MAT Expansion Learning Network

Simplifying MAT Implementation for LA County SAPC Providers

County of Los Angeles
Public Health

CLAS ACT

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES
ACCESS TO COACHING AND TRAINING

CIBHS

CALIFORNIA INSTITUTE FOR
BEHAVIORAL HEALTH SOLUTIONS

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State and County Contract Requirements

As we enter the next wave of the opioid epidemic, it has become even more important for SUD programs in LA County to offer the most effective treatment possible. As experts in treating patients with the most complex and challenging issues related to substance use, providers in the SAPC network play a critical role in LA County's efforts to address this public health crisis. For some of the patients served by SAPC providers, Medications for Addiction Treatment (MAT) can save lives and improve long-term recovery. Given the potential benefits of MAT, County and State of CA contracts stipulate that all of their licensed providers either directly provide MAT or link patients in their care to MAT services.

SAPC recognizes that not all organizations have the capacity to deliver MAT onsite. That's why providers in LA County **have the flexibility to choose between two MAT options:**

LAC MAT Expansion Learning Network

Table 1. MAT Access Models

#1 DIRECT MODEL Directly Offering MAT	Provider agencies that have the knowledge, staff, and desire to directly offer MAT to their patients and provide a biopsychosocial model of integrated SUD on site.
#2 REFERRAL + LINKAGE MODEL MAT Referral	Provider agencies that do not offer MAT directly to their patients and must establish integrated services through referral and ongoing co-management relationships with other provider agencies (e.g., Opioid Treatment Programs [OTP] and/or non-OTPs that can offer MAT) to ensure patients have access to a biopsychosocial model of SUD care and MAT.

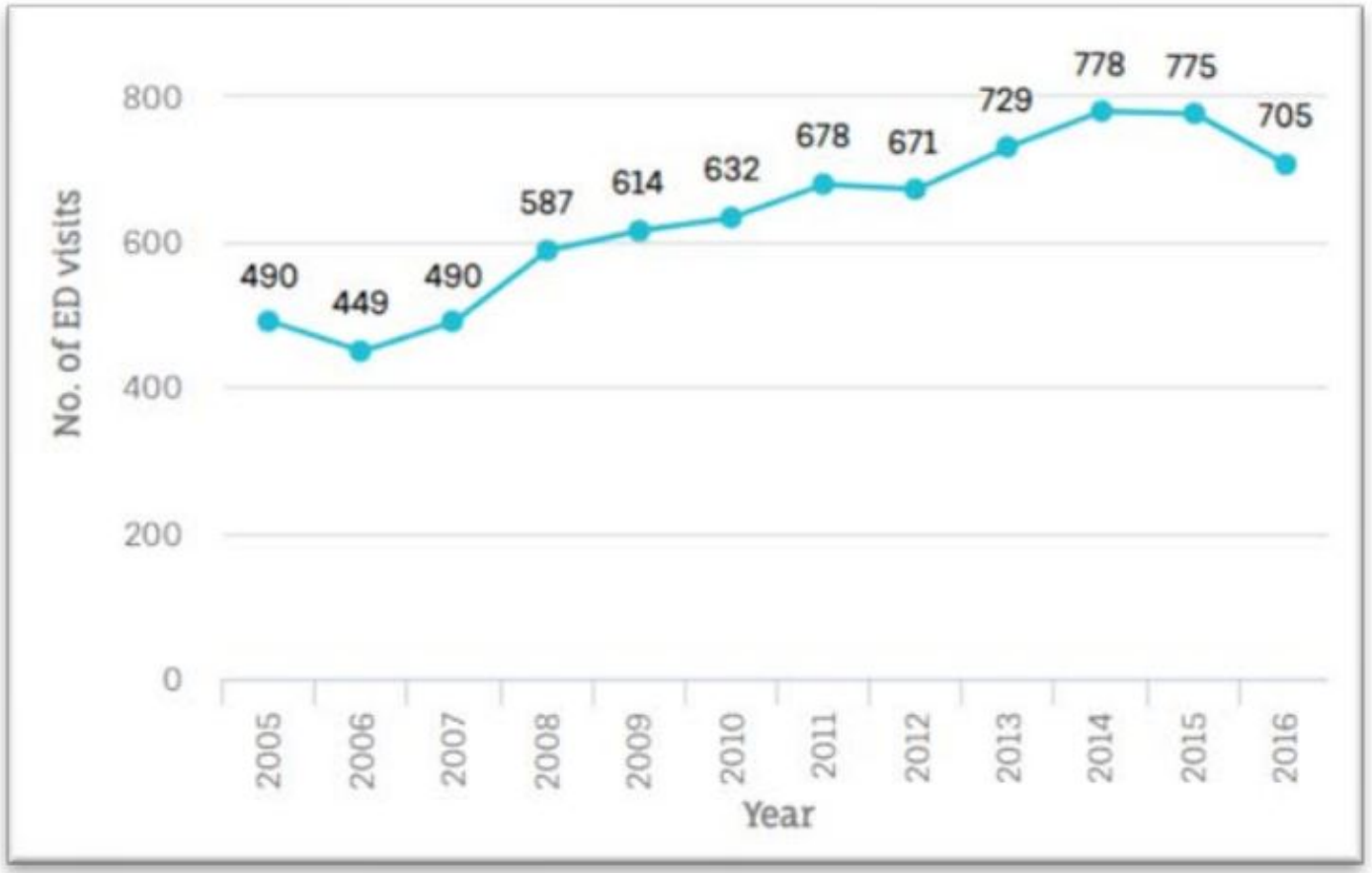
OPIOID ABUSE PREVENTION AND TREATMENT IN LOS ANGELES COUNTY

Local Data

Key Trends

- California had the 4th highest number of drug overdose deaths in the nation, 4,868 in 2017; the age-adjusted state mortality rate of 12.3 deaths per 100,000 people, however, was lower than the U.S. rate overall, 21.6.[1]
- In LA County, there were an average of 464 accidental opioid-related deaths per year from 2011-2017.[2,6]
- On average, individuals who died from drug overdoses died 30 years prematurely.[3]
- Hospitalizations and emergency department visits related to opioid diagnoses have increased 31% and 51%, respectively, between 2006-2017, with a substantial increase in costs associated with hospitalizations from opioid diagnoses.[4,6]
- According to the National Survey on Drug Use and Health 2012-2014, the prevalence rate of misusing/abusing prescription opioids in the past year in LA County is 4.7%, higher than the national average of 4.3%.[5]

Prescription Opioid Overdose/poisoning-Related Emergency Department Visits in LA County, 2005 – 2017[6]

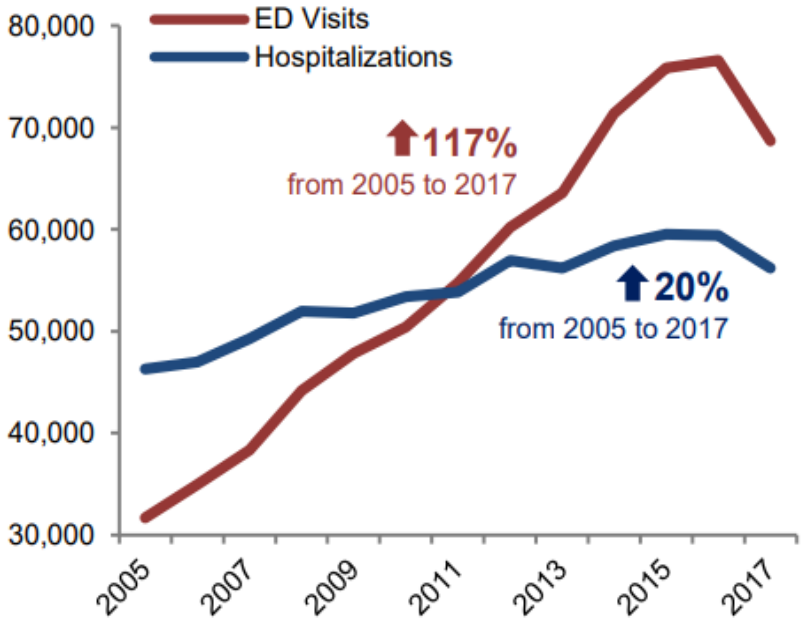


1 Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December 2018. 2LA County Medical Examiner's/Coroner. 3 LA County Department of Public Health Office of Health Assessment and Epidemiology. Mortality in Los Angeles County 2013: Leading causes of death and premature death with trends for 2004-2013. 4 California Office of Statewide Health Planning and Development. 5 Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health. 6 https://insight.livestories.com/s/v2/prescription-opioid-abuse-inlos-angeles-county-with-heroin-addendum/2a025c91-e626-482e-b5fb-c0db7fe58474/

Local Data

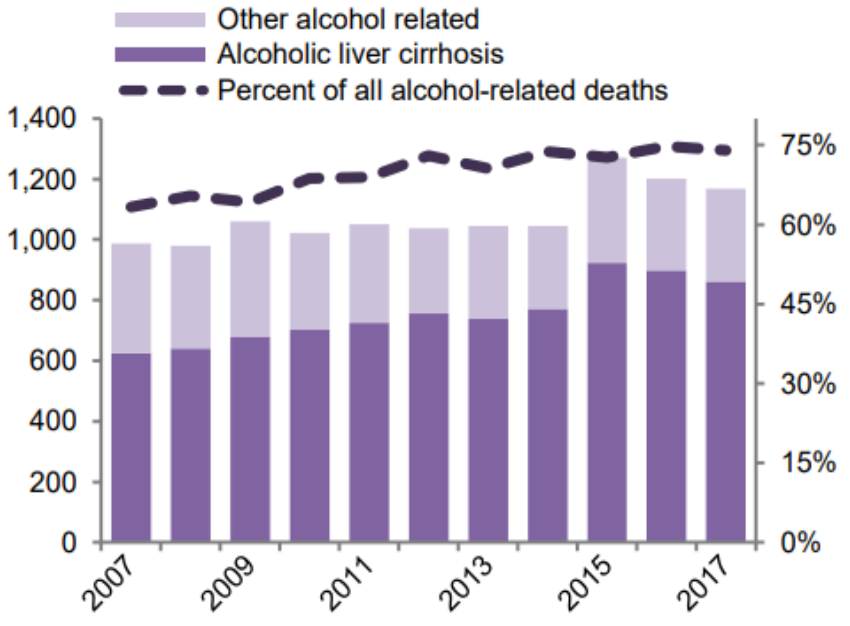
Healthcare Utilization

Number of Alcohol-related ED Visits and Hospitalizations in LAC, 2005-2017[6]

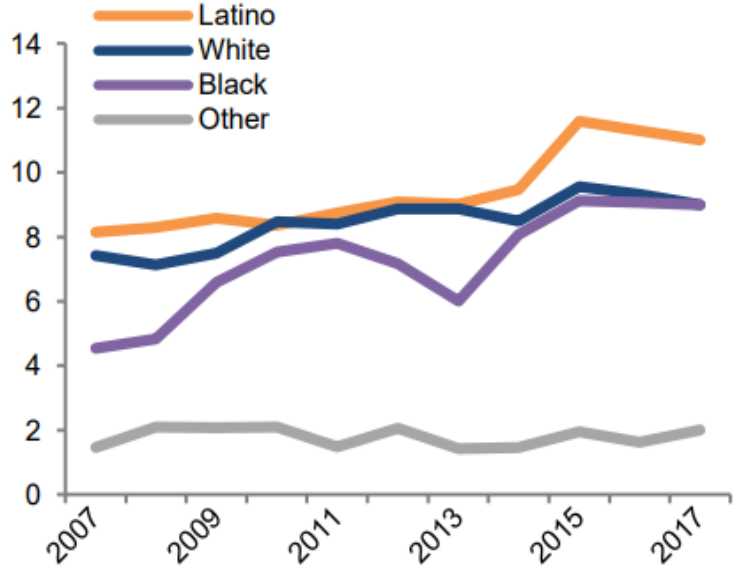


Mortality

Number of Alcoholic Liver Cirrhosis Deaths in LAC, 2006-2017[7]



Alcoholic Liver Cirrhosis Death Rate per 100,000 Population by Race/Ethnicity and Age in LAC, 2007-2017[7]



For substance use disorder treatment in LAC, call the Substance Abuse Service Helpline (SASH) at 844-804-7500, or visit Service &Bed Availability Tool (SBAT)
For more information on substance use disorders in LAC, visit http://publichealth.lacounty.gov/sapc/.
For more information regarding this data brief, please contact Tina Kim, Ph.D at tkim@ph.lacounty.gov

Expanding MAT: Driver Diagram/Barriers to Implementation

Far too many people who would benefit from MAT cannot obtain it

Financial and regulatory structure and rules	Fragmented payment system makes gaining reimbursement difficult
	MAT as an alternative to residential treatment may be a financial disincentive
	System design is based on regulatory requirements and payment rules and so is not aligned with MAT
	Incentives for longitudinal whole person vs episodic treatment of SUD
Provider knowledge, attitudes and beliefs	Re-entry individuals perceived to not need MAT
	Varying caregiver awareness and education about MAT
	Challenges with having MAT patients in waiting rooms, panels/case loads
	Patients' willingness to disclose relapse due to anticipated provider response
	Attitudes toward 'harm reduction' approaches, including MAT
	Stigma/discrimination towards MAT and MAT recipients
	Perception that MAT and behavioral services, social model are incompatible
Patient knowledge, attitudes and beliefs	Fear of medication prescribed by physicians due to past negative experiences with medications
	Both real and perceived terrible side effects of MAT
	Patient and community awareness and education about MAT
	Patients do not trust the 'system' and so do not disclose use
	Patients have informal networks that influence MAT adoption
	Stigma/discrimination around MAT from a number of perspectives (caregivers, patients)
	Desire to recover independently and show strength by going it alone
	Perception that MAT and behavioral services, social model are incompatible
Competing priorities	Competition for time and energy as well as confusion around what to focus on
	Adoption of MAT is not a high priority for providers who have many other critical issues
	Current readiness and functionality of providers is highly variable (from med management to oversight)
	Insufficient and/or inefficient prescribing capacity
	Lack of organizational and/or medical leadership support for MAT
Provider infrastructure	Organizational pathways, workflows and practice standards that support MAT
	Availability of convenient and culturally/personally comfortable entry points (EDs, SASH, CENS, self-referral)
	Resources to develop needed infrastructure (e.g. locked fridge)
	Accountability for high fidelity adoption of MAT practices
	Data gathering and measurement to support practice effectiveness, improvement and accountability
Coordination with key supports	Support for complex social determinants related to successful MAT
	Patients' informal networks influence MAT adoption
	Social supports are a critical ingredient to ongoing recovery
	Perception that MAT and behavioral services, social model are incompatible
	Coordination with multi-system partners to provide MAT in a whole person care approach
	Staff and patient navigation of community services and supports
	Exchange of patient information across the system for MAT referral and treatment

The MAT Workgroup

GOAL:

"with support from CIBHS and, SAPC, LA county contract providers will actively provide Medications for Addiction Treatment as required in State and County contracts."

AIM: Similar to how any medical clinic that treats diabetes is able to offer both behavioral counseling and medications for the treatment of diabetes, the ultimate goal is for eligible LAC residents is to be able to obtain (either directly or through referral) MAT from any publicly-funded SUD treatment provider site throughout the County, regardless of the level of SUD care (e.g., outpatient vs. intensive outpatient vs. residential vs. withdrawal management vs. inpatient vs. Opioid Treatment Program).

OBJECTIVES:

- Using a learning network collaborative approach, SAPC providers will implement one of two treatment models
- Engage and foster innovation at the local level to fine-tune rollout of the model chosen
- Improve access to standard of care for alcohol and drug addiction, improve public health and reduce mortality

System Level Implementation Team

Name	
Amy McIlvaine, CIBHS	PD, Coach
Charlotte Bullen, CIBHS	Coach
Eric Haram	SME-MAINE, Coach
Rod Libbey	Consultant/Coach
Liz Stanley Salazar	Consultant/Coach
Melissa Rodriguez, CIBHS	Project Coordinator
Samantha Spangler, CIBHS	Data, Evaluation
Dr. Mark McGovern	SME-Stanford University, IMAT SC

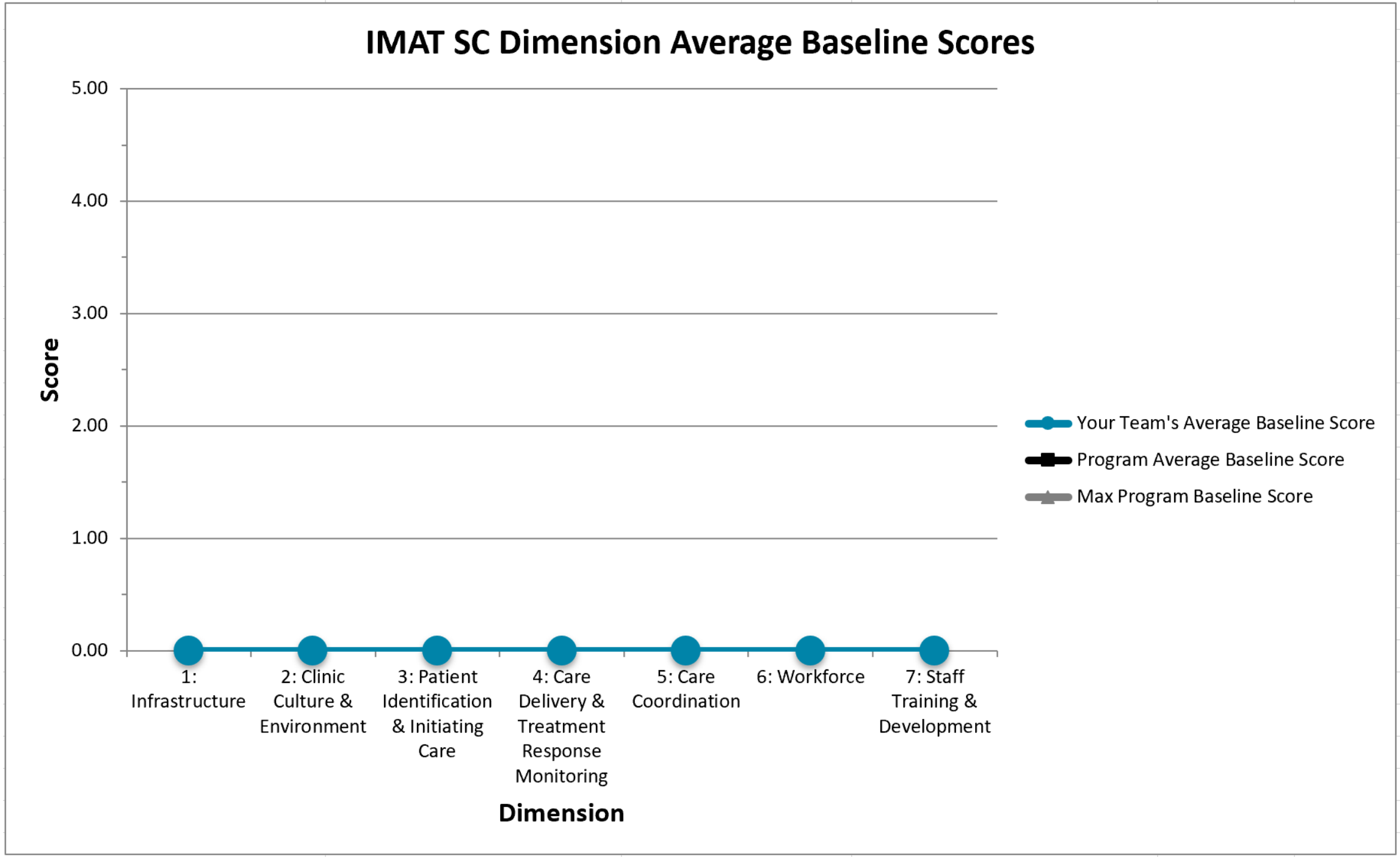
Peers, Prescribers, Community Partners, Primary Care, Providers in other states …….

Phase 2

Orientation and Readiness

October- November

- Secure Leadership Buy-In (Mission Fit and Business Case)
- Elect Model (1-Direct, 2-Linked)
- Staff and Organizational Readiness
- Complete Integration of Medications for Addiction in Specialty Care (IMAT-SC) Analysis and Assessment


IMAT SC Dimension Average Baseline Scores
5.00
4.00
3.00
2.00
1.00
0.00
Score
1: Infrastructure
2: Clinic Culture & Environment
3: Patient Identification & Initiating Care
4: Care Delivery & Treatment Response Monitoring
5: Care Coordination
6: Workforce
7: Staff Training & Development
Dimension
Your Team's Average Baseline Score
Program Average Baseline Score
Max Program Baseline Score

Phase 3

Training and Support – 5 months

- Resources, Coaching, “Meet Ups”, Peer Networking,

Approximate timeframe: 4-6 months

Attend the Kick off on November 12

- Schedule Site Visit with your MAT coach
- Develop Charter/Workplan

On-site custom staff training and orientation

- Identify training and support that your agency would benefit from.

Participate in support activities that will help you improve your MAT implementation practices.

Phase 4 Sustainability and Spread

Determined by agency

- If needed, ongoing coaching calls
- Improve MAT capability and/or capacity
- Develop a new Charter/Workplan

- Round 2

What is in it for you?

- Improve patient outcomes
- Business case
- Meet county and state contract requirements
- Simplify Implementation

Business Case

Came from IOP into OP	**12**						
	No. of Hours/Week	No. of Units per Week	Service (weeks)	Units/Group Session	Projected total Units	Interim Rates	Total Revenue
OP - Individual Services *	1	4	12	n/a	576	$36.38	$20955
OP - Group Services	4	16	12	12	2304	$33.68	$77598.7
Case Management	1	4	12	n/a	576	$36.82	$21208.3
	6	**24**	**36**		**3456**		**$119,761.92**
IOP	**12**						
	No. of Hours/Week	No. of Units per Week	Service (weeks)	Units/Group Session	Projected total Units	Interim Rates	Total Revenue
IOP - Individual Services *	1	4	8	n/a	384	$36.38	$13969.92
IOP - Group Services	9	36	8	12	3456	$36.38	$125729.28
Case Management	1	4	8	n/a	384	$36.82	$14138.9
	11	**44**	**24**		**4224**		**$153,838.08**
MAT Pro Services	**12**						
IMS	No. of Hours/Week	No. of Units per Week	Service (weeks)	Units/Group Session	Projected total Units	Interim Rates	Total Revenue
Inductions	1	4	1	n/a	48	78.95	$3789.60
Office Visits Weekly	0.25	1	12	n/a	144	78.95	$11368.80
Office Visits BiMonthly	0.25	0.5	12	n/a	72	78.95	$5684.40
Office Visits Monthly	0.25	0.25	26	n/a	78	78.95	$6158.10
	1.75	**5.75**			**342**		**$ 27,000.90**

Toolkit Content Overview

- Learning Collaborative Support Materials- LA specific guidelines, Improve/develop: patient and work flows, develop diversion/mitigation plans.
- Policies and Procedure guidelines and templates to meet county, state and National Accreditation standards.
- Hardcopy, thumb drive with resources
- Webinars, in-person training, custom content by program and region.

Accelerate and simplify sharing of innovation, success and adaptation

Next Steps

- **Today**
  - Sign up - 2-3 staff, who will attend the Network Kick off https://www.cibhs.org/pod/register-here.
  - Registration ends Wednesday, November 6.

- **ASAP**
  - Listen to the Webinar Orientation on how to complete the IMAT-SC
  - Staff fill out the IMAT SC assessment

- **Attend the Kick off on Tuesday, November 12**
- If you miss the kick off, attend a webinar and watch for updates regarding sign up for Round 2.

INCORPORATING **CLAS** INTO DAY-TO-DAY OPERATIONS

Benefits of your participation in this unique opportunity:

- Be provided with your individually assigned CIBHS staff.
- Individualized self-directed assistance in identifying the best CLAS plan for your agency.
- Receive assistance with developing quality actionable Policy and Procedures.
- Receive guidance on identifying threshold languages and disability services needed at each facility.
- Receive resources and training on recruitment, and retention of dedicated certified bilingual staff.

What's Next?

Though self-directed, SAPC-contracted providers **MUST** at least engage in the following:

- Meet with your assigned CIBHS staff at least once to discuss the development and implementation of your organization's CLAS plan.
- Staff attendance at a minimum of one illicit bias and/or CLAS training
- Completion of an agency wide CLAS plan to improve equitable access to SUD treatment services.

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1. Share a picture of this logo with your team, communicate what is coming.
2. Assign staff to take point for the project.
3. WATCH AND LISTEN - Schedule an introductory call with your CIBHS staff person to discuss your agency's development and implementation plan.
4. Design and develop quality actionable policies and plans to improve access and engagement for people seeking services.