we are recording our time together for internal purposes only.
- Please complete the evaluation that will be sent via email after the final session of this virtual event.
- Application for CME credit has been filed with the American Academy of Family Physicians. Determination of credit is pending
- A report of these proceedings will be produced within weeks and will include a copy of the presentation slide deck.
- Follow-up questions?
  - Contact Nayely Chavez
  - nchavez@healthmanagement.com

WELCOME

San Bernardino County Welcome

Dr. William Oglesby
Deputy Director of the Criminal Justice Substance Use Disorder and Recovery Based Services Division

SAN BERNARDINO COUNTY | Behavioral Health

*Please be sure to **mute** yourself by hovering your curser over the microphone (Mute) icon on the bottom left side of your screen and click. A red slash will appear.*

HEALTH MANAGEMENT ASSOCIATES

WELCOME

Health Management Associates Welcome

Presenter/Coach

Scott Haga, PA-C
Senior Consultant
HMA

Regional Lead

Charles Robbins, MBA
Principal
HMA

Coach

Rich VandenHeuvel, MSW
Principal
HMA

Southern California TA Coordinator

Nayely Chavez, MPH
Senior Associate
HMA

Coach

Bren Manuagh, LCSW-S
Principal
Coach for:

Optimizing Community Approaches to Challenging Populations with Opioid and/or Stimulant Use in the Justice System: Early Problem Substance Use

Expanding Access to MAT in County Criminal Justice Settings

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WELCOME: SAN BERNARDINO COUNTY PLANNING GROUP

- Dr. Jon Avalos, Addiction Medicine Physician
- Dr. Bill Oglesby, Deputy Director, CJSUDRS
- Michael Sweitzer, PM II, SUDRS
- Jennifer Alsina, PM II, SUDRS
- Dr. Hobart Lee, LLU Family Medicine
- Dr. David Lanum, ARMC
- Dr. Edward Pillar, ARMC
- Dr. Mike Sequeira, San Bernardino County Department of Public Health
- Dr. Christopher Berger, San Bernardino County Department of Public Health
- Tina Hughes, Inland Valley Recovery Services Upland Recovery Center

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AGENDA

DAY ONE

+ Welcome and Introduction
+ Why Are We All Here
+ Addiction 101
+ What's Working in San Bernardino County
+ BREAK
+ Introduction of the Future State Treatment and Recovery Ecosystem
+ Presentation of Process Flow Maps
+ Gaps and Barriers
+ Getting Ready for Session 2

DAY TWO

+ **Welcome**
+ **Recap and Refocus from Day 1**
+ **From the Front Lines**
+ **MAT Basics, Stigma, Regulatory Flexibility**
+ **BREAK**
+ **Other Important Concepts in SUD**
+ **Revisiting the Future State Treatment and Recovery Ecosystem / Gaps and Barriers**
+ **Key Features / Solutions**
+ **Future State Mapping of Key Features / Solutions**
+ **Goal Development and Next Steps**

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RECAP AND REFOCUS FOR DAY 2

RECAP FROM DAY 1

- Why we're all here
- What's working in San Bernardino County
- Gaps and Barriers

RECAP FROM DAY 1: GAPS AND BARRIERS

People	Process	Place	Communication	Miscellaneous
• Insufficient number of case managers, especially in rural areas • Limited number of MAT providers • Workforce issues (lack of filled positions, peer support specialists, SUD studies for certification) • Need to develop a workforce with cultural and linguistic competency • Lack of acceptance of MAT due to cultural biases	• Clients have to navigate many moving parts to access services (e.g. childcare, transportation, limited tech knowledge for telehealth) • Engagement and care coordination • Need for adolescent treatment at ALL levels of care • Treatment availability in a timely manner when the individual is ready for care • No real time access to availability of beds and services • Complexity of billing processes for both provider and county • Limited access to integrated whole person care	• Transportation, especially in rural areas • No 3.7 level of care in San Bernardino • Housing for the homeless population • Lack of residential beds	• Lack of communication among partners about 1) community resources and 2) how to access the resources • Connecting clients (beyond warm handoff) • Misunderstanding of what MAT is • Lack of understanding of what resources are available – no centralized source of truth • Lack of emphasis on prevention and early intervention	• Stigmatization by both providers and clients • Funding • Lack of capacity across all levels of care, including for high need high risk individuals • Lack of 'no wrong door' policy

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FROM THE FRONT LINES

Lived experience

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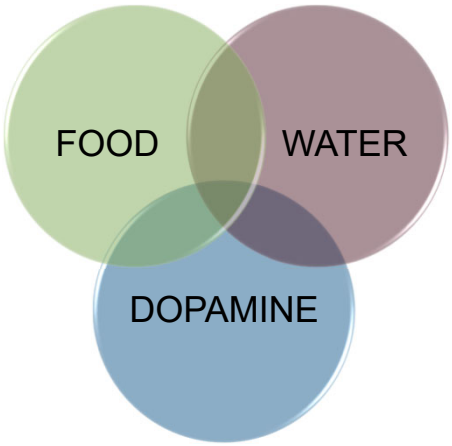
WELCOME

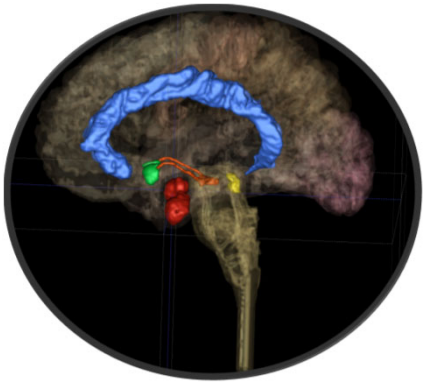
From the Frontlines

Vince Parker, Community Member

MEDICATIONS FOR ADDICTION TREATMENT

SURVIVAL





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Responses to Dopamine:

- Motivation and Drive
- Pleasure
- Food, Water, Chocolate

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WHEN SOMEONE STOPS OPIOIDS…

Opioid withdrawal

- Muscle, joint pain
- Nasal stuffiness
- Abdominal pain, nausea, diarrhea
- Restlessness/ irritability
- Dilated pupils
- Yawning
- Gooseflesh
- Tachycardia
- Sweating

Symptoms last 3-7 days

Dopamine depletion

- Increased cravings→ survival behaviors
- Reduced daily functioning
- Hampers decision-making

Persists for months to years after people stop using

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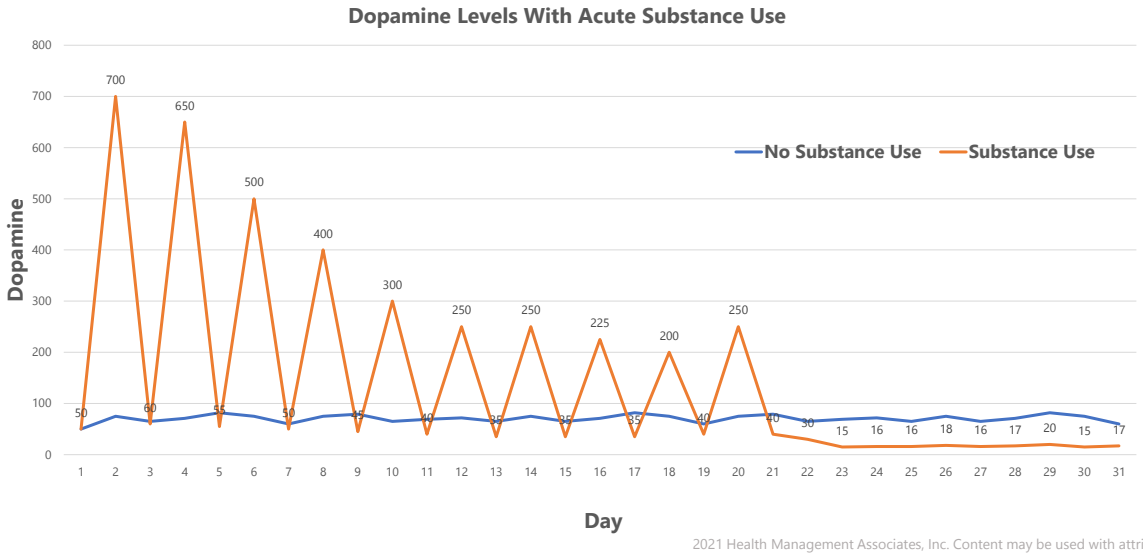
RELATIVE DOPAMINE LEVELS IN THE BRAIN



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MEDICATION-ASSISTED TREATMENT (MAT) INTRODUCTION- OPIOIDS

METHADONE

+ *Full agonist – weak binding*
+ Legal for treatment of OUD in 1972
+ Many changes to CSA over the years
+ Now regulated by SAMHSA

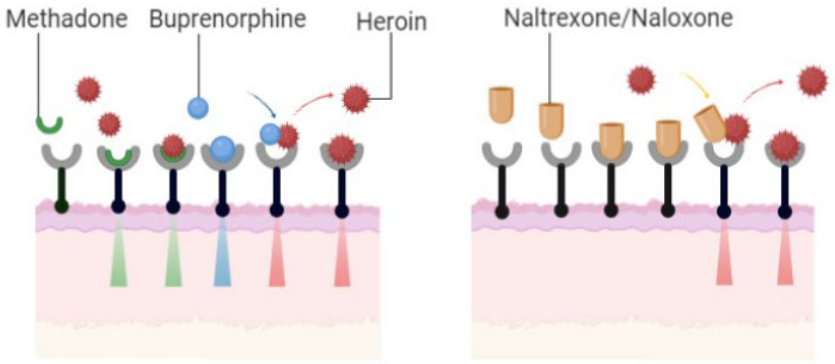
BUPRENORPHINE

+ *Partial agonist – strong binding*
+ Legal for outpatient treatment of OUD in 2002
+ MD/DO Take 8-hour course
+ PA/NP Take 24-hour course (2016)

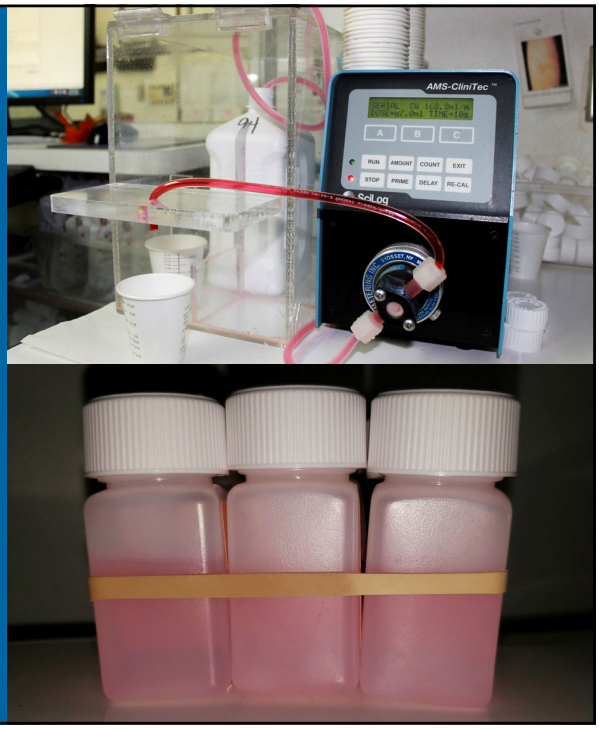
NALTREXONE

+ *Antagonist*
+ FDA approved for OUD in 2010
+ Can be delivered in any medical facility without extra training

MU OPIOID RECEPTOR BINDING



METHADONE



Source Methadone Dispenser: Tucson Sentinek.com, Jan. 20, 2015
Source Methadone Bottles: Shutterstock - 11.30.2018 : Six Methadone Bottles from mmtp clinic. by NYCstringer

METHADONE: WHAT AND FOR WHOM?

- Mu agonist without a "ceiling effect"
- Reaching a therapeutic dose takes time
  - <60 mg/d is not therapeutic
  - Typical dose 60-120 mg/d (if not pregnant)
  - Increased frequency and daily dose required during pregnancy
- Several significant drug-drug interactions
- Illegal to write prescription for methadone to treat OUD unless:
  - Covering a gap in treatment - 3 days are allowed
- Despite having the best outcomes, it has the highest level of stigma
- Difficult to get patients off after a few years of treatment

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

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METHADONE: GENERAL REGULATIONS (FDA, SAMHSA)

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

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BUPRENORPHINE

Source Patch: https://nationaladdictionnews.files.wordpress.com/2017/02/suboxone-pic.jpg
Source Implant: Daily Hampshire Gazette, Oct. 17, 2017
Source Pills: Adam Fedorko, 2006 Erowid.org
Source Injection: Hope by the Sea, Dec. 5, 2017

BUPRENORPHINE: WHAT AND FOR WHOM?

- Partial Mu agonist with ceiling effect
  - Available alone or in combination w/naloxone
  - Doses >32 mg don't cause greater effect
  - Different formulations (SL and buccal pill/film, implant, injectable)
- Greater binding affinity than full agonists
  - Start buprenorphine when client in mild-moderate withdrawal (to avoid causing precipitated withdrawal)
  - Other opioids are not as effective when buprenorphine is present
- Many ways to do induction (protocols needed)
  - <8 mg/d is not therapeutic
  - Typical does is 8-16 mg/d
  - Increased frequency and daily dose required during pregnancy
- Fewer drug-drug interactions than methadone
- DEA X-Waiver certification required with patient limits

Positive DSM 5 with a score of 2 or greater

Positive Drug Abuse Screening Test (DAST = 6 or greater) for opioids

Can make it to clinic for evaluation

Can afford the medication

BUPRENORPHINE: GENERAL REGULATIONS

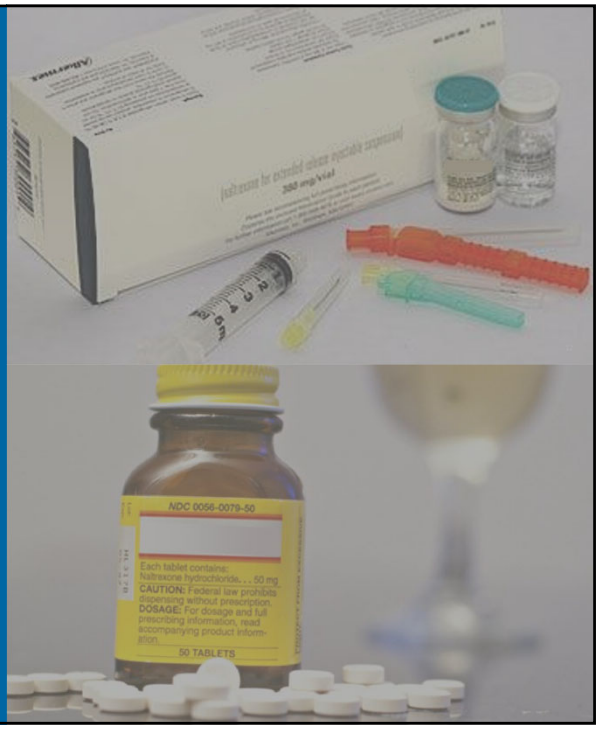
Approved in the 1981 for pain via an injectable form

Approved in 2002 for use in maintenance treatment for OUD

Now multiple forms:

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

NALTREXONE



Source Packaging and Materials: The Fix, May 5, 2013
Source Bottle: James Leynse/Getty Images

NALTREXONE: WHAT AND FOR WHOM?

- Mu opioid antagonist with high, competitive binding affinity
- Does not treat withdrawal or underlying dopamine depletion
- Must be opioid free x 7 days before starting
- More widespread acceptance in criminal justice and "abstinence-only" communities
- Evidence of decreased mortality is limited

Patients with a high degree of motivation (dopamine)

Patients with a history of OUD and Alcohol Use Disorder (AUD)

Patients who had poor results with methadone or buprenorphine

Can be useful for occasional use or after discontinuation of methadone or buprenorphine

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NALTREXONE: GENERAL REGULATIONS

No Federal regulations inhibit the use

Some payer restrictions make it difficult to obtain the long-acting injectable form

Multiple formulations:

- Pills at 25mg and 50 mg (50-100 mg for AUD)
- Long acting injectable 380mg (28-30 days)
- Implantable beads: lasts 6 months (0.9 ng/ml formulation contains 3.5 ng/nl of 6-beta-Naltrexol)

Coverage for long-acting formulations more difficult to secure

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NALOXONE

❶ Pull the auto-injector from the outer case

❷ Pull firmly to remove the red safety guard (do not touch the black base)

Source Nasal Spray: AP Photo/Matt Rourke
Source Instructions: Public Source

NALOXONE OVERVIEW: OD REVERSAL AGENT AS HARM REDUCTION

- Mu opioid antagonist used for opioid overdose (OD) reversal
- Shorter half-life & more rapid onset of action than naltrexone
- High affinity, competitive binding & displaces full agonists
- Intranasal or intramuscular by bystander
- May require more than one dose
  - Opioids have longer half-life than naloxone
  - Fentanyl contamination may require higher dose for reversal
- CA Assembly Bill 2760- Naloxone prescribing
  - >90mg Morphine Milliequivalents
  - Opioids + benzodiazepines
  - Increased risk of OD: History of OD or SUD

IS ALL ADDICTION THE SAME?

Patient 1

- Female
- Early life trauma
  - Neglect
  - Sexual assault
- Isolation from friends
- Early use of marijuana
- Heavy episodic drinking in early high school
- Opioids at 19 y/o
- Heroin at 22 y/o
- Unable to hold down job or relationships

Patient 2

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

MAT CONCLUSIONS

- Methadone and Buprenorphine have same efficacy regardless of mode of drug use (e.g., injection or oral pills)
- Using MAT is the standard of care
- There is no perfect answer!
- Involve your patients and enable access to all medications
- Building an addiction treatment ecosystem is the way; not just and opioid treatment system

LOW BARRIER TREATMENT: WHY THIS IS IMPORTANT

- The Problem: Low rates of initiating and sustaining treatment
  - Four out of five individuals with OUD do not receive treatment
  - There are many policy, programmatic and social barriers to treatment (and we've identified many of those in this county)
  - Populations at higher risk – persons experiencing homelessness (PEH), others with ambivalence
  - Individual influences are also a factor (e.g., co-occurring disorder [COD], female gender, stigma, competing needs)
- A Few Solutions:
  - Same-day and next-day appointments increase sustained treatment
  - Low barrier care reduces OD deaths and complications
  - Care coordination including peer specialists facilitates access when it's needed most
  - Tolerance of co-occurring conditions improves initiations and retention

ABOUT STIGMA

UNPACKING STIGMA

"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel." – *Maya Angelou*

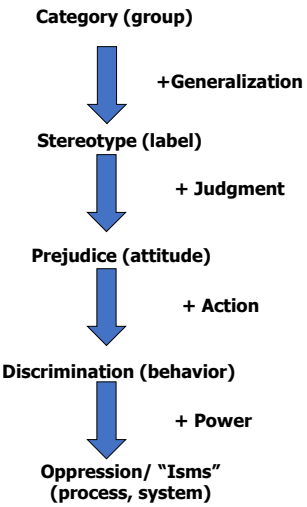
Picture from Unsplash.

CATEGORIES OF STIGMA

Self-Stigma

Social Stigma

Structural Stigma



S. Harrell, Ph.D.

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WORDS MATTER

Words are powerful... They can contribute to stigma and create barriers to accessing effective treatment

Avoid These Terms:	Use These Instead:
Addict, user, drug abuser, junkie	Person with opioid use disorder or person with opioid addiction, patient
Addicted baby	Baby born with neonatal abstinence syndrome
Opioid abuse or opioid dependence	Opioid use disorder
Problem	Disease
Habit	Drug addiction
Clean or dirty urine test	Negative or positive urine drug test
Opioid substitution or replacement therapy	Opioid agonist treatment
Relapse	Return to use
Treatment failure	Treatment attempt
Being clean	Being in remission or recovery

Source: Substance Abuse and Mental Health Administration

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BREAK

OTHER IMPORTANT CONCEPTS IN OUD/SUD

- Screening, assessment and level of care determination
- Data Sharing
- Policy/regulatory flexibilities
- [Drug Medi-Cal Organized Delivery System DMC/ODS]

SCREENING, ASSESSMENT & LEVEL OF CARE DETERMINATION

❑ Screening:

A rapid evaluation to determine the possible presence (risk) of a condition (high sensitivity, usually low specificity) (Toxicology testing is often erroneously referred to as "screening")

❑ 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

+ Screening is the act of identifying if someone is at risk for an illness
+ Screening tools are validated for use in specific populations
+ Screening for co-morbid conditions and suicide is critical

General Population	Pregnant Women	Youth
• National Institute for Drug Addiction (NIDA) – Quick Screen • Tobacco, Alcohol, Prescription, and other Substances (TAPS) • AUDIT (Alcohol only) • *Patient History Questionnaire (PHQ-9)* • *General Anxiety Disorder (GAD-7)* • *PTSD Checklist (PCL-5)* • *Columbia Suicide Severity Rating Scale (C-CCRS)*	• NIDA – Quick Screen* • 4 P's plus (license fee) • Substance Use Risk Profile – Pregnancy (SURP) • CRAFFT – for 12 -26 yo women (Car, Relax, Alone, Forget, Friend/Family, Trouble) • *Perinatal Mood and Anxiety Disorder (PMAD) – Edinburgh, PHQ-9, etc.*	• Brief Screener for Alcohol, Tobacco and other Drugs (BSTAD) (12-17yo) • Screening to Brief Intervention (S2BI) (12-17yo) • Problem oriented screening instrument for Teens (POSIT) • CRAFFT*

SCREENING QUESTIONNAIRES: MOTIVATIONAL INTERVIEWING and SBIRT

Motivational Interviewing builds trust and relationship (Partnership, Acceptance, Compassion, Elicit principles)

"An important part of primary care/prenatal care is screening for any risky conditions. Some of these conditions can be scary to talk about but are pretty common. Also, no matter the issue we have the ability to help work through it."

"Is it ok if I ask you some questions about those risks?"

Role of Screening, Brief Intervention and Referral to Treatment (SBIRT)

- Clients with positive screens need to be assessed for the presence of the disorder
- Screening, Brief Intervention and Referral to Treatment – **SBIRT***
- If the disorder is present, we can determine the severity and make appropriate referrals

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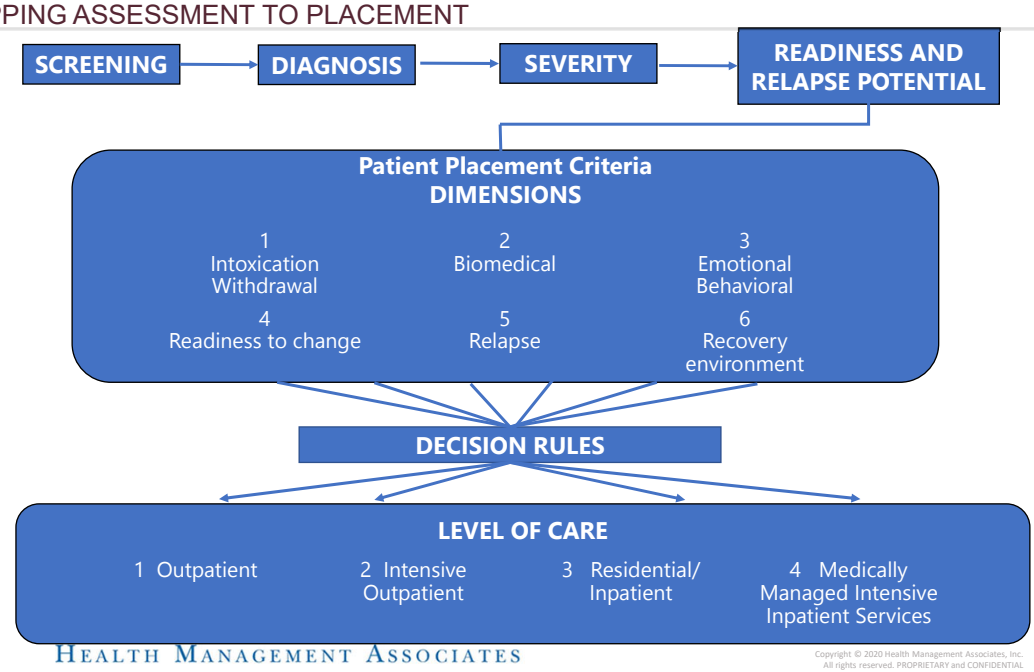
THE AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) CRITERIA: MAPPING ASSESSMENT TO PLACEMENT



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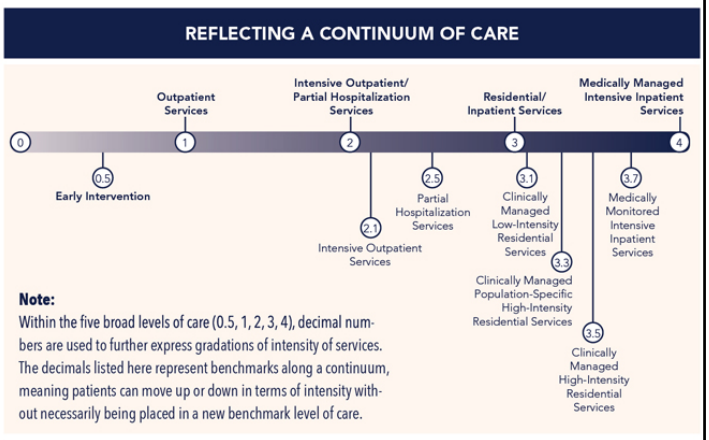
LEVEL OF CARE DETERMINATION

Evaluating for placement

- ASAM Criteria is the Gold Standard
  - CONTINUUM® and CONTINUUM Triage (Co-triage® tool (20 questions)
  - ASAM criteria are required in assessment tools used by DMC-ODS contractors
- Who is screened?
  - Patients positive for high/severe on assessment
- How administered?
  - On-line tool (i.e., the licensed ASAM tools)
- Who delivers?
  - Can be done by MA, RN or MD/DO
- How paid for?
  - Part of SBIRT payment



Source: The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (2013).

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WHICH OF THE FOLLOWING RESPONSES ABOUT INFORMATION SHARING FOR CLIENTS IN SUD TREATMENT IS FALSE?

A. You can share information if the client signs a valid release of information.

B. You can only share information with another SUD treatment provider if you have the specific name of an individual who will receive the information.

C. A primary care provider who occasionally treats patients with MAT, but does not hold their practice out to be an SUD treatment practice is not covered by 42 CFR Part 2.

D. Data about drug treatment can be shared without consent in an emergency.

WHY DO WE HAVE A DIFFERENT SHARING STANDARD FOR FEDERALLY-ASSISTED SUD SERVICES?

- HIPAA:
  - Passed in mid-1990s, updated in 2009 and 2013
  - Defines "covered entities" and "business associates"
  - "General" rule which healthcare operates to ensure data privacy/security
- 42 CFR part 2:
  - Enacted in early 1970s (No "HIPAA" at that time)
  - Ensure individuals seeking treatment for SUD would not be retaliated against
  - Proposed rulemaking and public comment due later this year

https://www.samhsa.gov/newsroom/statements/2021/42-cfr-part-2-amendments-process

TWO MAJOR REQUIREMENTS DETERMINE APPLICABILITY OF PART 2 RESTRICTIONS

Federally "assisted" services

- Direct funding for services
  - *Example:* Medicaid/Medicare SUD funding, or grant funding via SAMHSA
- Program Oversight/Certification
  - *Example:* SAMHSA-certified OTP
  - *Example:* individual treatment providers registered as X-waivered with the DEA

AND

Agency/individual delivering services must "hold itself/themselves out" as being an SUD treatment provider

- Facility
  - *Example:* freestanding programs or agency advertising itself as treating SUD
- Individual program/provider
  - *Example:* primary function is the diagnosis, treatment, or referral for treatment of patients with SUD
  - *Example:* addiction specialist, even in a facility that is not addiction-related

Source: https://www.hhs.gov/about/news/2019/08/22/hhs-42-cfr-part-2-proposed-rule-fact-sheet.html

WHICH OF THE FOLLOWING RESPONSES IS FALSE?

A. You can share information if the client signs a valid release of information.

B. You can only share information with an SUD treatment provider if you have the specific name of an individual who will receive the information.

C. A primary care provider who occasionally treats patients with MAT but does not hold their practice out to be an SUD treatment practice is not covered by 42 CFR Part 2.

D. Data about drug treatment can be shared without consent in an emergency.

REGULATORY FLEXIBILITIES: MANY DUE TO COVID-19 PUBLIC HEALTH EMERGENCY

TELEHEALTH

- Reimbursement parity
- Urban areas
- Client home as originating site
- SUD services allowed – including MAT
- FQHC/RHC/IHS may serve as distant sites
- Can be used for new client visits
- Audio-only can be used for some services
- Expanded choices for videoconferencing

PRESCRIBING AND PERSONAL HEALTH INFORMATION

- Three-day rule – Provider can conditionally administer/dispense (but not prescribe) narcotics to treat acute withdrawal
- SAMHSA authorizes OTPs/NTPs to dispense take-home MAT (up to 14-day supply)
- DEA authorizes "conditional" controlled substance prescribing without in-person exam
- DEA waives consent requirement for disclosure of patient information for treatment purpose in an emergency
- Enforcement discretion on HIPAA (Office of Civil Rights)

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REMINDERS ABOUT CONSENT AND DOCUMENTATION FOR TELEHEALTH (TH)

- Written consent from the patient is the best and many clinics have TH consents as part of standard consent package
  - May not be able to obtain written consent during a pandemic
  - Written or verbal consent for telehealth must be documented in note
- Documentation of TH visits should be the same as for comparable face to face visits
- Other TH best practices
  - Document location of patient (in case of emergency and for billing)
  - Procedures for technical problems/interruptions
    - Review at each visit (provide and solicit phone number)
    - Provide information in your FAQs for telehealth
  - Patient privacy and safety
    - Provide information in your FAQs for telehealth
    - Safety and comprehensiveness of assessment

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OVERVIEW OF COUNTY RESPONSIBILITIES: SPECIALTY MENTAL HEALTH SERVICES, DRUG MEDI-CAL, AND DMC-ODS

Specialty Mental Health Services Program (Mandatory)	Drug Medi-Cal State Plan Services (Mandatory)	Drug Medi-Cal ODS expansion under 1115 waiver (Optional for counties)

+ Counties provide services directly and/or contract with specialty mental health providers
+ Does not cover Substance Use Disorders
	+ Provided by DHCS-certified SUDS providers
	+ DHCS contracts with county alcohol and drug programs but if county fails to contract, DHCS will directly contract
	+ Limited scope of SUD services
	  + EPSDT Eligible Children
	  + Pregnant and Postpartum moms
	+ Not subject to state or federal managed care requirements
	+ Historically disconnected from both Medi-Cal managed care plans and County Specialty Mental health
		+ 38 counties are participating, setting up the ODS "plans" through integration with prior DMC providers, expanded partnerships with Medi-Cal plans and providers, and development of new treatment sites
		+ Adds American Society of Addiction Medicine (ASAM) criteria for assessment and "continuum of care" services, including case management
		+ Includes beneficiaries at risk of developing SUDS who need early intervention
		+ ODS counties must meet federal managed care requirements, including MOUs with Medi-Cal managed care plans for referrals and coordination

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WHAT ARE THE BENEFITS TO OPERATING A DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM OR DMC-ODS?

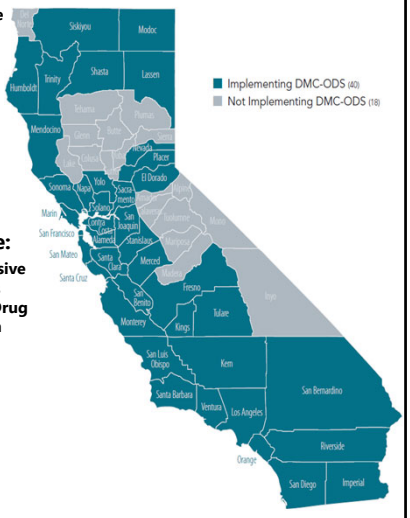
Drug Medi-Cal Organized Delivery System (DMC-ODS) (adopted under 2016 Section 1115 Medicaid Waiver): Expanded Medi-Cal Treatment options for Opt-In counties

Medi-Cal's effort to:
Dramatically expand, improve, and reorganize its system for treating people with substance use disorder (SUD)

DMC-ODS aims to:
Demonstrate that providing organized SUD care improves health outcomes while reducing overall costs

DMC-ODS' Services are:
Significantly more comprehensive than the limited set of services provided under the standard Drug Medi-Cal "state plan" program

DMC-ODS Participation is Voluntary:
As of July 2020, 38 counties were implementing and providing services under the DMC-ODS pilot. These counties account for 97% of the Medi-Cal population statewide



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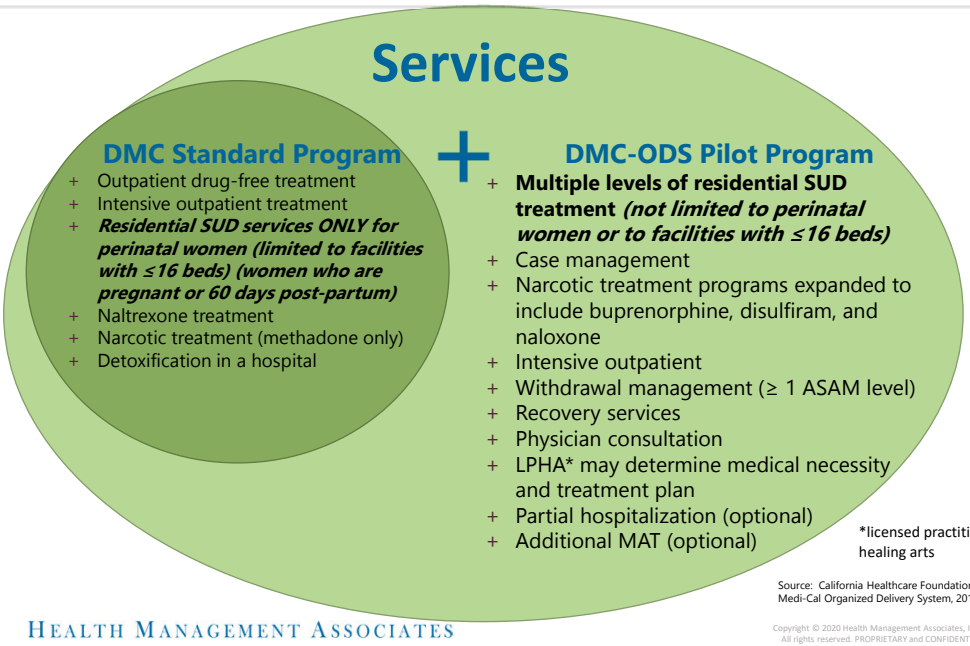
UNDERSTANDING THE DMC & DMC-ODS PROGRAMS:



*licensed practitioner of the healing arts

Source: California Healthcare Foundation, The Drug Medi-Cal Organized Delivery System, 2019

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ADDITIONAL WAYS TO FUND/PROVIDE MAT PROGRAMS OUTSIDE THE DMC-ODS SYSTEM

+ Federally Qualified Health Centers (FQHC) MAT in Primary Care
  + Optimal MAT program billing is through the prospective payment system (PPS)
  + Additional FFS billing to Medi-Cal managed care plans using care coordination codes, may be available – not all clients meet these criteria
  + Shared medical visit codes for MAT refill groups (99212-99214)
  + Behavioral health services within primary care setting are also reimbursed through the PPS rate (no same day billing)

+ Primary Care providers can also bill separately (+/- bundled payments)

G2086	OFF BASE OPIOID TX 70MIN	$ 355.35	First month
G2087	OFF BASE OPIOID TX, 60 M	$ 314.60	Subsequent months
G2088	OFF BASE OPIOID TX, ADD30	$ 61.69	Additional time

+ Emergency Departments can also bill separately (includes RVUs)

G2213	INITIATION, ASSESSMENT, REFERRAL, SUPPORT SVCS	1.30 Work RVUs 1.89 Total RVUs

  + Medicare pays $65.95, Medi-Cal $58.05

HEALTH MANAGEMENT ASSOCIATES

RECAP GAPS AND BARRIERS

GAPS AND BARRIERS: IDENTIFIED ON *5/11/21*

People

- Insufficient number of case managers, especially in rural areas
- Limited number of MAT providers
- Workforce issues (lack of filled positions, peer support specialists, SUD studies for certification)
- Need to develop a workforce with cultural and linguistic competency
- Lack of acceptance of MAT due to cultural biases

Process

- Clients have to navigate many moving parts to access services (e.g. childcare, transportation, limited tech knowledge for telehealth)
- Engagement and care coordination
- Need for adolescent treatment at ALL levels of care
- Treatment availability in a timely manner when the individual is ready for care
- No real time access to availability of beds and services
- Complexity of billing processes for both provider and county
- Limited access to integrated whole person care

Place

- Transportation, especially in rural areas
- No 3.7 level of care in San Bernardino
- Housing for the homeless population
- Lack of residential beds

Communication

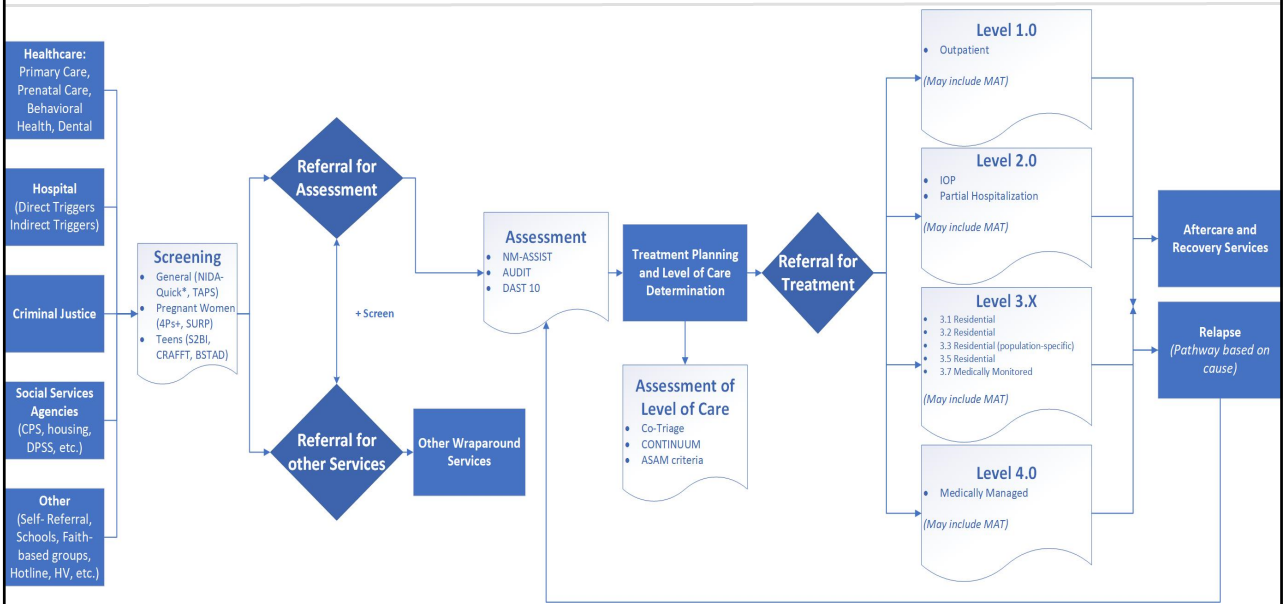
- Lack of communication among partners about 1) community resources and 2) how to access the resources
- Connecting clients (beyond warm handoff)
- Misunderstanding of what MAT is
- Lack of understanding of what resources are available – no centralized source of truth
- Lack of emphasis on prevention and early intervention

Miscellaneous

- Stigmatization by both providers and clients
- Funding
- Lack of capacity across all levels of care, including for high need high risk individuals
- Lack of 'no wrong door' policy

BUILDING A TREATMENT RECOVERY ECOSYSTEM

TREATMENT AND RECOVERY ECOSYSTEM: OVERVIEW



KEY FEATURES & SOLUTIONS

KEY FEATURES & SOLUTIONS

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

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

KEY FEATURES & SOLUTIONS

Earlier we went through an exercise to identify gaps and barriers, now we are going to identify key features of an ideal treatment and recovery ecosystem.

Definition of a key feature:

- Aspect/element/characteristic/process/program of any of the components on the scaffolding or anything that should be part of the treatment and recovery ecosystem
- Key features should be solution-oriented and responsive to the identified gaps and barriers

Examples of key features:

- Centralized SUD treatment bed or appointment locator
- Uniform screening tool and process to be used at every entry node
- Building or contracting with provider for a missing and needed LoC in the system

CRITERIA TO CONSIDER WHEN IDENTIFYING KEY FEATURES & SOLUTIONS

Implementation and County Goals	• Supports one or more of the County Goals • Within control of the team • Extent of resolution of problem (e.g., addresses root causes, gaps/barriers) • Ease of implementation (i.e., "low hanging fruit")
Acceptance and Buy-in	• Team interest or buy-in • Leadership or Management interest and support
Impact	• Influences a significant portion of the population with SUD/OUD • Potential effects on other systems • Urgency of problem
Cost	• Resources required to implement (e.g., people, money, time) • Return on investment expected (e.g., improved outcomes, less resources required) • Resources/cost to maintain (e.g., money and time)

KEY FEATURES & SOLUTIONS
REFLECTIONS

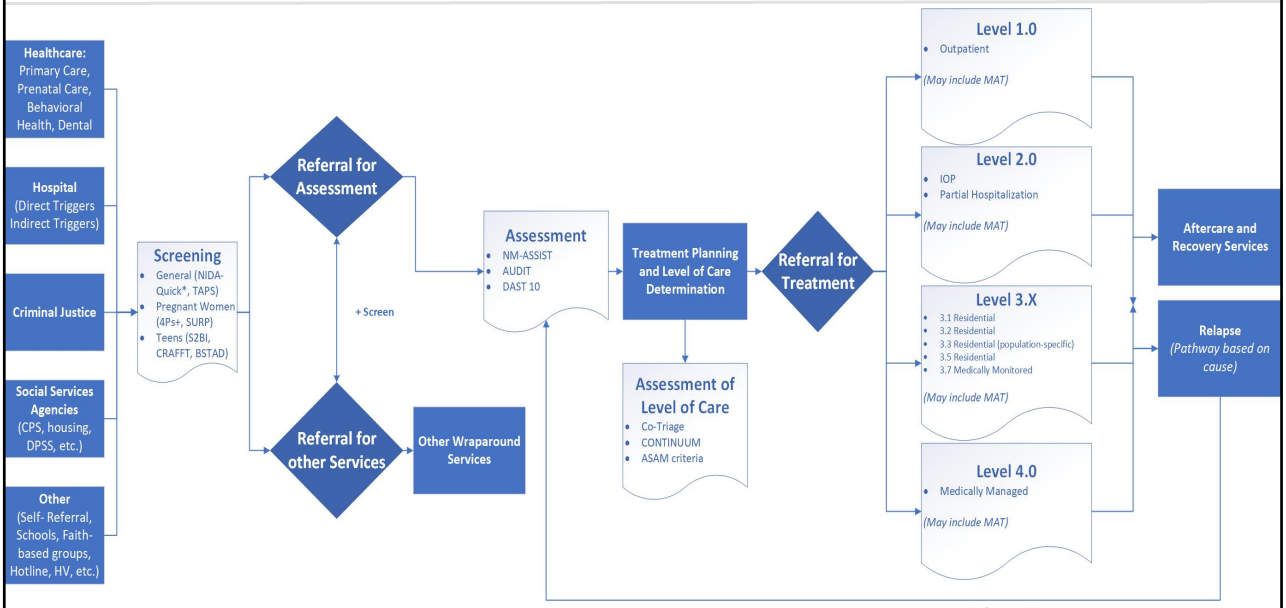
KEY FEATURES & SOLUTIONS REFLECTION: REFLECTION (5 MINUTES)

- Thinking about your county and the criteria for identifying key features/solutions (Ease of implementation and concordance with county goals; Acceptance and buy-in; Significance of impact; Cost):
  - Think about what is missing and/or would address the significant gaps and barriers applicable to your treatment and recovery ecosystem
  - Jot those down on scratch paper
  - Share those in the upcoming breakout session

KEY FEATURES & SOLUTIONS
BREAKOUT

KEY FEATURES & SOLUTIONS
REPORT OUT

FUTURE STATE MAPPING OF KEY FEATURES & SOLUTIONS

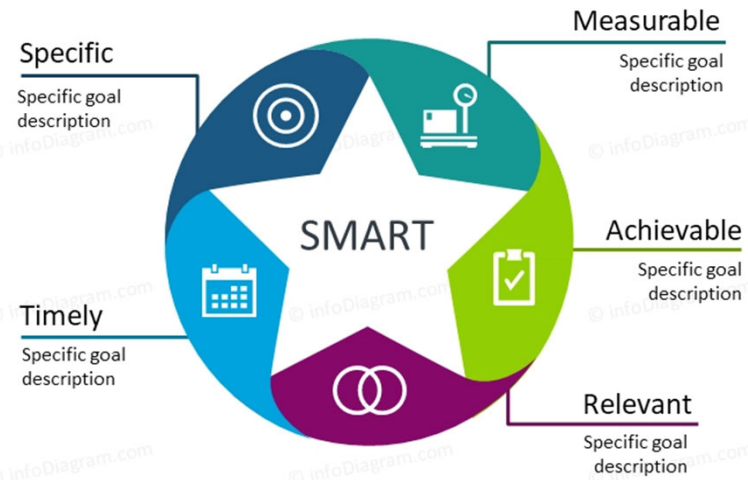


FUTURE STATE MAPPING OF KEY FEATURES & SOLUTIONS

Share Ecosystem

GOAL SAMPLES

SETTING SMART GOALS



SAMPLE COUNTY GOALS DISCUSSION:

County Eco-System
By *[date]*, develop a county eco-system map of all SUD treatment providers, ED Bridge, NTP/OTP, Pharmacies, MAT expansion projects, and related support services to increase and systematize information sharing and coordination across other SUD initiatives/funding steams and partners.

Provider network
By *[date]* establish reasonable benchmarks to build MAT provider capacity to ensure network adequacy.

Data
By *[date]* determine what data is available and create a dashboard to better understand service utilization, to identify potential areas for increased focus and to establish annual benchmarks.

Access to Evidence-Based Care
Between *[date A]* and *[date B; 6 - 12 months later]*, increase the number of patients accessing MAT in county operated facilities by XX% per quarter.

POLL Questions

1. Thinking about this goal, please rank its priority to the substance use disorder ecosystem?
By [date], develop a county eco-system map of all SUD treatment providers, ED Bridge, NTP/OTP, Pharmacies, MAT expansion projects, and related support services to increase and systematize information sharing and coordination across other SUD initiatives/funding steams and partners.

- High priority
- Moderate priority
- Lower priority

2. Thinking about this goal, please rank its priority to the substance use disorder ecosystem?
By [date] establish reasonable benchmarks to build MAT provider capacity to ensure network adequacy.

- High priority
- Moderate priority
- Lower priority

3. Thinking about this goal, please rank its priority to the substance use disorder ecosystem?
By [date] determine what data is available and create a dashboard to better understand service utilization, to identify potential areas for increased focus and to establish annual benchmarks.

- High priority
- Moderate priority
- Lower priority

4. Thinking about this goal, please rank its priority to the substance use disorder ecosystem?

Between [date A] and [date B; 6 - 12 months later], increase the number of patients accessing MAT in county operated facilities by XX% per quarter.

- High priority
- Moderate priority
- Lower priority

SAMPLE COUNTY GOALS DISCUSSION:

If interested in further building out the goals and joining a smaller workgroup, put your name and email on chat….

NEXT STEPS
(NOW WHAT DO WE DO?)

TECHNICAL ASSISTANCE AND COACHING
(WE'VE GOT YOUR BACK)

SOR TECHNICAL ASSISTANCE (TA)

- The program offers TA, coaching and training.
  - Material is presented in various formats.
  - The content is created and delivered by HMA subject matter experts.
- All materials are available on the project website addictionfreeCA.org.
- Continuing educational credit is offered at no cost to attendees for many of the components.

TECHNICAL ASSISTANCE: WHAT HAPPENS NEXT?

Coaching Options

- Most popular: 1:1 practice coach for up to 12 months
- Streamlined TA: 1:1 practice coach for limited time period
- Quick start TA: Brief TA encounter (1-2 sessions) to address specific questions/issue

Complete a TA application on addictionfreeca.org:

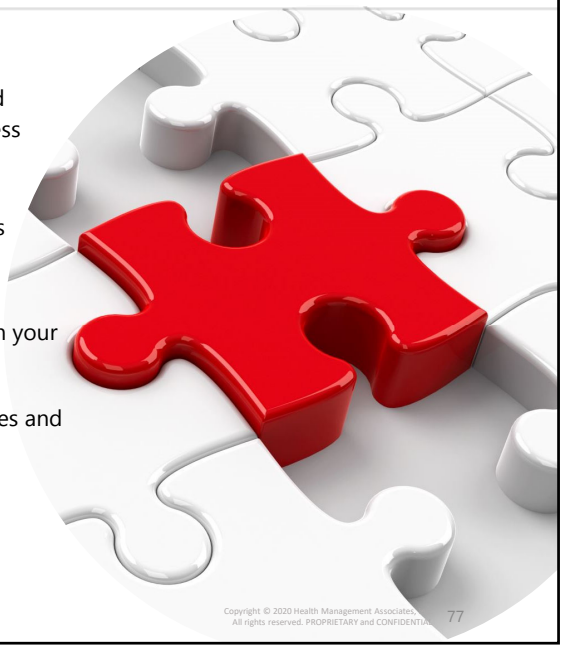
- Please complete only one application per agency process
- Coordinate with your leadership and colleagues

How do we do it:

- Complete online practice assessment (link will come from your TA Coordinator)
- TA coach will be assigned; first coaching call scheduled
- On 1st call Coach will review notable assessment responses and work with you on SMART goal development

Benefits:

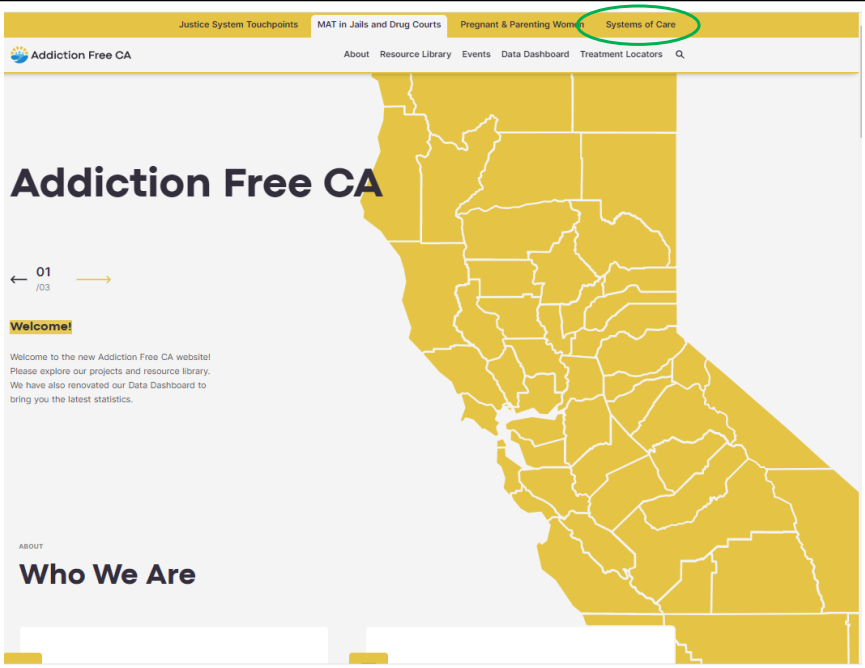
- Ready access to experts in the field
- Shared learning and best practices
- Accelerates your goals for SUD treatment

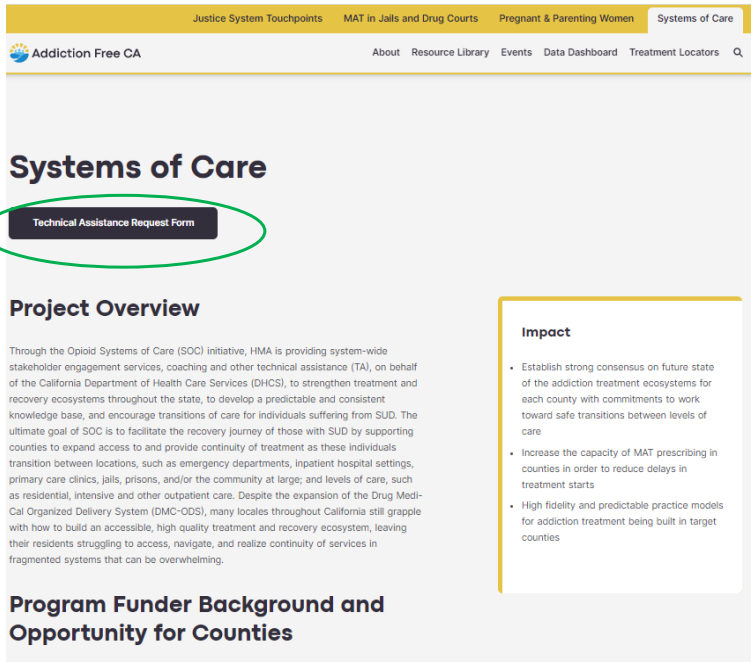


HEALTH MANAGEMENT ASSOCIATES

ADDICTIONFREECA.ORG

HEALTH MANAGEMENT ASSOCIATES





UPCOMING FROM HMA (CME AVAILABLE*)

Upcoming Webinars

- "Addressing Stigma, Myths and Overcoming Barriers to Care – Part I"
  - When: May 27, 12:00 pm
  - Registration flyer out soon
  - Office hours: June 3, 12:00pm
- "Addressing Stigma, Myths and Overcoming Barriers to Care – Part II"
  - When: June 9, 12:00 pm
  - Office hours: June 16, 12:00 pm
- "Screening Assessment and Level of Care Determination"
  - When: TBD (late June)

MAT Assessment and Workshop

- What is it?
  - Individual assessments of organizational positioning, gaps and barriers to optimal operation of MAT programs
  - Overview of full breadth of components and criteria for enhancing or starting sustainable MAT programs
  - Delivered in three, 2-hour sessions
- Who should participate?
  - Treatment programs administrators, managers, clinical and other leaders
  - Anyone interested in expanding, starting, or enhancing a MAT program
- The first workshop will occur on June 14, 16, 18

THANK YOU!

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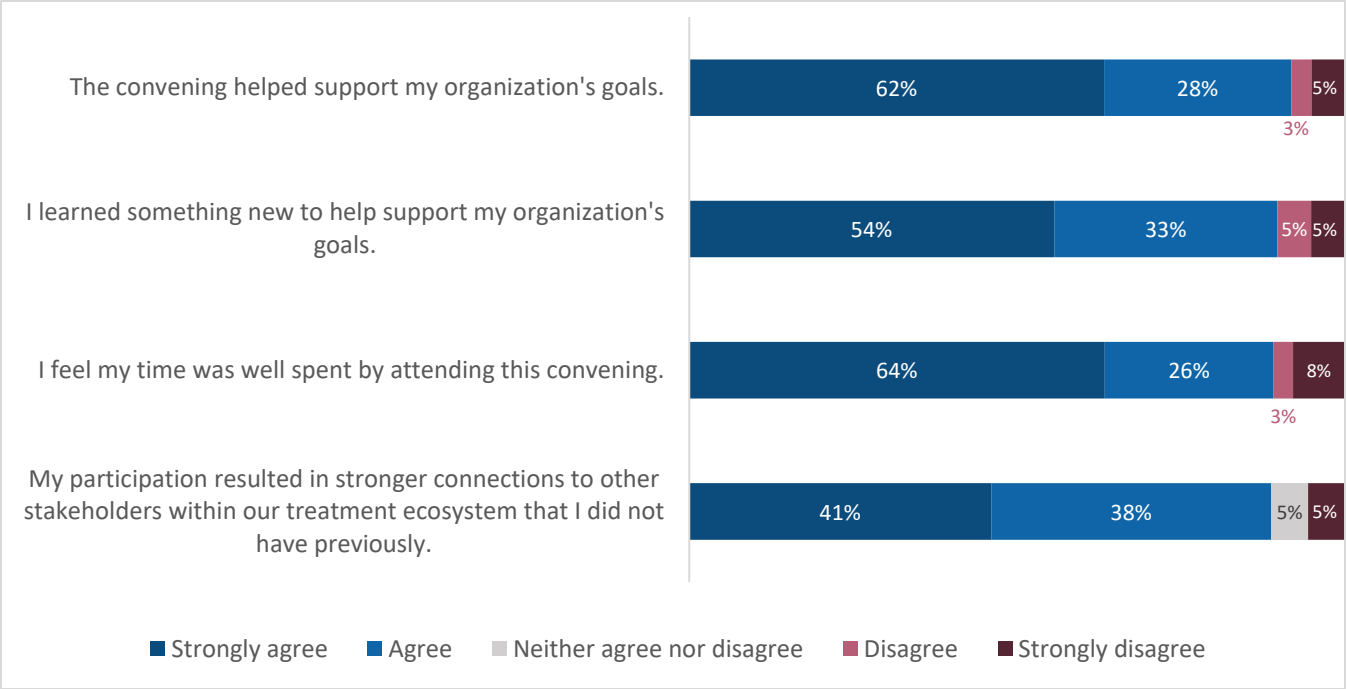
Summary of Evaluation Results

How strongly would you agree with the following statements?



Give an example of something new you learned today about addiction:

- Diagrams of the changing dopamine levels are helpful educational tools for my patients.
- How hard it is to receive MAT, even after asking for it.
- More in depth info on MAT treatment
- How MAT can assist a client on their road to recovery
- I am not a physician - so listening to the physician describing how the medication works and the doses was very interesting to me. It was good information
- It's treated so much differently than any other physical health condition and yet we often refer to it as a disease
- The lack of how much the public knows where to seek services within the County of San Bernardino
- How addiction works in the brain
- I gained a clearer understanding of the role of dopamine in reinforcing addiction.
- Reduction of opioid prescription and rise of opioid deaths
- Learned about the drugs used for MAT services
- Addressing stigma, need for funding ..
- The different medications and outcomes of MAT
- That they are coming out with a medication for meth
- That there is more help out there and resources
- The level of stigma concerning MAT
- Just more about MAT....the information was SO interesting and collaboration was amazing

Give an example of something new you learned today about addiction (cont'd):

- Food + Water + Dopamine = Survival
- That I do not know what services my own agency has.
- The additional new numbers of Medications added to treat SUDs
- MAT services
- that while our departments/agencies work to provide treatment and offer new options such as additional types of MAT services available there is still so much stigma attached to having an SUD and lack of information on how to get help
- Science has shown more brain activity with neurotransmitters
- Challenges with MAT getting to those in need
- How difficult it is for patients looking for an inpatient rehab position
- MAT bias
- It's become so much more widespread and there's more parity with healthcare for addicts
- My awareness of the many barriers opioid addicts face was brought to the surface
- I learned that other providers are experiencing the same challenges and that there is a willingness to work together to find solutions.
- That San Bernardino County currently has trials going on for treatment of Methamphetamine addiction.

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